René van Leeuwen

Towards nursing competencies in spiritual care

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"Mitch. Can I tell you something?"

Of course, I said.

"You might not like it."

Why not?"

"Well, the truth is, if you really listen to that bird on your shoulder, *if you accept that you can die at any time* - then you might not be as ambitious as you are."
"You might have to make room for some more spiritual things."

Spiritual things?

"You hate that word, don't you? 'Spiritual.' You think it's touchy-feely stuff."

Well, I said.

"Mitch," he said, laughing along, "even I don't know what 'spiritual development' really means. But I do know we're deficient in some way. We are too involved in materialistic things, and they don't satisfy us. The loving relationships we have, the universe around us, we take these things for granted."
He nodded toward the window. "You see that?" You can go out there, outside, anytime. I can't do that. I can't go out. I can't run. I can't be out here without fear of getting sick. But you know what? I appreciate that window more than you do."

Appreciate it?

"Yes, I look out that window every day. I notice the change in the trees, how strong the wind is blowing. It's as if I can see time actually passing through that window-pane. Because I know my time is almost done, I am drawn to nature like I'm seeing it for the first time.

Mitch Albom, *Tuesdays with Morrie*, 1997

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Chapter 1

General introduction and outline

General introduction and outline

Holistic nursing

As a nursing student I was taught to provide client-centred, so-called holistic nursing care to patients, and now as a lecturer I teach it to my own students. Taking a holistic approach means that all aspects of human functioning should be considered in assessing the individual patient's needs and in planning nursing care for that patient. Someone admitted to hospital for open heart surgery, for instance, has health needs that are not restricted to the functioning of physical aspects. The patient may also have psychosocial problems or needs that may threaten the status of his or her health, for example, fear of the operation, or a stressful relationship with relatives. To maintain or enhance the health status of that patient nurses should pay attention to all the relevant aspects of the patient's functioning. This holistic and health-related approach is emphasized in nursing models (Fawcett, 1995). Studies have also made clear that the health problems and needs of patients are related to many different aspects of human functioning (NANDA, 2007).

The holistic approach includes attention to the spiritual functioning of patients, because that may also affect a patient's wellbeing. Professional nursing organizations such as the International Council of Nurses and the Dutch Nursing Organization emphasize that nurses should pay attention to the spiritual aspects of nursing care (ICN, 2007; Leistra et al. 1999). Patients who undergo open heart surgery may fear dying or may be worried about whether they will recover and what life will be like if full recovery is not possible. Patients may be religious and may need to talk to or to pray with a pastor to help them cope with this life-threatening situation.

Spiritual care as an under-utilized aspect of nursing care

Attention to the spiritual element of human functioning within nursing has been emphasized and demonstrated in different nursing studies, but the lack of it has also been observed (McSherry, 2006; Ross, 2006). Narayanasamy (2001) states that the spiritual aspect of human beings receives little attention in nursing and that spirituality is an under-utilized aspect of care. In his opinion, carers must become more aware of the impact of spirituality on a patient's life and become more skilled in providing that care. McSherry (2006) states that the preoccupation with

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technological and material developments in society and within health care has replaced the notion of holistic and individualized care. On the other hand, he also observes a refocusing on the spiritual dimension within health care and within society as a whole. This renewed attention to spirituality is also recognizable in Dutch society, where spiritual matters are more openly discussed and expressed than in the recent past (Van de Donk et al. 2006; Bernts et al. 2007). McSherry (2006) identifies barriers that hinder the provision of spiritual care in nursing, namely, barriers within the economic and environmental context (e.g. time, staffing, organization), in the health care professional (lack of knowledge or skills, too sensitive or emotional) and in the patient (too sensitive or emotional).

Some Dutch studies also clearly point to the absence of systematic attention to the spiritual aspect of patient functioning in the nursing process. Prins (1995) concludes that hospital nurses insufficiently assess the spiritual needs of patients. In their analysis of the nursing reports of 153 hospital patients, Achterberg & Coenen (2000) relate that no problems or needs were formulated regarding the spiritual functioning of those patients. They conclude that nurses cannot recognize those kinds of needs and problems, or that they have been unable to translate them into the nursing reports. In a study of community health in the Netherlands, Tiesinga (2006) reports that the main barriers to the delivery of spiritual care are a lack of time to provide that care and a lack of knowledge and skills. Other main factors include the fact that spirituality is not given priority within health care and that health care professionals consider spirituality as a private issue for the patient. Tiesinga & Post (2003) confirm this and in their discussion of spiritual care in nursing they conclude that this matter should be given more systematic attention within the nursing process. They also state that the interest that is found is too free of obligation.

Considering these aspects, one may conclude that spiritual care in nursing is deemed important and relevant, but it lacks systematic attention due to various factors. One of these factors is that nurses are not well prepared for their spiritual care role. A number of authors emphasize the importance of this educational gap (Highfield et al. 2000; McSherry, 2006). Ross (2006) concludes that more attention should be paid to research within the area of education to gain more insight into its effects. What should be taught and how should it be taught? In other words, which

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competencies do nurses need to provide spiritual care? What educational methods are effective in developing those competencies? As a nursing lecturer I was very interested in finding answers to these questions. The observations mentioned above motivated me to start this study with the intention of contributing to a systematic embedding of spiritual care into nursing care and education.

Spirituality and health

The World Health Organization (WHO) defined health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' (WHO, 1992). Since its introduction the definition has been under discussion, one of the issues being the question of whether the spiritual domain should be added to it (Blok, 2004). The original definition has not changed as yet, but the debate continues. Other developments within WHO indicate that spirituality is indeed a health-related factor. WHO emphasizes the importance of attention to human activities in the area of spirituality in its International Classification of Functioning and also states that palliative care encompasses the spiritual aspects of patient care (WHO, 2001, 2007). The WHO Department of Mental Health recognizes aspects related to spirituality, religion and personal beliefs as aspects of the quality of life (WHO, 2002). From the perspective of health policy, spirituality and spiritual care seem relevant, which implies a relationship between spirituality and health and wellbeing. This notion is supported by studies regarding the relationships between spirituality, health and health care (Koenig, 2001; Ross, 2006). These studies show that research is being done among many different kinds of patient populations in physical, mental, chronic and palliative health care settings. This demonstrates the broad relevance of this subject to health and health care in general.

Growing attention to spirituality is also observable in the Dutch health care system. For a number of years specific studies have been published about the relationship between spirituality, religion and mental illness (Braam, 1997; Schreurs, 2001). These studies focus on the impact of religion on mental wellbeing and the attention it receives in treatment and therapy sessions. Studies in palliative care have also revealed the relevance and importance of spirituality (Jochemsen et al. 2002; Kuin et al. 2006).

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With regard to the results of studies on the connection between spirituality and health, it seems evident that aspects of spirituality can be important to patients being treated for various illnesses or receiving terminal palliative care. However, there seems to be a lack of research in the field of somatic health care within the context of Dutch healthcare. Hence the focus of this thesis will be on that sector of health care. The second chapter will explore the connection between spirituality and physical health. Considering the number of relevant studies being published in mainly medical and nursing journals, the impact of spirituality on health and health care cannot be ignored by health care professionals. The results of these studies can provide insight into the importance of spirituality to patients. That insight is fundamental to assess whether patients should be given spiritual care.

Spirituality and health care

Acknowledging the connection between spirituality and health implies that health care professionals should attend to spirituality in the care they provide to patients. Waaijman (2002) notes that interest in spiritual issues in today's health care sector is growing from two perspectives. Firstly, from the perspective of the patient: the patients must not be identified with their illness, people should not be medicalized, isolated, eliminated from or exploited by the treatment of their illness, their personal integrity should be respected. This is also stressed in recent Dutch studies on charitable care (Van Heijst, 2006) and presence in care (Baart, 2005) which provides a person-centred approach to health care.

Secondly, from the perspective of care: the spiritual life of the patient must be an explicit part of health care, nurses must be competently trained to address a patient's spiritual needs. Waaijman (2005) argues that health care professionals should focus on a so-called primordial kind of spirituality which is related to ordinary processes of human life such as birth, corporality, primary relationships and the course of life. The first notion refers strongly to a holistic view of nursing that was referred to at the beginning of this introduction. The second notion implies also taking care of the patient's spirituality.

Medical and nursing perspectives also emphasize that with respect to the spirituality of patients, interaction within the health care system should not be restricted to pastors, imams or hospital chaplains. Many authors have stated that

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other health care professionals, particularly physicians and nurses, should also be involved (Koenig, 2002; Puchalski, 2006; Steven Barnum, 1996; O'Brien, 1999; Steemers van Winkoop, 2001; Narayanasamy, 2001; Johnston Taylor, 2002; McSherry, 2006). Many of these authors also state that the integration of spirituality and health care is not common today and still depends largely on the attitude of the individual health care worker.

It should also be noted, however, that the issue of spirituality and health care is still under critical debate. This ongoing debate places emphasis on what might be expected from doctors and nurses (Koenig, 2002; Baldacchino, 2006). Should they assess a patient's spiritual needs and then refer the patient to a pastor, an imam or hospital chaplain, or should they provide some kind of spiritual care themselves? Tiesinga & Post (2003) wonder how the issue can be put on the health care agenda and how it can be freed from the idea that matters of meaning and purpose should be private and not for public discussion. The authors are also of the opinion that in times of growing individualization, rationalization, technical development and emphasis on legal aspects in health care, health care professionals should pay attention to spiritual aspects of care. However, they note the confusion about what might be expected from those professionals, questions about who is responsible for providing spiritual care and where the limitations are of that responsibility. Sloan (2006) criticizes the role of doctors when he states that doctors should always refer patients with spiritual needs or problems to a specialist (e.g. a pastor). In his view, a doctor is not a specialist in spiritual matters and could even harm the patient when attempting to address those needs or problems. Clearly the issue is controversial. In this thesis I explore the particular role of nurses in providing spiritual care.

Spirituality: conceptual framework

The concept of spirituality provokes different associations. It can be linked to religions, but there are also many non-religious forms of spirituality. It relates to all kinds of beliefs and world-views. This is illustrated by the 25th edition of World Spirituality, An Encyclopedic History of the Religious Quest (Cousins, 1985), a reference work on all kinds of religious and non-religious forms of spirituality including those occurring in Western society. Recent research in the Netherlands (van de Donk et al. 2006; Bernts et al. 2007) shows that people are tending towards

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more non-religious forms of spirituality. This is expressed in statements such as 'I think you should experience the truth inside yourself' or 'religion is something particularly personal for me and not something I would share in a group or community'. A general characteristic of today's spirituality might be that it expresses a person's individual belief system, which can be religious or non-religious. However, spirituality should not be completely uncoupled from established religions, because for many people their spirituality is related to their religion (Waaijman, 2002).

Spirituality must be characterized by its multidimensionality, which is important to finding a unifying definition of the concept. Within the context of this thesis it is important to clarify its meaning as a conceptual point of reference. McSherry et al. (2004) conclude in their systematic review of the nursing literature that many definitions are used within nursing, that they have different layers or meanings, and that spirituality can imply different things depending upon an individual's personal interpretation or world-view. They also conclude that spirituality is a concept whose meaning is highly individualized and dependent on the value an individual attaches to it. They recommend the use of a spiritual taxonomy that contains all the different meanings of the concept of spirituality.

In line with this view, a distinction can be made between two approaches to the concept of spirituality, namely a functional and substantial approach (Van de Donk et al. 2006). In the functional approach, spirituality is interpreted in terms of the function it has for the individual (e.g. patients) as well as in society at large (Jochemsen et al. 2002, Bouwer, 2004). This approach implies that every person is, in a sense, spiritual, but people differ with respect to the content of their spirituality. Contrary to the functional approach, the substantial approach formulates spirituality in terms of certain views, experiences or traditions, especially those with a specific common meaning and structure. Christian spirituality differs in this way from a humanistic form of spirituality, and within Christian and humanistic spiritualities different forms of these substantial spiritualities can be recognized. This substantial approach of spirituality is expressed in the Encyclopedia of Spirituality (Cousins, 1985) and is similar to the approach in nursing described by McSherry (2006).
Both approaches are useful in nursing. On the one hand, nurses should realize that each patient has a spiritual dimension with a personal content, which becomes

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apparent in specific personal needs, rituals and behaviour. As such, nurses should understand spirituality from the functional perspective. At the same time, individual patients may belong to a certain group or community with specific spiritual needs, rituals and behaviour. For example, Muslim patients express, to a certain degree, common needs and behaviours. Alternatively, patients show a more personal kind of spirituality that is unrelated to any other institutionalized form, such as a strong affinity with nature. Clearly, nurses should understand spirituality from the more substantial perspective as well. Hence, these two approaches are complementary in care practices.

The functional approach to spirituality is followed to in this thesis. This choice emphasizes the view that spirituality is an aspect of human functioning in addition to the physical, the psychological and the social aspects. This approach accords with the previously mentioned integral vision of human functioning implicit in the concept of holism. It also fits nursing models which make spirituality explicit (Neuman, 2002; Watson, 1998; Newman, 1994; Parse, 1995). Neuman (2002), for example, states that every person is spiritual in some way (consciously or unconsciously) and that spiritual needs or problems can arise during illness and its treatment. This functional approach includes all patients. The substantial definition does not include all patients in general as it entails opting for a particular spirituality which necessarily excludes some patients. The following definition of functional spirituality is used in this thesis: 'The religious and/or existential mode of human functioning, including experiences and questions of meaning and purpose' (Jochemsen et al. 2002, p. 6). This definition encompasses both religious and non-religious forms of spirituality.

Spiritual care in nursing

Because of the connection between health and spirituality, nurses should attend to spirituality in the care they provide to patients. This care can be conceptualized as spiritual care. Within the scope of this thesis it is important to make clear what is meant by the concept of spiritual care. Spiritual care is understood as the care nurses provide so as to meet the spiritual needs and/or problems of their patients. Some authors state that the care nurses provide is spiritual in itself (Bradshaw, 1994). This position holds that the nurse develops (or possesses) the kind of character that embodies the virtues and values of patience, kindness, compassion,

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unselfishness, loyalty, conscience and honesty. This view of nursing is close to the opinion that nursing is a vocation, an opinion which must be seen as a result of the religious roots of nursing. According to McSherry (2000), changes in society, especially through the processes of secularization, individualization and professionalization have resulted in nurses entering the profession not out of a vocation but because of a desire to have a career and to earn a secure income. According to this view, nursing care is no longer intrinsically a spiritual affair, which would assure that attention is paid also to the spirituality of patients. Attending to patients' spiritual needs and care should thus be made a more explicit component of professional nursing.

The basic assumption in this thesis is that spiritual care is a part of the professional function of nurses and thus it is their task to care to some extent for the spiritual needs and problems of patients. This assumption is supported by professional nursing organizations (ICN, 2006). The Dutch Professional Profile of Nursing states that nursing care presupposes a holistic perspective that includes physical, mental, social and spiritual aspects of human functioning (Leistra at al. 1999). The profile also states that in the future, questions of meaning and purpose will take a more prominent place in nursing-care practices, similar to questions about patient autonomy, insecurity, neglect, despair and suffering. The Nursing Code of Ethics (ICN, 2006) declares that the nurse should provide care to the patient as far as possible according to the cultural and spiritual identity of the patient.

According to these general statements one might expect the tasks undertaken by nurses in practice to be clear in terms of spiritual care and the skills required for executing them. However, there seems to be a gap between what is expected of nurses in theory and what is actually practiced (McSherry, 2006; Ross, 2006; Tiesinga & Post, 2003). This raises questions about how the task of spiritual care in nursing can become clearer, and the level of expertise which should be expected from nurses. In this thesis the nurses' role in spiritual care will be further explored and described in terms of the competencies required to provide spiritual care.

Education in spiritual care

When it comes to the expertise nurses need to possess to provide spiritual care, it appears that health care professionals feel inadequately prepared. There thus

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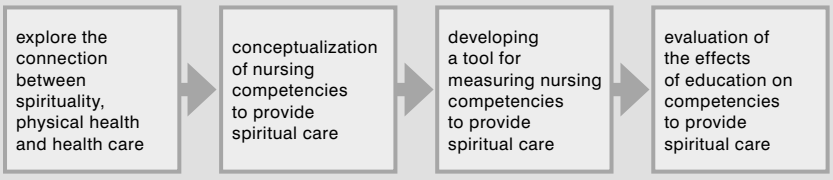
seems to be a role for nursing education. In a recent review of research on spiritual care in nursing, Ross (2006) states that there is much debate in the nursing literature about how, what and when spiritual care should be taught to nurses. According to the studies she investigated, it appears that nurses receive little education in the spiritual dimension of care. The hypothesis is that by obtaining a more structured form of education nurses will become more competent in providing spiritual care. The evidence to support this hypothesis is still limited. This thesis will contribute to this aspect of the discussion about spiritual care in nursing by exploring the content of spirituality and spiritual care in nursing education and by investigating the learning effects of a certain education received by a group of nursing students (see Chapters 7 and 8).

The scope of this thesis and the research model

This thesis examines the relationship between spirituality and health and the nurses' role in providing care for the spiritual needs and problems of patients, the competencies required to provide that care and the effects of spiritual care education on the competencies of nursing students. The first step will be to explore the relationship between spirituality, health and health care from a Dutch health care perspective, specifically from the perspective of the disciplines of oncology, cardiology and neurology. The following step will be to conceptualize the competencies required by nurses to provide spiritual care to patients and to develop an assessment tool to enable the measurement of those competencies. The final step will be to investigate the effect of education on the development of those competencies and to evaluate the hypothesis that education is an important predictor of the ability to provide spiritual care (see figure 1).

Figure 1 From exploration through conceptualization and operationalization to evaluation



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This model results in the following research questions:

1. How has the connection between spirituality and physical health been investigated and what are the results of that investigation?
2. What role does spirituality play in patients during physical illness and treatment?
3. What competencies do nurses need to provide spiritual care?
4. How do nurses handle spiritual aspects in health care practice and can nursing competencies for spiritual be identified in their conduct?
5. How can nursing competencies regarding the delivery of spiritual care be assessed?
6. What are the effects of a newly developed educational programme for student nurses on the development of their competencies in spiritual care?
7. What are the learning effects of the educational method of thematic peer review on the development of competencies for spiritual care provision?

This study uses qualitative and quantitative research methods. For the exploration of the experience of spirituality and spiritual care a qualitative approach was appropriate. For the assessment of the development of competencies and the effects of an educational method, quantitative and qualitative methods were applied. In this integrative approach both methods are seen as complementary, which enhances insight into the phenomenon of spirituality and spiritual care in nursing and contributes to the validity of this research (Polit & Hungler, 1997).

Outline of the thesis

Chapter 1 provides a general introduction.

Chapter 2 describes the connection between spirituality and physical illness. It reports the outcome of a systematic review of studies on this subject published from 1992 to 2002 in the international medical and nursing literature. It analyses the conceptual and methodological aspects of that research and gives recommendations for future research in this area.

Chapter 3 focuses on the relationship between spirituality and health. It describes the results of an explorative study of the spiritual aspects of illness within the context of the Dutch health care system. For this purpose patients, nurses and hospital chaplains within the fields of oncology, neurology and cardiology were interviewed in focus groups. From the analysis of the interviews, spiritual themes

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have emerged that seem relevant to patients in terms of illness and treatment of their illness, as well as during the process of dying.

Chapter 4 contains the results of an extensive review of international literature concerning the tasks, or competencies, that nurses need to deliver spiritual care. This review results in the description of a competence profile identifying six nursing competencies in the area of spiritual care with reference to the nurses' self handling (in chapter 4 mentioned as use of self), attention to spiritual care in the nursing process and attention to spiritual care in quality assurance and policymaking within the healthcare institution.

Chapter 5 describes the results of focus group interviews with patients, nurses and hospital chaplains in oncology, neurology and cardiology regarding the care nurses deliver according to the spiritual needs and problems of the patients. This chapter gives an indication of nursing practice in this area. Aspects of nursing competencies derived from the theory (Chapter 4) can be recognized in practice, but it also becomes clear that spiritual nursing care does not seem to have a systematic place within that practice. Factors possibly related to that conclusion also become apparent in the interviews.

Chapter 6 deals with the development of the Spiritual Care Competence Scale (SCCS), a tool to measure nursing competencies in providing spiritual care. The competencies described in Chapter 4 were used as the items of the tool. In this chapter the psychometric quality of this tool is evaluated, resulting in a valid and reliable tool containing six dimensions of competencies concerned with spiritual care, which are able to be used at a group level in nursing and educational practice.

Chapter 7 describes the effects of a course in spiritual care given to a group of nursing students from two nursing schools in the Netherlands, with respect to the development of their competencies in providing spiritual care. The quantitative approach of the study employed a statistical analysis of the students' self-assessments on the Spiritual Care Competence Scale (SCCS). In addition, it analysed the teachers' scores of student analysis of the vignettes. The study shows the effects on the development of student competencies to provide spiritual care.

Chapter 8 describes the qualitative effects of the course in spiritual care on the development of students' competencies. For this purpose student reports from reflective group sessions were qualitatively analysed and different themes emerged from that analysis regarding the content of the reflective group sessions and their learning effects.

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Chapter 9 discusses the results of the different studies, with a special focus on the impact of education on the development of nursing competencies for the delivery of spiritual care.

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Chapter 2

The connection between spirituality and health in physical healthcare: an analysis of medical and nursing-related studies

R.R. van Leeuwen, L.J. Tiesinga, H. Jochemsen, D.Post (2004)

Tijdschrift voor Gezondheidswetenschappen, 82 (5), 307-316

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Abstract

This article outlines the results of a systematic analysis of 31 medical and nursing-related studies concerning the cohesion and relationship between spirituality and health in the physical healthcare sector. The studies were analysed on the basis of thesis focus, type of research, population, sample size, operationalization of spirituality and research results. The analysis shows that medical studies are primarily aimed at revealing a significant relationship between spirituality and health, whereas healthcare studies are aimed at describing patient convictions, experiences and needs as regards healthcare. The results of the analysed studies are presented according to a number of main themes, but fail to show unique cohesion between spirituality and health. Positive, negative or no cohesion may be concluded as a result. Mutual comparison of the studies is difficult due to methodological differences. A particular problem is the operationalization of the concept of spirituality, which varies from specific religious experience to personal attitude. It is imperative that follow-up research is based on the primary issue of spirituality, so that a valid operationalization of the concept of spirituality can be separated from the concept of religion.

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Introduction

Attention has been directed at spirituality as a theme and in its connection with health and healthcare in recent scientific contributions to Dutch medical and healthcare literature (Tiesinga & Post 2003, Tiesinga et al. 2002). These contributions are reflective in nature and reveal different aspects to this theme. The issue of what spirituality entails has been considered and it is noted that there is a lack of conceptual clarity. To place the theme within the framework of this article, we seek to position spirituality in the context of the ethical and religious functioning of human beings, including questions regarding the meaning of life and of meaningfulness (Jochemsen et al. 2002). The contributions referred to above also describe the roles of doctors and nurses and the competencies they need for spiritual care provision to patients, including a clearly defined task description for the spiritual care provider. The authors unanimously agree that patients do require spiritual attention in care provision in one way or another.

The abovementioned contributions and similar foreign publications (Koenig et al. 2001, McSherry & Cash, 2000, Narayanasamy, 2001) also focus on scientific research concerning spirituality in relation to health and healthcare and the methodological implications thereof. This study presupposes a connection between patient spirituality, patient functioning and possibly their health, and this assumption in turn drives our analysis of scientific studies of the relationship between spirituality and health. The aim is to describe how such studies measure the connection between spirituality and physical health, what conclusions may be drawn from these studies and what can be obtained from this for follow-up research.

The following questions form the basis of this study:
– what are the hypotheses ventured in medical and healthcare studies on the relationship between spirituality and health?
– which types of research are employed?
– how is spirituality operationalized in these studies?
– what are the results of these studies?

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Method

This investigation consists of a systematic analysis of scientific studies concerning the cohesion between spirituality and health. A literature search was carried out using Medline, Cinahl, Picarta and Invert. The following terms were used in the search - spiritualiteit (spirituality), spirituele behoeften (spiritual needs), religie (religion), religieuze behoeften (religious needs), lichamelijke aandoeningen (physical disorders), curatieve zorg (curative care), ziekenhuis (hospital), huisarts (general practitioner), gezondheid (health), kwaliteit van leven (quality of life), welzijn (wellbeing).

The literature search returned 122 results, 31 of which were chosen on the following inclusion criteria:
– publication in a scientific medical or nursing-related journal between 1990–2002
– concerned with curable patients between 18 and 85 years of age
– concerned the relationship between spirituality and physical health
– accountable methodologically as regards its central question, research design, results and recommendations

After initial study, the articles were systematically described using the following guidelines – article title and authors, central question focus, sample size, research type, operationalization of spirituality and research results.

Results

The results of this exploratory study are systematically represented in Table 1.

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Table 1 medical and nursing-related studies about the connection between spirituality and health in physical healthcare

author(s) year and country of publication	central question focus	N	research type	operationalization of spirituality	results
Reynolds & Kaplan 1990, United States	association between social contacts and cancer incidence	6848	medical, quantitative, cohort, correlational	medical, church membership, church attendance	association between the religious variables and cancer incidence is not shown
Saudia et al. 1991, United States	relationship between health locus of control and prayer as a coping mechanism prior to heart surgery	100	medical, quantitative, cross-sectional, correlational	prayer, Helpfulness of Prayer Scale	96 patients indicated having used prayer in coping with preoperative stress. Within this group, 70 patients showed maximum scores on the Helpfulness of Prayer Scale. Results did not reveal a relationship between the helpfulness of prayer and the measure of locus of control. The patient does perceive prayer to be helpful as a coping mechanism
Goldbourt et al. 1993, Israel	predictive factors for long-term mortality as a consequence of coronary heart-failure	10059	medical, quantitative, cohort, correlational	religious/secular education, self-definition of religion, synagogue attendance	mortality was 20% lower among orthodox believers
King & Bushwick 1994, United States	convictions and attitudes of hospital patients regarding faith, healing and prayer	203	cross-sectional, descriptive	religious preferences, faith, frequency of church attendance, experience, function of prayer, confidence in recovery	77% – doctors should take spiritual needs into account 37% – doctors should discuss faith/religion 48% – doctors should be prepared to pray with patients 68% – doctors never talked about faith/religion

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author(s) year and country of publication	central question focus	N	research type	operationalization of spirituality	results
Roberts et al. 1997, United States	influential factors on the conceptions of patients with gynaecological cancer concerning end-of-life decisions	147	medical, quantitative, cross-sectional, descriptive	influence of religion in coping with disease, sustaining a feeling of self-worth and maintaining hope	religion is important in life for 76% of subjects where 49% indicate an increase in religiosity since the onset of disease. 0% indicate a decline in religiosity. 93% believe that religiosity sustains hope. 41% feel that religiosity supports feelings of self-worth. 17% indicate that religiosity provides meaning to suffering
Matthews et al. 1998, United States	the relationship between religious involvement and prevention of disease, coping with disease and recovery	nn	medical, review	included are studies that use measurements of religious commitment such as frequency of church attendance, religious involvement, support from personal religious beliefs	religious involvement appears to be a factor that plays a role in disease prevention (depression, addiction and physical disorders), longevity, effective coping with disease and the furtherance of recovery. Research outcomes remain limited and sometimes contradictory. Results are promising and require further investigation. Enquire into the significance of religion using an anamnesis form; direct patients to religious activities which promote health
Mc Bride et al. 1998, United States	the relationship between patients' general health perception, physical pain and intrinsic spirituality	442	medical, quantitative, cross-sectional, correlational	INSPIRIT (questionnaire concerning intrinsic spirituality)	low positive correlation between spirituality and general health (r 0.18, $p<0.001$) No correlation with pain. Differences in health are greatest between the group with low spirituality and groups with intermediate or high levels of spirituality

author(s) year and country	central question focus	N	research type	operationalization of spirituality	results

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author(s) year and country of publication	central question focus	N	research type	operationalization of spirituality	results
Kaldjan et al. 1998, United States	the role of spiritual convictions of HIV patients in end-of-life decisions	90	medical, quantitative, cross-sectional	will to live, fear of dying, declaration of hope and meaningfulness, religious feelings and practices, feelings of guilt regarding HIV infection and perceiving HIV as a punishment	patients who believe in God's forgiveness were more open to discussing resuscitation status than patients who regarded HIV as a punishment (p=0.043 and p=0.009 respectively). Patients who pray show a greater will to live (p=0.025) and find faith helps when thinking about death (p=0.065). The fear of death is greater when accompanied by feelings of guilt and punishment concerning HIV (resp. p=0.01 and p=0.039), and less among those undertaking religious activities (Bible reading (p=0.01) or attending religious gatherings (p=0.015)
Woods et al. 1999, United States	the relationship between religiosity and the affective and immune status of HIV-seropositive homosexual men	106	medical, quantitative, cross-sectional	religious coping (trust in God, consolation), religious behaviour (prayer, attendance of meetings, reading religious material and conversations about spirituality)	a positive association between religious coping and lower scores on depression (p=0.01). There is no association with immune status. Religious behaviour was positively associated with more T-helper cells (p=0.01). Regression analysis shows that associations of religious measures are not influenced by a measure of self-efficacy and coping
Ehman et al. 1999, United States	the influence of spiritual or religious views on medical decisions of patients when they become seriously ill	177	medical, quantitative, cross-sectional, descriptive	general questions concerning religiosity, the influence of spiritual/ religious sentiments on medical decisions and on whether doctors should enquire into these sentiments	90% believe prayer to occasionally influence recovery from disease, 45% claim that these spiritual or religious views will influence their decisions regarding serious illness and 94% think doctors should enquire into such views when patients become seriously ill

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author(s) year and country of publication	central question focus	N	research type	operationalization of spirituality	results
Mc Coll et al. 2000, Canada	change in spiritual views following post-traumatic handicap	16	medical, qualitative, open-interview	5 spiritual themes – self-consciousness, security, trust/hope, purpose in life and vulnerability	7 participants (n=16) indicated a change in spirituality shortly after the onset of their handicap. 2 experienced both gain and loss, 5 experienced gain. The loss/ gain concerned awareness, closeness to others, trust, meaningfulness and vulnerability
Simmons et al. 2000, United States	correlation between spiritual and/or religious factors on quality of life in ALS patients	96	medical, quantitative, cross-sectional, correlational	the Idler index of Religiosity (public and private religiosity)	positive correlation between quality of life and religiosity/spirituality (p=0.001)
Murphy et al. 2000, United States	effect of religiosity and spirituality on the use of medical technology and attitudes with respect to the process of dying	46	medical, quantitative, cross-sectional	Fetzer indicators of spirituality and religiousness – religious behaviour, religious coping, daily spiritual practice, convictions and values	spirituality/religion influences choices regarding medical techniques and helps patients cope with the process of dying
Schnoll et al. 2000, United States	relationship between demographic disease variables, spirituality and psychosocial adaptation in cancer patients	83	medical, quantitative, cross-sectional	the purpose of life test (measure of meaningfulness), Spiritual Well-being scale, SWBS (religious wellbeing and spiritual wellbeing	Descriptors: Female (Beta 0.25 – p<.05), shorter disease duration (Beta 0.18 – p<.05) and shorter level lower stadium disease (cancer) (Beta 0.26 - p<.05) is associated with higher levels of spirituality, which is an inverse predictor for a higher level of psychosocial adaptation (Beta 0.80 – p<.05)

author(s) year and country	central question focus	N	research type	operationalization of spirituality	results

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author(s) year and country of publication	central question focus	N	research type	operationalization of spirituality	results
Mueller et al. 2001, United States	association between religious involvement & spirituality and physical health, mental health quality of life and other health effects	350 studies	medical, review	selection of studies in which validated measures were used to determine religious involvement and spirituality, and where statistical significance was tested	the majority of studies show a valid association between religion and/or spirituality and positive health effects regardless of research design and research populations (very diverse). Recent studies in particular show this association after correction for possible confounders. It is concluded that a causal link between religious involvement and/ or spirituality and health effects is difficult to reveal.
Koenig et al. 2001, United States	the role of religion in coping with serious illness (coping)	nn	medical, non-systematic review	religious involvement	in serious cases, patients revert to religion (coping mechanism, control, hope and meaningfulness). Religious involvement of patients leads more often to psychological growth than to defeat or being overpowered by the negative experiences that are a consequence of disease.
Sephton et al. 2001, United States	the relationship between spirituality and immune functioning in women with metastasized breast cancer	112	medical, quantitative, cross-sectional, correlational	the importance of spiritual/religious expression and the frequency of attendance at religious gatherings	women with high 'spiritual expression' scores showed higher absolute values of white blood cells and lymphocytes. There is a positive relationship between the frequency of attendance at religious gatherings and the number of T-helper cells (range correlation coefficients 0.16 - 0.24)
Tate & Forchheimer 2002, United States	differences in quality of life, life satisfaction and spirituality between rehabilitation and cancer patients	208	medical, quantitative, cross-sectional, correlational	The Functional Assessment of Cancer Therapy-Spiritual (FACT-SP) spiritual wellbeing	association between spirituality, life satisfaction and quality of life (r 0.16 - p<.02). Spirituality is a significant predictor of life satisfaction among rehabilitation patients but not among cancer patients

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author(s) year and country of publication	central question focus	N	research type	operationalization of spirituality	results
Strawbridge et al. 1997, United States	long-term association between frequent attendance at religious meetings and mortality	5286	medical, quantitative, cross-sectional, cohort, correlational	frequent and infrequent church attendance	lower mortality among frequent church attendees (RR 0.64 – CI 0.53-0.77). The effect decreases with an increase in health and social contact, but remains significant (RR 0.77 – CI 0.64-0.93)
Emblen & Halstead 1993, United States	spiritual needs and interventions in surgical patients	38	healthcare, qualitative, cross-sectional, in-depth interviews	questions regarding spirituality and spiritual needs and experiences	spiritual needs are relevant to religious convictions and practices, values, relationships, transcendency, affections, communication and miscellaneous (e.g. questions, death or crisis)
Ferrell et al. 1998, United States	quality of life in women with breast cancer	21	healthcare, qualitative, cross-sectional, open in-depth interviews	not specified (open interview)	important spiritual themes with respect to quality of life – uncertainty and signs of hope, change in priorities, meaning-of-life, transcendence/life after death. Some women (breast cancer patients) indicate that spirituality is an unimportant aspect
Fryback & Reinert 1999, United States	experience of spirituality in individuals with a terminal diagnosis (HIV/AIDS)	15	healthcare, qualitative, cross-sectional, open in-depth interviews	not specified (open interview)	important concepts in experiencing spirituality – belief in a higher power, recognition of mortality, self-actualization, spirituality as a bridge between hopelessness and meaningfulness. Patients who assign meaning to their condition experience a higher quality of life compared to before falling ill
Fernsell et al. 1999, United States	relationship between spiritual wellbeing and the impact of illness in people with colon/ rectal cancer	121	healthcare, quantitative, cross-sectional, correlational	Spiritual Wellbeing Scale	significant negative correlation between spiritual wellbeing, existential wellbeing and aspects of the demands of illness (DOI). No significant relationships were identified between religious wellbeing and DOI

author(s) year and country	central question focus	N	research type	operationalization of spirituality	results

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					identified between religious wellbeing and DOI

author(s) year and country of publication	central question focus	N	research type	operationalization of spirituality	results
Sowell et al. 2000, United States	the role of spiritual activities in reducing the negative effects of disease-related stress factors in women with HIV	184	healthcare, quantitative, cross-sectional, correlational	spiritual conviction, spiritual activities	significant negative correlation between spiritual activities and emotional distress (r=-.212). Positive correlation between spiritual activities and quality of life (r=.229)
Baldacchino & Draper 2001, Great Britain	the use of spiritual coping strategies during illness	5	healthcare, review	spirituality is interpreted in terms of both religion (relationship with God) and non-religion (meaningfulness)	coping strategies (for believers and non-believers) – meditation/contemplation, relationships with others, hope of improvement, giving and receiving love, appreciating nature. Addition for believers – religion, relationship with God, prayer, church attendance
Chan et al. 2001, China	perception of social support in Chinese women with gynaecological cancer	18	healthcare, qualitative, cross-sectional, in-depth interviews	what is perceived as being supportive during illness	experiences of religious individuals – strong support from God, religion helps in coping with disease through acceptation of God's will or through the cause-consequence relationship in which they believe, feeling of inner peace and help in dealing with fear of both death and suffering, social support from members sharing the same religion, hope
Hermann 2001, United States	spirituality of the terminally ill/ dying and their spiritual needs	19	healthcare, qualitative, cross-sectional, in-depth interviews	what does the world mean to you in terms of spirituality? which spiritual needs arise from this?	spirituality is associated with religion/God, spiritual needs, positive thinking/views, experiencing nature, religion, completing things, partnership, involvement and control

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author(s) year and country of publication	central question focus	N	research type	operationalization of spirituality	results
Rutledge & Raymon 2001, United States	long-term effects on quality of life in women who survived cancer following a weekend retreat	41	healthcare, quantitative, cohort	Quality of Life Breast Cancer (QOL-BC), spiritual wellbeing, uncertainty, religious activities, spiritual change, importance of spiritual activities, positive change, meaning of life, hope	patients feel positive with respect to spiritual change since their diagnosis, all individual scores on spiritual wellbeing changed significantly over time, substantial change, fewer feelings of uncertainty and spiritual change
Tuch et al. 2001, United States	relationship between spirituality and psychosocial factors in people with HIV	52	healthcare, quantitative, cross-sectional, correlational	Spiritual Perspective Scale, Spiritual Wellbeing Scale (SWBS), Spiritual Health Inventory	Existential Well-Being (subscale of SWBS) is positively correlated to quality of life (r=.52)0, social support (.45), effective coping strategies (r=.044) and negatively related to perceived stress (r=-.35), uncertainty (r=-.44), psychological distress (r=-.36) and emotionally directed coping (r=-.43). Religious wellbeing has little or no significant connection with psychological measures.
Hallstaed & Hull 2001, United States	investigating the process of spiritual development in women with cancer during the first five years of treatment	10	healthcare, qualitative, cross-sectional, in-depth interviews	what does the term spirituality mean to you? which experiences have shaped your spirituality? describe experiences, people or situations related to your diagnosis or treatment that influenced your views on spirituality	spiritual experiences are individual and non-static, spiritual growth takes place in the period following diagnosis and is not necessarily related to age. There are three phases in coping with cancer – grasping the concept of cancer, gaining awareness of personal limitations, learning to live with uncertainty
Treleor 2002, United States	the use of spiritual convictions by patients and family members in giving meaning to physical limitations and reacting to the challenges of living with such limitations	30	healthcare, qualitative, cross-sectional, in-depth interviews	spiritual convictions and responses with respect to the handicap? How is the influence of the church on spiritual experiences perceived with respect to the handicap	trials and difficulties contribute to spiritual challenge, trust and strengthening through faith in God, leading a thankful and happy life despite being handicapped. Spiritual convictions stabilize life, add meaning to experiencing a handicap and add support. Expecting support from churches

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Nearly a quarter of the articles reviewed describe patient populations with a variety of physical disorders (King & Bushwick, 1994, Matthews et al. 1998, McBride et al. 1998, Koenig et al. 2001, Tate & Forchheimer, 2002, Emblen & Halstead, 1993, Fryback & Reinert, 1999, Baldacchino & Draper, 2001). The remaining articles involve research among a single specific patient population, with a relatively large number of studies involving patients suffering from various forms of cancer (Roberts et al. 1997, Schnoll et al. 2000, Sephton et al. 2001, Ferrell et al. 1998, Fernsel et al. 1999, Chan et al. 2001, Rutledge & Raymon, 2001, Hastead & Hull, 2001) and patients with AIDS/HIV (Kaldjan et al. 1998, Woods et al. 1999, Sowell et al. 2000, Tuck et al. 2001). The sample sizes vary greatly between studies. This is primarily explained by the fact that quantitative and qualitative studies were both represented, with the latter category being based on much smaller sample sizes. Medical research shows an emphasis on quantitative research, while nursing-related research focuses on qualitative methodology. Most studies (23) employed a cross-sectional design. The remaining studies are reviews (4) and cohort studies (4).

Central questions used across studies

The central questions vary greatly among the studies investigated. Medical studies focus on revealing a significant relationship between spirituality and health, while nursing studies are more exploratory in nature – aiming at describing opinions, experiences and patient needs in this area. This reveals a difference in primary focus between the two disciplines.

In quantitative studies, the central question concerns

– the relationship between spirituality and various health measures such as incidence, mortality, blood pressure and immune functioning (Reynolds & Kaplan, 1990, Goldbourt et al. 1993, McBride et al. 1998, Woods et al. 1999, Sephton et al. 2001, Strawbridge et al. 1997.
– the relationship between spirituality and psychosocial aspects such as locus of control, stress, coping and quality of life (Saudia et al 1991, Simmons et al. 2000, Schnoll et al. 2000, Tate & Forchheimer, 2002, Fernsell et al. 1999, Sowell et al. 2000, Tuck et al. 2001.

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– the role of spirituality in illness and decisions concerning illness, treatment and dying (King & Bushwick, 1994, Roberts et al, 1997, Ehman et al . 1999, Murphy et al. 2000).

In qualitative studies, the central question relates to
– spiritual empiricism, experiences and personal views during and after illness or handicap (McColl et al. 2000, Fryback & Reinert, 1999, Halstead & Hull, 2001, Treloar, 2002).
– the patients' spiritual needs and the desired interventions (Emblen & Halstead, 1993, Hermann, 2001).
– their perception of quality of life and the role of spirituality in this (Ferrell et al. 1998, Rutledge & Raymon, 2001)
– the role of spirituality in relation to psychosocial factors such as experiencing social support or stress (Chan et al. 2001, Tuck et al. 2001).

The reviews included in this study concern the connection between spirituality and prevention and recovery of health, and the influence of spirituality in coping with disease (Matthews et al. 1998, Mueller et al. 2001, Koenig et al. 2001, Baldacchino & Draper, 2001). Spirituality is not the central theme in a number of these studies (Reynolds & Kaplan, 1990, Goldbourt et al. 1993, Ferrell et al. 1998, Chan et al. 2001). The connection with spirituality in these studies is evident only after the discussion of the research results as they also enquired into other aspects, such as spiritual behaviour.

Operationalization of spirituality

The studies displayed diverging operationalizations regarding the concept of spirituality. Most of the quantitative studies approached operationalization in religious terms (Reynolds & Kaplan, 1990, Saudia et al. 1991, Goldbourt et al. 1993, King & Bushwick, 1994, Roberts et al. 1997, Woods et al. 1999, Simmons et al. 2000, Murphy et al. 2000, Strawbridge et al. 1997). This is particularly the case for studies carried out in the USA, where 94% of the population claims to be religious (Koenig et al. 2001). Some studies show restriction of these religious variables to one or a few objectively established aspects of religiosity, such as church or

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equivalent membership, meeting attendance and/or prayer (Reynolds & Kaplan, 1990, Saudia et al. 1991, Strawbridge et al. 1997). Other studies involve more subjective aspects of religiosity such as religious views, religious experiences, trust in God, religious coping and disease through guilt and punishment (Goldbourt et al. 1993, Roberts et al. 1997, Kaldjan et al. 1998, Woods et al. 1999, Ehman et al. 1999, Sephton et al. 2001, Sowell et al. 2000). These studies also involve variables that may not be specific to religion, such as hope, sympathy, spiritual convictions and spiritual activities.

Various studies employed instruments to measure spirituality and religiosity. Some instruments could only measure either religiosity (Simmons et al. 2000) or spirituality (McBride et al. 1998). Other instruments measured aspects of both religiosity and spirituality (Murphy et al. 2000, Schnoll et al. 2000, Fernsel et al. 1999, Rutlegde & Raymon, 2001, Tuck et al. 2001). These instruments are presented as valid and reliable in the studies in which they were employed. However, in the Netherlands, Garssen et al. (2001) investigated various such instruments and concluded that many had not been proven to be reliable in that they had not been thoroughly tested. The scales used do not conform to the demands spirituality places on them because religious colouration is often involved – hence the potential non-validity of such instruments in a Dutch context. It renders the instrument or instruments in question useless. Culturally specific aspects are important in operationalization.

The qualitative studies primarily employ spirituality as a concept, using various definitions. All studies involve in-depth interviews using topics such as self-consciousness, solace, trust and hope, purpose in life and vulnerability (McColl et al. 2000), and questions regarding spirituality, spiritual needs and spiritual experiences (Emblen & Halstead, 1993, Hermann, 2001, Halstead & Hull, 2001) or the way in which solace is sensed and experienced. Several studies show explicit religious colouration by asking subjects about the influence of church support (Chan et al. 2001, Treloar, 2002). Two studies report the use of open questions, but their content is not specified Ferrell et al. 1998, Fryback & Reinert, 1999). There is a wide range of operationalizations regarding the concept of spirituality, which renders valid and reliable comparison between studies difficult.

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Research results

As previously noted, direct comparison among studies is made difficult through methodological differences – particularly due to the lack of uniformity regarding the definition of the concept of spirituality. This also influences the comparison of results across the studies. Some studies report a positive connection between spirituality and health where others report no connection at all. Some studies claim a negative connection between these concepts. An analysis of the results allows the following general statements to be made:

The connection between spirituality and aspects of physical health

Studies investigating this relationship show no univocal tendency. Some studies report the following positive correlations – low mortality rates in populations showing specific religious behaviour (membership of a religious community and church attendance), (Goldbourt et al. 1993, King & Bushwick, 1994, Roberts et al. 1997, Matthews et al. 1998, McBride et al. 1998, Kaldjan et al. 1998, Woods et al. 1999, Ehman et al. 1999, McColl et al. 2000, Simmons et al. 2000, Murphy et al. 2000, Schnoll et al. 2000, Mueller et al. 2001, Koenig et al. 2001, Sephton et al. 2001, Tate & Forchheimer, 2002, Strawbridge et al, 1997) better immune status in women breast-cancer patients with high 'spiritual expression' scores (Sephton et al. 2001), shorter illness duration and low-level disease persistence in women cancer patients with high indicated spirituality levels (Schnoll et al. 2000), less depression and higher physical resistance in patients indicating better spiritual wellbeing (Fernsel et al. 1999).

Other studies either show very weak correlation or no correlation at all between aspects of spirituality and health (Reynolds & Kaplan, 1990, Saudia et al. 1991, McBride et al. 1998, Woods et al. 1999, Fernsel et al. 1999). One particular longitudinal study concerning the relationship between cancer and functioning in a social context showed no statistically significant correlation between religious behaviour (church membership and church attendance) and cancer incidence (Reynolds & Kaplan, 1990). A study among patients with HIV showed no statistically significant association between religious behaviour and immune status)Woods et al. 1999'. A study among patients with colon/rectal cancer showed no significant relationship between religious wellbeing and 'demands of illness') Fernsel et al. 1999.

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The cohesion between spirituality and the perceived quality of life

A number of studies (McColl et al. 2000, Simmons et al. 2000, Mueller et al. 2001, Tate & Forchheimer, 2002, Ferrell et al. 1998, Sowell et al. 2000, Rutledge & Raymon, 2001, Tuck et al. 2001) report a positive correlation between spirituality and quality of life. These studies were carried out among various populations – including patients with cancer, HIV and ALS. Quality of life was measured using various instruments. The positive effects that were noted are described as experiencing spiritual growth through disease (McColl et al. 2000, Rutledge & Raymon, 2001), experiencing psychosocial wellbeing (Sowell et al. 2000, Tuck et al. 2001) and being content with life (Tate & Forchheimer, 2002). Several studies involving disabled patients with cancer report that spirituality has little or no positive effect on their coping with disease, and that they regard disease as an overall loss (McColl et al. 2000, Tate & Forchheimer, 2002, Ferrell et al. 1998).

The role of spirituality in coping with disease and the experience of social support
A number of studies show that spirituality helps in positively coping with disease (Kaldjan et al. 1998, Simmons et al. 2000, Fryback & Reinert, 1999, Treloar, 2002, Garssen et al. 2001, Zock & Glas, 2001). These studies also note that certain aspects of spirituality help in perceiving social support. These effects relate to religious aspects (support through prayer, God or the religious community) (Saudia et al. 1991, Kaldjan et al. 1998) and/or non-religious aspects (relaxation through meditation or contact with nature) (Tuck et al. 2001).

The role of spiritual convictions in disease and treatment – Several studies explicitly showed that faith plays an important role during illness and treatment, especially among religious patients (King & Bushwick, 1994, Roberts et al. 1998, Ehman et al. 1999). They demonstrate that patients expect doctors to enquire after religious views or needs and to act accordingly. One study (King & Bushwick, 1994) showed that doctors often omit this. It was also demonstrated that patients' spiritual convictions can affect essential medical decisions regarding particular individuals (Kaldjan et al. 1998, Ehman et al. 1999, Murphy et al. 2000). A study among HIV patients (Kaldjan et al. 1998) showed that patients deal with illness more positively if they have positive religious views, such as a belief in a merciful God, rather than negative religious views, such as a belief in a vengeful God.

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Spiritual needs during illness and treatment

A number of mainly nursing-related studies describe spiritual needs important to patients during their illness and treatment (Emblem & Halstead, 1993, Fryback & Reinert, 1999, Chan et al. 2001, Hermann, 2001, Tuck et al. 2001, Treloar, 2002). Such needs are diverse and some studies place them within a specific religious context – referring to being supported by God or church – while others do not – expressing the concept in terms of hope, contact with nature or communication. The test population composition plays an important role in this. Researchers claim that knowing about such needs does help health professionals signal and provide such care during care provision.

Conclusion

The aim of this study was to describe how the connection between spirituality and health is explored in medicine and nursing studies, and what can be gleaned from such studies for follow-up research. This literature study is, however, limited to nursing and medical studies. Nonetheless, the following may be concluded from our findings:

Research in physical healthcare is carried out across populations of diverse composition, with a relatively large number of studies involving cancer patients. It is noted that medical studies are largely quantitative in nature while nursing studies are qualitative in nature.

The concept of spirituality is operationalized in various ways. It appears as a personal attitude to meaningfulness and the perception of meaningfulness as expressed in the context of a variety of themes. It also appears in an explicitly religious context, through conspicuous religious behaviour and/or religious convictions.

No univocal connection between spirituality and physical health is evident from these studies. The results vary from positive to negative correlation, to no correlation at all. Despite the fact that the majority of studies indicate a positive correlation, it is difficult to draw general inferences from this fact as the studies are too diverse in

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their spiritual orientation and methodology to permit this. It should be noted that comparable spiritual orientations do not lead to uniform results. Hence, it appears that aspects of religiosity diverge in their application. Again, it should be noted that differing measurement scales are used. The qualitative studies reveal an individual attitude that develops in a personal way through a patient's life. There are patients who experience support through their faith during illness, or who become more aware of their purpose in life. Others indicate no such experience.

Discussion and recommendations

Spirituality in combination with health, disease and healthcare is the subject of scientific research in both medicine and nursing studies. Reports of studies concerning this theme are published in international medical and healthcare journals on a regular basis. This is intriguing from a Dutch perspective as there have been few studies on this issue conducted in the Netherlands (Tiesinga & Post, 2003, Tiesinga et al. 2002). It should be noted that this applies to physical healthcare in particular. Spirituality is a widely accepted issue in mental healthcare, and the relationship between spirituality, religion and health is accorded more attention as a result (Braam, 2001, Kalmthout et al. 2001, Zock & Glas, 2001).
The outcome of this study highlights the need for further research into the connection between spirituality and healthcare. The results of many studies reviewed here are noteworthy in themselves. Most studies reveal a positive effect but, depending on a limited comparability, it is clear that the results are often contradictory and questions ought to be raised regarding the connection between spirituality and health. For example, there could be other variables at play here that have not been addressed. It should be noted that various studies have been corrected for covariates, such as smoking and eating behaviour, physical exercise and social support (Reynolds & Kaplan, 1990, Goldbourt et al. 1993, Kaldjan et al. 1998, Woods et al. 1999, Tate & Forchheimer, 2002).

Some critics (Sloan et al. 1999) conclude that even the best studies only show weak and inconsistent evidence to suggest an association between spirituality and health. Others oppose this view (Koenig et al. 1999) by stating that the best epidemiological studies reveal a strong association between spirituality and health.

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They hold that spirituality belongs to the category of psychosocial aspects and that research in this area is undisputed. It is imperative that there should be a methodologically sound investigation with a clear-cut hypothesis, well-defined concepts and adequate design. Improvements should certainly be made with respect to conceptualization based on the outcome of this study.

Partially contradictory results need not be reasons for doubting the existence of a relationship and the subsequent need for the conduct of further research. The results presented up to this point provide an incentive for additional research. It is however essential that further study be conducted using clear-cut concept definitions. It appears that the terms spirituality and religion are often interchangeable. These terms should be self-contained and their operationalization should be kept separate. Use of the concept of religion alone will not suffice in a Dutch context. Many people would not describe themselves as religious in any way. However, there are as many instances of non-religious spirituality as there are people. This makes research very difficult, and thus underlines the importance of the development of a valid and applicable instrument for the Dutch context.

It is not possible to put forward a solid proposition on the basis of this study concerning the connection between spirituality and health. The outcomes of the various studies are too diverse to permit this, though this does militate in favour of further research. It is important to initiate study in which the central question is based on the connection between spirituality and health, and where operationalization of the concept of spirituality is culture-specific in terms of spiritual practice, perception, convictions and/or experiences. A clear-cut separation from religion as a concept is imperative. Research populations could be combined to gain understanding of aspects specific to a particular category of patients and/or for patients in general.

Several disciplines involved in healthcare currently conduct research involving spirituality. Future studies should look into the possibility of a multidisciplinary approach.

The role of care provider is addressed in some of the studies cited. This could be a point of interest in a Dutch context to gain insight into the care that doctors and nurses provide in this area and the effects thereof.

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Key points

- Medical studies are primarily focused on the connection between spirituality and health, while healthcare studies concentrate on patient convictions, experiences and needs.
- Results from previous studies are not univocal. Comparison between studies is difficult owing to differences in methodology and definitions of spirituality.
- The research topic is to a large extent culture-bound. For this reason, research in a Dutch context is recommended.
- It is imperative that the concepts of 'spirituality' and 'religion' are clearly delineated in follow-up studies.

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Chapter 3

Aspects of spirituality concerning illness

R.R. van Leeuwen, L.J. Tiesinga, H. Jochemsen, D Post (2007)

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Abstract

The spiritual dimension of illness, health and care may be seen as an unique aspect in addition to the physical, mental and social dimension. This contribution describes experiences of patients, nurses and hospital chaplains in relation to the spiritual aspects of being ill. Qualitative research was performed with the design of a focus group study, consisting of 13 focus groups with a total of 67 participants. A purposive sample was used comprising patients, nurses and hospital chaplains working in oncology, cardiology and neurology in different institutions and regions in the Netherlands. The qualitative analysis consisted of open coding and the determining of topics, followed by the subsequent attachment of substantial dimensions and characteristic fragments. Data were analysed by using the computer program Kwalitan. Spirituality play various roles in patients lives during their illness. There is a wide range of topics that may have an individual effect on patients. Despite differences in emphasis, the topics play a role in different patient categories. Although the spiritual topics seem to manifest themselves more clearly in long-term care relationships, they may also play a role during brief admittance periods (such as treatment decisions). The spiritual topics that arise from this study offer care givers a framework for signalling the spiritual needs of patients. The question is not whether spirituality is a relevant focus area in care, but how and to what degree it plays a role with individual patients. Follow up research should aim at further exploration of spiritual aspects in care, the relationship between spirituality and health and at effective training of caregivers.

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Introduction

The spiritual dimension of illness, health and care may be seen as a unique aspect in addition to the physical, mental and social dimensions (Tiesinga et al. 2002, Koenig et al. 2001, McSherry, 2006). The relation between spirituality and healthcare is part of medical scientific research (Koenig, 2002, van Leeuwen et al. 2004) and triggers different reactions in the scientific community. It is indicated that spiritual care helps patients to cope better with their illness. It provides a sense of direction, new hope and inner peace, allowing patients to accept and cope with problems that cannot be solved (Culliford, 2002). Although spiritual aspects of clinical care are important, the subject should be approached carefully because it is misleading to say that it will benefit a patient in every situation (Hawker, 2003). Based on a study of addiction care (Day et al. 2003), it was concluded that spirituality can be a strong reason to reject certain forms of care. With respect to the relationship between spirituality and health, the placebo effect is mentioned (Nethercott, 2003), in which effects are based on 'believing' in something. The different views and outcomes call for further scientific study. The reason is obvious, because despite the different views, spirituality is increasingly being recognized and acknowledged as an aspect of clinical care, which plays a role concerning illnesses and should therefore be considered by care givers in their professional practice (Koenig, 2002).

A recent review (Narayanasamy, 2001) describes research on this topic in nursing. It stated that most of the respondents in these studies acknowledged that the spiritual dimension was an important part of their lives, providing a source of strength, hope and well-being, especially during illness, loss and/or hospitalisation. The studies focussed on different patient groups and took place in different care settings and cultural contexts. The author concludes, although research has been small in scale and results can not be generalised, the spiritual dimension is invaluable and highlights areas for further investigation. She recommends the need to continue to explore and describe facets of spirituality and spiritual care.

In emphasizing the importance of spirituality among patients, it is pointed out that spirituality is culturally determined. Each patient is a unique individual whose needs are influenced by cultural convictions and values and spirituality is expressed and shaped by the accepted practices and beliefs of a particular culture (McSherry,

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2006, Narayanasamy, 2001). This raises the question whether there are differences in experiencing and expressing spiritual needs during illness between patients and caregivers in different countries. This was the reason for studying the phenomenon of spirituality in the context of Dutch health care. This current study focuses on aspects of spirituality, that play a role for oncology, cardiology and neurology patients and took place in the period May-December 2004.

The concept of spirituality lacks clarity in nursing literature. In a review of definitions of spirituality it is argued, that because there are myriad of definitions with different layers of meanings, spirituality can imply different things depending upon an individual's personal interpretation or worldview (Ross, 2006). In this study the so called functional approach of the concept of spirituality is used (McSherry & Cash, 2004). This approach represents the claim that human beings express their common function of spirituality in different forms and contents. The following description of 'spirituality' was used as a point of departure: 'the ideological or religious functioning of a person, including questions of finding and experiencing meaning' (Jochemsen et al. 2002). This definition emphasizes the fact that spirituality can be explained in a religious as well as in a non-religious way. This is a relevant factor in health care, given the fact that patients also have different spiritual backgrounds. The aim of this study was to determine whether and how spirituality plays a role for patients who have physical complaints within the context of Dutch clinical somatic health care, and how this may influence the practice of care givers. In order to gain more insight, the experiences of patients, nurses and hospital chaplains in oncology, cardiology and neurology were examined.

Methods

This study is part of a larger study of spiritual aspects of illness and aspects of spiritual care. The results of this extensive study are reported in two separate articles. This article focuses on the spiritual aspects of illness. The other article describes aspects of spiritual care in nursing (van Leeuwen et al, 2006). The research method used in this study is similar to the method we described in our earlier paper. Therefore we now only give a brief description.

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The current study involved the use of focus groups (Krueger & Casey, 2000) that consisted of patients, nurses and hospital chaplains who were selected from the specialist fields of cardiology, oncology and neurology. The participants were selected across a certain geographical area. Selection criteria were: recent hospital admittance (patients) and work experience (nurses and hospital chaplains). Selection took place according to the method of purposive sampling. The patients were recruited from patient organisations by making an announcement on their websites. Nurses were recruited from nursing organisations and by approaching hospitals in different regions. Hospital chaplains were also recruited from hospitals in different regions. They had a religious and a humanistic background. Groups were formed containing a maximum of 5-6 people (table 1). The hospital chaplains were assigned to three groups. Some participants cancelled their interviews due to illness, transport problems or personal reasons. The ideological background of the participants was consistent with the Jewish-Christian and humanistic roots that largely characterize Dutch society.

Table 1 Focus group participants

Group	Number of Groups	N	Specialism	Characteristics
Patients	4	25	cardiology 7 oncology 13 neurology 5	Male/female ratio 9/16 Average age 58 (range 44-82) Average hospitalization 4,4 weeks (range 1-30)
Nurses	6	30	cardiology 10 oncology 11 neurology 9	Male/female ratio 2/28 Average age 39 (range 28-54) Average work experience of 10 years since qualifying
Hospital chaplains	3	12	Christian 10 Muslim 1 Humanistic 1	Male/female ratio 9/13 Average age 50 (range 33-58) Average of 12 years professional experience

A topic list was used for the focus group interviews and each participant received the definition of the concept of spirituality (see introduction) prior to their interview in order

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to create the same frame of reference across group members. By reading this definition participants could prepare themselves on the theme of spirituality. At the start of the interview the moderator gave an additional explanation if requested by participants. For some of the participants the theme of spirituality became more clear during the interview because of the experiences that other participants put forward. Then they were more able to tell their own experiences and could become more concrete. This phenomenon showed the appropriateness and relevance of this research method.

The interviews were recorded on audiotape, which were processed into fully typed transcripts which were the basic material for analysis. These results were included in the analysis. The qualitative analysis consisted of open coding and the determining of topics, followed by the subsequent attachment of substantial dimensions and characteristic fragments (Krueger & Casey, 2000, Baarda & de Goede, 2000). Analysis was performed with the computer program Kwalitan (Peters, 2000), which was also used to analyze the groups and the relationship between the groups. Measures taken to guarantee the reliability and validity of the research included separation between reporting/observing and taking the interview, trial interviews, constant briefing in the research group, 'peer debriefing' with a professional in the field of research and spirituality, data triangulation, the keeping of a journal and application of 'thick description', enabling outsiders to assess the generalization quality of the research results (Lincoln & Guba, 1985, Smaling, 1996).

Immediately after each focus group meeting a debriefing took place between the researcher and the research assistants to discuss the first verbal and non-verbal remarks. The outcomes of the debriefing became part of the qualitative analysing process and generated indicators for the next meetings.

After concluding the analytical phase of the study the topics identified in the interview texts were ordered with the aid of a modification of Fitchett's spiritual dimensions model (Jochemsen et al. 2002, Fitchett, 1993). This model is an example of the so called functional approach of spirituality. On the basis of many interviews with patients Fitchett distinguished different dimensions in the functioning of patients. Another reason for using this model was the fact that this model was successfully used in the Netherlands in a research about spiritual needs among patients in palliative care (Jochemsen et al. 2002).

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Ethical dimensions of this research

All respondents participated voluntarily in the research. Before the focus groups started the participants received written information about the purpose and content of the study and what was expected from them during the focus group meeting. They could withdraw from the study at any time. Results were presented without any opportunity to identify the response of individual group members.

Results

In describing the results of the focus group interviews we will focus on the spiritual aspects concerning illness in general and on the differences between groups of patients. The general themes in this section are described within the spiritual categories from the modified Fitchett model of spiritual assessment (Jochemsen et al. 2002, Fitchett, 1993). These themes are summarized in table 2 (page 51). It is emphasized that this categorization took place after the process of analysis was completed. The Fitchett model played no role during the interviews and interpretation processes.

Spiritual themes in relation to illness in general

Belief and view of life

Themes according to belief and view of life were both positively and negatively loaded. Positive in the sense that some of the patients during illness and treatment were trusting in God, were not afraid to die because of their faith, believed in miracles en found strength in themselves, their faith and nature.

patient: what I read in the Bible gave me a lot of faith and rest. Yes, I could leave it in Gods hands easily. It has deepened my faith, my illness has enriched my life.
patient: I have experienced that I received an unbelievable power, and I thought, this is nature. When my relatives collapsed I became stronger.

Some respondents talked about faith and view of life in a negative way by saying that they were angry at God, had fear of dying and facing God or could no longer draw any strength from their faith. Patients are also confronted with so-called

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questions of life and death such as questions why they got this illness or doubts about their belief.

patient: I feel there must be something over there, but for me it is no longer God. Too much has happened in my life. My mother died, my mother in law died and now I am ill myself.
patient: I am not religious any more. I stepped out. The reason for that were the many deaths of young people in my family. And then I was thinking when someone wishes the best for the world, then he is very wrong.

Goal in life and life balance
Confrontation with their own vulnerability and own mortality influences the patients' balance of life. Some of the respondents experienced the illness as an experience of loss, because they could not go on living as they did before the illness. They were confronted with their limitations. Some patients experienced their situation as a fate, in which they could find rest or in which they could give their illness a place in their life. For some of them it had to do with the end of life and the acceptance of death or having no fear of dying.

patient: but eeeh, that cardiac arrest, then I realised that I had been dead, If you know what I mean, that was the most confronting for me during my illness.
patient: everybody gets his turn. Everyone has his own cross to bear. Every one gets it in his own way on his own time. Let's make something of it.

Patients told in the interviews that coping with their illness is a process one ultimately has to go through on one's own and that gives sometimes a feeling of loneliness. They emphasized that this confronted them with the question how to live on with that illness. They expressed that with questions such as 'how long do I still have to live', 'what is left to do for me in my life' and 'what is still important for me now I am ill?' It seems that by the confrontation with a severe illness the patient is becoming more aware of his personal history. Patients told that they are looking back on their life more and made up a kind of balance. Some of them took hope and strength out of earlier difficult life experiences that helped them to fight against setback now.

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patient: then they told me 'sir, it is a pity, but it is no good'. I was totally stunned. That was very bad news I could not cope with.
patient: before the accident my work was my life. I have got a brain damage and after a period of time I realised that most of the people who had such damage will not recover. Then I asked myself the question: how do I have to go on with my life?
hospital chaplain: when the patient got that bad message, he started looking back: 'what have I done with my life when I reached this age now'.

The balance of life is also related to themes that were put forward and that were called 'ending life' and 'dying'. Many respondents (especially nurses) associated the theme of spirituality in first instance with questions about dying. When the interviews proceeded they also related it with illness. The remarks respondents made about dying dealt with questions about death, dying, a last wish and the wish to die.

patient: and then I thought, I prefer to be dead, because this is not life what I am experiencing
nurse: he was terminally ill and then we arranged that he could go for one night to his boat to be with his dog. We took all the medical equipment with him. It was his last wish.

Experience and emotions
During their illness patients have feelings of anxiety that were described by the respondents as (existential) fear, concern, anger, rebelliousness and grief. The (existential) fear was about fear of dying, for the uncertainty and for God. Respondents told that patients are concerned about loss of relations because of dying and because of possible fatal consequences of an operation. The anger and rebelliousness were directed against the sickness itself or against God, expressed by so called 'why questions'. Grief can play a role when the patient faces the consequences of the illness.

nurse: a boy awoke at night and told me that he wanted to talk because he had feared. He told me that it has become more severe when a colleague of mine asked him 'and when you will have your bone marrow transplant, do you realise that things can go wrong?'

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patient: I was full of anger. I thought, I have got this life threatening disease and there are lots of criminals walking around who's life is nice and easy and someone like me who does not hurt anybody, is eeh.....

Different respondents also mentioned the impact of physical aspects. In one of the interviews breast cancer patients participated. They told about there feelings of shame when they were confronted with their own body after the breast operation. Different respondents said that physical contact is experienced by patients as supportive on difficult moments during their illness.
Some of the patients had experienced special images and visions. They were mainly religious from origin, for example one talked about a visible contact with mother Mary or with angels. Some patients saw a great light, what they called near death experience. All the respondents called this positive experiences which gave them some kind of rest.

patient: a near death experience...., yes what did see,.....their was a tunnel and I saw a light and my grandfather, who was waiting for me. Since that time I don't feel I am alone.

Courage, hope and growth
'Acceptance' and 'letting go' were important themes mentioned in the interviews. It entails that patients can give meaning to their illness, that they can surrender themselves to the new situation and seek new perspectives in life. The way in which patients handle this new situation differs for every person. Some patients could accept their situation rather easily, while others had more difficulty with it or could not accept it at all (at the moment).

patient: in my rehabilitation they were all focussing on the way I had to cope with the new situation and that I had to accept it. But I said 'I can only accept it when I am sure that I need not go on in the way I did before'.
hospital chaplain: many patients are seeking, but on the long term many of them realised that the solution had to come out of themself.

The following mechanisms were mentioned that had helped patients to cope with their illness: humour, positive thinking, to be open about their feelings, experience

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of comfort and keep fighting. It turned out that the way patients used these mechanisms depends on the way that they fit for every person. The need of comfort was mentioned by several patients, meaning not only the comfort the patient got for example from relatives, but also that the patient was able to encourage and comfort his relatives.

patient: I want to get the positive out of it. After all I have dealt with it during my illness, I still see a message for my self and the possibility to develop myself in a certain way.
nurse: I realized that when I let the patient talk about his or her life, that it was comforting for that patient.
patient: I keep fighting. I will make something of my life. I keep fighting. I am doing that for all my life.

Religious and spiritual practices and customs

Many respondents told that patients were supported by the use of one or more of the following practices and customs: prayer, meditation, reading religious or spiritual textbooks, listening to religious or spiritual music, visiting (religious) services in the hospital and visiting the hospital chapel for a moment of silence. For some patients there were custom practices they wanted to continue while they were in hospital. For some other patients these needs were felt during their stay in the hospital.

patient: On Sunday I asked if they would bring me to the service in the hospital. At home I always visit that services. Then they brought me to it with all the medical equipment.
patient: sometimes thoughts are running around in my head. And when I cannot stop my thoughts, then I start praying in my own way. Then I am talking with God or with myself or anyone else.

Some patients are also using various rituals and symbols, like burning candles, praying the rosary, the use of healing stones. Some of the nurses told that when the patient reached the terminal stage of illness, the relatives asked for giving the unction or, in case of Roman Catholic patients, the last rites.

Nurse: sometimes I see patients with some kind of little stones. They got them for example from their (grand) children to bring luck en get healed.

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Relationships

Relationships are especially important for patients during illness. Patients mentioned the fear of loneliness. They said that ultimately they had to cope with the illness all by themselves. The support from and contact with fellow sufferers was mentioned by different patients as very supportive.

patient: I discovered I had to do it all on my own. Ultimately I was thrown back upon my own resources.
patient: I feel that I am most connected en supported by people who gone through the same I did.

Patients are also asking themselves the question if they can go to work again or they realise that they have to find a whole new life fulfilment. In this relational aspect also the experiences and feelings of the relatives of the patient have a place. They can express feelings like sorrow, concern, fear, panic and the acceptance or non acceptance of the situation. Some relatives express the problems they have with their faith. Some respondents reported the tensions that arose in the relationship between the patient and a relative.

nurse: Some times ago I nursed a women who knew that she would die soon. She was very busy with making lists with practical instructions for her husband how he had to care for their little child. For her husband, this was very confronting. That stressed their relationship.

Authority and guidance

When patients were asked if they experienced some guidance in their life during the illness, some of them mentioned the role of their faith. In this the religious patients showed a different view. Some of them experienced a positive guidance because they said they had felt strength and support from God. On the other hand some religious patients said they experienced fear of God or were angry at God because he had taken all good things from them. Non religious patients said they had to find their own way in dealing with the illness.

hospital chaplain: I meet patients who said that the illness has brought them very close to God. One patient said: 'I would say, If I did not have that I don not know

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where I should be now. My faith has supported me very much. Because at the end you lose everything, also my wife, and who is left then?

Some patients put forward that they were confronted with decisions about life and death and the meaning of their view of life in this context. Some patients expressed their fear of euthanasia.

patient: the doctor said to me 'when you become a cardiac arrest again, do we have to resuscitate you?'. That question frightened me, that I am directing my own life and death.

Table 2 Aspects of spirituality concerning illness

Spiritual themes derived from the interviews	Dimensions of themes derived from interviews	Spiritual categories (Jochemsen et al. 2002, Fitchett, 1993)
Trust	Trust in/ angry at God; illness enriches faith; longing for faith; belief in miracles	Faith and ideology
Strength	Strength from nature, self, strength from faith: yes/no	
Life questions	Religious/non-religious questions; meaning of illness; why?, spiritual doubt	
Confrontation	Vulnerability; immortality; experience of loss	Life purpose and life balance
Destiny	Resignation; coming to terms with the illness, being alone at the end of the day;	
Coping	Real coping starts at home; patient more contemplative in follow-up treatment	
Perspective	How long do I have? what remains? what is important? quality of life?	
Life history	Looking back on life; hope, strength and the will to fight from previous experience	
Dying	Final wish; good-bye; closure of life; questions about death; death wish	
Existential fear	Fear of death, of the unknown, of God	Experience and emotions
Concern	For family/relations at dying; fatal consequences of operation	
Anger	Angry with illness; angry with God	
Sorrow	Realizing consequences of illness; powerless	
Visions and images	Virgin Mary; angels; near-death experience; relatives; positive, peace	
Physical	Confrontation with violated body; need for physical contact	

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Accepting	Long (mourning) process; coming to terms with illness; submission; self acceptance; moment and place in time	Courage, hope, and growth
Letting go	Able/not able to let go of life; finding a new perspective	
Positive thoughts	Seeing new possibilities; illness as a friend; taking good care of self	
Being open	Patient determines how to express him/herself; character	
Comfort	Needs of patient; patient comforts/encourages relatives	
Fighting	Fighting to live	
Coping	Healthy and unhealthy; humour	
Prayer/meditation	Fixed ritual or on occasion; able to handle illness; strength/wisdom; with existential questions/spiritual low; support in dying process, yoga	Religious/ spiritual customs
Scripture/music	Bible; Koran; religious hymns	
Services/gatherings	Brings peace, meditation, prayer; away from everything, curiosity	
Rituals and symbols	E.g. serving, anointing, baptism; candles, rosary, images, pebbles	
Loneliness	Fear of loneliness; losing social contacts	Relationships
Family situation	Concern for children; how will my family cope after I die	
Fellow-sufferers	For real understanding; support fellow patients during admittance	
Work	To work or not to work; finding new way to live	
Experience and emotions of family/ relatives	Sorrow; worry; fear; panic; accepting: yes/no; faith problems; conflicts due to different level of experience than patient	
Image of God	Positive: strength, support, bottom line; negative: fear, took everything away	Orientation source and guide line
Decisions around treatment	Treatment: yes/no; (fear) of euthanasia; resuscitation policy	

Differences between respondents

The topics described appeared in each patient category, although they may have been expressed differently by each patient. Among cardiology patients we can distinguish between patients with acute ailments (heart attacks) and those with chronic ailments (heart failure). The first group is characterized by a high degree of resistance, a low degree of resignation, and the (continuous) search for possible

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treatments, which hinders reflection on their personal situation. Self-reflection is more apparent in the other group:

Nurse: a patient in his early 60s said: 'I want a heart transplantation; I'll sell my house and make sure I have enough money so that you can get me a heart.' He could do nothing else. Then there was a 34-year-old woman with heart disease who was about to die. With her I saw more peace of mind and rest; she realized that the end is near. But in the category of patients who have had a heart attack or need a transplant, it's just live, live, live!

With neurology patients, communication problems (for example aphasia) may be the reason why aspects of spirituality are not expressed by patients or are not recognized by caregivers. These patients indicate that as a result they appear to receive little attention from caregivers, leaving them with the impression that the caregivers are avoiding contact. Especially during the initial phase, neurology patients tend to find their situation unacceptable. Nurses speak about reactions similar to those in a mourning process.

Patient: I wonder if they even thought about whether I was dealing with it. The rehabilitation was focussed on accepting and dealing with it; they went on and on about it. And I said: I will not accept this until there is nothing else left. I wanted to get the most out of it.

In the case of oncology patients, the results show that during follow-up treatment they expressed more questions on how to find a sense of purpose and communicated more with the caregivers as compared with their first treatment, which was usually dominated by the initial shock and the consequences of the diagnosis (what can be done, what are my options?). From this we can conclude that if a patient is dealing with a long-term illness the spiritual aspects may play a more explicit role in the patient's life and will be discussed more often with the caregivers. In addition, the social context of a patient plays a role (family, partner, work). On the one hand, patients may find support in their social environment, but on the other hand it may lead to questions ('will I be able to go working again') and tensions (family members who try to find a sense of purpose in the situation or who are at a different stage of the process than the patient). In general, it can be said that the

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topic is relevant at all stages of life. Nurses distinguish between younger patients, in whom they notice more resistance, and older patients, in whom they sense a higher degree of resignation. The nurse's personal emotions seem to play a role here as well. Different nurses indicated that they were moved by the situation of the patient and fail to come to terms with a young patient dying.

Nurse: There was a 27-year-old young man with cancer who was about to die. If you are 80 years old, you can expect to die. The family was so sad. Everyone had difficulty in accepting the situation, not least the young man himself.

Discussion

This study confirms that spirituality affects the perception of illness. Results show that patients clearly indicate this and caregivers are able to confirm it. An essential element is the personal perspective on these aspects, leading to distinguish between many different spiritual aspects, which are presented thematically in this study.
According to the literature the spiritual needs and sources cover a wide range and include vertical, transcendent (religious) elements and horizontal existential elements. Studies show that nurses tend to view spirituality in broader terms than patients who see it more in terms of religion or expressed difficulty in defining it (Narayanasamy, 2001). Our study shows that both nurses and patients first tend to view spirituality in religious terms. The reason for that could be that in Dutch society people are more familiar with the concept of religion than with spirituality. The use of the functional definition of spirituality could have contributed to this view, because religion was explicitly mentioned in that definition. Participants' responses to the initial questions usually were limited. Informants seemed to need time to feel comfortable talking about such an intimate topic. The same experience is described in a study among cancer patients (Taylor, 2003). This raises questions about the possibility of communication on spiritual matters between the nurse and the patient. It seems that a relationship of faith and trust is needed.

This study shows that the spiritual categories of the modified Fitchett model are useful for categorizing the spiritual themes that emerged from the analysis (Fitchett,

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1993). The resulting overview (table 2) can serve as a basic tool for caregivers in observing and signalling spiritual aspects in care practice. In a study about spirituality in nursing Bash (2004) stated that he is not convinced that it is possible to develop assessment tools that are sensitive, flexible and accurate enough to identify the spirituality of all patients, or even the majority, because of the fact that a person's spirituality may be so difficult to identify, that it will not be possible to measure it. The tool that can be derived from this study should be considered as a frame of reference that nurses can use in their relationship with the patient. Ultimately, the nurse's assessment of the real spiritual need of the patient, depends on the spiritual sensitivity of the nurse herself. In this we agree with McLaren (2004) who emphasises that definitions and related concepts of spirituality can only provide a starting point from which nurses can engage in spiritual nursing. That is the reason that many authors stress the need for development of spiritual self-awareness of nurses, which is an important condition for the nurse to meet the spiritual needs of patients (McSherry, 2006, Narayanasamy, 2001, van Leeuwen et al. 2006).

The spiritual topics play a role in different patient categories. There seems to be a difference between on the one hand patients who stay in hospital for a relatively brief period (acute ailments) or those who are in the first phase of diagnosis and treatment, and, on the other hand, patients who have been ill for a longer period and who are therefore confronted with caregivers on a regular basis. This raises the question of whether spirituality should (or can) be an area of attention for caregivers when dealing with the first group. There are studies in acute settings that all explicitly describe spiritual needs of patients in an acute care setting (Highfield & Cason, 1983, Narayanasamy, 1995, Ross, 1997, Walton, 1999). Maybe caregivers should trained to be more alert in recognizing spiritual needs in that acute settings.

The study shows the relevance of spiritual aspects during illness, indicating that there is a relationship between spirituality and health. Spiritual aspects can be of vital importance to patients when they are dealing with their illness, their relationships, when making decisions, facing the prospect of death, etc. In addition, spirituality may have an obstructive effect on the normal functioning of a person. This topic does not address the question whether or not spirituality is a relevant

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area of attention in care, but how and to what degree it plays a role in individual patients. This is what caregivers should look for. In today's health care essential human aspects threaten to disappear from view. These aspects can be regarded as spirituality and seem to play a relevant role in the process of illness and care.
The relationship between spirituality and health should receive more attention in research, especially in nursing. In medicine much relevant research have been done in this area (Koenig et al. 2001), but in nursing this research is limited (van Leeuwen et al, 2004, Narayanasamy, 2001). The exploration and description of aspects of spirituality concerning to illness should be continued, but in agreement with Ross (2006) we recommend that future studies also should focus on the associations between variables of health and spirituality.

To increase attention for spiritual aspects in care, we propose that educational programmes of caregivers pay more attention to this topic. For nurses these competencies have already been described and in practice been recognized (van Leeuwen et al. 2006, van Leeuwen & Cusveller, 2004, Baldacchino, 2006). Follow-up research should focus on further exploration of spiritual aspects in care, as well as effective education of caregivers.

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Chapter 4

Nursing competencies for spiritual care

René van Leeuwen & Bart Cusveller (2004)

Journal of Advanced Nursing, 48 (3), 234-246

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Abstract

Aim. This paper aims to answer the question: What competencies do professional nurses need to provide spiritual care?

Background. Nursing literature from The Netherlands shows little clarity on the qualities that nurses require to provide spiritual care. Although the international literature provides some practical guidance, it is far from conclusive on the required qualities of nurses.

Method. A qualitative literature review was conducted to draw together information from the nursing literature in order to formulate nursing competencies. A format developed for higher nursing education in the Netherlands was used; this consists of description of a general domain, specific competencies, vignettes, key focus and objectives.

Results. The resulting competency profile has three core domains (awareness and use of self, spiritual dimensions of the nursing process, and assurance and quality of expertise) and six core competencies (handling one's own beliefs, addressing the subject, collecting information, discussing and planning, providing and evaluating, and, integrating into policy).

Conclusion. This literature review yields a competency profile that may help to structure future care, research and education in spiritual care by nurses. Implications of the work for future research and education are discussed.

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Introduction

In its policy statement Professional Profile of Nursing, the Dutch National Centre for Nursing and Caring Professions explicitly includes spirituality as a key focus in nursing practice (Leistra et al. 1999, p. 12). It states that nursing care presupposes a holistic perspective that includes physical, mental, social and spiritual aspects of human functioning. In order to provide holistic care, nurses must be competent to intervene on a physical, mental, social and spiritual level. The competencies required to provide physical, psychological and social care have been clearly documented in the nursing literature. However, in the context of nursing in The Netherlands, it is unclear which nursing competencies are vital to providing adequate spiritual care.

Our study is a first attempt to remedy this situation (Van Leeuwen & Cusveller 2002). In this paper, we share the results of a literature review conducted in 2002 with the aim of pulling together the competencies nurses are supposed to posses for the provision of spiritual care. First, we clarify the definition of spirituality that we adopted. Secondly, we briefly describe the methodology of our project. Thirdly, we present the results of our literature review in a format developed for this purpose. Finally, we explore some implications for nursing research and education.

Spirituality: a functional approach: definition issues

In the nursing literature, authors define and use the term 'spirituality' in a number of different ways, such as searching for meaning, adhering to a religion, balancing energy or basic trust (Tanyi 2002). Hence, it is difficult to tie the concept to a single meaning. Rather than having one fixed meaning, the notion of spirituality seems to refer to a 'family' of different yet connected meanings. Therefore, to establish a working definition for use in our literature review, we did not attempt to define what spirituality is, or what forms or content belong to it 'essentially'. Rather, we focussed on the variety of things that people do, or the variety of ways in which they function. It could be said that human beings have physical, mental and social functions, or function in physical, mental and social ways. By the same token, it could be said that they have a spiritual function, or function spiritually. This approach to human

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spirituality could be called ‘functional’ rather than substantive: it focuses more on how a person makes meaning in their life rather than on what that specific meaning is (Fitchett 1993, p. 40).

In this spiritual function, the beliefs, practices and lives of human beings express their relationship to that which transcends the physical, mental, and social. It involves activities, convictions and attitudes relating to fundamental features of human existence, such as death, suffering, vulnerability, dependency, the inevitability of choices and the sacred. This is not to say that there is a common form or content to human spirituality; it represents the weaker claim that human beings express their common function of spirituality in different forms and content. For the purpose of our study, the notion of spirituality will be used to denote the religious and existential mode of human functioning, including experiences and questions of meaning and purpose (Jochemsen et al. 2002, p. 12).

Spirituality in relation to health and illness

How does spirituality relate to nursing? In the patient-nurse relationship, spirituality is expressed in various spiritual areas or themes (hope, growth, strength, authority, belief and so on), as well as in various forms and contents. More important for the nursing process, however, is how spirituality is manifested in relation to patients’ health and illness. When we take illness as distorted human functioning, we may define nurses’ professional responsibility as a supportive, palliative or preventive response to certain ‘dysfunctions’. It follows from this working definition that nurses’ professional responsibility for spiritual care depends on the relationship between a patient’s spiritual function and their health situation.

First, there is the patient’s ‘customary’ or ‘everyday’ spirituality, which they might want to continue during a period of care. For instance, a patient used to praying, meditating, reading scripture or worshipping may want to continue doing so during their stay in hospital or during home care. As the nurse is, at least in part, responsible for making the patient’s stay possible, this customary spiritual function is part of the focus of nurses’ professional responsibility, which assumes the ability to support this function.

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Secondly, there is a phenomenon that could be called the 'spirituality of illness or crisis'. People confronted by disease or handicap, giving birth, or imminent dying are vulnerable to changes or reactions in the way that they relate to their existence, habits, beliefs and way of life. For many, this is a 'healthy' response to a crisis. For some, these responses result in spiritual distress, a struggle with the meaning of life or a conflict related to faith. As these spiritual responses to illness are direct and urgent consequences of the reasons why patients were being cared for in the first place, the spiritual function is part of the focus of nursing and requires competence in this area.

Thirdly, a patient's spiritual function itself may be 'distorted', i.e. in need of treatment. Patients do not usually want a state of spiritual distress to continue during their stay. Nor is it always a direct and urgent consequence of the reason why a patient is being cared for. A patient who is hospitalised for bone fracture surgery may also suffer from certain despairing expectations about their marriage or work. This despair is not something that the patient would want to see continued during their hospital stay, nor is it related to their fracture, surgery or subsequent care. However, this patient's moods, attitudes and decisions may affect the nursing process and the patient-nurse-relationship. In this case, the episode of spiritual distress itself needs to be addressed. Nurses' responsibilities and competencies to deal with this form of spiritual distress may be limited, but the relationship between patients' spirituality and nurses' responsibilities requires them, at the very least, to work in a multidisciplinary team and support other health workers who can attend to such patients' spiritual distress.

Spirituality and professional responsibility

Another preliminary aspect worth mentioning is that the varied nature of human spirituality will also include nurses' own forms of spirituality. This is important, because they will always bring their own personal 'frames of reference' to bear on practice, including the spiritual care provided. This means that there is room for a nurse's personal convictions when providing spiritual care, in terms of talking about faith in the same way that they talk about other things. There may, however, be tensions between personal convictions and the interventions asked of them when

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caring for patients' spirituality. Again, the requirement is that nurses handle such conflict-provoking situations in a professional manner, and this demands competence in this respect.

Lastly, we would like to point out the general importance of good working conditions and an environment that facilitates nurses to provide adequate spiritual care. They do not only need to be competent on the level of the patient-nurse relationship, but also need an organizational context conducive to providing adequate spiritual care and the competence to make use of it.

In summary, we found reason to search the literature for material on nursing competencies in spiritual care as defined above. These are competencies relating to:
- nurses' professional responsibility for direct patient care;
- handling the limitations of that responsibility;
- interacting with health care providers in a professional manner; and
- dealing with the contextual conditions for spiritual care.

Method

Research questions

The notion of 'competencies' denotes complex sets of skills used in a professional context, i.e. the clinical nursing process. Being competent depends on correct assessment of a clinical situation and on the ability to implement knowledge and skill in the right way at the right moment. Equivalents of this notion are capability and capacity.

The leading question for our literature review was: What are the competencies a nurse needs to possess for providing adequate spiritual care? We divided this question into four sub-questions that relate to the content and implications of this body of nursing literature:
- Which nursing interventions and activities relating to spiritual care are described?
- What are the requirements in respect of nurses' professional attitudes to spiritual care?

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- Which organizational conditions that might impact on spiritual care are described?
- Can a nursing competency profile for spiritual care be derived from an analysis of this literature?

Research procedures

The literature review was qualitative, semi-structured and explorative. Results were documented in an analytical framework (Table 1) consisting of the stages of the nursing process, to which we added contextual aspects and referral to other disciplines (as this appeared to be of particular importance in the case of spiritual care). Thus, the analytical framework contained the following elements, derived from the Dutch Professional Profile for Nursing (Leistra et al. 1999):

- Patient-related interventions and activities, consisting of: monitoring/observing, assessing, helping/coaching, teaching/advising, prevention and co-ordination of care;
- Co-operation with other experts; and

Table 1 Analytical framework

Patient-related tasks
• Observation/assessment/diagnosis
• Coaching
• Information and advice
• Prevention and education
• Continuity and co-ordination of care
Organisation-related tasks
• Multidisciplinary co-operation
• Fostering institutional conditions
Profession-related tasks
• Attitude and personal qualities
• Professional responsibility, knowledge, vision and methodology

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• Organizational and personal conditions in the clinical context.

An on-line literature search was carried out using the databases Invert and Picarta (in Dutch), as well as Medline and CINAHL (in English). Search terms used were: nursing, spiritual care, competence, nursing interventions and nursing education. When searching in English, care was taken to retrieve literature originating from different countries rather than just the United States. Secondly, key internationally acclaimed works were included (Benner Carson 1989, Stevens Barnum 1996, O'Brien 1999, McSherry & Cash 2000, Narayanasamy 2001, Taylor 2002). In addition, special attention was given to Dutch and German sources, as they relate to the Dutch culture in both nursing and spirituality. Lastly, care was taken to include literature that focussed on clinical interventions in nursing practice, rather than philosophical reflection.

RvL prepared written summaries of each relevant article or chapter. BC and the advisory committee checked these summaries for accuracy. In addition, BC prepared summaries of six randomly selected articles and compared them to RvL's summaries. No substantial differences appeared. Following this, we categorized relevant skills, roles and activities related to spiritual care independently, using an analytic framework sheet for each summary. RvL then combined the data from each analytical framework sheet in a single cumulative analytical framework. During this process, overlapping sets of skills were labelled together as one competency. Again, BC and the expert committee checked the results of this step for accuracy and found them to be satisfactory. No new information emerged from the last few articles with summaries. After combining 29 articles and chapters it was decided that the sample had been sufficient to cover the issues involved.

Results

Table 2 shows how the findings of the literature review were related to the elements of the analytical framework. It became clear that spiritual care pertained to all facets of a nurse's professional competencies with the notable exception of prevention and health education, on which no clear findings could be reported.

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Table 2 Results presented within the analytical framework

Observation/assessment/diagnosis
• Asking questions about spirituality, faith, religious background. Checking which practices, rituals, symbols and traditions support the patient. Probing the meaning of faith and meaning for the patient (Pieper & Van Uden and Van Uden, 2000; Steemers, 2001; Rijksen & Van Heijst, 1999; Driebergen, 2001; Weiher, 2001; Jochemsen et al., 2002)
• Making use of tools: queries, interview techniques, instruments (Stoll, 1979; Rijksen & Van Heijst, 1999; Eliens & Frederiks, 2002; O'Brien, 1999)
• Communication skills: active listening to religious biography, life story, non-verbal expressions (Prins, 1996; Rijksen & Van Heijst, 1999; Greenstreet, 1999; Steemers, 2001; Ganzevoort, 2000)
• Recognising the patient's symbols/symbolic language (Weiher, 2001)
• Clarifying by asking for additional information, checking first impressions, and structuring information (Rijksen & Van Heijst, 1999)
• Formulating existential questions with the patient, 'diagnosing' spiritual distress; determining the patient's position on the continuum of spiritual well-being, and opportunities to meet needs and solve problems (Rijksen & Van Heijst, 1999; Westrik & Van Leeuwen, 1999; Van Leeuwen & Hunink, 2000; Steemers, 2001; Driebergen, 2001)
• Distinguishing spiritual needs and problems from pathology (Campinha-Bacote, 1995)
• Creating conditions (time, room, resources) for access to the patient's spirituality and spiritual needs (Greenstreet, 1999).
Coaching
• Watching over the patient after receiving bad news (Prins, 1996)
• Supporting those with longterm illness in terms of self-awareness, accepting, coping, and enjoying the good moments (Steemers, 2001)
• Creating conditions for spiritual guidance, prayer, meditation, reading and listening to music (time, room, availability, being present, sense of security, enhanced patient mobility) (Leetun, 1997; Ross, 1996; Stevens Barnum, 1996; O'Brien, 1999; Greenstreet, 1999; Narayanasamy, 1999; Steemers, 2001; Van Veluw, 2001; Driebergen, 2001)
• Being near, being present, adequate use of touch (Taylor et al., 1995; Stevens Barnum, 1996; O'Brien, 1999; Greenstreet, 1999; Steemers, 2001; Van den Berg, 2001; Weiher, 2001)
• Focusing on faith, worldview, spirituality, meaning and religion from the patient's perspective, and interventions such as pastoral and spiritual care, reducing anxiety and offering comfort. Addressing questions of life and meaning against a background of religious biography. Helping to put life events in perspective. Promoting meaning, self-respect and hope. Clarifying perspective on life and identifying inconsistencies. Taking note of thoughts and feelings evoked by handicap, illness, suffering or death. Supporting patients in their quest for meaning. Addressing issues relating to coping with illness,

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dying and the meaning of life. Supporting self-actualisation. Stimulating conversation and communication about painful experiences and events, anxiety, insecurity and future plans with others. Encouraging enjoyment of the everyday. Being a companion. Offering supportive opportunities to make changes and decisions. Encouraging patients to define values, goals and personal opinions. Not giving false hope, but enabling patients to express themselves. Gaining access to motives and mental images of the patient and family, to their existential experiences, of temporality and the downsides of life (Taylor et al., 1995; Stevens Barnum, 1996; Leetun, 1997; Pieper & Van Uden, 2001; Rijksen & Van Heijst, 1999; Westrik & Van Leeuwen, 1999; Narayanasamy, 1999; O'Brien, 1999; Steemers, 2001; Van Veluw, 2001; Driebergen, 2001; Weiher, 2001; Jochemsen et al., 2002).

- Evaluating if the nurse has focussed adequately on the patient's story, if the fundamental problem has been identified adequately, if the method used has been attuned to the patient's situation and how the indicator 'spiritual integrity' played a role (Rijksen & Van Heijst, 1999; Narayanasamy, 1999; Steemers, 2001)
- Taking care that patients can express their faith and/or spirituality by way of celebrations, rituals and conversations, with or without nurses' support (Steemers, 2001)
- Exhibiting communication skills: asking and listening actively, noticing non-verbal behaviour, using silences, reflecting content and emotions, making the problem concrete, summarising, connecting to goals, reflecting aloud and concluding. Communicating with patients from different cultural backgrounds, and reflecting on cultural differences (Taylor et al., 1995; Stevens Barnum, 1996; Prins, 1996, Leetun, 1997; Westrik, 1999; O'Brien, 1999; Greenstreet, 1999; Narayanasamy, 1999; Steemers, 2001; Van Veluw, 2001; Van den Berg, 2001; Driebergen, 2001)
- Focusing on spirituality in everyday care. Making use of environment, atmosphere, commitment, attention and sensitivity. Giving good physical care. Alleviating suffering. Observing daily rituals (courtesies, goodbyes and farewells). Intervening respectfully in intimate areas (Stevens Barnum, 1996; Van den Berg, 2001; Weiher, 2001; Jochemsen et al., 2002)
- Helping to apply techniques: meditation, counselling, relaxation exercises, therapeutic touch, visualising, writing letters, repatterning and alternative interventions not available in regular care (Leetun, 1997; Stevens Barnum, 1996; Driebergen 2001; Eliëns, 2002).
- Involving the family in spiritual care. Coaching the patient in relations and social ties in the terminal phase. Noticing obstacles in communication. Coping with bereavement. Arranging visits (Leetun, 1997; Ross, 1996; Eliens & Frederiks, 2002; Narayanasamy, 1999; Weiher, 2001; Jochemsen et al., 2002)
- Providing terminal spiritual care: bringing a close to an evaluation of one's life and/or life goals, to life itself, material matters. Promoting courage, hope and growth. Tending to religious practices and rituals. Coping with emotions, wishes for death and/or requests for euthanasia (Jochemsen et al., 2002).
- Arranging visits by consultants and experts (Jochemsen et al., 2002).

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Information and advice
• Informing the patient about pastoral care and availability for conversations. Avoiding alienating patients with questions about religion/faith during admission (Prins, 1996; Driebergen, 2001)
• Offering information on daily routine and rules, facilities, support within the institution, availability of chapels and rooms to retreat to (Driebergen, 2001)
• Informing the patient and family about night accommodation for family and significant others (Jochemsen et al., 2002)
Prevention and education
No clear findings
Continuity and co-ordination of care
• Creating continuity in spiritual care, especially with patient transfer and discharge, recording data and agreements, making use of patient files (Jochemsen et al., 2002).
• Careful planning of work, using the patient's care plan for spiritual care, attuning to the patient's individual situation, setting realistic goals and defining existential questions, care goals, methods and criteria for evaluation (Ross, 1996; O'Brien, 1999; Narayanasamy, 1999; Greenstreet, 1999; Rijksen & Van Heijst, 1999; Driebergen, 2001; Jochemsen et al., 2002).
• Evaluating the adequacy of assessments of existential questions and the method used (Rijksen & Van Heijst, 1999).
Multidisciplinary co-operation
• Referring the patient, when wanted, to a pastoral caregiver or counsellor for questions relating to faith and meaning. Overseeing the patient's total well-being. Being available for specific rituals (Prins, 1996; Stevens Barnum, 1996; Westrik, 1999; Pieper & Van Uden, 2000, Van den Berg, 2001; Driebergen, 2001; Jochemsen et al., 2002)
• Seeing to it that a contact with the pastor or counsellor is arranged. Informing and referring the patient (Prins, 1996; Steemers, 2001)
• Facilitating informal contacts with the pastor or counsellor (Prins, 1996)
• Consulting the pastor or counsellor and addressing the patient's needs in interdisciplinary communication (Ross, 1996; Van den Berg, 2001)
• Referring the patient, if needed and wanted, to a nurse with the same faith or to a member of his own faith-community (Westrik, 1999; Driebergen, 2001)
Fostering institutional conditions
• Including spirituality in quality assurance policy (Stevens Barnum, 1996)
• Enhancing integral spiritual care in treatment, policy and vision. Enhancing the role of management and institutional culture. Persuading management of the importance of

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spirituality (Borsjes et al., 2001; Steemers, 2001; Jochemsen et al., 2002).

- Working from a shared framework, not depending on individual interests or workload (Prins, 1996)
- Participating in nursing audit and inter-colleague coaching in spiritual care (Jochemsen et al., 2002)

Attitude and personal qualities

- Showing respect for the patient's outlook and way of life. Accepting patients of a different persuasion to that of the nurse. Making the distinction between one's own faith and that of the patient. Avoiding imposing one's own perspective on the patient. Avoiding last-minute evangelism (Eliens & Frederiks, 2002, Rijksen & Van Heijst, 1999; Greenstreet, 1999; Westrik, 1999; O'Brien, 1999; Steemers, 2002; Borsjes et al., 2001)
- Reflective use of one's own worldview or religion. Recognising the positive effects of expressing one's own worldview (Borsjes et al., 2001)
- Reflecting on one's own limitations and being able to set limits for oneself in providing spiritual care. Accepting that some may not have an ability/wish to provide spiritual care. Coping with limited abilities, interest and experience. Knowing how to refer when not competent. Knowing when referral to a pastor or spiritual counsellor is needed (Taylor et al., 1995; Ross, 1996; Prins, 1996; Greenstreet, 1999; O'Brien, 1999; Driebergen, 2001)
- Knowing pitfalls in spiritual care that inhibit adequate recognition of spiritual questions and needs, such as physical complaints, superficial listening and putting one's own background to the fore (Prins, 1996)
- Recognising one's own feelings, spirituality and shortcomings. Recognising and coping with emotions in patients, such as sadness, and fear of dying, suffering and death. Being able to give a spiritual self-diagnosis. Acknowledging the impact of the spiritual diagnosis of the patient on oneself. Spiritual introspection. Paying attention to one's own spirituality. Knowing one's own interest in and experience of the subject. Knowing and caring for oneself. Having an orientation on hope, confidence and belonging. Reflecting on one's own spirituality and the chances, limitations and awareness of the spiritual dimension in one's own life. Recognising one's own quest for the meaning of life. Having experienced crises. Being prepared to 'give' oneself. Reviewing one's own beliefs. Awareness of the relation of one's own spirituality to the care provided. Being able to formulate one's own experiences of and views on illness. Being able to reflect on the meaning of spirituality. Having access to one's own opinions and emotions. Coping with anxiety and tension. Accepting defeats and failures. Coping with tension between professional responsibility and daily reality. Deepening one's professional role and identity (Prins, 1996; Ross, 1996; McSherry & Draper, 1997; O'Brien, 1999; Greenstreet, 1999; Westrik & Van Leeuwen, 1999; Narayanasamy, 1999; Cone, 1997; Steemers, 2001; Van den Berg, 2001; Weiher, 2001; Driebergen, 2001; Jochemsen et al., 2002)
- Refraining from denigrating and stereotyping people, religious denominations, worldviews and spiritualities. Being prepared to admit wrong interpretations (Campinha-Bacote, 1995; Narayanasamy, 1999; Rijksen & Van Heijst, 1999; Driebergen, 2001)

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- Being involved, open, compassionate, hospitable, interested in spirituality, authentic, sensitive, sincere, reliable, perceptive, honest, flexible and present. Showing empathy, trustworthiness, unselfish attention, calmness, surrender, and love for the loveless, ungrateful, noncompliant, aggressive and unreasonable. Commitment to cry with, laugh with, accept, care unconditionally, provide warmth and appreciate (Taylor et al., 1995; Stevens Barnum, 1996; Ross, 1996; Leetun, 1997; O'Brien, 1999; Narayanasamy, 1999)

Professional responsibility, knowledge, vision, methodology

- Engaging helpfully in coping with psychiatric illness, and recognizing the importance of mystic and religious experiences in mental health care (Pieper & Van Uden, 2002; Borsjes, 2001)
- Developing vision for spiritual care, patient-oriented care, matters of meaning and perspective, and giving them a more prominent place in nursing care. Working from a holistic perspective that expresses the multidimensional and integrated functioning of patients, and encompasses physical, social, mental and spiritual aspects. Appreciating the importance of spiritual care, cultural values, individual variation and uniqueness. Recognizing that spiritual care is not to be equated with procedures and standards, or opinions on norms and values in relation to illness and health. Directing attention to patient experiences (Ross, 1996; Prins, 1996; McSherry & Draper, 1997; Leistra et al. 1999; O'Brien, 1999; Borsjes et al., 2001)
- Having knowledge of the bases of religions, existential questions, outlooks on life, worldviews, expressions of ultimate questions, practical information on religions. Knowing about cultural aspects of mental health, expressions, dysfunctions, dimensions and needs of spirituality. Appreciating that spirituality is more than religion. Knowledge of developmental stages in faith, the contribution of other disciplines, Christian theological, existential influences, the distinction between religious/non-religious, and the biological basis of spirituality (Campinha-Bacote, 1995; Prins, 1996; Ross, 1996; McSherry & Draper, 1997; Eliens & Frederiks, 2002; Rijksen & Van Heijst, 1999; Narayamasamy, 1999; Greenstreet, 1999)
- Acquiring methodology: observation, probing, intervention, knowledge of assessment tools and nursing process (Eliens & Frederiks, 2002; Rijksen & Van Heijst, 1999; Narayamasamy, 1999; Greenstreet, 1999; O'Brien, 1999; Steemers, 2001)
- Professional responsibility for spiritual care of problems in this area may have urgent consequences for patients' well-being. UKCC: being competent in identifying patients' spiritual needs, designing a care plan and contributing to providing and evaluating care using a problem-solving approach. NBS: being able to assess spiritual care, plan, intervene and evaluate on behalf of individual patients, friends and family. AACN: being able to understand the importance of human spirituality in order to recognise the relationship between religion, culture, behaviour, health and recovery, and be able to plan and provide adequate care (Ross, 1996; Westrik, 1999)

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Using the accumulated data in the cumulative analytical framework, RvL re-formulated the competencies found in the literature in the form of a 'competency profile' (see Table 3). This profile presents the answers to the research questions in a structured way. The sources from which the competencies were derived, are detailed in the right-hand column relating to each competency in the table. This provides an indication of how these articles contributed to the formation of the competencies in the profile. We suggest, furthermore, that the accumulated data in the analytic framework lead to three 'domains', or elements, relating to: the person of the nurse (attitude and personal qualities, professional responsibility, knowledge and vision); the nursing process (observation, assessment, diagnosis, coaching, information and advice, continuity and co-ordination of care, and multidisciplinary co-operation); and the institutional context of the care provided (fostering institutional conditions).

Selecting only those that were mentioned in multiple sources, six main competencies emerged in the three domains described above. We have labelled these domains:

- Awareness and use of self: this domain consists of competencies concerned with the way that nurses relate to patients
- Spiritual dimensions of nursing: this domain contains competencies required to handle different phases of the nursing process
- Assurance of quality and expertise: this domain pertains to competencies in handling contextual conditions for providing spiritual care within the organization

Furthermore, the six resulting competencies were described according to guidelines suggested by Pool-Tromp et al. (2001), including:

- A description of the competency (as labelled above);
- Vignettes indicating situations in which such behaviour is appropriate;
- Key focus for behaviour;
- Desired results.

An outside expert (from the Pool-Tromp et al. 2001 group) was consulted about the appropriateness of our use of the competency description model, and this resulted in a final reformulation. The result is shown in Table 3.

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Table 3 Proposed description of nursing competencies for spiritual care

Domain	Vignettes*	Competencies for spiritual care	References
A. Awareness and use of self	Nurse: At first, I did not realise that patient's story had touched me. I made a few notes in her care plan: she had no relatives, never got married, lived in her parent's house for a long, long time. She was afraid about what was to come. In my first talk with her she said 'I hope God is not going to test me all that much, because I don't know if I will be strong enough, but I want to trust Him'. Those words touched me: 'I want to trust Him'. In the grocery store I thought 'How can you trust in something like that? How can anybody have a confidence that strong?' It kept chasing me. It made me restless and even annoyed. (Steemers 2001, p. 96) An older man stayed here who had been through quite a lot. He had cancer and there was no hope. He was very religious. A few years ago he had lost his wife and he had never been able to accept this loss. He then faced a situation in which life didn't mean that much to him anymore. He wanted to request euthanasia but this conflicted with his faith. 'I cannot make a request for euthanasia; what will They Up There think? If I do that, I will be in another part of heaven and I may never see my wife again.' In short, a conscientious conflict. I could not help that man with this conflict. I asked if he would like to see a pastor and talk about it. He said 'Yes'. And it was very good. He appreciated that. Not that it solved all his problems, but he found some rest and he was able to go home. (Prins 1996, p. 111)	A.1 Nurses handle their own values, convictions and feelings in their professional relationships with patients of different beliefs and religions Key focus for behaviour: • to show respect for patients' beliefs; not to be prejudiced against people, churches or religions; not to label spirituality as pathological; not to force one's own beliefs on patients; • to reflect on the interaction between one's own spirituality (values and convictions) and response to the care one provides: e.g. feelings of frustration, distress, fear of illness, suffering and death, and the effects of personal experiences; • to recognise and admit personal limitations in providing spiritual care and to communicate these to the patient and the team; • to refer to another provider of spiritual care (another nurse or spiritual counsellor or pastor) in a timely and appropriate way. Desired results: To provide appropriate spiritual care to meet the needs of patients	Campinha (1995), Prins (1996), Ross (1996), McSherry & Draper (1997) Eliens & Frederiks (2002), Cone (1997), Greenstreet (1999), Narayanasamy (1999), O'Brien (1999), Westrik (1999), Steemers 2001, Borsjes et al (2001), Driebergen (2001), Weiher (2001), Van den Berg 2001, Taylor 2002, Jochemsen et al, (2002), McSherry & Cash (2000)
	The man was in a lot of pain. I offered to call the doctor for pain medication. But he wanted to bear the pain. To me that was a very strange answer. I had always	A.2 The nurse addresses the subject of spirituality with patients from different cultures in a caring manner	Prins (1996), Taylor et al. (1995), Ross (1996), Stevens Barnum (1996),

	learned that pain is neither good nor necessary and that it was to be combated with all means available. We got to talk about it. 'Pain has a meaning that is not unimportant', he said. 'When you go through your pain without sedating yourself, you build up a positive karma. Pain does not only have a cause, but a reason as well.' (Steemers 2001, p. 186) Their oldest son died that afternoon. He was a Hindu. After the last care for the deceased boy, his parents sat next to him for a while. When I entered the room and ask if there was anything else I could do for them, they asked me to take their deceased son from the room. I was very surprised. I did not expect it at all. I also couldn't understand it. They could read the surprise on my face. His mother looked at me and said 'We want him to leave us rather than the other way around. If we went away we would leave him alone, and we do not want to do that. (Steemers 2001, p. 178)	Key focus for behaviour: • To listen actively for aspects of patients' customary spirituality and spiritual aspects of the episode of illness, handicap, etc.; • To accept the other person, to be committed and compassionate, encouraging, empathetic, authentic, sensitive, sincere, unselfish and accessible, and to use touch; • To use relevant conversation skills (e.g. support the patient after receiving bad news, explore aspects of transcultural communication). Desired results: To make patients feel understood in their spiritual needs and to give them the opportunity to express thoughts and feelings about their spirituality	Leetun 1997, Eliens & Frederiks (2002), Greenstreet (1999), Narayanasamy (1999), O'Brien (1999), Rijksen & van Heijst (1999), Westrik (1999), Pieper & Van Uden (2000), Steemers (2001), Ganzevoort (2001), Borsjes et al. (2001), Driebergen (2001), Van Van Veluw (2001), Weiher (2001), van den Berg (2001), Jochemsen et al. (2002)
B. Spiritual dimensions of nursing	I grew up in a Pentecostal family. Every day we read from a bible study guide. Prayed before and after meals and before going to sleep. I still pray. Now I've been admitted to hospital. I've had no contact with anyone about matters of faith. I had when was admitted for the first time. I would appreciate to have the opportunity to talk to someone about my faith. Religion is simply never spoken about, but I would like to. A nurse with the same faith would be nice, but she doesn't have to be.' (Borsjes 2001, p. 55) On the table next to her bed she kept a silver tobacco box. According to the inscription the little box contained pipe tobacco. The box puzzled me. I couldn't imagine this lady smoking a pipe. I thought she probably kept something else in the box. She saw me looking and smiled. She told me 'I have been	B.3 The nurse collects information about the patient's spirituality and identifies the patient's need Key focus for behaviour: • To collect, organise and clarify information about the patient's customary spirituality, religious background, biography, mystical and religious events and experiences, and the role of habits, rituals, symbols and traditions in daily life; • To ask and observe how patients' spirituality influences the way they relate to and deal with episodes of illness, handicap, etc., and how an episode of illness, handicap, etc., influences the patient's spirituality (e.g. noticing non-verbal behaviour and symbolic language); • To use assessment tools and queries in an appropriate fashion (e.g. Stoll, 1979; O'Brien, 1999)	Campinha (1995), Prins 1996, Eliens & Frederiks (2002), Greenstreet 1999, O'Brien (1999), Rijksen & Van Heijst (1999), Westrik (1999), Ganzevoort (2001), Pieper & van Uden (2000), Borsjes et al (2001), Driebergen (2001), Weiher (2001), Steemers (2001), Jochemsen et al (2002)

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	a widow for ten years now. My husband died quite suddenly. He used to smoke this tobacco fervently He even used this little box the very day he died. I have always kept it carefully. I still miss him every day and when I have too much sorrow, I open the tobacco box. Then I can smell the fragrances of the past, the fragrance of homeliness, togetherness and happiness. This little box has become very dear to me. Often it will suffice just to pick it up. It brings my husband back for a moment. And then I'm able again to go through another day. (Steemers 2001, p. 94-95) We always ask very carefully, because not everybody wants nurses to know these things about them. So we first ask them: 'Would you like us to mention your religion? Perhaps there will be times when we have to take that into account. Maybe you have certain dietary wishes, or want to worship on Sundays, or talk to a pastor.' (Prins 1996)	• To determine and report (in writing) the patient's spiritual needs. Desired results: To make an assessment of the patient's spiritual situation so that possible caring interventions meet the patient's spiritual needs.	
	A hospital chaplain: Right now, I'm running this way and that. Ideally, the nurse should offer the services of the hospital chaplaincy according to a diagnosis, from which you can work with the patient. At the moment, the information only comes my way when things are already starting to give trouble. That problem once used to be a slight difficulty, it is only that it was never noticed among the multitude of other difficulties.' (Prins 1996, p. 99) A condition for adequate referral is that the nurse in her co-ordinating role does not only direct the request to a hospital chaplain, but that she also talks to the patient prior to that. (Prins 1996, p. 102) Nurse: When people see their disease as a punishment from God for something wrong they did in the past,	B.4 The nurse discusses with patients and team members how spiritual care is provided, planned, and reported. Key focus for behaviour: • To report verbally and in and writing about the patient's spiritual functions (including assessment, planning, intervention, evaluation) and ensure continuity of spiritual care; • To help co-ordinate which health professionals could best provide the spiritual care needed for the patient; • To make use of nurses with the same conviction as the patient in providing spiritual care (when possible and desirable);	Prins (1996), Ross (1996), Stevens Barnum (1996), Eliens & Frederiks (2002), Rijksen & Van Heijst (1999), Westrik (1999), Pieper & Van Uden & Van Uden (2000), Driebergen (2001), Steemers (2001), Weiher (2001), van den Berg (2001) Jochemsen et al (2002)

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	when illness is interpreted in religious terms, I always get a pastor involved. Meaning, when people's spiritual background starts playing a role. That touches on religious themes, which are not my turf. (Prins 1996, p. 104) As we speak, I am doing a bible group led by the hospital's pastor. I never dared to speak about religious experiences, as they are often easily labelled as pathological and also because I was uncertain about them being 'healthy'. I have experienced talking about them as a liberation of sorts. (Borsjes 2001, p. 48)	• To refer the patient to a pastor or another spiritual leader (when desirable) and see to it that contact is established; • To consult a pastor (if needed) in case the nurse has questions about spiritual care for the patient. Desired results: To provide a multidisciplinary effort to meet the spiritual needs of patients.	
	I never dared to tell this to anyone. When our baby died, my husband said there was no point in talking about it. 'You won't get it back by talking about it, you'll only rip our wounds open', he said. I have remained silent since that day. But that didn't make my grief go away. On the contrary, it seemed to hold me in its jaws. I could not accept her death, I could not give it a place in my life. She was my little girl, the meaning of my life. Now that I have told my story the pain surges up again, but I also feel some relief. It is getting lighter inside me. It was not right to keep the lid on it all that time. If I release it, maybe I will be released. (Steemers 2001, p. 49-50) Mr. G. has leukaemia. He has been admitted to the hospital and his situation is deteriorating rapidly. One day he asks if he could go to church on Sunday. He was raised a Catholic but has not gone to church regularly for many years. 'I sense the need more and more every day to talk in silence. Sometimes to God', he once said. He kept a children's bible in his room. Sometimes he asked a nurse to read a passage to him. He was too tired to read for himself. The church visit was also exhausting for him, but he said it meant a lot	B.5 The nurse provides spiritual care and evaluates it with the patient and team members. Key focus for behaviour: • To help patients to continue their spiritual habits (customary spirituality), such as religious rituals, prayer, worship, reading and listening to music; • To provide information about facilities in the institution (chaplaincy, chapel, celebrations); • To monitor spiritual expression while providing basic patient care (climate on the unit, time for physical care, daily routines); • To pay attention to patients' thoughts and feelings about handicap, illness, suffering and dying; • To discuss questions that patients may have about the meaning and purpose of life against the background of their life stories (e.g. fears and insecurities, sifting through their outlook on life, supporting coping, accepting, decision-making, drawing up a balance sheet about life, wishes about death); • To offer hope and comfort (asking about plans, helping to set goals, encouraging enjoyment of life, emphasising the good moments);	Prins (1996), Taylor et al (1995), Ross (1996), Stevens Barnum (1996), Leetun (1997), Eliens & Frederiks (2002), Greenstreet (1999), Narayamasamy (1999), , O'Brein (1999), Rijksen & Van Heijst (1999), Westrik (1999), Pieper & Van Uden (2001), Driebergen (2001), Steemers (2001), Van Veluw (2001), Weiher, 2001), Van den Berg (2001), Jochemsen et al (2002)

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	to him to be together with other patients and to pray. (Eliens & Frederiks 2000, p. 129) I had already been caring for him for months. From his medical records I knew a little bit about his life, but he kept very much to himself. On my nightshift, I found him crying. I'd never seen any emotion from him and was very surprised. I was taken aback when I saw him weeping. I walked up to his bed, put my hand on his shoulder and asked 'Is there anything I can do for you?'. He shook his head, unable to speak. I reflected then on what I would like someone to do for me in such a sad situation. While I was standing there, I noticed his glass was empty. 'Would you like a glass of water?', I asked. He nodded. I fetched a fresh glass of water for him and put it next to him. I also gave him a few extra tissues and went away quietly. After thirty minutes, he rang. He thanked me for the water and the tissues and started talking. He allowed me to get to know him. I will never forget that man. (Steemers 2001, p. 50) He was very restless. His hands kept moving around. I asked myself what I could do for him as a nurse. We could not talk anymore. We always maintained a good relationship. From our conversations I remembered he had a rosary. He was a Muslim and that's why I remembered talking about the little rosary and prayer. I looked in his drawer and there it was. I took it out and put it in his hands. Then he calmed down. I saw his lips form words. He was praying. 'Praying is being with God', he once told me. I saw now that it was true. (Steemers 2001, p. 102) A patient's daughter: I don't cry for my mother's death, but because of everything that happened: that she never thanked me; that I never had the feeling that it was alright that I existed. I rather cry for the mother that	• To apply relaxation techniques; • To coach family and friends with regard to spirituality (e.g. giving information about facilities in the institution such as services of chaplains, supporting communication with the patient, monitoring their own feelings and emotions); • To check if there has been enough attention to the patient's story, if the patient's need has been formulated adequately and if the care provided has been attuned sufficiently to the patient's need. Desired results: To provide patients with professional spiritual care that meets their spiritual needs.	

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	she was not, who I longed her to be. (Van den Berg 2001, p. 7)		
C. Assurance of quality and expertise	In the public's eye the hospital is famous because of good publications and good research. We're the best academic hospital. In addition, good patient treatment statistics are very important to the staff. But if all that gets in the way of what treatment means to a patient, you are just on the wrong track. The hospital may get good grades for hotel services or whatever, but what happens in the dialogue between doctor and patient or nurse and patient is much more difficult to sell to the outside. That is the internal 'score'. Emphasis on that score depends on the person in charge. But if we do not increase our awareness of the personal care for people, we can no longer call ourselves a top-notch hospital. (Prins 1996, p. 107-108) We have group meetings every two months. We take it in turn to present an experience we have had. At first we though it would be very difficult. After all, it is not merely about a patient but also about your own experience with spirituality. Along the way we have learned that it can be very interesting and fun to discuss patients' experiences, how you interact with them, what you say and how. Our biggest mistake is that we want to be counsellors and advisors too quickly. It is a wonderful lesson that we give each other every time. We also learn that we all face the same questions and have the same doubts. (Steemers 2001, p. 106)	C. 6 The nurse contributes to quality assurance and improving expertise in spiritual care in the organisation. Key focus for behaviour: • To address work problems in unit meetings and to coach colleagues with regard to spiritual care; • To make policy recommendations about spiritual care supervisors and administrators; • To implements projects for improvement of spiritual care. Desired results: To integrate spiritual care into the overall care process in the institution.	Prins (1996), Stevens Barnum (1996), Eliens & Frederiks (2002), Greenstreet (1999), Borsjes et al. (2001), Steemers (2001), Jochemsen et al. (2002)

*Vignettes have been translated from the Dutch.

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Discussion

On the basis of this literature review, we have been able to formulate competencies that nurses need for providing spiritual care. Firstly, the following nursing interventions and activities regarding spiritual care are described in the nursing literature:

- The nurse is able to collect information about the patient's spirituality and to identify the patient's need
- The nurse is able to discuss with patients and team members how spiritual care is provided, planned, and reported.
- The nurse is able to provide spiritual care and to evaluate spiritual care with the patient and team members

Secondly, these requirements concerning the nurse's professional attitude regarding spiritual care are described in the nursing literature:

- The nurse is able to handle their own values, convictions and feelings in her professional relationships with patients of different beliefs and religions
- The nurse is able to address the subject of spirituality with patients from different cultures in an caring manner

Thirdly, the organizational conditions for the provision of spiritual care are described as follows:

- The nurse is able to contribute to quality assurance and the expertise improvement regarding spiritual care in the organisation

Using the interventions and conditions from the literature review, the components of competencies understood in the abovementioned manner, yield the nursing competency profile for spiritual care as shown in the table.

Study limitations

On a theoretical level, it is still an open question how spiritual care fits into the realm of professional nursing responsibility. Although the first section of our paper provides an initial perspective, overlaps and differences between the expertise of nurses and pastors/chaplains are still unclear. As this issue is pertinent to interdisciplinary co-operation and referral, it deserves further investigation.

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We are aware of the limited scope of the literature review itself and the small number of researchers making the selections. While saturation was reached after summarising 29 documents, it is hard to tell whether a much more comprehensive study might have different outcomes. However, our claim that our findings sufficiently represent much of the existing body of literature is supported by the fact that our competency profile resembles elements of well-grounded studies such as those conducted by Nayaranasamy (1999, 2001), Greenstreet (1999) and Cone (1997).

It is clear that the results of the literature review are not the results of a survey of clinical experience. The practical validity of the competency profile remains to be tested, for instance by interviewing nurses and patients in our own country. In addition, the research questions were general in nature; there was little distinction between fields of nursing, categories of health problems, or spiritual backgrounds of patients. Although the general structure of the competency profile may be useful, it might be the case that specific spiritual functioning differs across settings and contexts.

Conclusions

Implications for research

Taking these two limitations together, the following areas for research may be suggest ed. Firstly, patients' expressions of spiritual function may appear differently in different health problems. This means that nurses may need different competencies when working in maternal and neo-natal care, care for people with disabilities, care of those with long-term conditions, care of the dying, and so on. Secondly, and related to the first point, various aspects of spirituality may differ across the settings in which nurses work. Their professional responsibilities and, thus, their competencies may vary in settings that range from community care, rural areas, and missionary work to 'high-tech', inner-city, acute, intensive care and academic hospital settings. Thirdly, in multicultural societies, nurses may have to deal with patients from different religious and cultural groups in different ways. Competencies appropriate to each of these three areas (problems, settings and culture) have received little attention. Further research is needed in these areas to provide solid bases for nursing competency profiles.

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Implications for education

Lastly, how these competencies could be embedded in nurse's development as professionals and what a competency profile for spiritual care in professional nursing means for nurses' own personal spirituality are also matters of further investigation. If accepted, therefore, domains and competencies in our profile have implications for nursing education (McSherry & Draper 1997; Ross 1996). We will hint in some directions of possible further development and investigation.

First of all, this competency profile may provide a guideline for designing educational programs. It might serve as a backbone for a nursing curriculum in spiritual care. From the competencies, program objectives, module objectives and content could be developed

Nursing students must learn to provide spiritual care in a systematic way. Curriculum components, for instance those addressing the nursing process and communication skills, should also address the variety of spiritual expressions in the patient's behaviour. By way of case studies and role-playing essential aspects of spiritual care can be highlighted. Moreover, nurses will be expected to contribute to the contextual and organisational conditions for spiritual care, for instance by influencing staffing and building policy, as spiritual care takes time, personnel and private surroundings. This means nurses have to learn to perform quality assessments of nursing care and to produce policy recommendations for their effective management.

An essential condition for adequate spiritual care, seems to lie in the nurse's use and awareness of self. Developing the right attitude in spiritual care needs to be aimed explicitly at handling the nurse's own spirituality in relation to the patient's spirituality. For this development relates directly not only to one's skills of communication with the patient, but also to relating to a patient with different beliefs, to the limitations of sharing one's own faith with a patient, and to coping with conflicts in one's own conscience.

One form of education that may support such attitude development is the "reflective education" model. Reflection is to be understood as considering and critically

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reviewing one's own conduct, emotional responses and thoughts with the purpose of learning from these experiences and putting this learning experiences to future use in a conscious manner. It is a way of structuring one's own experience in a clinical situation, involving real life problems, in their context, through reflection, by interacting with other learners.

Such a model offers opportunities to encourage reflection, involving explicitly the student's full personality. To state the point in relation to spiritual care: spiritual care means support of the patient's spiritual function, but it also requires support of the nurse's own spirituality. Those two are connected in the patient-nurse relationship. Reflection will have to make that connection transparent for the students. They must become aware of their values and convictions and of the way these are entangled with the care they provide.

Although work remains to be done in different directions, we believe a valid attempt has been made to outline extant information. Especially in the area of education, some important challenges for the development of professional nursing appear. This paper is intended as a contribution to this development.

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Chapter 5

Spiritual care: implications for nurses' professional responsibility

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Abstract

Aim. This paper aimed to gain insight into the spiritual aspects of nursing care within the context of healthcare in the Netherlands and to provide recommendations for the development of care in this area and the promotion of the professional expertise of nurses.

Background. International nursing literature suggests that caregivers are expected to pay attention to spiritual aspects of patient care. In Dutch nursing literature the spiritual dimension is becoming more and more a focus of attention. Despite this, there is a lack of empirical data from professional practice in the Netherlands.

Method. Data were collected by means of focus group interviews. The sample was made up of the specialist fields of cardiology, oncology and neurology and divided into groups of patients, nurses and hospital chaplains. The interviews took place between May and December 2004. Data were qualitatively analyzed using the computer programme Kwalitan.

Results. Different spiritual themes emerged from the interviews. There were different expectations of the nurse's role with regard to spiritual aspects. The main themes derived from this research can be recognized as aspects of nursing competencies that are reported in the literature. However, the attention to spiritual aspects in the nursing process is not clear cut. It seems to be highly dependent on personal expression and personal commitment.

Discussion. The study raises questions about the nurse's professional role in spiritual care. The study shows that different factors (personal, cultural, educational) play a role in the fact that spiritual care is not systematicly embedded in nursing care. Further research on the impact of that variable is recommended.

Relevance to clinical practice. Nursing care implies care for the spiritual needs of patients. to provide this care, nurses need to be knowledgeable regarding the content of spiritual care and the personal, professional, cultural and political factors influencing it. They also need to be able to participate in policy and decision-making discussions of spiritual care in clinical nursing practice.

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Introduction

The role of spirituality in health and healthcare is recognized by health professionals (Koenig, 2002). The claim that nurses should take account of aspects of spirituality derives from a holistic perspective on human functioning and in nursing (O'Brien, 1999, McSherry, 2000). Narayanasamy (2000) takes an ideal view of healthcare with spirituality forming part of a holistic perspective. By this he means that a human being consists of body, mind and spirit, and that these dimensions are interconnected and interdependent. Spirituality, therefore, is an integral part of the nursing domain. There is an increasing research base for spiritual care (O'Brien, 1999, McSherry, 2000, Narayanasamy, 2000, Taylor, 2002). On the contrary, nursing is becoming an increasingly important source of insight into the relationship between aspects of spirituality, health and healthcare. However, certain aspects of the topic are contested, such as the conceptualization of spirituality and the nurses' role in providing spiritual care. McSherry et al. (2004) emphasize the different conceptualizations of spirituality in the nursing literature. They conclude that the goal of achieving a universally accepted definition of spirituality would seem to be impossible. They argue that a person's view of the concept depends on his or her view and interpretation of the world. These authors present a classification of the different meanings of the concept of spirituality, on a continuum ranging from a strictly religious meaning at one end to a strictly humanistic, existential meaning at the other. This multidimensional approach is not only a result of philosophical analysis, but can also be concluded from empirical evidence (Flannely et al. 2002, Johnston Taylor, 2005). Flannely et al. (2002) implicitly emphasize the multidimensional approach of spirituality by holding that a strictly religious interpretation of spirituality is problematic for an adequate assessment of the spiritual needs of, particularly, non-religious patients. Van Leeuwen and Cusveller (2004) accept the multidimensionality of spirituality by choosing what they have termed a functional approach to spirituality (Fitchett, 1993). They describe spirituality as the religious and existential mode of human functioning, including experiences and the questioning of meaning and purpose (Jochemsen et al. 2002). This definition reflects the view that human beings express their common function of spirituality in different forms and content. This functional definition is used in the study that is reported in this paper.

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Reviews show that there has been research into aspects of spiritual care in various settings. On the basis of a review of nursing journals for gerontology, Weaver et al. (2001) found that religion and spirituality are of great importance for older patients in clinical situations. Spirituality, they suggest, plays a vital role in the lives of older people who are suffering from illness. They also found that nurses are strongly confronted with their own spirituality when delivering spiritual care to patients, which means that providing spiritual care for the patient, in fact, also affects the nurse him or herself. From a review of nursing journals for oncology, Flannely et al. (2002) found that there are different expectations between nurses and hospital chaplains regarding the role of nurses in providing spiritual care. These differences mainly focus on when a nurse should refer the patient to the hospital chaplain. The issue in question is whether the nurse can handle certain aspects of spirituality by themselves and, consequently, when referral is needed. Narayanasamy et al. (2001) emphasized that there is confusion about the role of nurses in relation to spiritual care and he identified different perspectives from which nurses approach spiritual care (personal, procedural, cultural and evangelical). This study shows the different dimensions of spiritual care.

Van Leeuwen and Cusveller (2004) described three domains of nursing competencies for spiritual care on the basis of a literature survey. These domains are self-awareness and communication, spiritual dimensions in the nursing process, and quality assurance and expertise development on spiritual care. They suggest that, despite the descriptions of these competencies, there is still confusion with regard to distinctions between the professional responsibility of nurses and that of other healthcare professionals.

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In summary, nursing literature shows that spirituality and spiritual care are part of the nursing domain, but that there are still questions to be answered about the content and borders of spiritual care in nursing. Little empirical data are available from Dutch healthcare about this aspect of nursing. More research was needed to explore spiritual care and to contribute to the discussion on this aspect of nursing care. On the basis of these considerations a qualitative focus group study was performed within the context of clinical somatic healthcare in the Netherlands in May-December 2004.

Aim

The aim of the study was to answer the question in what way do nurses pay attention to aspects of spirituality of patients within the context of Dutch clinical somatic healthcare and what can be inferred from this empirical data with respect to the professional role of the nurse in spiritual care. The purpose of this study was to contribute to the debate on the nurse's role in spiritual care on the basis of that empirical evidence.

Methodology

Data were collected by means of focus groups in the form of group interviews. The focus group method is a form of qualitative research that uses accepted systematic procedures for data collection, data handling and data analysis. In the case of this study the method allowed the researchers to obtain in-depth perceptions of people in a complex topic like spiritual care. (Krueger, 2000). In particular, the group-dynamic effect allows participants to recognize each other's experiences in relation to spiritual aspects, as well as pointing out similarities and differences, and encouraging them to consider or reconsider their own experiences and views. The group size created a confidential atmosphere, which allowed an in-depth study. The role of the discussion leader was of vital importance in ensuring that all participants could have their say during the discussions. In reality, some participants are more dominant than others, which can hinder the collection of data, in turn affecting the reliability and validity of the research. Trial interviews and the debriefings following the interviews proved to be vitally important.

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Sample

In this study a convenience sample was used, that was formed using a 'double layer design' (Krueger, 2000), consisting of the specialist fields of cardiology, oncology, and neurology, which were further divided into groups of patients, nurses, and hospital chaplains. The following criteria were used for the sample:

- Nurses: qualified for a minimum of four years and working at least 50% of a full-time position.
- Patients: recent hospital experience (admitted within the past 2 years).
- Hospital chaplains: at least 5 years of professional experience.

The specialities were selected based on a literature search (Van Leeuwen et al. 2004), with a further distinction made between acute and chronic ailments. Table 1 contains the main parameters of the focus groups.

Table 1 Focus group participants

Group	Number of Groups	N	Characteristics
Patients	4	25	Male/female ratio 9/16 Average age 58 (range 44-82) Average hospitalization 4,4 weeks (range 1-30)
Nurses	6	30	Male/female ratio 2/28 Average age 39 (range 28-54) Average work experience 10 years since obtaining a degree
Hospital chaplains	3	12	Male/female ratio 9/3 Average age 50 (range 33-58) Average of 12 years' professional experience

The starting point was to form groups of 5-6 participants to guarantee sufficient opportunity for in-depth interviews. This has been accomplished. Drop-out among participants is a problem when using focus groups, therefore 8 participants were approached for each group. There were drop-outs in several groups as the result of illness, transportation problems and personal reasons.

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The participants participated voluntarily and were recruited through different means (patient contact groups, hospitals, professional organizations). Geographical spread was taken into account in this study and the ideological background of the participants was consistent with the Judeo-Christian and humanistic roots that characterize Dutch society. Ethical approval from an ethics committee was not necessary. There was no dependency of the participants and the research method was not burdensome or risky. Before the focus group members decided to participate they were given detailed information about the research and their role in it. They could withdraw at any time in the process.

Data collection

An interview schedule consisting of open questions was used for data collection. Each participant received information on the research in advance, including the following definition of spirituality: the existential or religious mode of human functioning, including experiences and questions of meaning and purpose (Jochemsen et al. 2002). This was perfomed to provide a spiritual frame of reference for the participants in the case they were not familiar with the word 'spirituality'. The interviews were recorded on minidisc and a written report was made during each interview, setting out the main topics of the interview and salient non-verbal responses. Following each interview a debriefing was held by the interviewer and the research assistants.

Data analysis

The interviews were transcribed in full and this material was then qualitatively analysed per group and between the different groups using the computer program Kwalitan (Peters, 2000). The reports from the debriefings were also included in the analysis. The analysis process consisted of the following steps:

- Segmentation and coding of transcripts
- Describing substantial themes in a tree structure
- Categorizing the themes and matching the characteristics of the fragments.

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Validity and reliability

During the research, methodological measures were taken to ensure the reliability and validity of the research. These are recorded in Box 1.

Box 1 Reliability and validity measures applied in the focus group research

- Making use of the definition/description of the term 'spirituality' and working with a topic list. Testing topic list in a trial interview
- Trial interviews were held in order to develop the roles of interviewer and assistants
- Keeping the roles of reporter/observer and the interviewer separate during interview
- Debriefing by research group after each interview to discuss the initial impressions
- Keeping a reflexive journal with methodological and theoretical notes on findings/ thoughts connected with the research
- Frequent meetings and discussions in the research group concerning the processing of interviews and analyzing the data
- Peer debriefing: assessment of all steps in the research by a professional in the field of research and spirituality
- Person triangulation: patients, nurses and hospital chaplains
- Recording the interviews on audio tape, from which written transcripts were made in full and which were used for the analyses
- Use of the computer program Kwalitan (Peters, 2000) to process and analyse the research data
- A written research report including all steps in the research
- Verifiability of the research through systematic recording of all documents and reports
- 'Thick description': phenomena are described and explained in the research report, and illustrated by means of typical excerpts from interviews from the interviews (Lincoln and Guba, 1985, Maso and Smaling, 1998, Polit and Hungler, 2000, Krueger & Casey, 2000)

Results

The following description of results will briefly address the themes that were derived from the interviews. These themes are illustrated with quotations from different participants of the interviews. Table 2 gives an overview of the themes that the analysis identified from interview texts. These are categorized into six nursing competencies for spiritual care (Van Leeuwen and Cusveller, 2004). The table also provides more insight into the different dimensions of the themes, obtained as the result of the coding process.

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Table 2 Aspects of spirituality concerning illness

Nursing competencies for spiritual care (van Leeuwen & Cusveller, 2004)	Themes derived from interviews	Dimensions
Handling one's own values and convictions	The nurse's spirituality	Reaction as a person, influenced by professional practice, has an influence on professional practice, role of upbringing, life history, life experience and professional experience, age
	Attitude	Sensitive, human, warm, patient, caring, careful, well-informed, a calling, involved, listening, attention, recognition, respect, non-judgemental, showing of self, holistic view, honest, unintrusive, not interpretive, courage, authenticity, enjoying life, trust, giving, taking time, solution-oriented versus reflective, age, life experience
	Personal emotions	Inner conflict, being personally moved, strength-helplessness, importance of expressing emotions
Communication with the patient	Relationship of trust	Connection necessary, limited by admission period, recurrence, presence
	Communication skills	Empathizing, confirming, encouraging, expressing/channelling emotions, listening, not focused on solutions, taking time, right moment, non-verbal, challenging, breaking bad news
	Talking about spirituality	Circumstances: evening/night, same faith, spontaneous, needs time, familiar with spiritual/religious language, often coincidental, not structural Content: attention, illness process, future, getting things organized, telling of story (including past), death, last wishes, saying good-bye, family situation, helping get through difficult moments, preparing for major treatment, conversation with family/ partner
	Communication problems	Avoiding (aphasia, foreign language), generation gap, not enough time, mis-understandings/misassociations about spiritual issues, privacy (sharing room)

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Establishing the need for care	Anamnesis	Time (can be too early), subject taboo, wrong associations by patient, defensive reactions Anamnesis questions: some are asked, some not, which faith, need for pastor, church, meditation centre, religious experience, life style, wishes, values/convictions (Gordon), how were previous situations handled (coping), important periods in life
	Identifying spiritual needs	Identifying: watching for emotions, ambiguous reasons; strange behaviour, if the nurse is personally moved
Care attuned to patient/ disciplines	Planning/nursing plan/ reporting	Often not structural, depends on person, integrated as psychosocial functioning (coping), standard nursing plan 'ideological need'
	Organization of care	Little continuity experienced, depending on people, system of prime responsibility: nurse positive, spiritual advisor, discussion with team supervisor, volunteers/hostesses play a role
	Disciplines	Physician: questions surrounding resuscitation, quality of life, nurses standing up for patients Spiritual advisor: need/no need, preference for own pastor, relating to surgery and/or treatment Referral by nurse: at patient's request, own initiative, patient with strong beliefs, death situations, longing for old religious values, life questions, after breaking bad news, if nurse has no time, life full of struggles, indefinable questions, face-to-face conversation, comfort Social work: advice on finding purpose, referral by nurse
	Multidisciplinary meetings	Initiative often from spiritual advisor, raising awareness, input nursing depends on person, often a lack of time
Implementing and evaluating health care	Interventions	Depends on person, attention during basic care, warmth, presence, physical contact, comfort, encouragement, conversation, care and attention

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		to family, praying with patient (controversial/referral), terminal care, using tools for coping (looking at pictures, list of questions), setting priorities when it really matters
	Evaluation	Especially after a difficult conversation, often stays between nurse and patient
	Time	Patient realizes that nurse is busy, nurses feel they lack time, no time means not wanting to make time: referral to spiritual advisor
	Nursing team	Planned and spontaneous meetings, sharing, venting emotions and experiences, reflection, acceptability of treatment, quality of life, not able to figure things out by yourself, inner conflict, suffering, illness perception of patient and/or partner, creates a bond, support, understanding, trust, able to cope with work, cannot be discussed with all colleagues
	Cultural aspects	Positive ward culture: close team, outgoing culture, good information and guidelines, clear vision of care, daily personal attention, positive attitude of supervisor, good atmosphere Negative factors of hospital culture: dominance of medical-technical aspects, tension between cure and care, evidence-based work, commercialization
Quality care/ improving professional expertise	Education	None during basic programme, but basic skills sufficiently trained, present in specialist programmes (oncology), practice learning is important
	Need to improve professional expertise	Conversation techniques, developing sensitivity to the topic, becoming aware of one's own sense of purpose, experience important too, knowledge of religious/spiritual movements, language, traditions, sense of purpose at work

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Expectations of the role of nurses

Participants had different expectations concerning the role of nurses in spiritual care. Patients, in general, emphasize a need for the attention and presence of nurses and want nurses to display good professional skills, by which they mean physical care. In general, nurses wondered what their own responsibility was in this area. Hospital chaplains had opinions varying from being able to identify problems and making referrals to having reflective contact with patients:

Patient: Can you expect a nurse to be an all-rounder? Should he/she be an expert in psychology and religion as well as health care in order to have a conversation with you on these subjects?
Nurse: I find it difficult to say whether it is part of my professional duty, or whether it is something personal.
Hospital chaplain: It is wonderful when nurses discuss questions about life with a patient, but it's just a lucky coincidence. I believe I don't expect it in general from nurses. Nurses mustn't think that they can solve everything, because they can't.

Nurses' own spirituality

Participants indicated that, in the case of spiritual care, it is important for nurses to show who they are and that they respond on a personal level. Patients wondered if they could expect the same from all nurses. Some nurses related that they had been spiritually moved by patients, for instance when a patient is suffering or displays spiritual courage. Nurses appeared to be influenced by their upbringing, their personal history and experiences, which causes them to pay attention to spiritual aspects. Personal spiritual experiences of nurses also played an important role, and these are not necessarily restricted to certain age groups. Patients noticed that older nurses pay more attention to spiritual aspects.

Nurse: My brother was killed in an accident when he was 20 years old. My father did not take it well and the worst possible thing happened: my brother was never mentioned again. My mother is 86 now and has lost another son. When we talk about it, which I do more often now, the pain is so sharp that she can burst out

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crying every time. This is how I came up with the idea of asking a patient ‘how do you talk about it with your family?

Nurses indicated that as they grew older and gained more personal and professional experience, they noticed and paid more attention to spirituality. Whether or not a nurse is religious also seems to have an effect. Patients noted differences between nurses who are religious or not. There was a certain recognition when they interacted, and some patients indicated that they had a better connection. Several patients stated that it must be the patient who initiates this type of contact. It was perceived in a negative way if a nurse imposed her faith too much. All participants were convinced that the relationship between patients and nurses must be based on trust. Hospital chaplains were under the impression that religious nurses were more likely to refer patients to them.

Attitude of the nurse

All participants pointed out which characteristics should be part of a nurse’s basic attitude with regard to spiritual care. Patients used words such as ‘sensitive’, ‘human’, ‘warm’, ‘patient’, ‘caring’, ‘careful’, ‘well-informed’, and ‘involved’ to describe this attitude. Some referred to it as a 'calling'. Nurses emphasized qualities such as showing respect and not judging people who have different religious views. Hospital chaplains believe that nurses are naturally inclined to find solutions. This is in contrast to the 'spiritual attitude', which requires more reflective qualities:

Hospital chaplain: Nurses must have a more reflective attitude, paying attention to the helplessness, sorrow and disappointment of the patient. These things can be communicated and shared while the patient is being washed or cared for. Nurses focus strongly on finding solutions: ”we have a problem and we will solve it”. There is much to be gained from listening to what is truly important to the patient’

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Nurses' emotions

It seems that aspects of spirituality are also connected to certain emotions displayed by nurses. This became especially apparent during the interviews when situations of inner conflict were mentioned (how can this dying patient speak so positively about God?), being personally moved by a patient (confrontation with suffering), and feeling powerless (feeling that nothing can be done for the patient, or not being able to reach the patient):

Nurse: What I always find challenging is a patient who has a different view on life than I do. I try to accept people for who they are and respect them, and I do this. The other side of it is that I am confronted with myself, because I have different ideas about life.

In many cases the nurse won't discuss these aspects with the patient, but it does lead to personal reflection. Nurses also mentioned situations in which they could barely handle the emotional burden and were personally hurt. This gave rise to ambivalent thoughts because some nurses said that these emotions should be permitted, but wondered whether this is right.

Nurse-patient communication

A wide range of spiritual topics was discussed in conversations between nurses and patients. Factors that may enhance the communication about spiritual issues between patient and nurse could be derived from the interviews. In many cases conversations occurred during the evening and night shifts, when there was more time. It also appeared that such conversations started spontaneously, without any kind of planning. Openness on the side of the patient as well as the nurse determined whether such a conversation occurred. Another factor seemed to be whether the nurse and patient shared the same ideology and were able to recognize each other's religious language:

Nurse: I talked to a young woman with cancer. She does not have long to live. She has a young child and she said: "I work and I'm often tired". I try to start a

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conversation with her; umm, what do you want in this life?, what do you find important right now? – your work, your child, or both?

According to patients, a generation gap between the patient and nurse can be an obstacle. Some said that they talked more about spirituality with older nurses. Specific communication problems may cause a nurse to avoid contact with the patient (such as aphasia with neurology patients and patients who speak a different language). The lack of privacy in a room is also considered a decisive factor:

Nurse: Privacy is sometimes a difficult thing for patients who share a room with others. Sometimes you can't talk with a patient, or because he or she feels uncomfortable. Or sometimes the patients appear to be at different stages of coping or they deal with things differently. It can be very challenging when someone is constantly dealing with death while someone else is not.

Assessment and nursing plan

Spiritual aspects play a role in various ways in the assessment process. In many situations this was limited to one or two questions, such as whether the patient belongs to a religious community or would like to see a pastor. In some situations nurses seemed to ask further questions, for example about the patient's spiritual views or how the patient has handled previous situations. Sometimes the topic of spirituality was not mentioned at all:
Nurse: 'With patients who have acute heart problems I do not bring it up because they will immediately think they are dying, which is not good at all. If you bring it up, you should do so gently at a later stage of the process, but in the acute phase, I think it is inappropriate.

Some nurses indicated that the intake interview is not the right time. In their view, the basis of trust is not yet there, which could trigger a defensive reaction from the patient ('they'll send a minister and I don't want that'). Generally, we observed that, in practice, no attention is paid to spiritual aspects in the nursing plans. Some of the oncology nurses recorded it as a coping problem, rather than a spiritual problem.

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Nursing interventions

Important interventions in the area of spiritual care that were mentioned include aspects relating to the nurses' attitude and to communication. The decision to intervene seemed highly dependent on the personal choice of the nurse, and was often spontaneous. An exception to the rule appeared to be care during the dying phase, when care seemed to be more systematic. In a limited number of situations, nurses sometimes prayed with a patient. Patients appreciated it in these situations because it was their wish. Occasionally this raised questions within the team. A few nurses used tools to talk about spiritual aspects, such as pictures to help the patient tell his or her personal history, and models to deal with the illness:

Nurse: Then she asked me if I could pray. I said that she moved me by asking that, and that I sensed that she was scared. I told her that I recognized it and then I prayed the Lord's Prayer with her. This has moved me deeply and I also talked to my colleagues about it, who wondered if it was okay. To this woman it meant a lot.

Personal limits

Several nurses stressed the importance of not crossing one's personal limits. They believed that a process should only be started with the patient if the nurse is able to follow it through.

Nurse: ' patient was brought to the IC during the night shift. Her condition had acutely deteriorated. A student brought her some mail the next day. She went over to the patient and out of the blue she said: 'Do you want this, do you want to go on?' The patient softly replied 'No, no'. Then the student said: 'I have to leave now, to get back to the ward'. The patient said 'No, no, don't go'. The student was upset. She didn't know what to say.

Organization of care and multidisciplinary co-operation

Nurse referrals to or involving the hospital chaplains either occurred at a patient's request or were initiated by the nurse. Hospital chaplains said that nurses were often the driving force during multidisciplinary meetings when it came to making people

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aware of the relevance of spiritual aspects. Both nurses and hospital chaplains agreed that nurses raised a relatively small number of spiritual matters in these meetings.

Nurse: We had a 50 year-old man with lung cancer. He was back after 3 months, and it was a disappointment for him, going back to chemo. He was married, had four children. I thought: 'What should I do now?' I thought of spiritual care, but immediately wondered how I should bring it up. I always have the feeling that I should talk around it or else they wouldn't be willing to listen. But he needed it so much. I talked to him about it and he actually wanted this.

Different indications were mentioned for referrals to the spiritual advisor. Social work also focused on helping patients find a sense of purpose. In practice, this lead to different referral behaviour by nurses. The referral seemed to depend on whether the particular discipline was present in the multidisciplinary meeting and on the nurse's interpretation of such issues. Nurses who associated these issues with unhealthy ways of coping were inclined to refer patients to a social worker. In the cooperation with physicians that occurred when decisions were made on treatment, nurses emphasized their role as 'the patient's advocate'.

Evaluation and reflection in the nursing team

The evaluation of spiritual aspects was confined to the nurse and the patient. When nurses experienced problems with the patient, they were more inclined to discuss it in team meetings. Team meetings occurred spontaneously and on a regular basis. Nurses considered these sessions to be very supportive. They created a mutual bond of understanding and trust, allowing the nurses to cope better with their work. It should be noted that spiritual aspects could not be discussed with all colleagues. Nurses knew which colleagues were open to it and they found the right person to talk to:

Nurse: I know which people I can easily talk to about it and which people I can't. It’s the colleagues who also talk about it with patients that I know are more open to it. I also know very well which people I shouldn’t talk to about this, because they think it is out of line, or they do not see it as part of nursing.

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Time

Patients saw that nurses were busy and understood that they had little time and attention for a conversation. They clearly defended the nurses on this. However, patients felt that time could sometimes be made available, and some explicitly said that they were disappointed by the lack of attention. Nurses also admitted that they sometimes had little or no time for the patient and, hence, for spiritual aspects. They also realized that, in some cases, it is a matter of having to set the right priorities and choosing the right moment. Another point raised was that if nurses said they did not have time, they actually meant that they did not feel like talking (an avoidance mechanism).

Patient: Nurses do not have any time. They want to listen and then they sit on the side of your bed and then they have to leave again. They are open to it, but they don't have time to have a normal conversation.

Cultural aspects

There are different factors in the ward and hospital culture that may influence spiritual care. With respect to ward culture, the following were mentioned as having a positive influence: a close team, an outgoing culture, being well-informed about patients, a care vision based on personal attention to patients, a supervisor who has a positive attitude, and a good atmosphere within the team. With regard to hospital culture, there was an emphasis on factors that had a negative influence, such as: the corporate approach together with experiences of increasing commercialization, the dominance of medical-technical aspects that cause tensions between cure and care, the emphasis on evidence-based care. This gives people the impression that the human aspect of care is in danger:

Hospital chaplain: The organization is very much focused on efficiency, high-tech and controlling processes. These have produced wonderful results. But the relationship between humans has suffered.

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Education

Little or no attention is paid during the basic training of nurses to explicit spiritual aspects. However, many nurses noted that the basic communication skills that are essential in providing spiritual care were sufficiently trained at school. There was a need for additional training, involving topics such as spiritual conversation methods, personal spiritual awareness and how to apply this in professional care, information on spiritual/religious movements and the language and traditions that go with it, and finding a sense of purpose at work.

Discussion

These results suggest that attention to spiritual issues in the nursing process is present but not clear-cut; it seems very divers and largely dependent on the personal expression of the individual nurse. These findings confirm the conclusion of Narayanasamy (2001) that the approach to spiritual care is apparently largely unsystematic and delivered haphazardly. This raises questions about the relationship between a nurse's professional responsibility and his or her personal convictions regarding spiritual care. The research also shows that the experiences and expectations of the nurse's role vary among patients, nurses and hospital chaplains. This matches the findings of Baldacchino (2003), who suggests that responsibility for spiritual care lies with the caregivers, but also with the patient's significant others (family, partner, own pastor). This seems to indicate a crucial role for the patient concerning the question of which spiritual needs play a role in his or her situation and who is to minister to those needs. Should we then accept that attention to spirituality within the nursing profession is simply a coincidence, as stated by a hospital chaplain in one of the interviews, or should we expect more from a nurse? Perhaps mixed focus groups with patients, nurses and hospital chaplains can shed some more light on this in future research.

This study indicates that the basic care activities that seem to form the essence of spiritual care are a nurse's presence, listening, respect. Many authors emphasize these aspects but also mention many other aspects of spiritual care (O'Brien, 1999. McSherry, 2000, Narayanasamy, 2001, Taylor, 2002). It seems also that nurses

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hardly know what their responsibility is with respect to spiritual care. In theory many of the expectations of nurses can be described in competencies for spiritual care that go far beyond basic skills (Van Leeuwen and Cusveller, 2004). The main themes of the present study can be recognized as aspects of these competencies. However, the results of this research suggest that these aspects of spiritual care are poorly structurally embedded in nursing practice and barely form part of the professional competence of most nurses. According to Cone (1997), several stages should perhaps be introduced into the nurse's role in spiritual care, ranging from basic responsibility (listening, supporting practices) to a real spiritual connection between nurse and patient, based on the same emotional and spiritual frame of reference. Not all nurses should be expected to operate at this latter level.

On the other hand, we suggest that in addition to an inadequate context for spiritual care in nursing practice other factors play a role as well (age, experience, upbringing, spiritual involvement, time, cultural aspects). This has also been recognized by McSherry (2000), who stated that nurses should give due thought and attention to the demands and pressures that many nurses encounter in their practice.

Another important reason for poor spiritual care by nurses in general may be the lack of education (McSherry and Draper, 1997, Bush, 1999, Greenstreet, 1999, Narayanasamy, 1999, Baldacchino, 2003). Research studies show that nurses, after following nursing training programmes about spiritual care, experience more spiritual awareness and deepened relationships with patients and feel more competence in providing spiritual care. (Groer et al. 1996; Bush,1999; Catanzaro & McMullen, 2001, Fu-Jin, 2001; Hoover, 2002; Jootun & Lyttle,2004). In agreement with Johnston Taylor (2005), we recommend that more studies be performed on the relationships between relevant variables (education, personal factors, cultural factors, etc.). They may generate insight into the effects of training programmes on the professional delivery of spiritual care.

Limitations of the study

This study has some limitations that may have affected the validity of the results. First, it should be noted that a convenience sample was used. This might have

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biased the results and rules out generalizability of the results. Many of the participants were willing to participate because they were explicitly interested in the theme of spiritual care. Second, there were no participants with an Islamic background in the focus groups. This group forms a substantial part of the population in the Netherlands. It is important for further research to include this group to obtain a more representative view.

Another aspect that should be considered is the relatively wide range of professional experience between nurses and the duration of the hospital stay of patients. This might have influenced the difference in experience with aspects of spiritual care.
The focus group method seemed to be adequate in answering the research questions. Despite measures to prevent people from dropping out, some did. It is not known whether this affected the outcome. The role of the discussion leader is also of vital importance. All participants must have their say during the discussions. In reality, some participants are more dominant than others, which can affect the reliability and validity of the research. The trial interviews and the debriefings proved to be vitally important.

Conclusion

The research findings indicate that attention to spiritual issues in nursing care is not clear cut. The nurse's own spirituality may play an important role in paying attention to spiritual aspects in nursing practice. In addition to this 'personal factor', other factors seem to influence the provision of spiritual care (age, experience, spiritual involvement, upbringing, time, cultural factors and education). The participants in the focus groups also had different expectations of the nurse's role in spiritual care. It is suggested that future research should focus more on the factors that influence spiritual care in nursing, to clarify the nurses' professional responsibility in this respect.

Contributions

Study design: RvL, LJT, HJ, DP; data collection and analysis: RvL and manuscript preparation: RvL, LJT, HJ, Dp.

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Chapter 6

An Instrument to measure Nursing Competencies in Spiritual Care: validity and reliability of the Spiritual Care Competence Scale (SCCS)

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Submitted

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Abstract

Aim. The purpose of this study is to develop and determine the validity and reliability of the Spiritual Care Competence Scale (SCCS) as a tool to measure nurses' competencies in providing spiritual care to patients.

Background. According to nursing literature, care for patients' spiritual needs and/or problems is an aspect of nurses' patient care. Acquiring the relevant competencies to provide spiritual care is indicated as an essential professional skill. Measuring these competencies and their development is therefore important and the construction of a tool was thus recommended.

Method. Students from two bachelor level nursing schools in the Netherlands (N=197) participating in a cross-sectional study were assessed. Construct validity was evaluated by factor analysis and internal consistency was estimated with Cronbach's alpha and the average inter-item correlation. In addition, the test-retest reliability of the measure was determined at a 2-week interval between baseline and follow-up (n=109).

Results. In this study an instrument (Spiritual Care Competence Scale) was developed, consisting of six core domains of spiritual care-related nursing competencies. These domains were labelled as: assessment and implementation of spiritual care (Cronbach's alpha 0.82), professionalization and improving quality of spiritual care (Cronbach's alpha 0.82), personal support and patient counselling (Cronbach's alpha 0.81), referral to professionals (Cronbach's alpha 0.79), attitude towards patient's spirituality (Cronbach's alpha 0.56) and communication (Cronbach's alpha 0.71). These subscales showed a good internal consistency, sufficient average inter-item correlations and a good test-retest reliability.

Conclusion. Testing the psychometric properties of a tool for measuring nursing competencies in spiritual care among a nursing student population demonstrated valid and reliable scales for measuring nurses' spiritual care competencies. The psychometric quality of the instrument was satisfactory.

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Introduction

In nursing literature, the need to educate nurses in spiritual care and the measurement of the effects of such education is widely recognized (Highfield & Amenta, 2000; Stranahan, 2001; Strang et al. 2002; Ross, 2006). With regard to competencies related to spiritual care in the field of nursing, there is a call for the testing of already existing competency profiles and relevant frameworks to determine to what extent they contribute to caregivers' ability to provide spiritual care (McSherry, 2006).

One question to be answered is surely exactly which competencies nurses are expected to acquire so as to provide spiritual care, and how these can be assessed. This article describes a research study investigating the development of a tool for measuring nursing competencies for spiritual care. Spiritual care in nursing concerns the care nurses deliver relative to the religious and existential needs of patients, including their questions and experiences of meaning and purpose (Jochemsen et al. 2002). Competencies in spiritual care refer to a complex set of skills employed in a professional context, that is, the clinical nursing process. A competence is defined as the ability to perform a task with desirable outcomes. It integrates the cognitive, affective and psychomotor domains of nursing practice (Meretoja et al. 2004). More than one author describes the nature and content of nursing competencies for spiritual care (Van Leeuwen & Cusveller, 2004; Baldacchino, 2006). Several studies describe the use of an assessment tool for spiritual care. All studies describe the effects of the education and training of nurses in the area of spiritual care. Table 1 provides an overview of these studies and the assessment tools they considered.

We can distinguish between different measures developed to assess the effects of training in the area of spiritual care. On the one hand, some measures include aspects which do not seem relevant in relation to the measurement of a set of competencies, such as the frequency of the spiritual care given, the content of the training programme and items evaluating the programme's adequacy (Highfield et al. 2000; Meyer, 2003). On the other hand, there are items concerning the opinions or attitudes of health professionals toward spirituality and spiritual care (Meyer, 2003) and these elements can be seen as relevant aspects of spiritual care

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competencies. Furthermore, there are studies of factors that may influence the provision of spiritual care itself, such as the burden of the disease on the patient or the level of fear of death, the extent to which patients have adapted their lives to the disease and the nurse's compassion for the patient (Wasner et al. 2005).

Table 1 Tools to measure the effects of education and training in spiritual care

Title, Authors	Items considered	Scale
Spiritual Care Perspectives Scale (SCPS) Highfield et al. 2000	• Frequency of providing spiritual care • Ability to provide spiritual care • Comfort level while providing spiritual care • Training/education in spiritual care (checklist) • Adequacy of training • Influence of people living with cancer/terminal illness on spirituality	Rating 1–5 1=rarely or never 5=every day (except item 4)
Student Survey of Spiritual Care (SSSC) Meyer, 2003	• Spiritual care is an essential component of holistic nursing care • Spiritual wellbeing is an important part of health promotion • I have sufficient knowledge to conduct a spiritual assessment • I am able to identify spiritual distress • I am not interested in the topic of spirituality • I feel adequately prepared to provide spiritual care • I respond to spiritual distress by listening and being concerned • I feel spirituality is a personal matter that should not be discussed with the patient • I respond to spiritual distress by asking the patient and/or his or her family whether they have any special practices they use to express their spirituality	Rating 1–6 1=strongly disagree 6=strongly agree
Numeric Rating Scale (NRS) Wasner et al. 2005	• Quality of life • Compassion for the dying • Compassion for oneself • Attitude towards one's family • Fear of dying • Fear of death • Satisfaction with work • Work meaningful • Attitude toward colleagues • Work-related stress	Rating 0–10 0=not at all 10=very much

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To us, the origin of these instruments remains unclear and their psychometric properties have not been evaluated. As these tools measure at the item level, the reliability or internal consistency of single items cannot be evaluated. Items were not analysed by exploratory factor analysis used to detect the underlying dimensions of spiritual care competencies. Meyer (2003) gives a reliability coefficient of .84 for her 9-item scale. However, the absence of indices of psychometric quality for these assessment tools raises questions about their validity and reliability. In all the above-mentioned studies the students' spirituality was assessed with the assumption that this may also serve as a predictor of the capacity to provide spiritual care. For these purposes, existing tools were used (Paloutzian and Ellison, 1982; Idler, 1987; Howden, 1992; Cella, 1997; Reed, 1991).

This study focuses on an instrument's psychometric aspects in measuring nursing spiritual care competencies. The tool developed for this purpose was based on the nursing competency profile described by Van Leeuwen & Cusveller (2004). This profile is based on an extensive literature review. Baldacchino (2006) confirms these competencies in a study performed among nurses. In their competence profile, Van Leeuwen & Cusveller (2004) distinguish spiritual care competencies that focus on the role of the self in delivering spiritual care, spirituality as part of the nursing process and the nurses' contribution to quality assurance and promotion of expertise within the healthcare institution.

The question we are addressing is whether a reliable and validated assessment tool for measuring the spiritual care competencies of nurses can be developed on the basis of this competency profile. This issue was elaborated into the following research questions for our study:

1. What is the construct validity of the chosen assessment tool (SCCS) to measure the nurses' spiritual care competencies?
2. What is the internal consistency of such an instrument?
3. What is the test-retest reliability of the instrument?

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Method

Design: cross-sectional study.

Subjects: a sample was used comprising third and fourth-year nursing students from two bachelor level nursing schools (n=197).

Measures: The questionnaire contained 35 questions concerning spiritual care competencies derived from the nursing competency profile as developed by Van Leeuwen & Cusveller (2004). Students were asked to indicate on a 5-point Likert scale how they estimated their own level of competency in spiritual care. For **example:** 'Helping the patient continue his daily spiritual customs and rituals', with the response options 1=strongly disagree – 5=strongly agree.

Procedure: the data were collected in January 2006. Respondents completed the questionnaire independently, in their classrooms under the guidance of field workers. Permission to conduct the study in the schools was obtained from the schools' management. Students received written information about the study prior to participation and gave informed written consent.

Analyses: items belonging to the six hypothesized dimensions of competencies with respect to spirituality were explored with factor analysis. To reduce the set of items to a smaller set of variables with common characteristics based on underlying dimensions, principal component analysis (PCA) with Varimax rotation was performed. Communalities (the proportion of a variable's variance shared by two or more variables), Eigen values (the proportion of variance by one factor), scree plots (graph-plotting of each factor showing the relative importance of each factor), explained variance and component loadings were examined to determine the factor structure. A scree plot indicated six dimensions. Items were selected according to the following criteria:

1. A factor loading >.50 on the hypothesized factor and <.30 on the other factor were set as evidence.
   A component is a group of linear combinations of items all indicating the same underlying construct. This criterion was considered appropriate in this study in order to create homogeneous and robust scales.
2. Items with dual factor loadings >.40 were eliminated from the factor analysis. Thus, where an item loaded inconsistently on one factor this was considered to be a violation of the assumption that the item should contribute exclusively to the hypothetical factor or construct.

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Reliability was examined with the Cronbach's alpha internal consistency coefficient for each dimension of the scale. A Cronbach's alpha ≥.70 was considered sufficient (Streiner & Norman, 2003). However, since the alpha coefficient is dependent on the number of items in the scale, a high internal consistency reliability estimate can be obtained by either having many items, highly intercorrelated items, or a combination of the two (Clark & Watson, 1995). Thus, Cronbach's alpha is essentially a function of two parameters: the number of scale items and the mean inter-item correlation (MIIC) among the items (Cortina, 1993). Whereas the degree of item intercorrelation is a straightforward indicator of internal consistency, the number of items is not meaningfully related to the internal consistency of a construct. According to the guideline produced by Briggs & Cheek (1986), the MIIC should fall within an optimal range of between .20 and .50 but should not be less than .15 (Clark & Watson, 1995; Taylor et al., 2003).Therefore, taking the upper value of the range MIIC≥ 0.25 seems reasonable. In estimating the internal validity of the scales, the following criteria were used:

1. Cronbach's alpha coefficient between ≥.70 (Nunnally & Bernstein, 1994) and ≤.90 (Streiner & Norman, 2003) were considered as indicators of a reliable scale.
2. MIIC≥.25 was considered as a sufficient level of internal consistency or reliability. Scales with a lower mean inter-item correlation were removed.

To determine the instrument's stability, the test-retest reliability was determined by means of a t-test in a different sample (n=109).

Approval from an ethics committee was not necessary. The research was not burdensome or risky. The directors of the nursing schools consented to the performance of this research in writing. The students were informed about this research on paper and they were asked to participate voluntarily. They were told that they could withdraw from the research at any time in the process.

Translation procedure

The translation of the 27 Dutch items in the ultimate questionnaire into English was carried out by forward-backward translation (Jones et al. 2001) performed by a native speaker from the Groningen University Language Center. It was concluded that most of the items were translated in such a way as to leave no meaningful semantic differences between the Dutch and the English versions, though a few

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items needed to be discussed with the researchers involved in this study and the translators in order to clarify minor differences. Some item descriptions were modified to attain a greater degree of familiarity among those items belonging to the same domain. The current English version of the questionnaire is a valid instrument that accords with the original Dutch version (see Appendix A).

Results

All of the questionnaires returned (n=197) were suitable for this study. The mean age of the respondents was 20 (SD 1.3, min. 18, max. 30).
From the explorative factor analysis, six spiritual care competency dimensions can be derived. These six dimensions explain 53% of the total variance. They were identified under the following labels: assessment and implementation of spiritual care, professionalization and improving the quality of spiritual care, the personal support and counselling of patients, referral to professionals, the attitude towards the patient's spirituality, and communication. Out of the original 35 items, 27 were included in the final version of the measure. Table 2 shows the six dimensions (subscales) with their respective related items, the factor loading per item, Cronbach's alpha, and the mean inter-item correlation (MIIC) of each dimension.

The 'assessment and implementation of spiritual care' dimension refers to the ability to determine a patient's spiritual needs and/or problem, and to the planning of multidisciplinary spiritual care. This includes written intra and inter-professional communication of spiritual needs and spiritual care. The 'professionalization and improving the quality of spiritual care' dimension contains the activities of the nurse aimed at quality assurance and policy development in the area of spiritual care. It refers to contributions to the institutional level that transcend the primary process of care, and with which the nurse also contributes to the promotion of professional practice. The 'personal support and patient counselling' dimension was seen as the heart of spiritual care, with items operationalized in terms of interventions. They indicate the actual provision and evaluation of spiritual care with patients and their relatives. 'Referral to professionals' is the dimension relating to cooperation with other disciplines in healthcare that take responsibility for spiritual care, for which

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Table 2 Principal component analysis of nursing competencies for spiritual care

Nr.	Dimensions and items	Loading	CA	MIIC
	Assessment and implementation of spiritual care		.82	.44
1.	Oral nursing reports on the spiritual functioning of the patient	.82		
2.	Written nursing reports on the spiritual functioning of the patient	.78		
3.	Documenting the nurse's contribution to spiritual care in the patient's care plan.	.68		
4.	Coordinating spiritual care in multidisciplinary consultation	.57		
5.	Coordinating spiritual care in dialogue with the patient	.55		
6.	Oral and written reporting of the spiritual needs of the patient	.52		
	Professionalization and improving the quality of spiritual care		.82	.43
7.	Policy recommendations to management regarding spiritual care	.80		
8.	Contributing to professionalism and expertise in spiritual care	.70		
9.	Coaching healthcare workers in providing spiritual care	.70		
10.	Implementing quality improvement projects in spiritual care	.63		
11.	Contributing to quality of care regarding spiritual care	.62		
12.	Addressing work related problems in relation to spiritual care	.55		
	Personal support and patient counselling		.81	.41
13.	Helping the patient to continue his daily spiritual customs and rituals	.72		
14.	Providing spiritual care to the patient	.71		
15.	Providing information to the patient regarding facilities for spirituality and spiritual care in the healthcare institution	.69		
16.	Addressing questions regarding spirituality to the patient's relatives	.68		
17.	Attending to the patient's spirituality during daily care	.68		
18.	Evaluating spiritual care with the patient and the team	.58		
	Referral to professionals		.79	.56
19.	Referring the patient with spiritual needs adequately to another healthcare worker	.80		
20.	Assigning spiritual care adequately	.64		
21.	Knowing when to consult chaplaincy	.61		
	Attitude towards patient spirituality		.56	.25
22.	Being open to (other) spiritual beliefs in patients	.70		
23.	Not forcing personal spirituality upon patients	.64		

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Nr.	Dimensions and items	Loading	_	MIIC
24.	Showing respect for the patient's spiritual beliefs	.61		
25.	Recognizing personal limitations in spiritual care	.50		
	Communication		.71	.60
26.	Listening actively to the patient's 'life story'	.80		
27.	Showing an accepting attitude toward the patient's spirituality	.74		

CA=Cronbach's alpha; MIIC=Mean inter-item correlation

the chaplaincy is mentioned explicitly as a core discipline. Personal factors relevant to providing spiritual care, furthermore, were placed under the 'attitude towards patient spirituality' dimension. This dimension revealed a poor Crohnbach's alpha, but the inter-item correlation indicates a homogeneous scale. Lastly, contact and communication between nurse and patient are essential aspects of spiritual care. This surfaces as a separate dimension in the factor analysis and was designated as the 'communication' dimension. Eight items did not correlate with the underlying hypothesized construct and were removed from the original list of 35 items.

The principal component analysis with Varimax rotation provided evidence of the multidimensionality of SCCS. The Pearson correlation coefficients (r) between the components were calculated using summated respondent scores on the individual scale components and the proportion of linearly explained variance (r^2) between components, were estimated by squaring (Table 3). Although only the associations between communication, referral and caring were trivial due to random error, the other ten statistically significant correlations were appraised as weak. However, the associations between professionalization, assessment and referral were appraised as substantial (with proportions of explained variance >.20) indicating that those regarding spiritual care as being a significant part of care delivery and health policy are more likely to evaluate, implement and refer spiritual care to those with more expertise in this field. A similar result was found in appraising the association between the attitude towards assessment, evaluation and referral to more skilled professionals, indicating that those who tend to assess and report a patient's spiritual needs and implement spiritual care in the organization are more likely to refer patients with spiritual needs to professionals with professional religious or spiritual expertise.

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Table 3 Scale components correlations (r) and linearly explained variance (R^2) between components

	Assess.	Profes.	Caring	Refer.	Commun.	Attitude
I Assessment		.51 (.26)	.39 (.15)	.48 (.23)	.16 (.02)	.21 (.04)
II Professionalization			.43 (.18)	.47 (.22)	.20 (.04)	.14 (.02)
III Spiritual support				.40 (.16)	.12 (.01)	.17 (.03)
IV Referral					.11 (.01)	.21 (.04)
V Communication						.30 (.09)
VI Attitude						

The test-retest procedure (Table 4) revealed a statistically significant difference between baseline and follow-up for the 'professionalization and improving the quality of spiritual care' subscale. However, the importance of these changes over time was found to be trivial according to the Cohen (1988) thresholds (ES≤0.20).

Table 4 Test-retest reliability analysis at 2-week time interval

	Baseline Mean(SD)	Follow-up Mean(SD)	P-value	Effect Size	95% CI (ES)
Assessment and implementation of spiritual care	19.95 (3.19)	19.77 (2.94)	0.53	ns	
Professionalization and improving quality of care	16.24 (3.54)	16.89 (3.64)	0.03	0.18	-0.09 0.45
Personal support and counselling of patients	19.40 (2.84)	19.63 (2.78)	0.37	ns	
Referral to professionals	9.38 (1.87)	9.39 (1.72)	0.95	ns	
Attitude towards patients spirituality	15.25 (1.65)	15.20 (1.78)	0.83	ns	
Communication	8.02 (0.95)	7.88 (0.92)	0.16	ns	

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After completing the psychometric analysis, additional interviews were performed with individual students (n=8) to clarify the content of the 'attitude towards patient's spirituality' subscale. Although the psychometric outcomes of this subscale were satisfactory, obtaining more insight in the students' considerations through self-assessment on this dimension might be helpful in promoting the validity and reliability of this subscale. The students were selected at random. Written transcripts of the interviews were analysed. The results of the interviews showed that students had different interpretations of the items according to their 'attitude towards patient's spirituality'. Some interpreted them mainly from their own, usually religious, frames of reference and asked themselves to what extent they would be able and prepared to interact in the support of patients of other faiths or convictions, such as Muslims. Other students approached the items from a wider perspective than merely their own convictions and asked themselves what could be expected from a nurse in a professional sense. Some students made an immediate connection with one or more specific themes within the realm of spiritual care, such as praying with a patient, euthanasia or interacting with other faiths. Others wrestled with the fact that they wanted to see how their own faith might influence the relationship with the patient. From this perspective, for instance, they had difficulties with 'not forcing one's own religion or faith upon another' item. They thought this item had been formulated with a negative connotation and found it difficult to score themselves. These students admitted that they had given a socially acceptable answer. Lastly, students indicated how certain items, such as showing respect, being open or not imposing their own faiths, seemed to overlap, so that they tended to give the same scores.

Other factors that were mentioned and may have influenced scores on these items related to the availability of clinical experience. Recent experience in nursing practice, especially in mental health, was clearly relevant to the scores on the scale. After having had such experience, students tended score themselves lower in the interview than they did previously when filling out the questionnaire. Students without clinical experience scored themselves on the basis of their own opinions of the spirituality theme acquired through classes and literature. From the interviews it also became clear that students tended to give themselves scores regarding spiritual care on the basis of their own ways of dealing with spiritual experiences and issues in their personal lives. Some described themselves as being open-minded and proactive towards others, while other students did not feel very comfortable

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with the topic, spirituality being a personal matter and something they found difficult to communicate about with others.

Conclusion and discussion

On the basis of this study a valid and reliable tool (SCCS) could be developed for the measurement of nursing competencies in spiritual care. It consisted of the following dimensions: assessment and implementation of spiritual care, professionalization and improving quality of spiritual care, personal support and patient counselling, referral to professionals, attitude towards patient spirituality, and communication. According to this study's research questions we conclude that the subscales of the SCCS show a strong construct validity and internal consistency. The test-retest procedure demonstrated a significant difference between baseline and follow-up for the 'professionalization and improving the quality of spiritual care' subscale. However, the importance of these changes over time was trivial according to the psychometric thresholds. The SCCS is suitable for measuring nursing competencies on a group level in the education or training of students and nurses in institutional teams, for instance. It can also serve as a tool for the further research into nursing care competencies. In general, the items relating to attitude were too abstract and vague, causing respondents to read their own operationalizations into them.

Nurses' attitudes towards a patient's spirituality as a component of spiritual care is regarded as an important aspect of nursing competency (Van Leeuwen & Cusveller, 2004; Baldacchino, 2006; McSherry, 2006). Studies have shown that the way a nurse relates to his or her own spirituality is an important predictor of the quality of the spiritual care he or she will provide (Highfield et al. 2000; Meyer, 2003; Wasner, 2005). The interviews performed as part of the present study support this conclusion. The students' individual interpretations of the 'attitude towards patient's spirituality' subscale items seemed to have played an important role in creating more diversity in responses on these items. The other derived subscales of the tool pertain to more instrumental aspects of the competency (assessment, quality control and communication skills). During their training students possibly acquired a more uniform understanding of such items, whereas aspects of attitude touch upon the personality of the particular nurse. The confrontation with spirituality

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involves the nurses' personal beliefs and convictions. We are inclined to conclude that the students' own convictions about spirituality played an important role when filling out the questions, especially where aspects of attitude are concerned. The same applies to the degree to which students already had some clinical experience with patient spirituality. This study shows how recent, often intense experiences during internships influence how students score themselves. This is in line with Meyer (2003), who found that clinical experience leads to a reassessment of values, especially those involved in spiritual care. This would explain why Highfield et al. (2000) and Wasner et al. (2005) included items in their assessment tools that refer to aspects of nurses' attitude, for example, what it means for the nurses' attitude to care for patients with cancer or a terminal condition, or on their deathbed. Some of the students interviewed indicated that clinical experiences during internships particularly influenced their scores, as after the experience they saw themselves as being less competent. This will then be a systematic factor leading to differences in scores, as students from the same year may be in different stages of their development when it comes to such aspects of attitude. In any event, the items corresponding to aspects of 'attitude' allow too much room for respondents to read their own personal opinions and experiences into the questionnaire.

Relevance for practice

The SCCS can be used for practical, educational and research purposes to assess students' and fully qualified nurses' competencies in the provision of spiritual care at a group level. Assessment can provide information about the areas in which nurses should receive training to become competent. The tool can be used in follow-up research on nursing competencies in providing spiritual care. Despite the fact that the instrument has primarily been developed on the basis of sources in nursing (literature and students), it is interesting to consider to what extent the instrument is sufficiently generic to be of use in other healthcare disciplines (physicians, paramedics or social workers for example). Recent literature suggests that spiritual care may also be a task required of other healthcare workers (McSherry, 2006). Therefore, we recommend the SCCS also be tested in disciplines other than nursing.

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Limitations

The instrument was tested on a homogeneous group of Christian nursing students. They did not represent the total population of nursing students. It would be interesting to study the scores of non-Christian respondents. Clinical and life experiences may also be important predictors of nurses scoring on competence in delivering spiritual care. Such experience, in general, remains limited among nursing students. Therefore, another topic for further research would be to determine how more experienced nurses would score the items and what this might mean for the quality of the instrument. The above-mentioned limitations require further research into the SCCS in order to eliminate the effects of selection and information bias and limiting factors to strengthen the validity and reliability obtained thus far.

Contributions

Study design: RvL, LJT, BM, HJ, DP; Data collection: RvL; Statistical analysis: BM, RvL, LJT; Manuscript preparation: RvL, LJT, BM, HJ, DP

This study is part of the Ethics of Care research group research programme of the Ede Christian University headed by Henk Jochemsen.

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Appendix Spiritual Care Competence Scale

1 = completely disagree/2 = disagree/3 = neither agree or disagree/4 = agree/5 = fully agree

Attitude towards patient spirituality	
1) I show unprejudiced respect for a patient's spiritual/religious beliefs regardless of his or her spiritual/religious background	
1 - 2 - 3 - 4 - 5	
2) I am open to a patient's spiritual/religious beliefs, even if they differ from my own	
1 - 2 - 3 - 4 - 5	
3) I do not try to impose my own spiritual/religious beliefs on a patient	
1 - 2 - 3 - 4 - 5	
4) I am aware of my personal limitations when dealing with a patient's spiritual/religious beliefs	
1 - 2 - 3 - 4 - 5	
Communication	
5) I can listen actively to a patient's 'life story' in relation to his or her illness/handicap	
1 - 2 - 3 - 4 - 5	
6) I have an accepting attitude in my dealings with a patient (concerned, sympathetic, inspiring trust and confidence, empathetic, genuine, sensitive, sincere and personal)	
1 - 2 - 3 - 4 - 5	
Assessment and implementation of spiritual care	
7) I can report orally and/or in writing on a patient's spiritual needs	
1 - 2 - 3 - 4 - 5	
8) I can tailor care to a patient's spiritual needs/problems in consultation with the patient	
1 - 2 - 3 - 4 - 5	
9) I can tailor care to a patient's spiritual needs/problems through multidisciplinary consultation	
1 - 2 - 3 - 4 - 5	
10) I can record the nursing component of a patient's spiritual care in the nursing plan	
1 - 2 - 3 - 4 - 5	
11) I can report in writing on a patient's spiritual functioning	
1 - 2 - 3 - 4 - 5	
12) I can report orally on a patient's spiritual functioning	
1 - 2 - 3 - 4 - 5	

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Referral

13) I can effectively assign care for a patient's spiritual needs to another care provider/care worker/care discipline

1 - 2 - 3 - 4 - 5

14) At the request of a patient with spiritual needs, I can in a timely and effective manner refer him or her to another care worker (e.g. a chaplain/the patient's own priest/imam)

1 - 2 - 3 - 4 - 5

15) I know when I should consult a spiritual advisor concerning a patient's spiritual care

1 - 2 - 3 - 4 - 5

Personal support and patient counselling

16) I can provide a patient with spiritual care

1 - 2 - 3 - 4 - 5

17) I can evaluate the spiritual care that I have provided in consultation with the patient and in the disciplinary/multi-disciplinary team

1 - 2 - 3 - 4 - 5

18) I can give a patient information about spiritual facilities within the care institution (including spiritual care, meditation centre, religious services)

1 - 2 - 3 - 4 - 5

19) I can help a patient continue his or her daily spiritual practices (including providing opportunities for rituals, prayer, meditation, reading the Bible/Koran, listening to music)

1 - 2 - 3 - 4 - 5

20) I can attend to a patient's spirituality during the daily care (e.g. physical care)

1 - 2 - 3 - 4 - 5

21) I can refer members of a patient's family to a spiritual advisor/pastor, etc. if they ask me and/or if they express spiritual needs

1 - 2 - 3 - 4 - 5

Professionalization and improving the quality of spiritual care

22) Within the department, I can contribute to quality assurance in the area of spiritual care

1 - 2 - 3 - 4 - 5

23) Within the department, I can contribute to professional development in the area of spiritual care

1 - 2 - 3 - 4 - 5

24) Within the department, I can identify problems relating to spiritual care in peer discussions session

1 - 2 - 3 - 4 - 5

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25) I can coach other care workers in the area of spiritual care delivery to patients								
1	-	2	-	3	-	4	-	5
26) I can make policy recommendations on aspects of spiritual care to the management of the nursing ward								
1	-	2	-	3	-	4	-	5
27) I can implement a spiritual-care improvement project in the nursing ward								
1	-	2	-	3	-	4	-	5

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Chapter 7

The effectiveness of an educational programme for nursing students on developing competence in the provision of spiritual care

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Submitted

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Abstract

Aim. The aim of this study was to determine the effects of a course for nursing students on developing competence in spiritual care and the factors that might influence the effects.

Background. Studies suggest that role preparation in nursing on spiritual is poor. For the assessment of competence few or no explicit competency framework or assessment tools seemed to be used.

Method. This study had a quasi-experimental longitudinal observation design (pre - post test)). The subjects were students from nursing schools in the Netherlands (n = 97). The intervention consisted of a module on spiritual care. Competencies were measured by the Spiritual Care Competence Scale (SCCS). At T^1 vignettes were added with the purpose of assessing the quality of the students' own analyses. Data were analysed by t-test procedures and regression analyses.

Results. Analysis showed statistically significant changes in scores on the subscales of the SCCS between groups (T^1) and over time for the whole cohort of students (T^2) . Internship showed as a negative predictor for three subscales of the SCCS. Experience of spiritual care and a holistic vision of nursing showed both as positive predictors on certain competencies. A statistically significant difference was observed between groups in the student analysis of a vignette with explicit spiritual content.

Discussion. The outcomes raises questions about the content of education in spiritual care, the measurement of competencies and factors that are influencing competency development.

Relevance to practice

The results provide nurse educators insight into effects of education in spiritual care on students' competencies and helps them to consider a systematic place for spiritual care within the nursing curriculum. The SCCS can be used as a valid and reliable tool to assess nurse competency.

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Introduction

To enhance the quality of spiritual care delivered by health care workers relevant training seems necessary. Studies consistently suggest that nurses' competencies related to spiritual care are impoverished because of poor role preparation in nursing education in this area (Greenstreet, 1999; McSherry, 2006; Ross, 2006; Leeuwen et al. 2006). Further research into the content and effects of this aspect of education are important recommendations in such studies. Different studies describe the possible content of teaching programmes in spiritual care, ranging from touching upon the subject of spirituality and spiritual care throughout the curriculum over the years (Ross, 1996; Groer et al. 1996; Narayamasamy, 1999; Lemmer, 2002; Pesut, 2003; Callister et al. 2004) to specific teaching strategies or programmes (Catanzaro & McMullen 2001; Souter, 2003; Mitchell et al. 2006).

Table 1 shows an overview of the studies that have investigated the effect of spiritual care aspects of education on the competencies of health care workers. These studies recognize different kinds of educational programmes. Some studies deal with the placement of spirituality and spiritual care in the curriculum of basic degree programmes and the impact these programmes have on students (Pesut, 2002; Meyer, 2003; Sandor et al. 2006; Lovanio & Wallace, 2007). Other studies focus on specific groups of postgraduate health care workers (Highfield et al. 2000; Shih et al. 2001; Hoover, 2002; Milligan, 2004; Wasner et al. 2005). The content of the educational programmes differs. Some studies focus on the attention given to spirituality throughout the entire curriculum (Pesut, 2002; Meyer, 2003) whereas other studies concentrate on the effects of specific courses on spiritual care (Shih et al., 2001; Hoover, 2002; Milligan, 2004; Wasner et al., 2005; Sandor et al., 2005; Lovanio & Wallace, 2007). Most studies involve nurses and nursing students. Two studies follow a multidisciplinary approach (Wasner et al. 2005; Sandor et al. 2005).

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Table 1 Studies into effects of education in spirituality and spiritual care on students

Author(s)	Aim	Sample (n)	Educational method in spiritual care	Research method	Results
Highfield MEF, Johnston Taylor E, O'Rowe Amenta M, 2000 USA	Identify the formal and experiential spiritual care preparation of oncology and hospice nurses (ON/HN)	ON: 181 (26%) HN: 645 (55%)	o integrated in basic education o course during basic education o graduate coursework o continuing education o reading	Spiritual Care Perspective Scale (SCPS)	- adequacy of preparation: HN 51%/ON 64% - patient's influence on nurse's spirituality: 96% / 67% - recover own spiritual past - discover new beliefs - uncover present beliefs/ issues
Shih FJ, Gau HC, Mao HC, Chen CH, Kao Lo CH, 2001 Taiwan	Explore the usefulness of a teaching course for nurses to provide spiritual care in clinical settings	22 students MScN	18 week course: o classroom lectures o field trips (religions) o clinical experience o presentation of case study	analysis of narrative descriptions and case studies	usefulness for providing spiritual care: o clarifying theoretical concepts of spiritual care o providing a culturally bonded spiritual care plan o self-disclosing own personal value systems and spiritual needs o clarifying the symbolic meaning and impact of religious rituals

Author(s)	Aim	Sample (n)	Educational method in	Research method	Results

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Author(s)	Aim	Sample (n)	Educational method in spiritual care	Research method	Results
Pesut B, 2002 USA	Understand baccalaureate students' perceived own spiritual wellbeing and spirituality and explore students' perceptions of spiritual care, and how they changed during 4 years of education	35 1st year 18 4th year students at Christian university	Spiritual care throughout the curriculum o integrated model for integrating spirituality o journals, papers, conferences related to spiritual care o exploring personal beliefs and values o application in nursing practice	Spiritual-Wellbeing-Scale (1982) Additional questions: o define spirituality o spiritual care by nurses o talking with patients about own spiritual beliefs	Spiritual wellbeing (120) (Religious/Existential/ Spiritual) 1st year: 56/53/109 - 4th year: 56/50/106 4th year students: o write more about spiritually enduring growth o articulate difference between religion and spirituality o patient-centred approach in spiritual care (less emphasis on own agenda) o reciprocal nature of spiritual learning in nurse-patient relationship
Hoover J, 2002 UK	Evaluate the personal and professional impact of undertaking a 15-week degree level module on nursing as human caring	25 part-time students	Module about human caring: o transpersonal caring healing model (1999) o empirical: concept caring related to spirituality and suffering o aesthetics: art, poetry, mosaics, literature concerning the human condition, observation nurse-patient interactions o personal knowing through reflective practice	4 focus groups before and after undertaking module	Personal impact: o increased self-awareness o connecting with self and others o finding purpose and meaning in life o clarification of values Professional impact: o increased understanding of caring theory o more holistic approach to care o more committed to promoting healing in others; increased self-awareness

Author(s)	Aim	Sample (n)	Educational method in spiritual care	Research method	Results
Meyer CL, 2003 USA	Determine which student and environmental factors in nursing education contribute to the students' perceived ability to provide spiritual care	12 nursing schools: 6 religious (R) 6 public (P) students R/P: 90/190 staff: 47/58	Content of spiritual care education not explained	Students: o Spirituality Assessment Scale (SAS) o Student Survey of Spiritual Care (SSSC) Additional questions: o rating religious commitment o attention given to spirituality during nursing programme Faculty: four-item survey: o emphasis spirituality in nursing o content of classroom programme o clinical programme o informal interactions	o Student's personal spirituality strongest predictor perceived ability to provide spiritual care o Emphasis on spirituality in nursing programme serves as most significant environmental predictor o Inadequately prepared for spiritual assessment and providing spiritual care o Significant differences with students from colleges with religious affiliation: spiritual care essential component of holistic care; interest in spirituality; spirituality may be discussed with the patient o Increased awareness through specific courses and integration throughout curriculum
Milligan S, 2004 USA	Explore perceptions in providing spiritual care from qualified nurses undertaking a palliative care module as part of a post-registration degree course	59 students who had chosen to take a module on palliative care giving	Study programme: Palliative care Psychosocial perspective: exploration of the concepts of spirituality and spiritual care	Questionnaire covering the following areas: o perceptions of the nurse's role in spiritual care giving (5-point Likert scale) o problems associated with identifying and meeting spiritual needs (open questions) o factors affecting the nurse's ability to provide spiritual care (answering options)	o nurses are responsible for spiritual care o identifying spiritual needs regarded as difficult o evenly divided over how easy or difficult they found giving spiritual care to patients

Author(s)	Aim	Sample (n)	Educational method in	Research method	Results

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Author(s)	Aim	Sample (n)	Educational method in spiritual care	Research method	Results
Wasner M, Longaker C, Fegg MJ, Borasio GD, 2005 Germany	Investigating the effects of spiritual care training for professionals in palliative medicine	48 (76%) multidisciplinary participants in training course	Three and a half day training: o active compassionate listening o recognizing and addressing causes of emotional and spiritual suffering o exercises to connect with impaired patients o dealing with unfinished business o supporting mourners o non-denominational spiritual practices (contemplation and meditation)	Multi-moment measurement (0-1-2) o Spiritual subscale of Functional Assessment of Chronic Illness Therapy (FACIT-Sp) o Self Transcendence Scale (STS) o Idler Index of Religiosity (IIR) Additional questions: o main problems in handling death/dying (NRS) o changes as result of the course o rate single course contents o number of days off on sick leave	o 77% attitude towards coping improved through taking the palliative care course o 35% coped better with loved ones of patient with severe illness o 25% coped better with bereavement better after training o sick-leave days remained stable o FACIT-Sp increased directly after training and maintained level after six months o STS after training, not after six months o IIR: no change over time o FACIT-Sp and STS correlated o overall attitudinal score (NRS) correlated with FACIT-Sp and STS, not with IIR o no differences between nurses and other professional groups

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Author(s)	Aim	Sample (n)	Educational method in spiritual care	Research method	Results
Sandor MK, Sierpina VS, Vanderpool HV, Owen SV, 2006 USA	Identify and assess changes in spiritual experiences and perceived importance of spiritual issues in nursing and medical students taking part in a Spirituality and Clinical Care course	122 nursing students 293 medical students	Course: Spirituality and Clinical Care for first year students o empirical research related to spirituality and health o attending to spiritual concerns of patients o taking a spiritual history o discussing clinical cases and personal experiences related to spirituality	Pre-test/post-test design o Spiritual Experience Index Revised Scale (SEI-R) o Spiritual Importance Scale (SI)	o importance of spirituality/ spiritual care: increased significance (females, nurses higher) o personal importance: increased significance (females higher) o spiritual support and spiritual openness: females score higher than males o less dogmatism over time: medical students show larger decline
Lovanio K, Wallace M, 2007 USA	Develop and test a spirituality-focused education project to enhance nursing students' knowledge and understanding of spiritual care	10 sophomores demonstrating interest in spiritual care	Course: o half-day presentation of spirituality in nursing o 10 clinical conferences: definitions, spiritual dimension of nursing, spiritual interventions, personal reflection, reviewing articles, care plan, chaplain o application in own practice	Pre-test/post-test design/pilot Spirituality and Spiritual Care Rating Scale, SCCRS	Significant differences on SCCRS. Most substantial changes: o I believe spirituality is a unifying force which enables one to be at peace with oneself and the world (4.9/5.2) o I believe spirituality involves personal friendships and relationships (4.4/4.9) o I believe spirituality includes people's morals (3.9/4.6)

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All these studies show some kind of effect on the spiritual competency of health care workers. In general they show that students develop enhanced spiritual awareness, a more client-centred (holistic) approach, more knowledge about spirituality and spiritual care, improved communication skills and experience some kind of personal impact. Hoover (2002) describes this as the professional and the personal impact of a course on the nurse. Based on these studies one may conclude that education tends to have a certain positive effect on the competency of nurses.

The educational effects can be divided into an impact on spirituality and an impact on professional competence in providing spiritual care. Different assessment tools are used to measure the effect of education on the spirituality of students (spiritual awareness, spiritual wellbeing) (Pesut, 2002; Meyer, 2003; Wasner et al. 2005; Sandor et al. 2005; Lovanio & Wallace, 2007). Although these studies show different effects on students' spiritual awareness and spiritual wellbeing, the overall effect of education on students' spirituality seems evident. Meyer (2003) concludes that the students' personal spirituality is the strongest predictor of perceived ability to provide spiritual care.

No explicit competency framework or assessment tool is used to assess the effect of education on the ability to deliver spiritual care. Most of the described effects on spiritual care competency are based upon student-driven descriptions obtained through open-ended questioning. This raises questions about the specific competencies of nurses regarding spiritual care and how they can be measured. From a professional perspective, nursing competencies in this area and the relevant assessment methodology should be clarified.

In methodological terms, some studies shown in Table 1 employed a pre-post test design that showed some effect. A control group, however, is absent in all of the studies. The investigations into the effects of special courses on spiritual care, in particular, employed small convenience samples. Most respondents participated voluntarily which implies that they were already spiritually committed. This raises questions about the possible influence of selection bias on the results. The studies investigating the effect of nursing programmes in total student populations seem to show stronger evidence (Pesut, 2002; Meyer, 2003).

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These observations with regard to spiritual care, competency, education and methodological issues are taken into consideration in this study, which investigates the impact of a special course on spiritual care on the competency of Dutch nursing students to deliver spiritual care. The aim is to determine both the factors influencing the effects and the effects themselves of this course in spiritual care on nursing students' capability to deliver spiritual care. In order to do so we formulated the following research questions:

1. What effect does an educational course on spiritual care have on nursing students' self-perceived competency in spiritual care?
2. What influence do the following student-related factors have on this self-perceived competency: own spirituality, religious engagement, thinking about questions of life, vision of holistic nursing care and own experiences of spiritual care in practice?
3. In the assessment of students' analysis of vignettes is there a significant difference between respondents in the intervention group and those of the control group after finishing a course on spiritual care?

Method

Design

The study has a quasi-experimental longitudinal observational design (pre-test and post-test) involving a cohort of 97 nursing students in total. At baseline the students were divided into an intervention group and a control group. The intervention group followed the educational programme on spiritual care over a period of six weeks. At baseline and after six weeks all students completed a questionnaire that consisted of items listed in the Spiritual Care Competence Scale. Fourteen weeks after baseline the original control group also took the educational programme on spiritual care. When they finished the programme (20 weeks post baseline) the whole cohort of students completed the questionnaire a third time. The participants were not told that the questionnaire was related specifically to the educational programme on spiritual care, in order to control for results biased by socially desirable answers. Thus the items of the Spiritual Care Competence Scale were inserted between broader questions about nursing competencies in general.

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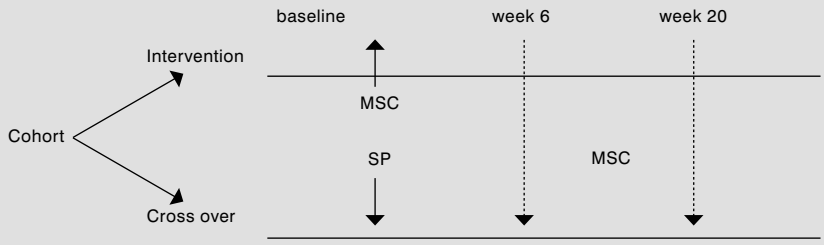
The research design is shown in Figure 1.

Figure 1 Research design



MSC = module spiritual care; SP = standard programme

Subjects

The subjects of this study were two cohorts of students from two bachelor degree nursing schools in the Netherlands (n = 97), who were in the third year of their educational programme. The students were participating in 12 educational groups. At the start of the study the groups were assigned to the control or intervention group on the basis of the plans for their practical training during that year.

Intervention

The intervention in this study consisted of an educational module aimed at developing nursing competencies for spiritual care in student nurses. Development of the module was based on the competency profile for spiritual care (Leeuwen and Cusveller, 2004). In addition, theoretical sources were consulted for the content of an education in spiritual care (Ross, 1996; Groer et al. 1996; Greenstreet, 1999; Narayanasamy, 1999; Bush, 1999; Shih et al. 2001; Catanzaro, 2001; Hoover, 2002; Meyer, 2003; Souter, 2003; Callister et al. 2004). This resulted in a module with the following content:

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- three educational sessions of three-hour duration on the concept of spirituality, spirituality in the nursing process and aspects of quality assurance of spiritual care at the institutional level;
- three two-hour training sessions in communication skills with respect to spiritual care within the context of the nurse-patient relationship (spiritual assessment and spiritual support) and the multidisciplinary team;
- four sessions of three hours spent reflecting on personal experiences related to aspects of spiritual care in nursing practice.

The course took six weeks. All elements of the module were presented by expert teachers.

Measurements

For the purpose of this study we developed a questionnaire that covered all the main nursing competencies that are generally expected to be present in advanced-beginner nurses in the Netherlands. The items regarding the competencies of spiritual care were taken from the Spiritual Care Competence Scale (Van Leeuwen et al. 2007) and added to a broader questionnaire. Some examples of items are: 'I am open to a patient's spiritual/religious beliefs, even if they differ from my own'; 'I can tailor care to a patient's spiritual needs/problems in consultation with the patient'; 'I can tend to a patient's spirituality during daily care (e.g. physical care)'. A five-point Likert scale was used (1 = strongly disagree/5 = strongly agree) for the answers to the questionnaire.

The SCCS contains the following subscales:

- assessment and implementation of spiritual care (Crohnbach's Alpha 0.82);
- professionalization and improving quality of spiritual care (Crohnbach's Alpha 0.82);
- personal support and counselling of patients (Crohnbach's Alpha 0.81);
- referral to professionals (Crohnbach's Alpha 0.79);
- attitude towards patient's spirituality (Crohnbach's Alpha 0.56);
- communication (Crohnbach's Alpha 0.71).

Psychometric testing of the SCCS has shown that it is a valid and reliable scale for measuring nurse competency in spiritual care (Van Leeuwen et al. 2007).

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Additional questions

To analyse student-related factors with regard to their self-perceived competency in spiritual care, the questionnaire posed additional questions concerned with the students' own spirituality, religious engagement, thoughts about life questions, vision of holistic nursing care, whether or not they were interns when completing the questionnaire and their practical experience of spiritual care during internship. Table 2 contains these additional questions.

Table 2 Additional questions in the questionnaire

Student's own spirituality
How spiritual would you rate yourself in terms of the following definition:
'Spirituality means the religious or existential mode of human functioning, including experiences and questions of meaning and purpose' (Jochemsen et al., 2002)
10 point scale: 1 (not spiritual) - 10 (extremely spiritual)

Influence belief/religion?
To what degree is your daily life influenced by your belief system/religion?
10 point scale: 1 (no influence) - 10 (totally influenced)

Thinking about questions of life
Do you ever think about life questions (e.g. the meaning of life, meaning of illness/suffering, life perspective, the end of life):
often - sometimes - never

Vision of holistic care
- In nursing care I think a nurse should tend to the physical, psychological, social and spiritual aspects of a patient (holistic)
- I think the holistic approach is a basic assumption in nursing

5-point Likert scale (1: strongly disagree - 5: strongly agree)

Are you in an internship at the moment: yes - no

Experience of spiritual care
- During my practical periods I have had moments of giving spiritual care
- During my practical periods my ideals about the nursing profession are being confirmed
- During my practical periods I feel that enough attention is devoted to the spiritual care of patients

5-point Likert scale (1: strongly disagree - 5: strongly agree)

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Vignettes

After 6 weeks, by which time the original intervention group had finished the course, the questionnaire contained two vignettes whose purpose was to assess whether respondents in both the intervention group and the control group would show any significant differences in the quality of their analysis of the vignettes. The respondents were asked to formulate the needs or problems of the patients described in the vignettes and describe the nursing care they would provide. The first vignette had implicit spiritual content and focused on questions about a patient's future and meaning of life after having had a heart attack. The second vignette had explicit religious content and was about an angry patient who was questioning God after coming out of remission.

The students' analyses of the vignettes were assessed by two senior nursing lecturers who were experts in the subject of spiritual care. Lecturer 1 assessed all the analyses of vignette 1 and lecturer 2 assessed the analyses of vignette 2. Both vignettes were evaluated with numeric qualification (ranging from one to five). The lecturers did not know to which group (intervention or control) a particular analysis belonged (see Appendix)

Procedure

The students were assigned to the intervention group and the control group according to their educational programme. Half of the students were on an internship at the time and were assigned to the intervention group since the course on spiritual care required experience and application in nursing practice. The other students were following another programme at school and were therefore assigned to the control group. Data were collected at three moments during the period December 2005 to June 2006. Respondents independently completed the questionnaire in their classrooms under the supervision of field workers. Permission to conduct the study in the nursing schools was obtained from the schools' management teams. Students received written information about the study prior to participation and gave written informed consent. Approval from an ethics committee was unnecessary because the research method was not burdensome or risky. Students could withdraw from the study at any time.

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Analysis

To answer the first research question, scores on the subscales of the Spiritual Care Competence Scale (SCCS) were analysed with t-test procedures. A comparison between the intervention and control groups was made at baseline and after six weeks. At baseline a t-test for equality of means was used to determine whether both groups had the same starting point. After six weeks a t-test for paired samples was used to assess whether there were any intervention-related differences between the two groups. After 20 weeks another t-test for paired samples was used to measure the change over time effect for the whole cohort of students. Effect sizes (ES) were calculated to measure the importance and magnitude of the observed effects. Middel et al. (2001) showed that the ES reflects relevance. An ES of 0.20 indicates 'no effect', an ES $>$ 0.20 but $<$ 0.50 indicates a 'small effect', while an ES $>$ 0.50 but $<$ 0.80 indicates a 'moderate effect', and an ES $>$ 0.80 indicates a 'considerable effect'.

Multiple regression analysis on the sample data was performed to answer the second research question, concerning the influence of six student-related characteristics scored on subscales of the SCCS. These characteristics were students' perceived spirituality, perceived religious engagement, thinking on questions of life, their vision of holistic nursing care, personal experience with spiritual care in practice and whether or not they were on an internship at the time of assessment. To answer the third research question on the vignettes, the differences given by lecturers with regard to the numeric qualifications between the intervention and control groups were analysed by a non-parametric t-test (Mann-Whitney test) to assess if they were significant ($p < 0.05$).

Results

Demographics

The 97 students (95 female and 2 male) participating in this study returned the questionnaire at all three measurement moments (intervention group n = 49; control group n = 48). The mean age of the respondents was 19.1 (SD 1.03, min. 19, max. 25). The students can be characterized as committed Christians with 99% being members of a church or faith community; 94% attend church weekly, 85%

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read the Bible on a daily basis, 93% pray every day and 74% are active in some religious discussion group or another. The students in the intervention group did their internship in hospital (63%), mental health care (25%) or in community health care (4%).

At baseline the students ranked themselves on a scale of one to ten on how spiritual they thought they were (mean 7.32, SD 1.48) and how important religion was to them in daily life (mean 7.78, SD 1.34).

Effects of the course on spiritual care

At baseline, both the intervention and control groups showed no statistically significant differences in self-assessed competencies in spiritual care across the subscales of the SCCS. After six weeks students in the control group differed in their self-perceived competencies from those following the educational programme in three subscales: 'professionalization and improving spiritual care', 'referral to professionals' and 'attitude towards patients' spirituality'. However, the magnitude of difference in attitude towards patients' spirituality has to be tagged as trivial (ES < 0.20). The size of statistically significant differences between controls and attendants of the educational programme on spiritual care is important according to Middel et al. (2001) (ES > 0.20) (see Table 3).

After collapsing both samples into the group exposed to the educational programme on spiritual care, statistically significant ($p < 0.05$) and important (ES > 0.20) changes over time were found across all the subscales (see Table 4).

Predictors of competencies for spiritual care

Multiple regression analysis showed statistically significant results between the dependent variable (competencies for spiritual care) and some independent variables. It shows that having or not having an internship influences the scores on the subscales 'assessment and implementation of spiritual care' (β-.351; p .001; R^2 .28), 'professionalization and improving quality of spiritual care' (β-.224; p .021; R^2 .22), and 'personal support and counselling of patients' (β-.219; p .031; R^2 .23). This means that interns had lower scores on these subscales compared to students without an internship.

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Table 3 Comparison between intervention group and control group after 6 weeks (T_1)

SCCS subscales	I/C	mean (SD)	t	df	sig.	ES
Assessment and implementation of	I	21.86 (3.05)	-1.27	48	.11	
spiritual care	C	22.04 (3.18)	-.57	48	.57	
Professionalization and improving	I	20.35 (3.35)	-3.95	48	.00	0.40
quality of spiritual care	C	19.40 (2.88)	-.95	48	.35	
Personal counselling and patient support	I	21.82 (3.03)	-.68	48	.50	
	C	21.43 (2.80)	.59	48	.56	
Referral to professionals	I	11.12 (1.52)	-3.53	47	.00	0.40
	C	10.64 (1.89)	.29	47	.77	
Attitude towards patient's spirituality	I	16.24 (1.49)	.63	46	.53	
	C	16.29 (1.60)	-2.24	47	.03	0.16
Communication	I	8.35 (0.93)	-.66	46	.51	
	C	8.35 (0.70)	.56	47	.58	

I = intervention group, C = control group Significance (sign.) = $p < 0.05$
Effect size (ES) <0.20 = no effect; 0.20-0.50 = small effect, 0.50-0.80 = moderate effect; >0.80 considerable effect

Table 4 Comparison baseline (T_0) and after 20 weeks for the whole cohort (T_2)

Subscales SCCS	T_0 - T_2	mean (SD)	t	df	sig.	ES
Assessment and implementation of	T_0	21.40 (3.24)	-5.21	96	.000	0.47
spiritual care	T_2	23.39 (3.09)				
Professionalization and improving	T_0	18.71 (3.51)	-9.87	96	.000	0.71
quality of spiritual care	T_2	22.59 (3.23)				
Personal counselling and patient support	T_0	21.76 (2.44)	-6.10	96	.000	0.53
	T_2	23.52 (2.54)				
Referral to professionals	T_0	10.42 (2.04)	-7.39	96	.000	0.60
	T_2	12.13 (1.51)				
Attitude towards patient's spirituality	T_0	16.05 (1.98)	-3.80	96	.000	0.36
	T_2	16.85 (1.45)				
Communication	T_0	8.34 (0.93)	-2.16	96	.033	0.22
	T_2	8.58 (0.89)				

Significance (sign.) = $p < 0.05$
Effect size (ES) <0.20 = no effect; 0.20-0.50 = small effect, 0.50-0.80 = moderate effect; >0.80 considerable effect

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The regression analysis also showed that the students' own experiences of spiritual care in practice statistically significantly explained the variance in the subscale 'personal support and counselling of patients' (_ .25[2]; p .020; R^2 .23). To clarify, students with such experience scored higher on that subscale compared to students who did not have such experience. Students with a more holistic vision of nursing care scored higher on the competency 'referral to professionals' (_ .237; p .026; R^2 .24). Other factors such as the students' own spirituality, own religious engagement and own thinking about questions of life showed no statistically significant prediction in the regression analyses. Age was also put in the regression model, but it did not appear as a significant predictor.

Analyses of the vignettes

The analyses of the vignettes showed that vignette 1, with its implicit spiritual content, had no significant ($p < .005$) differences in the given qualifications of the intervention group and the control group. Vignette 2, with its explicit spiritual content, showed significantly higher scores for students in the intervention group compared to those in the control group (see table 5).

Table 5 Analyses of vignette assessment between intervention group and control group

		N	Mean scores	Mann-Whitney U	Z	Sig.
Vignette 1	intervention group	40	48.2	1107.5	-.093	.926
Implicit spiritual content	control group	56	48.7			
Vignette 2	intervention group	39	64.1	426.5	-4.97	.000
Explicit spiritual content	control group	55	35.8			

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Conclusion and discussion

The results of this study showed that the course on spiritual care seems to have a particular effect on the planning and delivery of spiritual care, referrals to professionals and on professionalization and quality assurance. These significant effects are especially clear in the longer term. The students who started off as the intervention group at baseline perceived themselves after four months as more competent than immediately they had finished the course. This might be because the subject of spiritual care needs to be considered longer before it becomes internalized.

There is little or no effect on the subscales 'attitude towards patients' autonomy' and 'communication'. That might be because in student education there is already much emphasis on the attitudinal and communicative aspects of nursing care so that students already tended to score themselves highly in these subscales at baseline. In a comparative study between first and fourth-year baccalaureate students, Pesut (2002) found that fourth-year students wrote more about spirituality during their progression through the four-year educational programme and that they developed the more patient-centred approach important to spiritual care. This growth occurred during the standard educational programme and not because of any courses dealing specifically with spiritual care. Meyer (2003) also mentions the heightened spiritual awareness throughout the curriculum. This raises questions about the content of specific courses on spiritual care. Our study gives support to the opinion that a limited course should focus on the professional aspects of spiritual care and that attitudinal and communicative aspects should be integrated into the entire curriculum.

The use of the self-assessment method with regard to the ability to provide spiritual care is common in current studies in nursing (see Table 1). The question to ask is, if students perceive themselves as competent are they indeed really competent? The analyses of the vignettes must be seen as an attempt to give some objective insight into the students' actual competence. The student analyses of the vignettes can be seen as both a part of competence assessment and the implementation of spiritual care, because they were asked to analyse two patient-related cases. The students in the intervention group showed no significantly better analyses than

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those from the control group when it came to the first vignette with implicit spiritual content. In contrast, the vignette with explicit spiritual content showed a significant difference. This second vignette had a more religious perspective, which was probably more familiar to the students. That outcome raises questions about the interpretation of spirituality and spiritual care by students. Although the content of the course was not specifically focused on the religious aspects of spirituality, the students still interpreted the vignettes in those terms. It seems that they were biased by their personal, strongly religiously driven spirituality. Shih et al. (2001) emphasize the importance of detecting personal values. Hoover (2002) states that students need to know the patient's world to adapt their caring approach and adopt strategies to overcome constraints in themselves. Meyer (2003) emphasizes that students need to reconsider their values and personal spirituality through clinical experience. Sandor et al. (2006) mention the fact that students have to deal with their preoccupations with religious or spiritual matters.

The reflection sessions that formed part of the course in this study focused on these matters. They dealt with the students' personal experiences of aspects of spiritual care in nursing practice. Callister et al. (2004) report on student reflections in a reflective method called journaling. Students showed a growing self-awareness of values and beliefs and appreciation of how spirituality affects patients. Follow-up research into student reflections would be worthwhile to see if and how the content and process of these types of reflection sessions should be modified.

The students' personal spirituality did not change over time in our study and it was also not a predictor for their scoring on the subscales. This outcome shows no similarity with outcomes from other studies (Wasner et al. 2005; Sandor et al. 2006) that report a growing spiritual awareness and growth. Meyer (2003) reports that the students' personal spirituality was the strongest predictor of their perceived ability to provide spiritual care. This outcome, however, related to a study focused on factors in the whole curriculum of nursing schools and not on a specific course on spiritual care. Chung et al. (2007) also found that self-awareness (the self) had a significant relationship with the understanding of spiritual care and the practice of spiritual care of nursing students. Why the students' personal spirituality did not show as a significant factor (no personal spiritual growth and no predictor for perceived competencies) can be linked to the fact that the great majority scored

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themselves highly on spirituality and religiosity at the start of the study; there was less differentiation in these scores over time.

Our study shows the predictors that influenced the scoring of students on some subscales. Firstly, whether they have an internship or not influenced the scoring on three subscales. Interestingly, having an internship led to lower scores in general compared to not having an internship. The interns were probably confronted more often by their lack of competence, while students without internships may have tended to give more socially desirable responses. In addition to this outcome, having experience in spiritual care during the internship led to higher scoring on the subscale 'personal support and counselling of patients'. This shows the importance of specific practical experience with regard to spiritual care. This subscale focuses on nursing interventions. Personal examples from practical experience seem important for recognizing aspects of spiritual care and improving the ability to provide such care. Catanzaro & McMullen (2001) states that clinical experience also improves spiritual sensitivity and personal growth. In education this clinical experience should be used to improve competency in providing spiritual care. Mitchell et al. (2006) suggest using care mapping for this purpose, a dynamic and interactive method of linking theory and practice. The authors report that clinical environments offer a rich experience for students to explore the spiritual domain. The reflections in our study were focused on such clinical experience. We recommend further research into the effect of similar specific educational methods.

Secondly, the students' vision of holistic nursing care influenced their scoring on the subscale 'referral to professionals'. This outcome suggests that students think spiritual care must first be addressed by pastors and hospital chaplains and when nurses assess a patient's spiritual problem or needs, they should refer the patient to an expert and not provide the care themselves. This outcome might also confirm the frequent ambiguity detected in nurses' sense of responsibility for spiritual care (McSherry, 2000; Van Leeuwen et al. 2006), which has led to a lack of clarity about the position of the subject of spirituality within nursing curricula. Several studies confirm that spiritual care does not have a systematic place within curricula as do subjects dealing with physical, psychological and social aspects (Highfield et al. 2000; Catanzaro & McMullen, 2001; Meyer, 2003; Callister et al. 2004). Evidently

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education does enhance competence in providing spiritual care in individual nursing students. It appears that nursing schools may voluntarily incorporate spiritual care into their curriculum. The systematic position of spiritual care in nursing and its place in nursing education needs further, better organized debate.

The use of the crossover design appeared appropriate for answering the research questions. The fact that the original control group also undertook the course made the effect of the course become more evident over time. The original intervention group showed higher effect sizes than the original control group on three of the six subscales. On the other hand, the original control group showed more significant change immediately after finishing the course than did the original intervention group at the same time (T_1). With regard to the subscale 'attitude towards the patient's spiritual autonomy' the original intervention group showed no significant change at any measured moment. The original control group showed a significant change in that subscale at both T_1 and T_2. Perhaps a certain carry-over effect from the original intervention group to the original control group occurred over time because students were able to meet and share views of the course and its content with each other.

Relevance to practice

The results of this study are relevant to both nursing education in particular and nursing in general. The outcome gives nurse educators deeper insight into the content of education in spiritual care, the educational methods used and the possible effects on students' ability to provide spiritual care. It can help educators to consider a more systematic place for spiritual care within the nursing curriculum. The SCCS can also be used as a valid and reliable tool to assess nurse competency (at group level), which can give direction to the specific content of educational programmes and methods.

For nursing in general this study contributes to the need for a debate on the real place of spiritual care and the required competencies that student nurses need to develop. Education does have an impact on the development of competencies in spiritual care, but spiritual care does not yet have a systematic place in the practice of the nursing curriculum; it is presented to student nurses as theory.

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Limitation of this study

This results of this study may be limited in that they could be biased by the religious background (Christian) of the students involved. Follow-up research could clarify this issue if it also includes students from other spiritual and secular backgrounds.

Contribution to the manuscript
Study design: RvL, LJT, DP, HJ
Data collection: RvL
Statistical analyses: BM, RvL, LJT
Manuscript preparation: RvL, LJT, BM, DP, HJ

This study is part of the research programme of the Ethics of Care Research Group of the Ede Christian University headed by Henk Jochemsen.

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Chapter 8

Learning effects of thematic peer review: a qualitative analysis of reflective journals on spiritual care

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Submitted

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Abstract

This study describes the learning effects of thematic peer-review discussion groups (Hendriksen, 2002) on developing nursing students' competence in providing spiritual care. It also discusses the factors that might influence the learning process. The method of peer review is a form of reflective learning based on the theory of experiential learning (Kolb, 1984). It was part of an educational programme on spiritual care in nursing for third-year undergraduate nursing students from two nursing schools in the Netherlands. Reflective journals (n = 203) - kept by students throughout the peer-review process - were analysed qualitatively and grouped into themes. The analysis shows that students reflect on spirituality in the context of personal experiences in nursing practice. In addition, they discuss the nursing process and organizational aspects of spiritual care. The results show that the first two phases in the experiential learning cycle appear prominently, they are 'inclusion of actual experience' and 'reflecting on this experience'. The phases of 'abstraction of experience' and 'experimenting with new behaviour' are less evident. We will discuss possible explanations for these findings according to factors related to education, the students and the tutors and make recommendations for follow-up research.

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Introduction

Although education is seen as an important condition for developing nurses' competence in providing spiritual care, there is no systematic embedding of spiritual care in nursing education (Ross, 2006; McSherry, 2006; Van Leeuwen et al. 2006). There is a growing concern for the educational aspects of spiritual care in nursing.

First, there is concern for the proper competencies needed by nurses in order to provide spiritual care (Van Leeuwen & Cusveller, 2004; Baldacchino, 2006). This points to the way nurses engage their personality in relationship to patients and the role their personal spirituality plays in that relationship. It seems that nurses are expected to be capable of providing spiritual care in the nursing process and to be able to contribute to the organizational aspects of spiritual care.

A second area of study concerns the content of nursing education with regard to spiritual care. These studies show that in general a combination of educational strategies is applied, focusing on the development of knowledge, communication skills and attitude (Highfield et al. 2000; Shih et al. 2001; Marr et al. 2007). Other studies describe specific educational methods in reflective learning (Bush, 1999; Souter, 2003; Mitchell et al., 2006). Personal reflection has been seen as an essential skill in the learning process regarding spiritual care (Greenstreet, 1999; White, 2006; Van Leeuwen & Cusveller, 2004; Van Leeuwen et al. 2006).

A third area is formed by studies concerning the effects of education. In general, they show the effects of education in spiritual care on personal spiritual development and the development of professional competencies in the nurse. Some studies deal with the application of specific educational programmes (Hoover, 2002; Milligan, 2004; Wasner et al. 2005; Sandor et al. 2006; Lovanio & Wallace, 2007). Other studies consider the influence of nursing curricula in general (Pesut, 2002; Meyer, 2003).

The studies on specific educational programmes in spiritual care used a mix of educational strategies. However, the literature does not make clear what effect these methods have. The above-mentioned studies on reflective methods (Bush,

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1999; Souter, 2003; Mitchell et al. 2006) are examples of studies describing the content of the method and guidelines for its application from a theoretical point of view. They do not describe the practical effects of application. To gain more insight into the learning effects of specific educational strategies on the development of competence in the provision of spiritual care in nursing, research into these specific strategies seems necessary. Our study contributes to that research by focusing on the following questions:

- what is the content of the written reflections that students brought to the guided thematic peer-review sessions?
- which learning effects do students ascribe to these peer-review discussions?
- which factors relate to a particular learning effect?

Method

This study involves document analysis of reflective journals written by students for guided thematic peer-review sessions. These so-called non-elicited documents were not written upon the request of the researchers, as this factor had led to potential bias and data distortion in a previous study. (Denzin & Lincoln, 1994).

The applied method of guided thematic peer-review groups

Guided thematic peer review was part of a module dealing with spirituality and spiritual care provision in nursing. Peer review is a form of collegial support in which students discuss work-related issues and advise each other (Hendriksen, 2002). This method is based on the experiential learning model (Kolb, 1984) which contains:

- inclusion of actual experiences
- reflection on these experiences
- abstraction of these experiences into general terms
- directing and testing alternative strategies in new conditions

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Peer review is an adequate method to shape the reflective process with regard to spirituality and spiritual care. White (2006) states that - according to the learning process involved in spirituality and spiritual care - a reflective, experiential approach encourages the integration of theory into practice. He recommends the use of group learning and group reflection, particularly because spiritual matters are difficult to articulate, they may be emotionally challenging and that learning from and with each other may be effective. The peer-review groups were guided by senior lecturers.

Peer review took place in groups of four to six students and consisted of four three-hour sessions. Orientation took place during the first session in which students' starting points were discussed on the basis of an individually written self-reflective report using the competency profile for spiritual care (Van Leeuwen & Cusveller, 2004). After discussing these self-reflections, themes were set for the follow-up session. Prior to each follow-up session, students were to submit to all the other participants of the group their written reflections on both the previous discussion and the next theme to be discussed. Students were undertaking internships throughout the duration of the peer-review sessions (10 weeks).

Sample

This study includes 203 written journals (response 74%) from nine peer-review groups. A total of 39 third-year students from two nursing schools in the Netherlands were involved (ages ranged from 19 to 25 years). Not all journals were included because some students were unable to attend all of the sessions (e.g. due to illness). Only after completion of all the peer-review sessions were students approached and asked to share their journals, which led to the unfortunate discovery of the fact that some students had, by that time, destroyed their journals.

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Data collection method

After completion of the module, one of the researchers approached students in writing, providing information on the study and requesting permission to use the student's peer-review material for research purposes. Students were free to object to the use of their journals. None of the students objected and the journals were subsequently handed to the researcher involved in data analysis who rendered the material anonymous to allow for a masked study (Denzin & Lincoln, 2000).

Data analysis

The method of analysis as outlined by Baarda et al. (2005) was employed during qualitative analysis. This method involves the following steps:

- sorting the text contained in the reflective journals in terms of relevance. Only information pertaining to practical and organizational aspects of the discussion was removed from the journals
- splitting relevant text into fragments
- labelling fragments using an open-coding system
- arranging and reducing labels
- defining key labels and their subsequent dimensions
- determining validity of the labelling. To this end, material from a single group was kept separate to serve as a control. This material was read by the researcher after completion of the analysis process, after which the researcher checked whether the control contents could be placed within the existing key label overview. No further themes emerged, and saturation of research data was established
- determining intersubjectivity between researchers throughout the evaluation process. To achieve this, the researchers separately analysed one set of peer-review journals and discussed the individually formulated key labels. It was concluded that there was sufficient agreement concerning data interpretation and the labels as attributed. The remaining reflective journals were divided among the researchers

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Validity and reliability

Kwalitan software was used for qualitative analysis (Peters, 2000). The research group met on a regular basis to monitor the progress and content of the analysis. Literal citations from students' reflective journals have been included in this study report to illustrate the formulated key labels and dimensions. Citations were coded to ensure a wide-ranging selection. The analytical procedure used also ensured the validity and reliability of the qualitative analysis as described in the literature (Lincoln and Guba, 1985; Maso & Smaling, 1998).

Results

The results are shown using key labels and their corresponding dimensions as derived from the analysis. First they describe the actual themes that emerged during guided thematic peer review and, secondly, the effects of guided thematic peer review as indicated by students.

Use of self-respect in relation to personal and contrasting spirituality

Use of self-respect relates to the way in which students handle their personal characteristics in, for example, relating to a patient or colleague (Van Leeuwen & Cusveller, 2004). The following dimensions may be identified: handling (coping with) one's own (Christian) spirituality, coping with feelings, managing personal circumstances and dealing with contrasting beliefs.

Handling one's own spirituality

Students show insecurity in handling their personal spirituality and specifically their own Christian identity. Various students have difficulty handling their personal faith during contact with patients. Students with a strong Christian conviction want to relate their faith to others, while realizing that evangelism is not a part of the nursing profession. Students indicated that they felt supported by their faith and wished the same for their patients. Discussions focused on the difficulty that students experienced in dealing with the (Christian) convictions of patients. This raises questions for students.

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Student: A woman has to choose: either believe that her deceased grandchild has gone to hell or renounce her faith from which she derives her identity. How could her church make her believe this or act on this belief? (group l - segment 3)

Coping with feelings of uncertainty

Students point out that they are afraid of saying the wrong thing in communicating with patients. They often write that they have no answers and feel their own shortcomings. They are insecure when it comes to discussing spirituality and often do not have answers to questions, and this gives rise to feelings of inadequacy. They become aware of needing to assume a sense of humility toward patients. Students also describe feelings of contentment and encouragement in actual conversations on spirituality with patients.

Student: At that moment I really did not know what to do or to say. Do I ask enough questions? (group e, segment 11)

Role of personal life experiences

Being confronted with one's personal circumstances surfaced as a result of facing complex situations with patients. Talking about spirituality also meant confronting personally intense experiences for some students.

Student: I never thought that my move away from my home church would have such an influence on a conversation with a patient (group l, segment 13)

Dealing with contrasting faiths

Guilt feelings appeared with regard to this topic, as students felt they had to deny their own faith when offering support to a patient with a contrasting faith. Students wondered whether they were allowed to discuss religion with patients, and whether they were allowed to help in rituals such as reading the Koran or praying. Students generally agreed that one should not impose one's own opinion on patients.

Student: I found it difficult to read the Koran to a Muslim patient as it runs counter to my own faith (group k, segment 2)

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Provision of spiritual care

The following dimensions emerged: recognition of spiritual issues, attitudinal skills, nursing interventions and nurse responsibility.

Recognition of spiritual issues

An important point is increased awareness. Students tend to think 'too big' whereas spiritual issues are often noted in small things. By asking patients how they perceive their illness, one allows them to voice their spiritual questions and needs. Questions of life and death, illness and suffering are among the most common.

Student: When people are faced with illness, they are close to their own spirituality. They might ask such questions as 'why is this happening to me, am I being punished?' (group k, segment 14)

Attitudinal aspects

Students become aware of the importance of such attitudinal aspects as adopting an attentive attitude and showing respect. They realize that discussing spirituality with a patient is a way of being close, which emphasizes the importance of creating a secure environment and showing mutual trust.

Student: Listening is important. No matter how quickly you want to find a solution, you don't have that solution (group h, segment 2)

Nursing interventions

Numerous suggestions and practical tips are provided in the peer-review sessions. These are used by students to support them in the provision of spiritual care. Students recognize the importance of communicating personal boundaries. Students also pointed to the fact that they tended to offer solutions whereas they needed to learn that this is not always appropriate or possible.

Student: To ask existential questions etc. is really important, although it is scary at times. You do need to indicate your personal boundaries in these matters (group d, segment 1)

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Nursing responsibilities for spiritual care

There is ongoing discussion of the professional boundaries for nurses with respect to spiritual care provision and when referral is appropriate. 'Professional responsibility' was the discussion topic in several peer-review groups. Various nursing models were used as frames of reference to help label the spiritual needs of patients and to process these in the anamnesis and a nursing care plan.

Student: We need to look at spirituality in a more professional light because spiritual care provision is part of the nursing profession' (group k, segment 11)

Student: The Neuman Systems Model also encompasses the spiritual aspects of each human being. The spiritual variable should be included in creating an anamnesis (group e, segment 2)

Organizational aspects of spiritual care

As well as mentioning patient-bound conditions, students also included situations relating to organizational aspects in their journals.

Attention to spiritual care in the nursing process

Students note that there is little time for spirituality in everyday practice. Within the nursing department they point to such issues as the lack of a policy for spiritual care and the lack of attention paid to it throughout the nursing process. Lack of time is seen as a problem in spiritual care provision. The need to prioritize is emphasized here.

Student: It has not been incorporated into the nursing process yet. It's left up to each nurse (or not)? (tutor k, segment 5)

Colleagues

Students perceive a lack of understanding and knowledge, as well as prejudice against spirituality. They point out that when trying to discuss spirituality you should show sensitivity. During the peer-review sessions students became aware of the impact of ward culture on spirituality. Students attach importance to open

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discussion of spirituality with colleagues, and to paying attention to matters of spirituality during shift changes.

Student: According to my mentor, spirituality gets little attention because patients are admitted for only short stays. She said that patients will let us know if they need to talk about spiritual issues and problems (group k, segment 3)

The learning effect of guided thematic peer review

The learning effects as indicated by students may be summarized using these dimensions: i. gaining awareness, ii. developing self-confidence with respect to aspects of spiritual care provision and iii. developing a change-directed attitude toward spiritual care.

Gaining awareness

Students stated that peer review increased their awareness of personal spirituality and the place of spirituality in care provision. The learning effect was that students became aware of the spiritual care they were providing without actually realizing it. When spirituality was given the attention it deserved it led to an increased awareness of their involvement in spiritual care.

Student: I think it is now easier for me to talk to a Muslim about religion. I can be more meaningful to a patient and I won't only be supporting patients who share my own religion' (group a, segment 2)

Developing confidence

Students claimed that the peer-review sessions made them more confident of being able to enter into conversations about spiritual matters. Students said that discussing practical situations was helpful and this made them feel better able to cope with difficult situations.

Student: I'm learning to look at myself and my own attitude to this topic. I'm noticing personal growth (development) and I'm opening up to others (group a, segment 5)

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Change-directed attitude

Several students described their new undertakings on the ward with regard to spiritual care. Peer review had given them the necessary foundation.

Student: I'm implementing an existing guideline on spiritual care on the ward (group e, segment 2)

Conclusion and discussion

The analysis clearly shows that the students' learning process points to several professional aspects of spiritual care. The peer-review method seems initially to stimulate an increase in self-awareness to such effect that students gain confidence in their role as a provider of spiritual care. Some students also show a change-directed attitude. These results are confirmed by White (2006) and Rankin & DeLashmutt (2007) who also identified enhanced awareness and personal development regarding personal spirituality among participants of group discussions. They state that the participants were able to reflect on the spiritual aspects of specific practical experiences in relation to their personal spirituality. This was also shown by the reflective journals in this study in which students raised questions about their own Christian beliefs. The process of gaining awareness of personal spirituality is claimed to be an essential prerequisite for the provision of spiritual care (McSherry, 2006; Van Leeuwen et al. 2006). This aspect can be considered to be the professional nursing competence described by Van Leeuwen & Cusveller (2004) as 'use of self'. Using the competency profile for self-evaluation at the start of the sessions enhanced spiritual care in such things as nursing interventions and organizational or institutional aspects (Van Leeuwen & Cusveller, 2004) and led to a more focused content of the peer-review sessions. This is in line with the findings of Rankin & DeLashmutt (2007), who conclude in their evaluation of an educational course on spiritual care that topic-focused discussion fosters the application of reflective thinking on such difficult concepts as spirituality and spiritual care. This confirms the usefulness of the thematic peer-review groups applied in this study.

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This study makes clear that the peer-review discussions focus primarily on the first phases of the experiential learning model (Kolb, 1984) because they mention the entry of actual experience into reflection and opinion formation. This parallels findings from an analysis of reflective journals by Chirema (2007) who concluded that students reflect on the level of 'attending' and 'feeling' in their journals. The reflective journals show less of the integrative phase, during which students learn to detach themselves from actual experience, form abstract concepts and generalize the subject matter. In some cases there was evidence to suggest a relationship between a systematic approach to spiritual care through the use of nursing models and the nursing process. Testing new behaviour in practice is shown in topics such as 'feeling more confident' and 'commitment'. The journals report very few instances of new behaviour applied to nursing practice. It could be that students have not yet been adequately trained to reflect on this. In this context, Glaze (2002) emphasizes that the reflective capacity of students shows several developmental phases, starting with being confronted by the need to reflect and ending with the integration of reflection into personal actions. Developing competence in the provision of spiritual care possibly requires an internalized form of reflection in which abstraction and experimentation are integral to the student's basic skill palette.

Additionally, Donovan (2007) states that adequate preparation of students and continuing guidance by tutors is important for successful reflection. He draws these conclusions from an implementation study on reflection. Consequently, in our study we selected the guided peer-review model. We expected tutor guidance to stimulate the process of experiential learning, as described by White (2006). The analysis of the reflective journals was not directed at the tutor's role. Thus the students' reflections barely addressed the tutor's role. It seems, however, that the tutor's role is important, particularly with regard to providing content during the abstraction and experimentation phases of the learning process. The number of group discussions that took place (four) may also have played a role in the finding that students did not complete the reflective cycle. Analogous to supervision processes (Siegers, 2002), a longer cycle with a greater number of discussions might be introduced.

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Another possible explanation is that the students involved in this study were all in the stage of adolescence, during which abstract and reflective thinking is developing (Erikson, 1982). In that sense it is not surprising that they focused especially on the first two stages of the reflection process (inclusion of actual experiences and reflection on these experiences). This again shows the importance of a guided form of reflective learning, in which a tutor must be able to coach students in the application of the 'abstraction of these experiences into general terms' stage as well as 'directing and testing alternative strategies in new conditions'. Follow-up research could focus on the role of the tutor in the reflective learning process with regard to spiritual care and the application of specific learning strategies to enhance the reflective competence of students. The analyses of the reflective journals showed little or no enhancement of competence with regard to spiritual care in nursing practice. Completing the whole reflection cycle seems essential for developing competency because students will then be capable of reaching the level of abstraction (for example, theorizing about spiritual care) and test alternative behaviour (practice new competencies in spiritual care). Jochemsen & Hegeman (2007) introduce the method of deep reflection, which integrates moral and spiritual knowledge with experience and one's own spirituality in one's professional practice.

A final explanation might be the stage of spiritual development in the students. As noted above, the way student nurses cope with spiritual matters in health care practice is especially connected to their personal attitude towards spirituality. In describing the different stages of faith, Fowler (1981) states that individuative-reflective faith begins in the mid-twenties. During this stage the individual takes on personal responsibility for their beliefs and is able to reflect on them. This generates questions about the demands put on students in their late teens and early twenties who, according to Fowler (1981), are still in the synthetic-conventional stage. This stage can be characterized by conformism and a less reflective attitude towards faith and beliefs. Follow-up research should shed more light on the influence of cognitive and spiritual developmental aspects on the development of competencies in student nurses in the provision of spiritual care.

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Chapter 9

General discussion, Summary, Samenvatting

General discussion

Introduction

The studies included in this thesis will answer the research questions formulated in the general introduction. The importance of spiritual care in health care in general and in nursing in particular is confirmed by the results of these studies. The interviews with patients, nurses and hospital chaplains have made clear that there is a connection between spirituality and illness and that this connection can be characterized as multidimensional. It has also become clear which competencies nurses might be expected to show in the spiritual care they provide to patients. With this study a valid and reliable assessment tool was developed to measure the competencies. Finally, this study provides insight into the effects of education on the development of these competencies in student nurses. In this chapter, the results will first be summarized by answering the research questions and then discussed.

Main findings

1. How has the connection between spirituality and physical health been investigated and what are the results of that investigation?

The first study comprised an analysis of 31 medical and nursing studies on the connection between spirituality and health among patients with physical illnesses (Chapter 2). The medical studies focused particularly on revealing a statistically significant relationship between spirituality and health. The nursing studies focused on the exploration of the beliefs, experiences and needs of patients in the area of physical health care. The analysis of the studies showed no common connection between spirituality and physical health. The results show either a positive or negative or even no connection. Comparative analysis is difficult because of the differences in methodology. One main problem is the operationalization of the concept of spirituality, which ranges from a specific religious content to entirely personal interpretations. In addition, in many of the studies the research questions were not focused directly on spirituality itself; the results in this area are measured as a side effect. These aspects need to be addressed in follow-up research.

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2. What role does spirituality play in patients during physical illness and treatment?

The second study contains the results of focus group research with patients, nurses and hospital chaplains working in cardiology, oncology or neurology in Dutch health care. The results of this study show the relevance of spirituality to patients during illness and their subjective and personal interpretations. The multidimensionality of spirituality within the context of illness and treatment is confirmed. This study describes the relationship between spirituality and illness in themes. After concluding the analytical phase of the research, the themes that emerged were modelled in an adaptation of Fitchett's (1993) model of spiritual categories (Jochemsen et al., 2002). This model can be used by health care workers to assess the spiritual needs of patients.

3. What competencies do nurses need to provide spiritual care?

The third study is a literature review of the competencies that nurses need to provide spiritual care (Chapter 4). This resulted in the creation of a competence profile for spiritual care by nurses, covering three domains of competencies. The first domain, self handling, contains two competencies, one on the way a nurse personally copes with spirituality in the relationship with the patient, the other on the communicative aspects of spiritual care. The second domain, covering the spiritual dimensions of the nursing process, contains three competencies: spiritual needs assessment, nursing interventions and coordination of spiritual care. The third domain concerns the role of the nurse in quality assurance and the development of spiritual care policy in the health care institution. These competencies give direction to educational programmes on spiritual care in nursing.

4. How do nurses handle spiritual aspects in health care practice and can nursing competencies for spiritual be identified in their conduct?

The fourth study explores the way in which health care nurses handle the spiritual needs of patients (Chapter 5). The data resulted from focus group interviews with nurses, patients and hospital chaplains working in cardiology, oncology or neurology in Dutch health care. The results show that spiritual care is not

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systematicly embedded in nursing health care practice. The competencies for spiritual care provision derived from nursing theory (Chapter 4) were generally identified in practice but not in each individual nurse. The results show that personal factors play an important role in the concern nurses have for spiritual care. These factors are age, life experience, working experience and spiritual engagement. This study also demonstrates the different expectations of spiritual care between individual nurses, as well as among the groups of nurses, patients and hospital chaplains included in this study.

5. How can nursing competencies regarding the delivery of spiritual care be assessed?

The fifth study describes the development of a tool that measures competencies in nursing care, the Spiritual Care Competence Scale (SCCS) (Chapter 6). The basis for this tool was the profile of nursing competencies for the delivery of spiritual care (Chapter 5). Construct validity was determined by factor analysis. The tool consists of six subscales describing the following dimensions of competencies:

- assessment and implementation of spiritual care
- professionalization and quality improvement of spiritual care
- personal counselling and support of patients
- referral to professionals
- attitude towards patient's spirituality
- communication

The instrument was tested psychometrically in a group of nursing students. The subscales showed good internal consistency, adequate average inter-item correlations and good test-retest reliability. The results lead to the conclusion that the SCCS is a valid and reliable tool for the assessment of competencies for spiritual care on the group level, for instance in nursing teams or educational groups. For a broader (valid and reliable) application of this instrument, further testing is necessary in other nursing populations as well as among other health care workers (e.g. physicians, paramedics and social workers).

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6. What are the effects of a newly developed educational programme for student nurses on the development of their competencies in spiritual care?

The sixth study describes the results of an evaluation of the effects on third-year students in two Dutch nursing schools of an educational programme on spiritual care aimed at the development of competencies to provide spiritual care. The evaluation involved the use of the Spiritual Care Competence Scale (SCCS) as well as assessments of vignettes. The vignettes consisted of two patient-related cases, one with implicit spiritual content and the other with explicit spiritual content. The students were asked to assess these cases and to state what care they should deliver in the given case. In the first phase of the research the students were divided into an intervention group and a control group. The intervention group followed the educational programme on spiritual care. The first assessment with the SCCS at baseline (T_0) showed no statistical differences between the intervention group and the control group. After finishing the educational programme (six weeks after baseline), the intervention group showed statistically significant higher scores on the subscales of 'Professionalization and improving quality of spiritual care' and on 'Referral to professionals' (T_1). Fourteen weeks after baseline the original control group also followed the educational programme on spiritual care. After they had finished the programme (20 weeks after baseline), the total cohort of students (original intervention group and control group) scored statistically significantly higher on all subscales compared to baseline scores (T_1). The effects on the subscales of 'Attitude towards patient's spirituality' and 'Communication' were trivial.

The assessment of vignettes (at T_1, six weeks after baseline) showed that the intervention group scored significantly better statistically on the vignette with explicit spiritual content. Assessment of the case with explicit spiritual content showed no statistically significant differences between the two groups.

Regression analysis showed that not having an internship is associated with higher scores on the attitude scales 'Assessment and implementation of spiritual care', 'Professionalization and improving quality of care' and 'Personal support and counselling of patients'. This indicates that not having an internship has a weaker identification in these domains of spiritual care. The students' personal experience of spiritual care in nursing practice led to statistically higher scores on the subscale

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'Personal support and counselling of patients'. Students who show a more holistic attitude to nursing care scored statistically significantly higher on the subscale 'Referral to professionals'.

7. What are the learning effects of the educational method of thematic peer review on the development of competencies for spiritual care provision?

The seventh study is a document analysis investigating the learning effects of thematic (spiritual care) peer review in groups. These groups were part of a spiritual educational programme in which third-year students of two Dutch nursing schools participated. Reflective journals kept by the students were used for qualitative analysis. The analysis showed that students discussed subjects falling into three main themes: 'self handling in spirituality and spiritual care', 'delivering spiritual care to patients' and 'aspects of spiritual care policy in health care institutions'. The students mentioned different learning effects in their reflective journals. First, they noted an increasing awareness of the relevance of spirituality and spiritual care to nursing and how their own spirituality played a role. Secondly, they recorded their growing self-confidence in the delivery of spiritual care; some students demonstrated a new, change-directed attitude. Following Kolb's (1984) learning theory about experiential learning, the discussions in the peer-review groups were focused especially on the learning stages 'inclusion of factual experiences' and 'reflection on these experiences'. The stages 'abstraction of experiences' and 'experimenting with new behaviour' were seldomly found in the reflective journals. One reason why the students did not attain all the levels of reflection may be due to the relatively low number of group meetings. The students' psychological stage of development may be another explanation. In addition, tutor guidance might be required in this learning process but the reflective journals provided no information on this aspect of the teacher's role.

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Reflections

Methodological reflections

Combining qualitative and quantitative research methods

A combination of qualitative and quantitative methods was employed by the research featured in this paper. Both methods should be complementary and thus contribute to more valid and reliable data (Polit & Hungler, 1997). Each study used a single research method. For example, the spiritual aspects of illness were investigated but no other method was used to validate the spiritual themes emerging from that research. Follow-up research can contribute to further (external) validation of these themes. A multi-method approach (method triangulation) shows discernible added value, particularly in studies of educational effects. The studies in this research used the following methods: quantitative analysis of students' self-assessments on the Spiritual Care Competence Scale; quantitative analysis of students' vignette assessments; and qualitative document analysis of the reflective journals students kept during a peer-review process. This combination of methods provides additional insights on the students' development of competencies compared with a study than had used only their self-assessments had been used. The multi-method approach provides deeper insight into the learning effects of education in spiritual care. Razum & Gerhardus (1999) state that method triangulation is most useful when contradicting results are welcome. The different studies on the effects of education showed partly contradicting results. In their self-assessments, students rated themselves consistently highly on the levels of competence development, whereas more nuances were apparent in the assessment of the vignettes and document analysis. A combination of methods is desirable when assessing the development of competencies for spiritual care. The conclusion that method triangulation strengthens analysis and improves knowledge about educational effects is confirmed by Magnusson et al. (2005) in their research on education. The multi-method is recommended for assessing the validity and reliability of the results of learning processes.

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Generalizability of results

Internal validity and reliability of results is guaranteed by the way the various studies are conducted and confirmed. A question is whether the results of this study can be generalized to the total population of patients, nurses, hospital chaplains and nursing students?

Firstly, convenient samples were used for the focus group interviews. Since the respondents were not selected at random, there may have been some selection bias. It is also possible that respondents may have agreed to participate because of their higher than average interest in spirituality.

The group of patients participating in this study reflected Dutch society with its Judeo-Christian and humanistic roots. Individuals from other religious or spiritual backgrounds, especially those with an Islamic background (one million Dutch citizens) were not involved in the sample. This raises questions about the way the participants in these groups might have influenced the results of the study of the spiritual aspects of illness and the nurse's role in spiritual care. To prevent selection bias in follow-up research, the use of stratified, randomly assigned groups is recommended.

Secondly, did the students participating in the study on the effect of education on the development of competencies in spiritual care nursing represent adequately the total student population of the 19 Dutch nursing schools educating students at the same level? All these schools educate students according to generally accepted professional standards (Pool et al., 2001) but nationwide there is no common nursing curriculum. The schools are comparable to a certain degree, but each school may stress different aspects of its curriculum. According to age and gender, the sample of students used in this study is representative because all students attend nursing schools after secondary school and most are aged between 18 and 22. If part-time students had participated, the sample would have been less homogeneous and probably less representative.

Thirdly, in terms of the generalizability of results, the religious background of the participating students is a point of discussion. These students can be described as

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strongly religious (Christians). This becomes clear in their following characteristics: weekly church attendance (94%); daily bible reading (85%); daily prayer (93%); participating in religious study groups (74%). When asked 'how spiritual do you think you are?' (scale 1 - 10), 72% of the students scored themselves 7 or higher. When asked 'to what extent is your daily life directed by your faith?' (scale 1 -10), 88% scored themselves 7 or higher. Comparable characteristics of students from other schools are unavailable, as far as we know, and students from other religious backgrounds and non-religious students were not included in the sample. Considering the above, it must be concluded that the sample is not representative of the whole student population in all respects. Whether that led to a certain bias in the results can only be answered by follow-up research that includes students from other nursing schools with various religious, nonreligious and spiritual backgrounds. The hypothesis can put forward that there will be more effect of the educational programme on students who have a lower scores on the spiritual and religious rating scales.

Spiritual Care Competence Scale (SCCS)

In this study a tool was developed to measure nursing competencies in spiritual care, the Spiritual Care Competence Scale (SCCS). This tool finds its theoretical base in the nursing competence profile for spiritual care that was developed and described in an earlier stage of this study. The construct validity of the SCCS was confirmed by factor analysis, which resulted in six subscales characterizing the core dimensions of competencies for spiritual care in nursing. The psychometric analysis was done on the basis of measurements in a respondents group limited according to its size and characteristics. This analysis made clear that the SCCS is a robust, valid and reliable scale. The original competencies described in the nursing competence profile for spiritual care were also identifiable in the SCCS, which provides a strong foundation for further testing. This should take place in other populations of nurses, such as graduate nurses and those working in other areas than somatic health care (e.g. mental health care, geriatric care, community care and paediatrics). In this context it would also be interesting to test the general character of the tool by applying the SCCS in non-nursing populations such as physicians, paramedics and social workers. McSherry (2006) and White (2006)

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recommend taking a multidisciplinary approach to spiritual care and they suggest considering spiritual care a task not only for nurses but for other health care workers as well. Further development and application beyond nursing should contribute to advances in this multidisciplinary approach.

Conceptual reflections

The connection between spirituality and sickness and health

The general introduction to this study pointed out that both functional and substantial approaches to spirituality are relevant in nursing (Jochemsen et al. 2002; Donk et al. 2006). In the functional approach, spirituality is an aspect of human functioning standing alongside the physical, psychological and social aspects of functioning. The functional approach fits well with an integral, holistic approach to the patient. The substantial approach stresses the many and varied forms and expressions of spirituality and also emphasizes that individuals may have personal experiences or a personal interpretation of spirituality. The results of this study confirm that both approaches are indeed relevant to nursing.

The connection between spirituality and illness and health is clear in general (functional); specifically, however, for each patient spirituality is unique (substantial). Fitchett's (1993) model of spiritual categories and the modified form (Jochemsen et al. 2002) used in this study can serve as a functional frame of reference for nurses assessing the spiritual needs of patients. The interviews exposed spiritual themes that must be seen as examples of the substantial approach because they are more specific interpretations of general topics made by patients with specific illnesses (cardiology, oncology and neurology). Studies among other categories of patients show that other themes may emerge as well (Westrik 1998; Jochemsen, 2002; Ross, 2006; McSherry, 2007). The meaning spirituality has for patients can thus be explained to nurses and other health care workers. This suggests the use of care models and nursing models that make explicit the role of spirituality. These models can help health care workers and nurses to develop a truly holistic focus in the care they give to patients. Examples are the biological-psychological-social-spiritual care model (BPSS model) described by De Vries (2006) or the Neuman

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systems model developed for nursing (Neuman, 2002). The BPSS model (De Vries, 2006) justifies why all the dimensions of being human receive attention in care. De Vries (2006) gave content to the spiritual dimension of the model from the perspective of mental health. Neuman's systems model (Neuman & Fawcett, 2002) views the patient as an open-client system, which consists of physiological, psychological, social-cultural, developmental and spiritual variables in constant interaction with the internal and external environment.

Lastly, how can the above remarks on the connection between spirituality and illness and health be related to the analysis of medical and nursing studies described in Chapter 2? That outcome showed no unequivocal connection between spirituality and health. A distinction must be made between the medical and the nursing studies. The medical study sought a significant statistical connection while the nursing study researched the qualitative sense of the connection. This very much dependent on concepts being used. The outcome of the nursing study can be seen as validation of the outcome of the focus group interviews in this study.

Spiritual care in nursing

The conclusion that there seems to be a connection between spirituality and illness and health, demonstrates the relevance of this subject to nursing. It has already been noted in the general introduction that concern for the patient's spirituality is often not a systematic part of the care nurses provide to their patients. The results of the focus group interviews (Chapter 5) confirm that. These interviews also demonstrated the expectations patients and other health care workers have of the nurse's role. These varied from marginal to no involvement (assessing spiritual needs and referral to the hospital chaplain) to actively supporting patients in their spiritual needs. Personal spirituality is apparently an important factor for the nurse when deciding whether or not to provide spiritual care. Spiritually engaged nurses or those who had undergone certain major life experiences (life events) seem to be more sensitive to the spiritual needs of patients. This result shows that the nurses' own spirituality and spiritual experiences influence the way they handle spiritual care in practice.

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This conclusion is supported by the philosophy of nursing practice that says that nursing activity has both a constitutive and a regulative side (Jochemsen et al. 2006). The constitutive side describes the professional principles and norms fundamental to nursing practice (e.g. protocols, methods, laws, codes). The regulative side refers to personal motives, objectives, expectations, experiences of the nurse that inevitably play a role in the way the nurse provides spiritual care. This regulative side enables the nurse to make an individual assessment of practice and to act innovatively. When it comes to the regulative side of spiritual care practices, the results of this study demonstrated that the nurse's personal spirituality and experiences play an important role. This is also suggested by the analysis of the reflective journals of nursing students (Chapter 8). This means that the nurses' attitude towards spirituality influences the way they handle the spiritual needs of patients in health care practice. For example, a nurse with an aversion to spirituality can simply ignore a patient's spiritual needs. More awareness of the regulative side of nursing practice is important for nurses in general but it may be even more important when it comes to nurses' attitude toward spiritual care.

Nurse competencies for delivering spiritual care

In addition to the regulative side of nursing practice, something must be said about the constitutive side of that practice with regard to spiritual care. The constitutive side deals with the purpose of nursing practice and its fundamental principles and norms (Jochemsen, 2006). The goal of nursing practice in general, but of spiritual care practice in particular, can be described as the enhancement of health and wellbeing of patients. The connection between spirituality and illness and health in this study implies that health care workers should tend to this aspect in their care. The expectations placed on health care workers in general and on nurses in particular must be made clear. The competencies for the delivery of spiritual care developed in this study should be seen as contributing to the clarification of these principles, norms and rules of spiritual care in nursing practice. As far as can be gathered from the literature, this is the first time that professional responsibility for spiritual care is described in terms of competencies. Among responses to the competence profile already in the literature, McSherry (2006) states that the profile is a valuable attempt to describe the knowledge and skills of nurses in this area.

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He suggests broadening the use of the profile to health care workers in general, pointing to the generic character of the profile. A study among Maltese nurses validated five of the six competencies listed in the profile (Chapter 3), with the exception of the competence regarding quality assurance and expertise (Baldacchino, 2006). The author explains that nursing managers were not included in the sample and that quality assurance is still in its infancy in Maltese nursing. Tiesinga (2006) found the competence profile a useful tool for collecting data on the nurses' spiritual care role in community care.

Despite the support for the competence profile, it is still under debate. Waaijman (2004) is critical of the competence approach to spirituality and spiritual care. In his opinion the essence of the caring relationship between the nurse and the patient is in danger when too strong an emphasis is put on spirituality as an aspect of care and on the competencies of the caregiver. In his opinion, this is expressed by the fact that competencies are formulated in hands-on activities and attitudes. However, he considers such aspects as 'relationship with the patient', 'to be concerned', 'in dialogue with the patient', all explicitly mentioned in the competence profile, as categories of competencies that cannot be formulated in practical activities or attitudes. He says, 'There remains an area in these categories that cannot be planned and where strictly spoken nobody is competent because we will always be surprised. The other person faces us, touches us in his need, and we cannot protect ourselves against it. At this point we are passive and in a certain sense "incompetent". We are kneeling. We cannot stand it. We are passive and patient' (Waaijman, 2004, p.23). Waaijman believes it is essential to be aware of this passive component in the caring relationship with the patient. In this context Waaijman cites Buber (1966) who wrote 'becoming Me, I say You', asking in his turn 'what, in the caring relationship, will say You (patient) are touching Me (nurse), You are of concern to Me?' (Waaijman, 2004). He concludes that because care is in essence relational, it cannot be fully planned. The caring relationship has an active and a passive component and both components together are the essence of the contact between nurse and patient.

However, one might ask if the competence approach supported by this study places emphasis only on the active side of spiritual care and ignores the passive side. A basis assumption for this study was the functional approach to spirituality

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and spiritual care. In this context spiritual care is defined as caring for the spiritual needs of patients and spirituality is understood to be an aspect of human functioning. Waaijman points to the importance of the relational aspect in nursing in general and the passive side of that relationship in spiritual care in particular. With this statement he stresses what is important in spiritual care. To be in a real person-to-person relationship in spiritual care, nurses should be more aware of the passive side of the relationship. One of the hospital chaplains who participated in the focus group interviews mentioned the active, problem-solving attitude of nurses as a contra-indication for the delivery of spiritual care (Chapter 5). Spiritual care is often not about finding answers or solving problems but, for example, about closeness, expressing your own vulnerability or sensitivity. Nurses in the interviews (Chapter 5) mentioned explicit examples of situations in which they felt powerless or had intense emotions in contact with the patient. The passive side of the relationship emphasised by Waaijman (2004) is evident. Waaijman emphasizes that nurses should become more aware of the passive side. Such awareness can be explained as a competence itself or a part of a competence that nurses need to possess with regard to spiritual care.

The competence profile contains an item on handling one's own values, beliefs and feelings. The following description is part of that competence: 'To reflect on the interaction between one's own spirituality (values and convictions) and response to the care one provides, including feelings of frustration, distress, fear of illness, suffering and death, and the effects of personal experiences' (Van Leeuwen & Cusveller, 2004). The nurse needs to reflect on becoming more aware of this passive side of the caring relationship in spiritual care. It need not lead to answers or solutions. In this sense the passive side of spiritual care is part of the competence profile and complementary to the active side.

Limitations of nurses' professional responsibility in spiritual care

What are the limitations of nurses' professional responsibility with regard to spiritual care? For example, how far do nurses have to go in showing sensitivity and (lack of) authority in their relationships with patients and colleagues? According to

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Waaijman (2004), not every aspect of spiritual care can be planned. The personal characteristics of the individual nurse will play a role, which implies that not every nurse can be expected to show the same conduct.

The competence profile shows no sharply defined demarcation of professional responsibility. The connectedness model described by Cone (1997) can be helpful in clarifying this responsibility. The model describes three stages in the nurses' role in providing spiritual care. The first two are respecting the patients' spirituality (stage 1) and assessing spiritual needs and providing spiritual care by supporting and encouraging the patient (stage 2). Stage 3 is when the interpersonal spiritual connectedness between nurse and patient arises. This stage goes beyond the general professional relationship between nurse and patient and can show mutual sensitivity, deepened spiritual experiences and heightened transcendental experiences. The model can be interpreted as follows: stages 1 and 2 describe the professional responsibility for spiritual care that might be expected from all nurses. In stage 3, whether the nurse will provide spiritual care depends on the personal relationship between the nurse and the patient. On the one hand, the model can be helpful by clarifying the nurse's professional responsibility for spiritual care. On the other hand it raises questions, especially in stage 3. According to this stage the spiritual care a nurse provides can be completely indistinguishable in the total care plan of the patient because it is something personal between nurse and patient. However, this care should also be transparent to make it possible to assess whether it is contributing to the health and wellbeing of the patient. The prospect of health and patient wellbeing (or the prospect of a humane process of dying) must be the objective in every health care situation. The value of Cone's (1997) model is that it makes clear that in spiritual care nursing, with the exception of a certain basic level of spiritual care, the same level of spiritual care cannot be expected from all nurses in all situations. The results of the focus group interviews on the nurse's role in spiritual care confirm this (Chapter 5). This is supported by Smit (2006) who distinguishes the following four layers in spiritual communication: 1. Sharing general facts (e.g. where do you live, what do you do for a living); 2. Expressing feelings in general (how do you feel); 3. Talking about the belief system (what and why do you believe); and 4. Sharing spirituality (interconnectedness on a spiritual level). There is an inner threshold before each subsequent layer. The author states that thresholds are the highest before layer 1 (Will I make contact with this person?)

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and layer 3 (do we dare to be open to each other's souls?). This model suggests that spiritual care is not standardized, but that the content depends on the relationship between the patient and the nurse and their personal openness, sensitivity, etc. This seems an important conclusion about the professional responsibility of nurses according to spiritual care.

The influence of age and experience of nurses on their spiritual care giving

Other factors that should be noted in the discussion on responsibility in spiritual care are the age and experience of the nurse. The results of the focus group study of the nurse's role in spiritual care (Chapter 5) reveal that the age and experience of nurses influences their spiritual caregiving. Older nurses with more experience of life and work seem more open to aspects of spirituality in care. The study of the effects of a spiritual care educational programme also showed that specific experience in spiritual care nursing is a predictor of the level of competence, according to how the students assessed themselves (Chapter 7). The role of age and experience is also confirmed by other studies (Carroll, 2001; Stranahan, 2001; Narayanasamy et al. 2002). The question of what might be expected from novices or more advanced, expert nurses remains. Benner (1984) emphasizes the differences among nurses in general. The discussion section of the analysis of students' reflective journals (Chapter 8) refers to the stages of personal faith development (Fowler, 1981). Clearly, development of a personal faith (spirituality) and the competencies needed to reflect on that development starts by the mid-twenties. What consequences does this have on the development of competencies in spiritual care nursing in young adolescents in comparison with older and more experienced nurses? Follow-up research may shed more light on this aspect of competence development.

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The influence of cultural and organisational aspects within the health care institution on spiritual care giving

This study also showed that nurses' professional responsibility in providing spiritual care is also influenced by the culture, organization and policy of health care institutions (Chapter 5). Evidently, when the institutional culture is not or less conducive to devoting time and attention to the spiritual support of patients, tending to spiritual aspects of care will be considered of minor importance or not important at all. The vision and attitude of managers is crucial. Speaking about competencies and competence development in spiritual care makes no sense if these factors are not taken into account in the relevant discussions and implementation processes in health care practices. Bakker (2004) mentions developments on the meso and macro levels of health care that can influence patient-centred care in general and spiritual care in particular. The main developments he mentions are the prime importance of profitability, efficiency, technological developments and legislation of health care. The author recognizes the importance of holistic client-centred care in health care organizations but states that only the hospital chaplain is responsible for spiritual care. Because of the factors mentioned above, Bakker deems it less realistic to make other health care workers such as nurses and physicians responsible for this care. In his opinion, education of health care workers with regard to spirituality and spiritual care is attractive but nonetheless illusory. Giving their view on institutional health care policy, Gribnau & Pijnenburg (2004) regard spiritual care as going beyond the task of only the hospital chaplain. They emphasize the importance of education in spiritual care for health care workers (e.g. nurses and physicians). A tool for measuring organizational preconditions for spiritual care in palliative care (Jochemsen et al. 2002, Jochemsen, 2005) provides an example of how spiritual care can be implemented on a systematic basis in health care institutions in order to help assure the quality of spiritual care. This research commonly advocates the importance of systematic integration of spiritual care in health care organizations, but there is no shared vision of the degree of responsibility health care workers should take in spiritual caregiving. As stated above, the vision of health care managers is crucial. In terms of the competencies required (Chapter 4), it is of great relevance that nurses should be able to influence the policy of health care

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institutions. Various nurses participating in this study mentioned the importance of spiritual care, but also stated that they were given no time for it in practice. This leads to the question of how priorities are set in health care. In addition, how are nurses influenced by cultural and organizational influences so that they no longer act on important basic assumptions of nursing care, such as their holistic vision? It seems evident that in future discussions on the place of spiritual care in health care practice it is important to take an integral approach that connects professional aspects with social (increasing attention for spirituality in society), cultural and organizational aspects.

Assessment of competencies in the delivery of spiritual care and the effectiveness of education

This study provides insight into the way competence in spiritual care can be assessed. Watson et al. (2002) recommend a so-called multi-method approach, where assessment is done on the basis of different resources, such as self-assessment, simulations and clinical evaluation. The results of studies on the effects of an educational programme on spiritual care support this recommendation (Chapters 7 and 8). The following methods are used for competence assessment in this study: self-assessment, vignettes and analysis of reflective journals. Using a combination of methods in combination gives a more balanced picture of the development of competencies in students, but only from a limited perspective. Self-assessment covers the whole competence profile but it remains subjective. The vignettes offer an idea of the students' self-analytical and theoretical competencies in spiritual needs and care. The reflective journals show, in particular, their growing consciousness of spiritual matters. Despite this, this multi-method approach did not make evident which competencies students actually have in nursing practice. Other forms of assessment are necessary as it must be concluded that competence assessment is very complex. In the first place, the required level of competence should be clear (competence profile) and secondly, the methods required to assess various competencies need to be validated. There are no examples of competence assessments with regard to spiritual care in the literature. Shumway & Harden (2003) describe a systematic approach to competence assessment in the medical sector that may serve as an example for the development of a valid and reliable competence assessment tools in nursing.

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Despite these considerations, we conclude that the educational programme created for this study and applied at two nursing schools had a positive effect on the development of competencies in the students involved. This educational programme serves as an example of good nursing education practice.

Finally, it must be noted that the role of the teacher was not explicitly addressed in this study. The teacher might have an important role in the learning process in education in spiritual care. Catanzaro et al. (2001), Lemmer (2002) and Meyer (2003) emphasize the value of the teacher as a role model familiar with spirituality and spiritual care. These researchers observed an uneasiness with these topics among teachers in nursing educational practice. It is unclear whether this phenomenon had any effect on the education of students in this study. As with the students, all the participating teachers can be characterized as Christians; they may be expected to be familiar with the subject and show some commitment to it. Nonetheless, these thoughts must remain hypotheses because the teacher's role was not investigated in this study – reason enough to include this topic in future research.

Implications and recommendations

This study firstly shows the importance of spirituality to health and the importance placed upon it in the context of Dutch health care, thus drawing a connection with international developments in this area. Secondly, this study makes a substantial contribution to the development and measurement of nursing competencies in spiritual care and the role of nursing education in that development. Based on the outcome of this study, we make the following recommendations:

1. Research into the connection between spirituality and health should be continued. Considering the multidimensionality of spirituality, research within homogeneous samples is important. A distinction must be made with regard to specific illnesses and spiritual backgrounds (e.g. research into the spiritual needs of Islamic children with cancer). The focus of this research should be on the effects of spirituality and spiritual care on the health and wellbeing of patients.

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2. The issue of the place and content of spiritual care in health care and the competencies of health care workers in spiritual care should be discussed. The competence profile developed in this study can be used as a basis for this discussion which should include professional demands and social-cultural, organizational and personal aspects. With regard to personal aspects, further research should be done on the impact of developmental aspects (psychological and spiritual) on competencies for spiritual care in novice and expert nurses.

3. The spiritual categories model employed in this study can be used in health care practice for assessing the spiritual needs of patients. It helps health care workers to approach the spirituality and spiritual needs of patients according to the multidimensional character of spirituality.

4. The Spiritual Care Competence Scale (SCCS) developed in this study is a valid and reliable tool for the (self) assessment of competencies in spiritual care in nursing. It can be applied on the group level in nursing practice (teams) and in nursing education (learning groups). For further development of the SCCS, additional testing is recommended in other nursing populations (functions and work settings) and, in order to test the multidisciplinary character of the tool, in relevant populations of other health care workers, especially physicians, paramedics and social workers.

5. With regard to the assessment of competencies in the delivery of spiritual care, we recommend a multi-method approach varying from self-assessment to clinical evaluation.

6. Forms of experiential and reflective learning are essential in nursing education on spiritual care because consciousness of and the impact of personal experience plays a vital role in the way nurses (students) provide that care. Experimenting with new behaviour is important in developing competencies. Teachers must be able to coach students in the learning process and should serve as role models. They must have the expertise to stimulate students' reflection on experiences in spiritual care and new behaviour. The teacher's commitment to the subject of spirituality and spiritual care is a prerequisite.

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Summary

Introduction

Nursing students are taught to provide client-centred, so-called holistic nursing care to patients. Taking a holistic approach means that all aspects of human functioning should be considered in assessing the individual patient's needs and in planning nursing care for that patient. The holistic approach includes attention to the spiritual functioning of patients, because that may also affect a patient's wellbeing. Health care organisations, like the World Health Organisation (WHO) and professional nursing organizations such as the International Council of Nurses and the Dutch Nursing Organization emphasize that nurses should pay attention to the spiritual aspects of nursing care. This holistic and health-related approach is emphasized in nursing models and studies have made clear that the health problems and needs of patients may also be related to the spiritual functioning of humans. Attention to the spiritual element of human functioning within nursing has also been emphasized and proven in different nursing studies, but the lack of it has also been observed. Spiritual care in nursing is deemed important and relevant, but it seems to lack systematic attention due to various factors. One factor is that nurses are not well prepared for their spiritual care role. Authors emphasize the importance of this educational gap and conclude that more attention should be paid to research within the area of education to gain more insight into its effects. The observations mentioned above formed the start of this study with the intention of contributing to a systematic embedding of spiritual care into nursing care and education.

Chapter 1

This dissertation starts with an introduction of the subject of this study and the description of the research questions that have been investigated. Spirituality is relevant for health and health care is underlined and health care professionals should attend to it in their patient care. The concept of spirituality is clarified as a conceptual point of reference within the context of this thesis. Two approaches to the concept of spirituality can be distinguished, namely a functional and a substantial approach. Next, it is clarified why nurses should attend to spirituality in the care they provide to patients. This care will be conceptualized as spiritual care, which is understood as the care nurses provide to meet the spiritual needs and/or problems of their patients.

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It is explained why there seems to be a gap between what in theory is expected of nurses regarding spiritual care and what is actually practiced. The question is raised how the nature of the task of spiritual care in nursing can become clearer, and the level of expertise which should be expected from nurses. Since nurses feel inadequately prepared there seems to be a role for nursing education. The hypothesis is raised that by obtaining a more structured form of education nurses will become more competent in providing spiritual care, noting that the evidence to support this hypothesis is still limited. This thesis will contribute to this aspect of spiritual care in nursing by exploring the content of spirituality and spiritual care in nursing and in nursing education and by investigating the learning effects. This resulted in the following research questions:

1. How has the connection between spirituality and physical health been investigated and what are the results of that investigation?
2. What role does spirituality play in patients during physical illness and treatment?
3. What competencies do nurses need to provide spiritual care?
4. How do nurses handle spiritual aspects in health care practice and can nursing competencies for spiritual be identified in their conduct?
5. How can nursing competencies regarding the delivery of spiritual care be assessed?
6. What are the effects of a newly developed educational programme for student nurses on the development of their competencies in spiritual care?
7. What are the learning effects of the educational method of thematic peer review on the development of competencies for spiritual care provision?

Chapter 2

This chapter describes a study of the connection between spirituality and health in physical healthcare. Studies on this topic were analysed on the basis of thesis focus, type of research, population, sample size, operationalization of spirituality and research results. The analysis shows that medical studies are primarily aimed at revealing a significant relationship between spirituality and health, whereas healthcare studies are aimed at describing patient convictions, experiences and needs as regards healthcare. The results of the analysed studies are presented according to a number of main themes, but fail to show unique cohesion between spirituality and health. Positive, negative or no cohesion may be concluded as a result. A comparison

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between the different studies is difficult due to methodological differences. A particular problem is the operationalization of the concept of spirituality, which varies from specific religious experience to personal attitude. It is imperative that follow-up research is based on the primary issue of spirituality, so that a valid operationalization of the concept of spirituality can be distinguished from the concept of religion.

Chapter 3

This chapter describes a focus group study of aspects of spirituality concerning illness. For this purpose experiences of patients, nurses and hospital chaplains in oncology, cardiology and neurology within the context of Dutch somatic health care were explored. The study consisted of 13 focus groups with a total of 67 participants. The results show that spirituality play various roles in patients lives during their illness. There is a wide range of topics that may have an individual effect on patients. Despite differences in emphasis, all topics play a role in different patient categories. Although the spiritual topics seem to manifest themselves more clearly in long-term care relationships, they may also play a role during brief admittance periods (such as treatment decisions). The spiritual topics that arise from this study offer care givers a framework for signalling the spiritual needs of patients. The question is not whether spirituality is a relevant focus area in care, but how and to what degree it manifests itself in individual patients.

Chapter 4

This chapter focuses on the competencies nurses need to provide spiritual care. Nursing literature from The Netherlands shows little clarity on the qualities that nurses require to provide spiritual care. A systematic review of international literature was conducted to draw together information from the nursing literature in order to formulate nursing competencies. This resulted in the description of a competency profile which has the following three core domains with six core competencies:

- awareness and self handling:
  - o handling own values, convictions and feelings in their professional relationships with patients of different beliefs and religions
  - o address the subject of spirituality with patients from different cultures in a caring manner
- spiritual dimensions of the nursing process
  - o collect information about the patient's spirituality and identifies the patient's need

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- o discuss with patients and team members how spiritual care is provided, planned, and reported.
- o provide spiritual care and evaluates it with the patient and team members.

• assurance and quality of expertise
- o contribute to quality assurance and improving expertise in spiritual care in the organisation.

This competency profile may help to structure future care, research and education in spiritual care by nurses. Implications of the work for future research and education are discussed.

Chapter 5

This chapter provides insight into spiritual care in nursing within the context of somatic healthcare in the Netherlands. In Dutch nursing the spiritual dimension is becoming more a focus of attention, but despite this, there is a lack of empirical data from professional practice in the Netherlands. Data for this study were collected by means of focus group interviews. The sample was made up of the specialist fields of cardiology, oncology and neurology and divided into groups of patients, nurses and hospital chaplains. Different spiritual themes emerged from the interviews. There were different expectations of the nurse's role with regard to spiritual aspects. The main themes derived from this research can be recognized as aspects of nursing competencies that are reported in chapter 4. However, the attention to spiritual aspects in the nursing process is not clear cut. It seems to be highly dependent on personal expression and personal commitment. In addition to these personal factors, the study shows that other factors (cultural, organisational, educational) also contribute to the fact that spiritual care is not systematicly embedded in nursing care. The nurses' professional responsibility is discussed in this chapter.

Chapter 6

This chapter describes the development of an instrument to measure nursing competencies in spiritual care, the Spiritual Care Competence Scale (SCCS). For the measurement of the development of competencies for spiritual care the construction of a tool is important. In this study the validity and reliability of the SCCS is tested. The items for the instrument were derived from the competency profile described in chapter 4. Students from two bachelor level nursing schools in the Netherlands were assessed with the instrument. These data were used for analyses purposes.

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Construct validity was determined by factor analyses. This resulted in an instrument consisting of six core domains of spiritual care-related nursing competencies. These domains were labelled as:

- assessment and implementation of spiritual care (Cronbach's alpha 0.82)
- professionalization and improving quality of spiritual care (Cronbach's alpha 0.82)
- personal support and patient counselling (Cronbach's alpha 0.81)
- referral to professionals (Cronbach's alpha 0.79)
- attitude towards patient's spirituality (Cronbach's alpha 0.56)
- communication (Cronbach's alpha 0.71)

These subscales showed a good internal consistency, sufficient average inter-item correlations and a good test-retest reliability. Testing the psychometric properties of this tool for measuring nursing competencies in spiritual care among a nursing student population demonstrated valid and reliable scales. To enhance the validity and reliability on the instrument further testing in other populations is recommended.

Chapter 7

This chapter contains the results of a study regarding the effectiveness of an educational programme for nursing students on developing competence in the provision of spiritual care and factors that might influence the effects. This study employed a quasi-experimental longitudinal observational design (pre-test and post-test). The subjects were third-year students from two bachelor degree nursing schools in the Netherlands. The educational intervention consisted of a training module on spiritual care. Competencies were measured by the Spiritual Care Competence Scale (SCCS). Two vignettes were added with the purpose of assessing the quality of the students' analyses of care cases with a spiritual component. After finishing the training module (6 weeks after baseline) statistical significant changes for the intervention group were shown on two of the six subscales of SCCS. Over time (after 20 weeks) the whole cohort showed statistical significant differences in all six subscales of the SCCS related to baseline. Regression analyses showed internship as a negative predictor for the subscales 'assessment and implementation of spiritual care', 'professionalization and improving the quality of spiritual care' and 'personal support and counselling of patients'. Experience of spiritual care during internship and a holistic vision of nursing showed as positive predictors on, respectively, the subscales 'personal support and counselling of patients' and

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'referral to professionals'. Comparison of student analyses of the vignettes showed a statistically significant difference in the analyses of the vignette with explicit spiritual content in favour of the intervention group.

The outcome raises questions about the content of education in spiritual care, the personal role of spirituality for the student, the measurement of competencies and the student's opinion of spiritual care in relation to the systematic place of spiritual care within nursing and within nursing curricula.

The results provide nurse educators with an insight into the development of competencies for spiritual care within education and how to measure those competencies.

Chapter 8

This chapter describes the learning effects of thematic peer-review discussion groups on developing nursing students' competence in providing spiritual care. It also discusses the factors that might influence the learning process. The method of peer review is a form of reflective learning based on the theory of experiential learning. It was part of an educational programme on spiritual care in nursing for third-year undergraduate nursing students from two nursing schools in the Netherlands. Reflective journals (n = 203) - kept by students throughout the peer-review process - were analysed qualitatively and grouped into themes. The analysis shows that students reflect on spirituality in the context of personal experiences in nursing practice. In addition, they discuss the nursing process and organizational aspects of spiritual care. The results show that the first two phases in the experiential learning cycle appear prominently, they are 'inclusion of actual experience' and 'reflecting on this experience'. The phases of 'abstraction of experience' and 'experimenting with new behaviour' are less evident. Related factors to these findings (developmental stage of the student and the role of the tutor) are being discussed in this chapter.

Chapter 9

This final chapter provides a general discussion of the dissertation. After summarizing the main results methodological and conceptual reflections are given. From a methodological perspective spoken it is concluded that the internal validity and

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reliability of results is guaranteed by the way the various studies are conducted and confirmed. Generalizability of the results is discussed in this chapter related to the samples used. It was concluded that the subjects included in the research might not be representative for the whole population in all respects. Whether that led to a certain bias in the results can only be answered by follow-up research that includes participants with other religious (spiritual) and educational backgrounds.
The Spiritual Care Competence Scale (SCCS) was found to be a robust, valid and reliable scale.

To confirm this validity and reliability further testing is necessary in other populations of nurses and in other areas than physical health care. To investigate the generic character of the SCCS testing in non-nursing populations such as physicians, paramedics and social workers would be interesting.
Conceptual reflections are made in this chapter regard the connection between spirituality and illness and health and health care. The use of models of spiritual categories and of spiritual care in nursing is discussed. The expectations of the nurse's role is also been discussed as well as the influence of the nurses' own spirituality and spiritual experiences on the way they handle spiritual care in practice.

Within this context the competence approach to spirituality and spiritual care are also discussed, which makes clear that a reflective competence of the nurse is important in spiritual care. In this chapter the limitations of professional responsibility in spiritual care nursing is discussed too. Suggestions are given for the integration of professional and personal aspects of the nurses' responsibility in spiritual care. The role of institutional health care policy is also been discussed.
Finally the impact of education on competency development in the area of spiritual care is discussed, regarding the content of the educational programme, the assessment of competencies and the role of the teacher. Lastly, recommendations are given for follow up research.

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Samenvatting

Introductie

In het onderwijs aan studenten verpleegkunde wordt geleerd dat zij patiëntgerichte zorg moeten verlenen, wat ook wel aangeduid wordt als 'holistisch verplegen'. Met de holistische benadering wordt bedoeld dat alle aspecten van het menselijk functioneren worden betrokken bij het vaststellen van de zorgbehoeften van de individuele patiënt en bij de planning van de zorg voor die patiënt. Dit betekent dat verpleegkundigen ook aandacht hebben voor het spirituele functioneren van patiënten, omdat dat ook invloed kan hebben op het welzijn van die patiënten. Gezondheidszorgorganisaties, zoals de Wereld Gezondheid Organisatie (WHO) en verpleegkundige beroepsorganisaties zoals de International Council of Nurses (ICN) en Nederlandse verpleegkundige beroepsorganisaties benadrukken ook dat verpleegkundigen aandacht moeten besteden aan spirituele aspecten van verpleegkundige zorg. Dit wordt ook benadrukt in verpleegkundige modellen en uit onderzoeken blijkt dat de gezondheidsproblemen en -behoeften van patiënten gerelateerd kunnen zijn aan het spirituele functioneren. Uit onderzoek blijkt dat verpleegkundigen incidenteel wel aandacht hebben voor spirituele aspecten van het menselijk functioneren, maar dat het nog vaak aan die aandacht ontbreekt. Spirituele zorg wordt in de verpleging belangrijk en relevant geacht, maar het lijkt er op dat de systematische aandacht er voor ontbreekt. Eén van de factoren die hierbij naar voren komt, is dat verpleegkundigen niet goed worden voorbereid op het verlenen van spirituele zorg. In de literatuur wordt dit deskundigheidstekort onderkend en wordt het belang van onderwijs over spirituele zorg benadrukt en wordt onderzoek naar de effect van dat onderwijs aanbevolen. Het hierboven geschetste kader vormde het uitgangspunt voor deze studie. Het is de bedoeling om met de resultaten van deze studie een bijdrage te leveren aan de structurele inbedding van spirituele zorg in de verpleegkundige zorg en in het verpleegkundig onderwijs.

Hoofdstuk 1

Dit proefschrift begint met een introductie van het onderwerp en de beschrijving van de onderzoeksvragen. De relevantie van spiritualiteit voor gezondheid en gezondheidszorg wordt benadrukt alsmede de reden waarom werkers in de

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gezondheidszorg er aandacht voor moeten hebben in de zorg die zij aan patiënten verlenen. Het concept spiritualiteit wordt verhelderd als conceptueel referentiepunt binnen de context van deze studie. Er wordt hierbij een onderscheid gemaakt tussen twee benaderingen van het concept, namelijk een functionele en een inhoudelijke benadering. Vervolgens wordt verhelderd waarom verpleegkundigen aandacht voor spiritualiteit moeten hebben in de zorg die zij verlenen aan patiënten. Deze zorg wordt geconceptualiseerd als spirituele zorg, waarmee de zorg wordt bedoeld die verpleegkundigen verlenen voor de spirituele behoeften en/of problemen van patiënten. Verder komt de kloof aan de orde, die bestaat tussen wat in theorie van verpleegkundigen wordt verwacht op het gebied van spirituele zorg en wat daarvan feitelijk wordt gepraktiseerd. De vraag wordt opgeworpen wat de aard van spirituele zorg in de verpleging moet zijn en welke expertise op dit gebied van verpleegkundigen moet worden verwacht. Tenslotte komt naar voren dat gezondheidswerkers zich onvoldoende voelen voorbereid en dat er een rol is weggelegd voor het verpleegkundig onderwijs. De hypothese wordt opgeworpen dat met een meer structurele vorm van onderwijs op dit gebied, verpleegkundigen meer competent zullen worden in het verlenen van spirituele zorg. Het bewijs voor deze hypothese is vooralsnog beperkt. Dit proefschrift wil aan dit aspect van spirituele zorg in de verpleging een bijdrage leveren door het verkennen van spiritualiteit en spirituele zorg in de verpleging en het verpleegkundig onderwijs en door het onderzoeken van leereffecten op de competentieontwikkeling van verpleegkundigen. Dit resulteerde in de volgende onderzoeksvragen:

1. Hoe is de samenhang tussen spiritualiteit en lichamelijke gezondheid onderzocht en wat zijn de resultaten van dat onderzoek?
2. Op welke manier speelt spiritualiteit bij lichamelijke ziekte en de behandeling een rol?
3. Welke competenties moet verpleegkundige bezitten voor het verlenen van spirituele zorg?
4. Hoe gaan verpleegkundigen in de praktijk om met aspecten van spiritualiteit en zijn verpleegkundige competenties voor het verlenen van spirituele zorg herkenbaar?
5. Hoe kunnen verpleegkundige competenties voor het verlenen van spirituele zorg worden vastgesteld?
6. Wat zijn de effecten van een onderwijsprogramma voor studenten verpleegkunde op de ontwikkeling van competenties voor het verlenen van spirituele zorg?

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7. Wat zijn de leereffecten van de specifieke onderwijsmethode 'thematische intervisie' intervisie op de ontwikkeling van competenties voor het verlenen van spirituele zorg.

Hoofdstuk 2

In dit hoofdstuk wordt een onderzoek beschreven naar de samenhang tussen spiritualiteit en gezondheid in de lichamelijke gezondheidszorg. Het geeft een overzicht van de resultaten van een systematische analyse van 31 medische en verpleegkundige studies. De studies zijn geanalyseerd aan de hand van de onderzoeksvraag, de onderzoeksmethode, de populatie, steekproefgrootte, operationalisering van het concept spiritualiteit en de resultaten. Uit de analyse komt naar voren dat geneeskundige studies vooral gericht zijn op het aantonen van een statistisch significante relatie tussen spiritualiteit en gezondheid en dat de verpleegkundige studies zich meer richten op het beschrijven van overtuigingen, ervaringen en behoeften van patiënten op dat gebied. De resultaten van de geanalyseerde onderzoeken worden in een aantal hoofdlijnen weergegeven, maar tonen geen éénduidige samenhang aan tussen spiritualiteit en gezondheid. Er is sprake van een positieve, een negatieve of geen éénduidige samenhang. Een onderlinge vergelijking van de onderzoeken is echter moeilijk vanwege de methodologische verschillen. Een probleem is hierbij vooral dat het concept spiritualiteit zeer divers wordt geoperationaliseerd, variërend van een specifiek religieuze invulling tot een persoonlijke attitude. In vervolgonderzoek is het van belang dat spiritualiteit de primaire vraagstelling van het onderzoek is en dat er sprake is van een valide operationalisering van het concept spiritualiteit, waarbij het afgebakend is van het concept religie.

Hoofdstuk 3

In dit hoofdstuk wordt een focusgroep onderzoek beschreven naar aspecten van spiritualiteit die bij ziekte een rol spelen. Voor dit doel zijn ervaringen van patiënten, verpleegkundigen en geestelijk verzorgers verkend binnen de specialismen oncologie, cardiologie en neurologie, binnen de context van de Nederlandse lichamelijke gezondheidszorg. Het onderzoek bestond uit 13 focusgroepen met in totaal 67 deelnemers. De studie toont aan dat spiritualiteit tijdens ziekte op uiteenlopende wijze een rol kan spelen bij patiënten. Er komt een brede range van thema's naar voren. Ondanks accentverschillen, komen deze thema's bij de verschillende

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patiëntencategorieën naar voren. Ondanks dat spiritualiteit zich meer duidelijk lijkt te manifesteren in langduriger zorgrelaties, kan het ook een rol spelen tijdens korte opname periodes (bijvoorbeeld bij beslissingen rond een behandeling). De spirituele thema's die uit deze studie naar voren komen bieden zorgverleners een raamwerk waarmee zij spirituele behoeften van patiënten kunnen herkennen. De studie toont aan dat het niet de vraag is of spiritualiteit een relevant thema is in de gezondheidszorg, maar hoe en tot op welk niveau zij een rol speelt bij de individuele patiënt.

Hoofdstuk 4

Dit hoofdstuk is gericht op de competenties die verpleegkundigen moeten bezitten voor het verlenen van spirituele zorg. Verpleegkundige literatuur in Nederland maakt weinig duidelijk over welke kwaliteiten de verpleegkundigen op dit gebied dient te bezitten. Een systematische review van internationale verpleegkundige literatuur werd uitgevoerd om verpleegkundige competenties te kunnen formuleren. Dit resulteerde in de beschrijving van een competentieprofiel bestaande uit de volgende drie domeinen en zes competenties:

Zelfhantering:

- kan eigen waarden, overtuigingen en gevoelens hanteren in de relatie met patiënten met verschillende levensovertuigingen
- kan op betrokken wijze communiceren met patiënten uit verschillende culturen over spiritualiteit

Spirituele dimensies van het verplegen:

- kan informatie verzamelen over de spiritualiteit van de patiënt en in samenspraak met die patiënt de zorgvraag vaststellen
- kan in samenspraak met de patiënt en in overleg met andere disciplines de zorg voor spiritualiteit van de zorgvrager afstemmen en het eigen aandeel in die zorg plannen en schriftelijk vastleggen
- kan de zorg voor spiritualiteit van de patiënt uitvoeren en die zorg, in samenspraak met de patiënt, in het (multi) disciplinaire overleg evalueren

Kwaliteitszorg en deskundigheidsbevordering:

- levert een bijdrage aan de kwaliteitszorg en deskundigheidsbevordering op het gebied van zorg voor spiritualiteit binnen de zorginstelling

Het competentieprofiel kan helpen om toekomstige zorg, onderzoek en onderwijs met betrekking tot spirituele zorg te structureren. De implicaties hiervan worden in dit hoofdstuk besproken.

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Hoofdstuk 5

Dit hoofdstuk geeft inzicht in spirituele zorg door verpleegkundigen binnen de context van de lichamelijke gezondheidszorg in Nederland. In de verpleging in Nederland krijgt de spirituele dimensie meer aandacht, maar ondanks dat ontbreekt het veelal nog aan empirische gegevens over de professionele praktijk met betrekking tot spirituele zorg. Gegevens werden verzameld door middel van focusgroepen bestaande uit patiënten, verpleegkundigen en geestelijk verzorgers binnen de specialismen oncologie, cardiologie en neurologie. Verschillende spirituele thema's kwamen uit de interviews naar voren. Er waren verschillende verwachtingen van de rol van de verpleegkundige met betrekking tot spirituele aspecten. De belangrijkste thema's die naar voren kwamen zijn herkenbaar als aspecten van de competenties die in hoofdstuk 4 zijn beschreven. Echter, de aandacht voor spirituele aspecten door verpleegkundigen in het verpleegkundig proces is niet van systematisch van aard. De aandacht er voor lijkt in belangrijke mate afhankelijk van persoonlijke uitingen en persoonlijke betrokkenheid van de individuele verpleegkundige. De studie toont ook aan dat naast persoonlijke factoren verschillende andere factoren mede oorzaak zijn van het wel of niet ingebed zijn va spirituele zorg in het zorgproces (cultuur, organisatie, deskundigheid). In de discussie wordt aandacht besteed aan de verpleegkundige beroeps-verantwoordelijkheid met betrekking tot spirituele zorg.

Hoofdstuk 6

In dit hoofdstuk wordt de ontwikkeling beschreven van een instrument voor het vaststellen van verpleegkundige competenties voor het verlenen van spirituele zorg, de Spiritual Care Competence Scale (SCCS). Voor het vaststellen van de ontwikkeling van competenties voor het verlenen van spirituele zorg is de constructie van een meetinstrument van belang. In deze studie is de validiteit en betrouwbaarheid van het instrument getest. De items voor het instrument zijn afgeleid van het competentieprofiel dat is beschreven in hoofdstuk 4. Studenten van twee Hbo opleidingen verpleegkunde in Nederland hebben zichzelf beoordeeld met het instrument. Deze data zijn gebruikt voor de analyse. De constructvaliditeit werd bevestigd door middel van factoranalyse. Dit resulteerde in een instrument bestaande uit de volgende zes kerndomeinen voor verpleegkundige spirituele zorg:

- assessment and implementation of spiritual care (Cronbach's alpha 0.82)

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- professionalization and improving quality of spiritual care (Cronbach's alpha 0.82)
- personal support and patient counselling (Cronbach's alpha 0.81)
- referral to professionals (Cronbach's alpha 0.79)
- attitude towards patient's spirituality (Cronbach's alpha 0.56)
- communication (Cronbach's alpha 0.71)

Deze subschalen toonden een goede interne consistentie en toereikende gemiddelde inter-item correlaties en test-hertest betrouwbaarheid. De psychometrische testen toonden aan dat er sprake is van valide en betrouwbare subschalen. Om de validiteit en betrouwbaarheid verder te ontwikkelen wordt het testen van het instrument in andere populaties aanbevolen.

Hoofdstuk 7

In dit hoofdstuk worden de resultaten beschreven van een studie naar de effecten van een onderwijsprogramma over spirituele zorg voor studenten verpleegkunde op hun competenties voor het verlenen van spirituele zorg en naar de eventuele factoren die deze effecten beïnvloeden. Het onderzoek bestond uit een quasi-experimenteel, longitudinaal observationeel design (pre-test en post-test). De respondenten waren derde jaars studenten van twee Hbo opleidingen verpleegkunde in Nederland. De onderwijskundige interventie bestond uit een onderwijsmodule over spirituele zorg. De competenties werden gemeten met de Spiritual Care Competence Scale (SCCS). Twee vignetten werden toegevoegd met het doel de kwaliteit van de analyses van studenten te beoordelen van praktijksituaties met een spirituele component. Na afloop van de module (6 weken na baseline) kwamen statistisch significante verschillen naar voren ten gunste van de interventiegroep op twee van de zes subschalen van de SCCS. Twintig weken na baseline toonde het gehele cohort studenten statistisch significante verschillen op alle zes subschalen van de SCCS ten opzichte van de baseline meting. Regressieanalyse toonde aan dat het hebben van een stage een negatieve voorspeller was voor de subschalen 'assessment and implementation of spiritual care', 'professionalization and improving the quality of spiritual care' en 'personal support and counselling of patients'. Het hebben van ervaring met spirituele zorg tijdens stages en het hebben van een holistische visie op verpleegkundige zorg waren positieve voorspellers op respectievelijk de subschalen ' personal support and counselling of patients' en 'referral to professionals'. Vergelijking van de analyses van de studenten van de vignetten toonden een statistisch significant verschil met betrekking tot de analyse

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van een vignette met een expliciete spirituele inhoud ten gunste van de interventiegroep.
De uitkomsten roepen vragen op over de inhoud van onderwijs in spirituele zorg, de rol die spiritualiteit persoonlijk voor de student speelt, het meten van competenties en de opvattingen van studenten over een structurele plaats van spirituele zorg in de verpleging en het verpleegkundig onderwijs. De resultaten van deze studie bieden docenten inzicht in de ontwikkeling van competenties voor het verlenen van spirituele zorg en het meten daarvan.

Hoofdstuk 8
In dit hoofdstuk worden de leereffecten beschreven van thematische intervisie op de ontwikkeling van de competenties van studenten verpleegkunde voor het verlenen van spirituele zorg. Het bediscussieert ook de factoren die dat leerproces beïnvloeden. Thematische intervisie is een vorm van reflectief leren dat is gebaseerd op de theorie van ervaringsleren. Deze intervisie was onderdeel van een onderwijsprogramma over spirituele zorg voor derde jaars studenten van twee Hbo opleidingen verpleegkunde in Nederland. Reflectieverslagen (n = 203) die studenten tijdens het intervisieproces schreven zijn kwalitatief geanalyseerd en de uitkomsten zijn gethematiseerd. De analyse toont aan dat studenten vooral reflecteren op spiritualiteit op basis van persoonlijke ervaringen in de verpleegkundige praktijk. Daarnaast wordt gereflecteerd op aandacht voor spiritualiteit in het verpleegkundig proces en organisatorische aspecten van spirituele zorg. De resultaten tonen aan dat vooral de eerste twee fases van het proces van ervaringsleren naar voren komen, namelijk het inbrengen van actuele ervaringen en het reflecteren op deze ervaringen. De fasen van abstraheren en experimenteren met nieuwe gedrag komen niet of nauwelijks naar voren. Mogelijke verklaringen hiervoor met betrekking tot het onderwijs, de ontwikkeling van de student en de rol van de docent worden in dit hoofdstuk bediscussieerd.

Hoofdstuk 9
Dit laatste hoofdstuk bevat een algemene discussie over dit proefschrift. Nadat eerst de belangrijkste resultaten zijn samengevat worden enkele methodologische en inhoudelijke reflecties weergegeven. Methodologisch gezien kan geconcludeerd worden dat de interne validiteit en betrouwbaarheid van de resultaten is gegarandeerd door de wijze waarop de onderscheiden studies zijn opgezet en

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uitgevoerd. De generaliseerbaarheid van de resultaten worden in dit hoofdstuk bediscussieerd in relatie tot de gebruikte steekproeven. In de studies is weergegeven dat de verschillende steekproeven van deelnemers aan het onderzoek niet representatief zouden kunnen zijn in alle facetten voor de gehele populatie. Of dit heeft geleid tot een zekere bias in de resultaten kan alleen beantwoord worden in vervolgonderzoek waarin participanten zijn geïncludeerd met andere religieuze (spirituele) en onderwijs achtergrond.

De Spiritual Care Competence Scale (SCCS) is een robuuste, valide en betrouwbare schaal gebleken op basis van de meting in de betreffende steekproef van studenten. Om deze validiteit en betrouwbaarheid verder te bevestigen is het testen van het instrument nodig in andere verpleegkundige populaties en in andere sectoren dan de somatische gezondheidszorg. Om het generieke karakter van het instrument te kunnen onderzoeken, is onderzoek in niet-verpleegkundige populaties zoals bij artsen, paramedici en sociaal werkers ook interessant.

Inhoudelijk wordt in dit hoofdstuk ingegaan op de volgende aspecten:

- Het gebruik van modellen van spirituele categorieën en over spirituele zorg in de verpleging voor systematische inbedding van spirituele zorg in het zorgproces.
- Een reflectie op de competentiebenadering met betrekking tot spirituele zorg en op de vraag waar de grenzen liggen in de verpleegkundige beroeps-verantwoordelijkheid ten aanzien van spirituele zorg. Er wordt ingegaan op de integratie van persoonlijke (leeftijd, ervaring, eigen spiritualiteit) en professionele aspecten in de spirituele zorg en er wordt duidelijk gemaakt waarom de verpleegkundige met name in het kader van spirituele zorg een reflectieve competentie dient te bezitten.
- De invloed van organisatiegebonden factoren op de mate van inbedding van spirituele zorg in het zorgproces. Hierbij moet gedacht worden aan de rol van de instellings- en afdelingscultuur en de mate waarin spirituele zorg in beleid en organisatie is verankerd.
- De invloed van het onderwijs op de competentieontwikkeling op het gebied van spirituele zorg. Er wordt ingegaan op de inhoud van het onderwijs, de rol van de docent bij de competentieontwikkeling en de complexiteit van competentietoetsing.

Tenslotte worden aanbevelingen gegeven voor vervolgonderzoek.

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Dankwoord

Ik schrijf dit dankwoord in de maand die door verschillende media is uitgeroepen tot de maand van de spiritualiteit. Wie had, pak weg tien jaar geleden, gedacht dat er in de samenleving zo openlijk over spiritualiteit gesproken zou worden. Het was in die tijd dat ik mijn eerste stappen zette in het onderzoek naar de plaats van spiritualiteit in de verpleging. In 2002 heb ik de draad weer opgepakt en ben ik het verder gaan uitbouwen in een promotiestudie. Ik werd gedreven door een mengeling van professionele en persoonlijke factoren. Als professional was (en ben) ik van mening dat verpleegkundigen zorg hebben voor de patiënt als hele mens. Daarbij hoort ook de aandacht voor het spirituele, de levensbeschouwelijke kant van de patiënt. Het was (en is) mijn opvatting dat in theorie in de verpleegkunde het belang er van wordt beleden (in de holistische mensvisie), maar dat het in de praktijk het exclusieve werkterrein van de geestelijk verzorger lijkt te zijn. Ik vroeg mij af hoe dat komt en of dat terecht is?

De betekenis die ik zelf aan spiritualiteit ontleen is zeker ook van invloed is geweest op mijn besluit om aan deze studie te beginnen. Mijn persoonlijke spiritualiteit is christelijk geïnspireerd, die ervaar ik als de basis voor mijn leven en daar ben ik dankbaar voor. Het is deze inspiratie die mijn visie op verpleegkundige zorg mede bepaald. Wel wil ik benadrukken dat de uitwerking van het proefschrift primair is gericht op de professionele invalshoek.

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breed en professioneel kader hebt gezet. Ik sta versteld van het vele werk dat jij verstouwt. Jouw drukte heeft mij er niet van weerhouden je te benaderen, vooral ook omdat ik heb ervaren dat ik je altijd iets kon vragen, dat er toch altijd even tijd was voor overleg en dat je in staat was om op korte termijn op stukken te reageren.
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Curriculum Vitae

René van Leeuwen werd op 23 september 1956 geboren te Aalten. In 1971 behaalde hij het MAVO diploma en in 1975 het diploma van de Middelbare Detailhandelschool. In 1976 begon hij met de inservice-opleiding tot B-verpleegkundige in psychiatrisch ziekenhuis Veldwijk te Ermelo. Van 1979 tot 1980 was hij werkzaam als groepsverpleegkundige in datzelfde ziekenhuis. Van 1980 tot 1985 was hij als Praktijkopleider verbonden aan de inservice-opleiding tot B-verpleegkundige van psychiatrisch ziekenhuis Dennenoord te Zuidlaren. Vanaf 1985 tot heden is hij in verschillende functies werkzaam, waaronder die van docent en teamleider, aan de opleiding Verpleegkunde van de Christelijke Hogeschool Ede.

Van 1980 tot 1982 volgde hij de opleiding Docent ten behoeve van instellingen voor gezondheidszorg aan de Katholieke Hogere School voor Verpleegkundigen te Nijmegen. In 1986 voltooide hij aan diezelfde school de Opleiding tot Leraar Verpleegkunde Tweede Graad. In 1987 behaalde hij het diploma van de 1e Graads lerarenopleiding HBO-gezondheidszorg aan de Rijksuniversiteit Limburg te Maastricht. In 1998 ontving hij het doctoraal diploma Gezondheidswetenschappen, afstudeerrichting Verplegingswetenschap aan de Universiteit Maastricht. Van 2003 tot en met 2007 was hij lid van kenniskring van het Lectoraat ethiek van de zorg van de Christelijke Hogeschool Ede. Hij heeft bijgedragen aan publicaties op het gebied van psychiatrische verpleegkunde, kwaliteit van verpleegkundige zorg en verpleegkundige zorg voor spiritualiteit.

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