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**THE ROLE OF HEALTH CARE PROVIDERS IN PROVIDING SPIRITUAL
CARE TO PATIENTS: A CASE OF TAMALE CENTRAL HOSPITAL**

BY

IDDRISU MOHAMMED

UDS/CHD/0189/14

**THESIS SUBMITTED TO THE DEPARTMENT OF PUBLIC HEALTH, SCHOOL
OF ALLIED HEALTH SCIENCE, UNIVERSITY FOR DEVELOPMENT
STUDIES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE
AWARD OF MASTER OF PHILOSOPHY IN COMMUNITY HEALTH AND
DEVELOPMENT**

OCTOBER, 2018

UNIVERSITY FOR DEVELOPMENT STUDIES



DECLARATION

I hereby declare that this dissertation is the result of my own original work and that no part of it has been presented for another degree in this University or elsewhere:

Candidate's Signature:..... Date:

.....

Iddrisu Mohammed

Supervisors' Declaration

I hereby declare that the preparation and presentation of the dissertation were supervised in accordance with the guidelines on supervision of dissertation laid down by the University for Development Studies.

Supervisor's Signature: Date:

Name: Yidana Adadow (PhD)



ABSTRACT

Spiritual care is care which recognizes and responds to the needs of the human spirit when faced with trauma, ill health or sadness, and can include the need for meaning, for self-worth, to express oneself, for faith, support and perhaps for rites, prayer, sacrament or simply for a sensitive listener. The study assessed the role of health care providers in providing the emotional and spiritual needs of the patients in the adult wards of the Tamale Central Hospital. The study adopted the mix method approach which uses both quantitative and Qualitative methods. Primary and secondary sources of data were used to seek information for the research. Quantitative approached was also adopted to analyze the data. Using Likert scale values, the study reveals a mean value of 4.04 meaning nurses regularly listen actively to patients talk about their religious/spiritual beliefs, strengths, and beliefs about God. Data from the study further reveal that nurses regularly give patients or care takers the opportunity to talk about God and support coming from God. The study further revealed the following as the barrier to providing emotional/spiritual care to patients admitted to the adult ward of the hospital; Because of different beliefs of the staffs and the patients, most of the patients do not believe in superstition, lack of communication skills in giving this care, Lack of pastors and imams in the hospitals, Multiple beliefs of the patients. Thus, it is recommended that policy makers like the government and the Ghana health service should be encouraged to capture the spiritual needs of patients in the management protocols. The Tamale central hospital should employ health provisional who are well verse in spiritual health care provision in the hospital. The hospital should employ an Imam and a Pastor to help the healthcare providers in taking care of the spiritual needs of the patient.



ACKNOWLEDGEMENTS

A number of individuals have contributed tremendously towards the successful completion of this study for which I wish to acknowledge my appreciation.

I am most grateful to my supervisor Dr. Adadow Yidana a lecturer at the Department of Community Health and Family Medicine, School of Medicine and Health Sciences, University for Development Studies (UDS), Tamale for his patience looking through the study. His guidance, constructive criticism, suggestions and advice have made it possible to produce this piece of work.

I appreciate the time and support of the medical superintendent, matron and staff of the Tamale Central Hospital and all respondents very much.

For the role played by the coordinator of the program, Mr Akwesi Boakye-Yiadom

To the head of department, Dr. Michael Wombeogo, I am grateful for your diverse support to the write up of this project.

I am also grateful to all the authors of the books, articles, manuals, and other materials used to help me come up with this piece of work.

May Allah Bless you all



DEDICATION

This piece of work is dedicated to my late parents Iddrisu Mahama and Hajia Rahinatu



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LIST OF ABBREVIATIONS

AIDS	-	Acquired Immunodeficiency Deficiency Syndrome
HIV	-	Human Immunodeficiency Virus
SHS	-	Senior High School
SRC	-	Spiritual Care Rating Scale
TCH	-	Tamale Central Hospital
WHO	-	World Health Organization



CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Research on health, well-being and spirituality has grown in the Western context, with studies showing that spirituality is an important part of a patient's life when confronted with illness (Koenig, 2009). Empirical work, in particular, has documented that spirituality becomes particularly salient when patients have to deal with HIV and AIDS, cancer and heart disease (Koenig, 2009).

It has been argued that a failure to incorporate spirituality into nursing care by not addressing the spiritual needs of patients is unethical as spirituality is a part of being human (Miner-Williams, 2006) and contradicts holistic patient care. The lack of formal educational preparedness on spirituality and spiritual care appears to be the primary factor that has rendered nurses unprepared to deliver spiritual care (Barlow, 2011).

Several authors have noted that nursing education has provided few opportunities for the inclusion of spirituality and spiritual care (Dunn, 2008; Molzahn & Shields, 2008; O'Shea et al., 2011). This void leaves the nurse unprepared to meet the challenges of providing therapeutic spiritual care for patients and their families. Both Lubbe (2008) and Dunn (2008) assert that there is a need for spirituality and spiritual care activities to be included in the nursing curricula.

As modern medical science has yielded tremendous advances in new and exciting technologies to diagnose and treat disease. Health professionals have begun to emphasize the physiological and biomedical aspects of health care.



Doctors and nurses have increasingly been trained as expert technicians, equipped with the tools to treat illnesses quickly and efficiently. As a result, the person with the illness is often left out.

The neglect of the whole person in modern health care has resulted in wide-spread dissatisfaction both for patients receiving such care and for health professionals delivering it. That dissatisfaction may be interfering with patient recovery and contributing to a rise in litigation against hospitals and providers. According to DeLaune & Ladner (2006), people throughout history have dealt with pain, illness, and healing in spiritual ways. In many primitive cultures, a single person simultaneously held the positions of priest, psychiatrist, and physician.

Micozzi (2006) notes that “the blending of spirituality with the tenets of alternative, complementary, and integrative therapies provide individuals with a means of understanding how they contribute to the creation of their illness and to their healing” (p. 305). Healthcare professionals are entrusted with the holistic care of their clients. This means nurses and other healthcare providers care for the soul and spirit as well as for the body. By caring for individuals in a way that acknowledges the mind-body-spirit connection, healthcare providers acknowledge the whole person. Spiritual care is a part of holistic care (DeLaune & Ladner, 2006).

Sustaining the spiritual needs of hospitalized patients requires forming trust and sympathy with patient, providing desirable environment, appropriate communication of medical team with patient, and respecting the patient's dignity and beliefs. These issues



can receive sufficient attention from nursing team and be provided according to the patient's demand.

Therefore, it is suggested that in addition to general evaluation of patients, their spiritual needs in hospital would also be taken into consideration (Yousefi, & Abedi, 2011).

The vision of the Tamale Central Hospital is to have a fully established hospital with specialized units, results oriented, client focused and a well-motivated workforce for services delivery.

Key element in this vision statement is, “client focused”, which place emphasis on the role of doctors and nurses to focus on working on holistic healthcare fashion which considers physical, emotional, social, economic and spiritual needs of patients. (Shepherd, 2012; Monareng, 2013; Van der Steen, 2014) have observed how hospitals have neglected the provision of spiritual and emotional care in their holistic healthcare approaches. It is for this reason that this study has sought to assess the role of health care providers in providing the emotional and spiritual needs of the patients in the adult wards of the Tamale Central Hospital.

1.2 Problem Statement

Spiritual care to the patient in the health care delivery system seems to be lacking in the provision of holistic health care in Ghana. It is an area that seems to be making most health care providers uncomfortable. Sometimes in the treatment process some patients lament about the need to involve either their pastors or imams but meet the resistance of some health care providers. The 2016 annual reports of the Tamale Central hospital suggest that, the rate at which clients request for discharge against medical advice keep



increasing each year. Some of these requests for discharge against medical advice are often done to seek spiritual or traditional care elsewhere. Most of the times the patients return with complications of the underlying physical conditions which could have been taken care of at the same time with the spiritual needs at the health facility. The absence of this care affects the patients' emotional and spiritual wellbeing and goes a long way to complicate their condition especially at the terminal stages.

The hospital chaplain system seems not to be effective anymore. To some extent this area seems to have been neglected in the care of Ghanaian patients. What informs this situation is still not clear.

1.3 Main Research Question

What is the role of the health care provider in providing the emotional and spiritual needs of patients?

1.3.1 *Specific Research Questions*

This study is designed to answer the following questions:

1. To what extents are spiritual needs of adult patients admitted in Tamale Central Hospital provided?
2. What are the activities and issues engaged in providing spiritual care to hospitalized patients in the adult wards of the Tamale Central Hospital?
3. What are the barriers to providing spiritual care to patients admitted to the adult wards in the Tamale Central hospitals?



4. What can be done to remove barriers to provide spiritual care and increase the frequency of providing spiritual care to patients admitted to the adult wards of the Tamale Central Hospitals?

1.4 Main Research Objective

To assess the role of health care providers in providing the emotional and spiritual needs of the patients in the adult wards of the Tamale Central Hospital

1.4.1 *Specific Objectives*

1. To assess the extent to which emotional/spiritual care is provided to hospitalized patients in the adult wards of the Tamale Central Hospital.
2. To establish the activities and issues engaged in providing emotional/spiritual care to hospitalized patients in the adult wards of the Tamale Central Hospital
3. To identify the barriers in providing emotional/spiritual care to patients admitted to the adult wards in the Tamale Central hospitals.
4. To find possible solutions to the barriers in providing emotional/spiritual care to patients admitted to the adult wards of the Tamale Central Hospitals.

1.5 Significance of Study

Nurses today are being mandated by professional and regulating organizations such as The American Holistic Nurses' Association (2005) and The Joint Commission of Health-Care Organizations (2005) to incorporate spiritual assessment and interventions into their practice. In addition, it is postulated that failing to incorporate spirituality in nursing care by not addressing the spiritual needs of patients is unethical (Burkhart,



Solari-Twadell & Haas 2008; Helming, 2009). The Joint Commission on Accreditation of Healthcare Organizations policy stated that for many patients, pastoral care and other spiritual services are an integral part of health care and daily life.

Within the International Council of Nurses' Code of Ethics for Nurses spiritual care is included under "Nurses and people" as one of their four elements of standards of ethical conduct (Lind, Sendelbach & Steen 2011).

However, nursing education according to Pike (2011) and the Royal College of Nursing (McSherry & Jamieson 2010) showed that there is a dearth of research into spirituality from the patients' perception, and that there is a need for education to allow nurses to deliver spiritual care. The Royal College of Nursing launched its Dignity in Care Campaign in 2008, emphasizing the importance of treating patients with dignity and respect. These initiatives further highlight the importance of providing care for the spiritual needs of patients. In nursing literature, the need to educate nurses in spiritual care is widely recognized (Hanson & Andrews, 2012; Barlow, 2011; Barber, 2008; van Leeuwen et al., 2007). Spirituality is reflected in everyday life as well as in disciplines ranging from philosophy, literature, sociology and health care.

Barlow (2011) supported Dunn's (2008) view when he said that medical schools have begun offering courses in spirituality, religion and health. Several international schools of nursing have also incorporated into their programme issues of spirituality. Trends that appear to be driving this new interest in spirituality include many international studies that demonstrate the connection between spirituality and health improvement. Barlow (2011) added that there is a high demand from clients and patients that their spiritual



needs be addressed along with their physical, mental and emotional needs. Doctors in the United Kingdom and United States are using spiritual healers. Whilst they do not replace traditional medical interventions, they can be used alongside regular medical treatment. A doctor healer network meets to discuss ways in which they can effectively work together (Barlow, 2011).

In America, Care of the Human Spirit is currently taught as a Nursing and Health Studies elective.

Students are graded on class participation, reflective journals, an experimental exercise involving engagement with an unfamiliar faith and a scholarly paper addressing spirituality and health (Becker, 2009). In contrast, the education on spiritual care in Ghanaian context of nursing curricula appears lacking.

Nurses have provided spiritual care and support to their patients throughout the years with no formal training which attests to the importance of this level of care. Nurses also comfort patients who are suffering and dying. Many nurses pray with patients and support their spiritual needs (Graham, 2008). Deal (2008) conducted a descriptive phenomenological study in Texas with four nurses to explore their lived experience of giving spiritual care. Five themes emerged from the data. Spiritual care is patient-centered, spiritual care is an important part of nursing, spiritual care can be simple to give, spiritual care is not expected but is welcomed by patients and spiritual care is given by diverse caregivers including ward cleaners, doctors, ward clerks.



In this vein, spiritual care and spiritual care training is viewed as being an essential part of nursing care, not only in palliative care but also in many other areas of nursing care delivery (Narayansamy & Owen, 2001; Pike, 2011).

Research has also suggested that nurses can promote patients' healing by supporting them to use spirituality as a coping mechanism. This could include prayer, meditation and reflection or mindfulness (Myers, 2009). It is critical that professional nurses are capable of responding to their patients' spiritual needs in a competent and sensitive way. This highlights the need for formal training on spirituality and spiritual care. The lack of formal training in spiritual issues during basic nursing education renders the nurse virtually unprepared to meet the challenges of providing effective and therapeutic spiritual care for the client and the client's family (Sloma, 2011). They need to be informed of the rituals and beliefs of various religions and traditions which will help minimize embarrassing situations and avoid unintentional offensiveness. We cannot assume that all patients have the same religious or spiritual requirements and it is essential that health care professionals are provided with basic knowledge of the main religious traditions in Ghana.

Traditional healers are after all consulted by our patients on a regular basis (Lubbe, 2008). It is also hoped that such knowledge will find its way back into the curricula of nurse training institutions (Lubbe, 2008). It is envisaged that this study will create an awareness of the importance of spirituality in nursing practice. Motivation for nursing education to embrace spirituality can also be strengthened. The bed of knowledge uncovered by this study could also help nurses to become more comfortable with their



own spirituality, which is the initial step in developing awareness and sensitivity to patients' spiritual issues (Graham, 2008).

The art of nursing practice is thus not only task orientated, but involves the establishment of a therapeutic interpersonal relationship that is based on caring, warmth, congruence and empathy (Watson, 2002). This study will help health care providers recognize that patients are not only physical beings but spiritual beings as well and incorporate spiritual care of the client in the caring process. Students would find the results useful as a reference material as it will contribute to the body of knowledge. Also policy makers would find the results useful in policy making regarding holistic care giving to Ghanaian patients.

1.6 Scope of the Study

Contextually, the study examined provision of spiritual care to the patients admitted to the adult wards of the Tamale Central Hospital.

The research focused specifically on the established barriers in providing spiritual care to patients admitted to the adult wards in the Tamale Central hospitals. Geographically, the study was limited to providing the emotional and spiritual needs of the patients in the adult wards of the Tamale Central Hospital.

1.7 Organization of the Study

This research was organized into six Chapters. Chapter one entails the introductory aspect of the work which gives the background of the study, the specific problem of the study, the research objectives and questions, the significance of the study. Chapter two consists of review of relevant literature. Chapter three discusses the methodology and



approach of this study. Empirical results obtained from the study was presented in Chapter four and discussed in Chapter five. Chapter six covered the summary, conclusion and recommendations of the study.



CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter deals with review of literatures that are related to the topic under consideration. The literature relevant to the topic under discussion includes Understanding Spirituality, Lack of Emphasis on Spirituality in Nursing Education and Spiritual Care. From this literature, an overview is presented tracing the concepts and definitions of spirituality care from its beginnings and its application in healthcare provision. Also presented are the theoretical frame work, conceptual frame work and empirical evidence.

2.2 Definitions and Concepts

2.2.1 *Understanding Spirituality*

Most studies attempted to define the common elements of spirituality and how this could be reflected in nursing practice. Long (1997) cogently encapsulated the dilemma faced in defining spirituality as “touching the untouchable and clasping the unseen” (p.500). Henery (2003) opined that efforts to define spirituality were simply analytic attempts of scientific discourse to objectify spirituality. Spirituality, described here, as invisible and untouchable, suggests attempts by the scientific community to define this concept may be futile.

Historically, the roots of spirituality can be traced from religion. Medical and nursing services were traditionally offered by members of religious orders of various denominations, predominantly Christian (Modjarrad, 2004).



However, a view of spirituality from a Christian tradition is not necessarily culturally sensitive and may not reflect the multicultural profile of many contemporary societies.

Defining or understanding spirituality from a religious or theistic perspective may also not be in keeping with the modernist, multicultural or secular views of the term (McSherry & Cash, 2004).

Paley (2008c) proposed that the concept of spirituality could be conceived as having one end firmly looped around religion but also being “stretched” in various directions. Many authors argue that spirituality applies to everybody (Narayanasamy, 2004a). Therefore, any definition of spirituality must satisfy criteria related to inclusiveness and universality so that the concept of spirituality will be applicable to all individuals (McSherry & Draper, 1998). There is also a need to contextualize spirituality within the individual’s culture (Stranahan, 2001; Narayanasamy, 2006). However, current attempts and debates on the definition of spirituality have only served to create more confusion in the nursing profession (Paley, 2008b; Carr, 2008).

Without a clear understanding of what spirituality means and entails in practice, nurses will continue to be confused about the concept of spirituality, their roles and responsibilities in the provision of spiritual care, and the medico-legal implications underpinning spirituality in practice (Oldnall, 1996; McSherry & Ross, 2002; Handzo & Koenig, 2004; Lantz, 2007; McSherry et al., 2008). McEwen (2005) suggested that without clarity about spirituality, it is difficult to expect nurses to assess patients’ spiritual needs. A shared definition of spirituality becomes even more critical for nurses working in multicultural societies where the nurse and the patient may have differing views of what constitutes spiritual needs and care.



It is possible that a nurse may be aware of spirituality, but express intolerance toward a patient's view of spirituality if it differs from their own (McEwen, 2005).

Without a mutual understanding of spirituality being formed with the patient, the nurse may not be able to accurately assess needs, plan appropriate care, and identify appropriate resources to assist patients to meet their expressed spiritual concerns or needs (Hussey, 2009).

The lack of clarity about spirituality may not only contribute to a deficit in care, but inappropriate assessments and plans of care. For example, it could be possible for a nurse to confuse a patient's spiritual distress as being psychological in origin, consult a physician, and seek to have medication prescribed for the patient (Weaver, Flannelly, Flannelly, VandeCreek, Koenig, & Handzo, 2001). Ongoing confusion about spirituality may also explain, in part, why some nurses believe that they are not the most appropriate persons to address clients' spiritual needs (McEwen, 2005; Carr, 2008). Some may believe that spirituality is not relevant to their practice and is a topic of discussion for theologians (Handzo & Koenig, 2004).

2.2.2 *Attitudes*

Attitudes are defined as hypothetical construct that represents an individual's degree of like or dislike for something (Fishbein & Ajzen, 1975). Attitudes are assessed by asking questions or making inferences from behaviour. As attitudes are not directly observable, they are usually inferred from what people say or perceive. Or in other words, measures to assess the respondent's evaluation of the attitude (Fishbein & Ajzen, 1975).



Therefore, terms such as perception, perceived and understanding are used to explore participants' attitudes towards spirituality and spiritual care.

Based on the above definition, attitudes are inferred from the concepts explored in the framework. The emerging literature on spirituality in nursing may infer progress towards our understanding of spirituality in practice, but this is not the case. Swinton (2006) concluded that two decades have passed and our understanding of spirituality in nursing is still rather static. This lack of progress may be related in part, to the attitudes of nurses towards spirituality. Several studies identified that attitudes, that is the "heart and spirit" by which the nurse delivers spiritual care, play an important part (Pesut, 2002; Baldacchino, 2003). Swinton (2006) reported that some nurses showed apathy toward spiritual care. They rarely argue and deliberate the validity and appropriateness of the ways in which spirituality is conceptualized, understood, and practiced (Swinton, 2006). Nurses' attitudes may also contribute to an emphasis on providing physical care to patients rather than spiritual care (Carr, 2008). According to Carr (2008), some nurses believe they "cannot comfort the spirit if [they] cannot properly care for the body" (p. 695). This view may reflect how influences such as technical supremacy/ skill competency could easily shape nurses' perceptions and attitudes about spirituality. According to Chan et al. (2006), providing spiritual care requires a mindset change. Bradshaw (1997) purported that spiritual care is fundamentally inherent in the character of care and is not a self-conscious addition. Nurses' own spiritual well-being is equally important as it can become an unspoken element which underpins and affects the quality of care they deliver (Newson, 2007). Kendrick & Robinson (2000) added that when one self is content and whole, the "self" is able to reach out to understand and focus on



concerns of others when delivering spiritual care. Similarly, one phenomenological study investigating nurses' meaning and experiences of spiritual care found that nurses experience spiritual care through the development of caring relationships (Carr, 2008).

However, according to Burkhart & Hogan (2008), providing spiritual care can also be emotionally draining and decrease one's sense of well-being.

Therefore, in today's challenging healthcare environment, it is becoming essential for care providers to attend to their own health and well-being, including their spiritual health in order not to suffer work-related stress and burnout (Burkhart & Hogan, 2008; Anandarajah, 2008).

A review of studies on nurses' attitudes towards spirituality revealed a positive relationship between nurses' spiritual awareness and spiritual care practice (Stranahan, 2001). Various studies reported that spiritual education enhanced individuals' spiritual awareness which in turn fostered the development of positive attitudes and increased their sensitivity to the spiritual needs of those in their care (Shih et al., 2001; Pesut, 2002; Meyer, 2003; Baldacchino, 2008; McSherry et al., 2008; Chism & Magnam, 2009).

Lundmark (2006) reported that survey respondents with a nominated religion and those who engaged in activities such as meditation, praying or reading religious materials, were more likely to report positive attitudes towards spiritual care.

This concurs with other studies which showed that nurses' spirituality significantly influenced and supported their understanding and practice of spiritual care (Carr, 2008; Smith, 2006; Hubbell, Woodard, Barksdale-Brown, & Parker, 2006; Cavendish, Luis,



Russo, Mitzeliotis, Bauer, & McPartland-Bajo, 2004; Belcher & Griffiths, 2004; Treolar, 2000).

2.2.3 *Lack of Emphasis on Spirituality in Nursing Education*

An analysis of the literature revealed that some health professionals experienced difficulty demonstrating respect of, and, when appropriate, supporting patients' spiritual beliefs and choices (Pesut & Thorne, 2007). In other studies, nurses reported an inability to deliver spiritual care competently (Stranahan, 2001; Hubbell et al., 2006). It has been consistently noted that nurses were not ready and/or prepared to deliver spiritual care because of limited educational preparation in this area (Taylor et al., 2008; McSherry, 2007; Baldacchino, 2008; Lundmark, 2006; Hubbell et al., 2006; Meyer, 2003; Lemmer, 2002; Stranahan, 2001; Treolar, 2000; Highfield et al., 2000). The lack of educational preparation has been compounded by lack of available guidelines on spiritual assessment, interventions or explanation on how spiritual care is best achieved in practice (Gordon & Mitchell, 2004).

Hubbell et al. (2006) argued that inadequate educational preparation might contribute to nurses perceiving themselves as being incompetent and avoid spiritual matters. Highfield et al. (2000) and Lundmark (2006) affirmed this view. Both researchers reported a statistically significant relationship between self-estimated ability to give spiritual care and reported confidence and ease to provide it.

Studies investigating nursing students' perceptions on the adequacy of spiritual education reported that curricula time was insufficient (Pesut, 2002; Meyer, 2003; & Baldacchino, 2006). According to McEwen (2005), and Mitchell, Bennett, and Manfrin-



Ledetl (2006), content about spirituality was usually addressed as part of holism; and in the context of giving care to the dying. Meyer (2003) argued that the lack of time dedicated to spirituality in nursing curricula could subtly infer the lack of importance accorded to spirituality.

Burkhart & Hogan (2008) identified that leading nursing textbooks contained little content on spirituality. For example, they reported that “Lewis, Heitkemper, Dirksen, O’Brien, and Bucher (2007) allocated approximately one page on spirituality out of 1,884-page medical/surgical textbook, and that page was primarily associated with complementary/alternative care and end-of-life care” (Burkhart & Hogan, 2008, p. 929). Nursing faculty also report that more research is needed to determine appropriate spiritual content and teaching methods to foster spirituality (Bradshaw, 1997; Lemmer, 2002). Oldnall (1996) questioned the lack of emphasis on spirituality in nursing theories and models.

She postulated that the inherent elusive nature of spirituality may have contributed to its neglect by nursing theorists who may have perceived that it did not add any weight to nursing’s attempt to establish itself as a scientific discipline (Oldnall, 1996).

The conceptual confusion about spirituality may have contributed to nurse educators feeling uncomfortable about discussing or teaching such content. Misunderstandings about what constitutes spirituality may reinforce notions in educators and cause them to give little recognition or importance about the relevance of spirituality in an individual’s life, and forcibly affecting the ability to cope especially when one encounters a crisis or life event (Oldnall, 1996). In the same way that sexuality had been ignored in the past, a



similar approach is being accorded to spirituality (Oldnall, 1996). Not surprisingly, nursing students report needing to rely on their own experiential understanding and intuition under the auspice of the “art of nursing” to determine the meaning of spirituality and how it may be reflected in practice (Lemmer, 2002; Pesut, 2002; Catanzaro & McMullen, 2001).

Although nurses in one study reported receiving spiritual education from several sources, such as academic studies, continuing education and reading, 58% reported feeling inadequately prepared for spiritual care-giving (Stranahan, 2001). This was contrary to the common understanding by many nursing authors such as Narayanasamy (2006), Baldacchino (2006), and McEwen (2005) who suggested that the provision of education would improve spiritual care in practice. Therefore, a multiplicity of factors may contribute to nurses’ perceived inability to deliver spiritual care. From an ethico-legal perspective, nurses should not carry out spiritual care without guidance and educational preparation (McSherry & Ross, 2002).

Nurses have previously reported concern about the possibility of misdiagnosing and mistreating patients’ problems as spiritual distress (McSherry & Ross, 2002).

It has been argued that compared with the training and preparation of chaplains, nurses were not adequately prepared (Handoz & Koenig, 2004).

Chaplains in the USA and United Kingdom undergo a formal course in Clinical Pastoral Education, a 1,600-hour programme involving 400 hours of seminars about disease processes, beliefs of world religions, and advanced interpersonal skills.



The remaining 1,200 hours are spent in clinical situations providing care for people in conjunction with individual and group supervision (McClung, Grosseohme, & Jacobson, 2006). By virtue of their education, training, experience and supervision, chaplains are “individuals...qualified to provide care... and services” (JCAHO, 2005, p. 466). However, as nurses are always at patients’ bedsides, they are often expected to provide some level of spiritual care (Miner-Williams, 2006). Therefore, it seems that nurses require further spiritual education preparation to provide holistic care.

2.2.4 *Organizational and Cultural Factors*

Nurses’ reluctance to integrate spirituality in practice may be due to an increasing emphasis in healthcare towards a business model approach to services (Meyer, 2003). Educators today strive to prepare students for employment in a cash- constrained healthcare system, with high acuity, short length of stay and a growing number of elderly patients requiring healthcare services. There is an increasing financial imperative to shorten length of hospital stay in order to relieve the perennial issue of bed shortages and resource constraints (Hubbell et al., 2006; McEwan, 2005; McEwan, 2004; Vance, 2001).

Additionally, the current nursing workforce shortage may limit the delivery of services. Nurses are required to assume care for a larger number of patients, with multiple needs in a fast-paced environment where much of the personal care is relegated to healthcare assistants and there is less emphasis on personal interactions (Lundmark, 2006).



As the essence of spiritual care is relational, the nature of acute care provides few opportunities for nurses to build rapport with patients and/or their family or to identify patients who are in spiritual distress (Pulchaski, 2004).

Swinton (2006) suggested that nurses' apparent neglect of the spiritual might well be a symptom of a deeper spiritual problem in the wider healthcare system. Organizational expectations to deliver effective and efficient care to patients in a climate of high workloads and continuous change could influence the view of spirituality as an added burden or something to which the organization pays "lip service" (McSherry, 2007; Vance, 2001). It is, therefore, not surprising that some nurses believe that the organizational culture in which they work, mitigates against the prioritization of spiritual care and the importance of possible time-consuming one-on-one encounters (McEwen, 2005). Although nurses perceive that spiritual care is important, they may have learnt to disregard it due to vicarious learning and socialization in the workplace (Hubbell et al., 2006).

Several authors identified that the cultures of many western developed countries are becoming more secular, pluralistic, materialistic, as well as diverse (Paley, 2008b; Pesut, Reimer-Kirkham, Taylor, & Sawatzky, 2009). As such the meanings of spirituality have changed over time in some communities, and there is little uniformity (Clarke, 2009; Hussey, 2009). Increasing globalization and migration means that nurses commonly work in a multicultural healthcare environment where patients' spiritual needs may be quite diverse. This is challenging as each culture usually has a set of beliefs about the meaning of health/illness, health maintenance and rituals to prevent illnesses (Chiu, 2001). Some authors cautioned that this diversity has important consequences for



spiritual care to patients, no matter what faith, religion, and culture they themselves belong to (Conner & Eller, 2004; Hussey, 2009; MacLaren, 2004).

This analysis suggests that nurses are likely to have contact with patients of various faiths and cultures. There is no longer a distinct or homogenous culture and race in one country. Even in countries such as China, there are many different dialects, customs, and beliefs. If nurses are to offer culturally sensitive spiritual care, they require education and information about the customs, and practices of different cultures and races so as to avoid stereotypical assumptions (Gilliat-Ray, 2003).

2.2.5 *Individuality*

MacLaren (2004) proposed that spirituality in nursing has two aspects: personal and public. Nurses' personal spirituality which is "looking to things of the spirit" is influenced by their experiences, beliefs, and practices (MacLaren, 2004). The public aspect of spirituality is perceived as spiritual dealings with patients that are being made known (MacLaren, 2004). Nurses delivering spiritual care need to habitually look to things of the spirit. Such care would be characterized by an interest in spiritual matters and a willingness to discuss and provide spiritual care with a patient (MacLaren, 2004).

The analysis of papers in this review identified that most authors supported the view that a nurse's personal spirituality is a basic and critical quality that underpins and supports the foundation of holistic nursing and the whole nurse-patient relationship without the nurse articulating it (Carr, 2008; Belcher & Griffiths, 2005; Treloar, 2000).

Miner-Williams (2006) emphasized that in order to integrate spirituality into practice; nurses need to be at ease with spirituality in two respects. The first is to understand



spirituality and what it means to be human, and how life crises can affect and change the focus of one's perspective about life. Secondly, to enhance spiritual care, nurses should be nurtured and encouraged to develop their own spirituality and awareness.

Nurses must develop a sense of comfort about their own spirituality in order to be at ease and more inclined to discuss spiritual issues with their patients (Burkhart & Hogan, 2009).

Sheldon (2000) stated that in order to recognize a person's spirituality, an innate understanding of spiritual development is helpful. This could help nurses to be effective in helping patients to draw on their inner strength to find direction and meaning. Similarly, for faculty to "teach" spirituality, it is equally important for them to be spiritually aware before they can be comfortable and feel equipped to help students develop their spirituality (Lemmer, 2002).

Research studies (Burkhart & Hogan, 2009; Baldacchino, 2008; McEwen, 2005; Shih et al., 2001) suggest that the nurse's personal beliefs and values could influence their willingness to give of themselves, increase their sensitivity to others, as well as the ability to prioritize spirituality in their life. Developing nurses' reflection on their life values and beliefs has been found to enhance their delivery of spiritual care by sensitizing them to patients' spiritual needs (Burkhart & Hogan, 2009; Sawatzky & Pesut, 2005; Callister, Bond, Matsumura, & Magnam, 2004; Highfield et al., 2000).

Thus, spirituality in nursing involves caring for the person within and not primarily on providing physical care or information. Catanzaro and McMullen (2001) referred to this as blending the art of nursing with caring science. The nursing role is to support and



encourage patients as they search for their own answers to their questions and to use their own spirituality as a resource (Chiu, 2001). However, some nurses may misconstrue this to obtaining answers from patients about questions on standardized assessment forms such as, “What are your values or beliefs?” and “What is your religious preference?”, and referring patients to hospital chaplains for spiritual care. Although these actions might meet external accreditation requirements for spiritual care, such an approach may miss the spirit of caring in many respects.

2.2.6 *Spiritual Care*

A major goal of the spiritual care team is to provide “spiritual care” to all patients as part of whole-person medicine. What is spiritual care? Although assessing and addressing the spiritual needs of patients is an important part of it, spiritual care goes far beyond that. The way that ordinary health care is provided by the physician and other members of the healthcare can be “spiritual”. By that, I mean recognizing the sacred nature of the person being cared for and the holy obligation and privilege that health professionals have. More specifically, this means providing care with respect for the individual patient, a person with a unique life story; inquiring about how the patient wishes to be cared for, rather than providing the same care in the same way to everyone; providing care in a kind and gentle manner; providing care in a “competent” manner; and taking extra time with patients who really need it.

Spiritual care is the heart of what whole-person healthcare is really about, and has the potential to bring vitality back into the patient and into the practice of healthcare. However, it is not easy to do. Research indicates that only about 10% of physicians regularly conduct a spiritual assessment (and nearly 50% never do one) (Farr et al,



2006). Why is this so? The following are 10 barriers that stand in the way of spiritual care. These barriers are based on research by the Harvard oncology group at the Dana Farber Institute (Michael et al., 2014). They asked oncologists and oncology nurses why they did not routinely assess and address the spiritual needs of patients. Here is how they responded. After each barrier, I will suggest how to overcome it:

(1) Lack of Time. Spiritual care is just one more thing that health professionals are now being asked to do. They barely have enough time to perform required duties and document the results.

Many are concerned about opening Pandora's Box and not having adequate time to address the issues uncovered. There is temptation, then, to eliminate this "optional" activity (or defer it to others).

How to overcome: Doing a brief spiritual assessment must be a priority for the physician and addressing those needs a priority for the spiritual care team. This is not an optional activity, but central to providing "whole-person" medical care. The spiritual assessment can actually save time, improve the relationship with the patient, improve compliance, and make the physician's work more rewarding. The physician, as the director of the spiritual care team, cannot defer the spiritual assessment to anyone else. The spiritual care team, though, must be ready to fully address the patient's spiritual needs as their part of whole-person care.

(2) Discomfort. Many health professionals are not comfortable addressing this topic, particularly if they are not religious or particularly spiritual. Few health professionals



have training on how to assess or address the spiritual needs of patients in a sensible and timely manner, or what to do if spiritual needs are identified.

How to overcome: Comfort comes with training and practice. Sometimes health professionals must do things that are not comfortable with to improve the quality of care that patients receive.

(3) Making Patient Uncomfortable. Health professionals may fear that asking such questions will make the patient feel uncomfortable, or may not know how to respond if the patient says: “Why are you asking these questions?”

How to overcome: Research shows that most patients, especially when seriously ill, are not offended or made uncomfortable when the physician performs a spiritual assessment, and in fact, the majority would like health professionals to do so (McCord et al., 2004; Jennifer et al., 2006). If a patient asks why these questions are being asked, an appropriate response would be:

“We are doing this routinely as a show of respect for the beliefs and values of patients, which may influence their medical care”.

(4) Spirituality Not Important. Because spirituality is not important to the health professional, there is fear that the patient will ask about his or her own beliefs.

How to overcome: First, patients seldom ask health professionals about their personal beliefs. If they do ask, then a brief or general response usually satisfies the patient. The reason why most patients ask is that they are worried about how the clinician will treat



their beliefs. Reassuring the patient that their beliefs will always be respected and honored usually allays this concern.

(5) Topic Too Personal. Health professionals feel that this topic is too personal to ask about, or they are concerned that they don't have a private space to discuss it.

How to overcome: Clinicians deal with other sensitive areas related to health much more personal than asking about religious beliefs. Sensitive areas include sexual behavior or personal health habits, such as smoking, drinking, diet, or weight control.

Fear that these areas are too personal does not prevent health professionals from thoroughly assessing them.

(6) Done Better by Others. The physician believes that the spiritual assessment is done better by others.

How to overcome: Recognize that the physician is the leader of the healthcare team and needs to know about factors that could affect the patient's health and their compliance with the medical care plan.

(7) Patients Don't Want Spiritual Care from Doctors/Nurses. Health professionals believe that patients don't want them to address these issues.

How to overcome: As noted above, patient surveys indicate that only a minority of patients shows resistance to inquiry about spiritual needs,

Or wish to keep medicine and religion separate (McCord et al., 2004; Jennifer et al., 2006). Furthermore, doctors are usually only responsible for assessment in this model.

Once spiritual needs are identified, the chaplain or pastoral counselor is the health



professional who addresses them. One large study even found that when patients who did not want a visit from a chaplain and received one anyway, actually reported more satisfaction with their overall healthcare than did non-visited patients (Joshua et al., 2011).

(8) Power Inequality. There is concern that the power inequality between patient and health professional might lead to coercion.

How to overcome: Realize that coercion in this area is unethical and a violation of civil rights. Thus, it is never appropriate to do so. I will discuss this boundary issue further in the next section.

(9) Religious Beliefs Differ. The religious beliefs of the healthcare provider differ from those of the patient.

How to overcome: Realize that in this era of patient-centered medicine, the focus should always be on respecting and supporting the spiritual beliefs of the patient, whether or not the health professional agrees with those beliefs.

(10) Not Health Professional's Role. Healthcare providers feel that assessing and addressing spiritual needs related to medical care is not part of their role.

How to overcome: Realize that providing whole-person care is part of the health professional's role and whole-person care includes addressing this area.

All of these barriers could be overcome through training and practice. Future research, however, will be needed to determine whether training, careful dividing up tasks among



team members, and practice will make health professionals comfortable and fluent in spiritual care.

In the Duke-Adventist Health collaborative study, we plan to systematically examine exactly this—whether the forming and training of spiritual care teams to assess and address patients’ spiritual needs will affect health professionals’ attitudes and behaviors (which will be measured at baseline and then 3 and 12 months afterwards).

2.2.7 *Boundaries*

There are, however, boundaries to providing spiritual care. Sometimes health professionals go beyond their expertise and perform actions that are neither sensible nor ethically justifiable. Here are five behaviors that healthcare providers should almost never do. First, don’t prescribe religion to non-religious patients.

Even though religious involvement may be good for health, non-believers should not be encouraged to become religious. Furthermore, the spiritual assessment should be conducted in such a way that patients who do not consider themselves spiritual do not feel devalued. As noted above, the spiritual assessment should be framed in such a way that the patient understands that such questions are being asked as a matter of routine in order to provide whole person care to those who do have spiritual needs. Second, and related to the latter, don’t force a spiritual assessment if the patient is not religious. In that case, quickly switch to asking about what gives life meaning and purpose in the context of illness and how this can be supported. For these individuals, issues related to demoralization or death anxiety should be dealt with in a broad way using a holistic model grounded on humanistic beliefs and values. Third, don’t pray with a patient



before doing a spiritual assessment and unless the patient asks. While more than two-thirds to three-quarters of patients would like to pray with a health professional and deeply appreciate this (Oyama & Koenig, 1998; Harold, 1988), others might not. Fourth, in general, don't provide spiritual counsel to patients. Instead, always refer the patient to a trained professional chaplain or a pastoral counselor.

As noted earlier, the only exceptions might be if the health professional has pastoral care training, or if addressing spiritual issues is urgent and the patient refuses pastoral care or pastoral care is not available. Finally, don't do any activity that is not patient-centered and patient-directed. Remember, it's about the patient—not the health professional. Addressing spiritual issues is like a ballroom dance. The patient leads and the health professional tries not to step on his or her toes.

Finally, in order for the physician and other team members to deliver whole-person spiritual care to patients, they need to be whole-persons themselves. The difficult task of caring for sick challenges the physical, emotional and spiritual resources of most providers. For that reason, one major task of the spiritual care team is to support each other's spiritual needs that arise during the course of providing healthcare. Part of the role of the spiritual care coordinator and the chaplain is to ensure that the spiritual needs of team members are met. There are numerous spiritual resources that may help in this regard, depending on the provider's faith tradition (Chambers, 1963; Kugle, 2013).

Models, such as the one proposed here, and similar ones proposed by others (Michael et al., 2014), will need to be adapted to the unique settings and cultural environments that health professionals find themselves in—particularly as these models begin to be applied



in non-Western countries (and in hospital settings that may not reflect the religious values of the Adventist Health System).

2.2.8 *Historical Development of Spirituality in Nursing*

Spirituality has been present since the inception of nursing as a profession. Florence Nightingale (Lundberg & Kerdonfag, 2010) said that nurses should see to the spiritual needs of patients regardless of their religious beliefs.

She reasoned that if nature is the manifestation of God, then co-operation with nature, by facilitating healing, is co-operation with God (Macrae, 2001 cited in Miner-Williams, 2006: 812). In addition, she emphasized that the needs of the spirit are as critical to health as those individual organs which make up the body (Campbell, 2008).

According to Johnson et al. (2006), the pre-Christian era resulted in the development of the foundation and basis for caring and having charity for the infirm for generations to come. The Greeks considered nursing a noble art, and the Romans believed that prayer was important as they grappled with the ill (Johnson et al., 2006). The Israelites gift to nursing was their rules for the prevention of contagious diseases, and the idea of nursing being honorable and filled with respect dominated the Christian era (Johnson et al., 2006). It was the way Jesus attended to the infirm that set the standard for those who served to follow. Convents, monasteries and hospitals were established to care for the sick and this notion of spiritual care continued to develop into the eighteenth century (Carson, 1989 cited in Johnson et al., 2006: 60).

“Nursing care was provided by the religious orders that cared for the poor, abandoned children and the others neglected by society” (Carson, 1989 cited in Johnson et al.,



2006). The nineteenth century saw nurses beginning to provide total care and doctors being called only when absolutely necessary. As time progressed, the early twentieth century witnessed the birth of formal nursing programmes. Nursing theorists during this era were prolific, conscientious and adamant about how patients were viewed. The concept of holistic care gained sufficient strength that the total client (mind and body) was always considered.

Research into spirituality led to the development of tools to enhance the various studies being conducted to promote spiritual care, and nursing programmes at the University of Maryland began to offer elective courses in spirituality (Johnson et al., 2006).

Furthermore, nursing theorist Leininger, after experiencing a miraculous spiritual occurrence based on the power of prayer spoke of including spirituality more explicitly in her theory on nursing (Johnson et al., 2006), thereby allowing the interest in spirituality to grow.

Nursing in the late 20th century reached a consensus that the best care of patients is realized through focusing on the whole person, not only body and mind. An interest in the spiritual dimension of humankind and the relationship of spirituality to human health and wellbeing thus began to receive greater attention, both in practical settings, as well as the academic context (Van Dover & Pfeiffer, 2006; Deal, 2008).

As nursing entered the twenty-first century, addressing the spiritual needs of patients was seen as an important goal for nursing care. The role of spirituality in promoting health and improving patients' responses to illness began receiving attention. Scholars concluded that spirituality was a natural part of nursing care and that following this



approach enabled a nurse to care for the whole person (Vance, 2001; McClain, 2008; O'Brien, 2011; McSherry & Jamieson, 2010). Since nurses spend more time with patients than any other health care provider; the role of the spirituality and spiritual care in nursing practice was addressed (Barlow, 2011; Deal, 2008).

2.2.9 *The Role of Spirituality and Spiritual Care in Nursing*

“Nursing is really about being intuitive and spiritual and can be seen as a calling” O'Brien (2011). Not only is nursing care spiritual in nature, but nurses who have a better understanding of their own spirituality may be more effective in providing quality patient care (Koren et al., 2009). Nurses are present day and night with their patients and hence are in a position to maintain a patient's wholeness and integrity (Lundberg & Kerdonfag, 2010). Since a nurse's own personal spirituality permeates individual nursing practice; it is important that each nurse critically evaluates his or her own spirituality.

Becoming aware of one's spiritual perspective will enhance personal awareness and contribute to the provision of spiritual care to patients (Dunn, 2008; Graham, 2008).

Spiritual care, according to The Royal College of Nursing (Seymour, 2009) is care which recognizes and responds to the needs of the human spirit when faced with trauma, ill health or sadness, and can include the need for meaning, for self-worth, to express oneself, for faith, support and perhaps for rites, prayer, sacrament or simply for a sensitive listener. Spiritual nursing care begins with encouraging human contact in a compassionate relationship and moves in the direction the need requires. One reason for including spiritual care as part of the nursing curriculum is the belief that spirituality is a



universal attribute; part of the condition of being human, which directly influences the health of us all (Seymour, 2009).

“At a foundational level, spiritual nursing care is a process that begins from a perspective of being with the patient in love and dialogue, which may emerge into therapeutically oriented interventions that take the direction from the patient’s religious or spiritual reality” (Sawatzky & Pesut, 2005 cited in Monareng, 2012: 03). Spiritual care is a fundamental part of nursing that has been neglected (McSherry & Jamieson, 2010). It includes nursing interventions such as listening, being with the patient, showing empathy, supporting the patient, showing concern, facilitating participation in patient’s rituals and referring to spiritual leaders when necessary (McSherry & Jamieson, 2010; Khoshknab et al., 2010). Nurses are thus responsible for creating conducive physical, social and spiritual conditions for their patients’ recovery.

Sawatzky & Pesut (2005) saw spiritual care as an intuitive, interpersonal, altruistic and integrative expression that is contingent on the nurse’s awareness of the transcendent dimension of life, and that which reflects the patient’s reality.

It could be argued that if nurses do not undertake a spiritual assessment of their patients there will be no consideration of their spiritual needs. Without assessment, there can be no planning, implementation or evaluation of spiritual care, resulting in a lack of holistic care and neglect of the patient as a whole person. This implies that the essence of spiritual care is that nurses interact and use themselves in the nurse-patient relationship rather than simply a set of nursing actions. Thus, spiritual care is ‘being’ as opposed to ‘doing’ (Sawatzky & Pesut, 2005).



Spiritual care has also been viewed as that care that is embodied in the nurses' respect for patients' dignity, display of unconditional acceptance and love, honest nurse-patient relationship and the fostering of hope and peace (Sawatzky & Pesut, 2005). Existential perspectives view spiritual nursing care as care that extends to a more universal dimension that connects humans with a higher being, which may not necessarily be God as referred to by the religious perspective.

Monareng (2012) added that spiritual care includes activities that facilitate a healthy balance between the bio-psychosocial and spiritual aspects of the person, thus promoting a sense of wholeness and well-being. Earlier studies understood spiritual nursing as care engaged in; by identifying spiritual needs and concerns of patients and their families, and by responding appropriately based on careful assessment of each situation (Monareng, 2012).

Wu and Lin (2011) and Chan (2009) pointed out that understanding the spiritual dimension of human experience is important to nursing, because nursing is a practice-based discipline that focuses on the human being.

When a person is in tune with this vital and unifying force of the spiritual dimension, a more balanced state of physical, mental and social well-being may result, as it empowers the person to strive for meaning and purpose in life

(Watson, 1999 cited in Baldacchino, 2006). Spiritual care is that part of care which touches the unseen part of a person and gives that person faith, and a positive outlook on life even if the person cannot be cured.



2.2.10 *Spirituality and Religion*

Many definitions exist in the literature on spirituality due to its abstract and personalized nature. Potter and Potter (2006) conceptualized spirituality as the opportunity to be part of something beyond ourselves, the purposeful changing of consciousness to provide more access to varying mental perspectives, subtler levels of experience, deeper awareness of self, the awakening of the heart, a wider array of emotional experiences and states of consciousness that connects with the subtle realm of being. It has therefore been conceptualized as an inner, intangible guiding force behind our uniqueness that acts as an inner source of power and energy (Ellis & Narayanasamy, 2009).

Clarke (2009) concurred that spirituality is a personal search for meaning and purpose in life which may or may not be related to religion. It entails connection to self-chosen and/or religious beliefs, values and practices that give meaning to life thereby inspiring and motivating individuals to achieve their optimal being. This connection brings faith, hope, peace and empowerment which results in joy, forgiveness of oneself and others, awareness and acceptance of hardships and mortality, a heightened sense of physical and emotional well-being and the ability to transcend beyond the infirmities of existence.

Although several writers posit that religion and spirituality are inseparable and both constructs can be used interchangeably (Thornton 2005; Rieg, Mason & Preston, 2006), most others view spirituality as a broader concept that transcends culture and religion (D'Souza 2007; Lubbe, 2008).

Spirituality concerns our beliefs about our place in this world and seeks meaning and purpose in our lives; whereas religion can be likened to a container, rituals or liturgy that



we use to express and focus these beliefs (Ojink, 2009). Tokpah (2010) affirmed that there was a difference between both constructs and said that spirituality rather than religion is an appropriate focus for the spiritual dimension of the nursing model. This difference is echoed by Maier-Lorentz (2004); Barlow (2011) and Sloma (2011) who all portrayed spirituality as referring to a universal concept of connection with a Supreme Being that does not require any religious belief. Religiosity on the other hand, they believed related to membership of and adherence to the practice of a particular faith, tradition or sect. Despite these differences Deal (2010) and Barlow (2011) commented that using spiritual and religious resources gives patients and families strength to cope during crisis.

In a study with nurses, Narayanasamy (2006) found that most participants understood spirituality as being religious. Similarly, Dyson et al. (cited in Moberg, 2010: 1184) reported that most American nurses defined spiritual well-being in terms of their religious faith. They said that viewing spirituality as a distinct entity from religion portrays a very narrow conception of it. Religion has definable boundaries and is more about a systematization of practice, doctrines and beliefs within which social groups engage (O'Connor, 2001; Pedrao & Beresin, 2010).

Although religion is a social institution in which a group of people participate; it can be a rich resource for the expression of spirituality (O'Connor, 2001). Being a member of a religious group however does not necessarily mean that one is spiritual (Hanson & Andrews 2012). Spirituality is concerned with issues related to the significance and purpose of life, and spirituality is a broader construct which can be applied to all persons



of both religious and non-religious orientation (Ross and Narayanasamy cited in Nixon & Narayanasamy, 2010: 2260).

With regard to understanding religion and spirituality in relation to patients it has been said that patients' religious needs include making peace in one's relationship with God and others in one's life, readying oneself for the afterlife and attending to the ritualistic requirements of one's religion. A patient's spiritual needs however embrace finding meaning and a sense of control in one's life, forgiving oneself and others, obtaining forgiveness, reflecting on the course of one's life and one's accomplishments and saying goodbye to loved ones (Lubbe, 2008). The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite and comes into focus when a person faces emotional stress, physical illness or death (Wu & Lin, 2011). It is therefore important for nurses to understand spirituality and the pivotal role it occupies in a nursing context (Wu & Lin, 2011).

2.2.11 *Personal Spirituality amongst Nurses*

O'Brien (2011) wrote that nurses need to understand their own spirituality and their patients' spirituality, so as to provide holistic patient care. Nurses who have a better understanding of their own spirituality and its meaning may be less afraid to help patients address spiritual issues.

Nurses who are more spiritually aware are more sensitive to their patients' spiritual needs. They are able to understand patients' spiritual distress and spiritual needs, and are able to listen to patients' thoughts and concerns about their spiritual feelings; hence demonstrating a higher level of spiritual care (Barber, 2008; Wong, Lee & Lee, 2008).



In a survey with American nurses (n=208) by Shores (2010) it was found that 74% of nurses who had spiritual-awareness were better able to provide sensitive spiritual care as opposed to those who felt they had a lower level of spiritual care awareness.

A nurse's personal spirituality can help with managing his or her nursing role and its demands.

Cavendish et al. (2004) looked at the role of prayer as a performance enhancer for nurses (n=404). These scholars defined professional performance enhancement as nurses seeking guidance from a power beyond self in the provision of patient care, and in the implementation of the role and responsibilities of a professional nurse. Prayer was utilized by 18% of nurses for performance enhancement. These nurses used preparatory prayer in preparing for their work and petitionary prayer when asking for guidance and support in their nursing activities. Cavendish et al. (2004) suggested that prayer helps nurses to provide spiritual care to their patients. Prayer creates feelings of support and hope to assist meeting their patients' needs. Apart from prayer, there are other personal spiritual practices that nurses' use in their daily nursing practice.

Wehmer et al. (2010) reported that nurses also used other spiritual practices such as playing or listening to music (99.2%), helping others (95.2%), exercise such as walking (92.9%), family activities (88.9%), praying alone (87.3%), relaxation (81%), recall of positive memories (81.5%), praying with others (70.6%), visiting a house of worship or quiet place (70.6%), reading spiritual material (51.6%), meditation (31.7%) and yoga (31.7%). The three most commonly used practices was playing or listening to music, exercise such as walking and praying alone.



It is inevitable that nurses will encounter patients with spiritual concerns or issues. A nurse will therefore have to have some understanding of spirituality to deal with such issues (Hussey, 2009). A holistic approach is an instrument of healing, a facilitator in the healing process and one who honors each individual's subjective experience about health, health beliefs, illness and death (American Holistic Nurses Association 2009 cited in Sessanna et al., 2010: 252).

Barber (2008) conducted a spirituality awareness workshop with senior nursing students (n=11). The workshop included an oral history project and interviews with patients which aimed to explore nursing students' perceived meaning of spirituality.

It was found that through the workshop, nursing students became aware of their own spirituality and that it increased their comfort and understanding of the importance of providing spiritual care. The experience promoted personal awareness, professional awareness and spiritual awareness. All patients described the experience as meaningful, by offering a means to leaving their legacy and promote spiritual awareness. It is when patients are confronted with illness that their spiritual awareness comes to the fore. Seymour (2009) expressed that when others are suffering, it is our own personal spirit that helps us respond with care and compassion and it is important that we nurture patients in spirit as well. Caring for others requires knowledge about spiritual care and spiritual interventions in nursing practice.

2.2.12 *Spirituality and Spiritual Care in Nursing Practice*

Nurses should provide spiritual care simply by their caring presence and empathic approach, irrespective of their own personal spiritual beliefs and faiths. Setting standards



for spiritual care practice will help nurses not only to recognize the spiritual needs of their patients, but also to develop the necessary skills, knowledge and attitudes to deliver spiritual care whenever and wherever it is needed (Glasper, 2011). Since nurses are in a position to work closely with human beings they have access to their most intimate elements of human experience. Many nurses, however have difficulty addressing spirituality with their clients. (Taylor, 2007).

The literature reviewed has found that research on spirituality in a nursing context has proliferated abroad with strong attention being paid to holistic patient care (McSherry & Jamieson, 2010; O'Brien 2011; Taylor, 2007). In contrast, there is a dearth of empirical work on spirituality in nursing in South Africa. After an extensive literature search, the researcher was able to locate only one South African study which described the phenomenon of spirituality from the perspective of nurses and patients.

Mahlungulu & Uys (2004) utilized a qualitative approach with nurses (n=40), patients (n=4) and family relatives (n=4) to derive a definition of spirituality. They concluded that spirituality was a unique individual quest for establishing and/or maintaining a dynamic relationship with self, others and with God; having faith, trust and hope, inner peace and a meaningful life. Studies abroad provided a richer understanding of spirituality in nursing.

Ross (2006) undertook a systematic review of 45 articles on spirituality (1983-2005) in nursing practice.

They included 14 articles on nurses' perception of spirituality and spiritual care in nursing, 23 articles on patients' views of spiritual care in nursing, five articles that



compared nurses and patients' perception of the meaning of spirituality and spirituality in nursing, and three articles on spirituality in nursing education. The review identified three areas in which nurses can address the spiritual needs of patients viz. (1) assessing end-of-life spiritual needs, (2) spiritual environments such as quiet/private spaces, multi-faith rooms and chapels, (3) competency frameworks to help staff recognize and support spiritual needs and (4) qualities, skills and caring attributes of nurses such as the use of silence and touch. The results included learning techniques of active and compassionate listening and companionship; where the nurse moves beyond notions of expert carrier to a role which includes accompanying the dying person throughout their spiritual journey. Non-denominational spiritual practices such as prayer, contemplation and meditation were techniques identified that may help nurse augment their patients' peace and well-being.

Glasper (2011) also published a systematic review of literature on spiritual care which aimed to collate knowledge on spiritual care. The analysis revealed the following themes: (1) identification of the spiritual need of patients as part the of the patient's assessment, (2) a humanistic approach where psychosocial needs help nurses explore facets of spirituality.

These Include an exploration of a person's attitudes, beliefs, ideas, values and concerns about their own life and death issues including hopes and fears, (3) spiritual distress arising from loneliness of dying and (4) contemporary practice suggesting that spiritual needs must be assessed more regularly.





In order to meet spiritual needs nurses must be competent. Baldacchino (2006) used a two stage exploratory study to investigate nurses' competencies in the delivery of spiritual care. A survey using open-ended questions was used to ascertain the views of registered Maltese nurses (n=215). This was followed by in-depth interviews with 14 nurses from the same sample. The questionnaire incorporated nursing education, religious affiliation and spiritual care. The following four main themes emerged: the role of the nurse as a professional, the delivery of spiritual care, communication with patients, inter-disciplinary team and clinical/educational organizations and safeguarding ethical issues in care. These findings confirmed the pivotal role nurses play with regard to providing spiritual care.

In a similar study, Lundberg & Kerdonfag (2010) used a qualitative design to explore Thai nurses (n=30) provision of spiritual care. In-depth interviews were conducted using the following three semi structured open ended questions: "how do you perceive the spiritual needs of your patients and their families?", "what kind of spiritual care do you provide to your patients and their families?" and "how do you think spiritual care could be improved at hospitals?" Five themes emerged, namely: "giving mental support, facilitating religious rituals and cultural beliefs, communicating with patients and patients' families, assessing the spiritual needs of patients, showing respect and facilitating family participation in care". Lundberg and Kerdonfag (2010) concluded that spirituality was important when meeting the needs of their patients and patients' families, which supports the need for providing competent spiritual care.

Nurses, however, may be hesitant to provide spiritual care for the following reasons: failure to be in touch with their own spirituality, confusion about the nurse's role in

providing spiritual care, lack of knowledge, hesitancy to invade a patient's private "space", fear of imposing their own philosophy or religious preference on patients who may be vulnerable or in crisis and lack of time (Callister et al., 2004: 160). In response Monareng (2012) suggested that nurses develop a caring presence by encompassing the concepts of being available, listening, touching and providing spiritual support.

2.2.13 *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, careers 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 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 (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 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.

2.2.14 *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, 1998). 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).

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.

2.2.15 *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 (Bart, 2005) which provides a person-centered 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 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 are 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.



2.2.16 *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 author's 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, 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 et 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.

2.3 Theories

2.3.1 *Theoretical perspectives on religion, spirituality, mental health and social behavior*

This section outlines the theoretical underpinnings of the current study. Discussion focuses firstly, on the religion-spirituality nexus and highlights the need to differentiate “religious” from “non-religious” varieties of spirituality.



Subsequently, Woodhead's (1993) description of, and explanation for, the development of the New Spirituality is given lengthy attention. Woodhead's (1993) work identifies the New Age movement as having a primary role in the shift away from religion-based spirituality to a non-religious variety of spirituality.

Heelas's (1993) description of the New Age movement is also discussed in detail as it complements Woodhead's theory of the New Spirituality and provides insight into the nature of the New Age movement, its ideology, and associated activities. Sociological theories proposed by Emile Durkheim (Luckmann, 2003; Simmel, 1997), and current debates about secularization theory have been outlined. In combination, the works of these respective authors provide a means of understanding the reasons behind the rise in popularity of the New Spirituality, the worldview it promotes, and why the mental health and social behavior of those who endorse a nontraditional approach to the divine might differ from those who maintain a traditional belief in God.

Since the psychology of religion has given extensive attention to the religion-mental health relationship, a brief overview of psychological and psychiatric theories is also provided. These theories share some common ground with sociological theories in that socio-cultural contexts are considered to be one important dimension of religiosity. Since sociological and psychological perspectives on religion and spirituality are now intertwined with one another (Hill et al., 2000) and current debates about how religion and spirituality should be conceptualized and defined are predominantly taking place within the psychology of religion, psychological perspectives warrant due attention in this thesis. The following discussion identifies the conceptual overlap between religion



and spirituality, providing context to current debates about religion and spirituality and how the New Spirituality fits into these debates.

2.3.2 *The religion-spirituality nexus*

The main issue that frustrates attempts to find operational definitions for religion and spirituality, which clearly separate one from the other, rests on the fact that there is considerable overlap between these terms.

Even though “spirituality” appears to be seen as meaning the same thing as “religiousness” by some, others appear to view these terms as meaning something distinctly different (George, 2000). Indeed, among those who have written extensively about spirituality and religion, definitions for spirituality appear little different from those proposed for religion. Van Ness (1996) for example, suggests that being spiritual “is an attribute of the way one experiences the world and lives one’s life”.

Simmel (1997) defines religiousness in a similar fashion: What makes a person religious is the particular way in which he [sic] reacts to life in all its aspects, how he [sic] perceives a certain kind of unity in all the theoretical and practical details of life.

Although Van Ness (1996) distinguishes secular and non-secular varieties of spirituality, by proposing that secular spirituality is neither validated nor invalidated by religious varieties of spirituality. Its status is related to them but separable, it remains unclear from Van Ness’s definition what it is that makes secular spirituality ‘separable’ from religious varieties of spirituality. Woodhead (1993) on the other hand, argues that spirituality is distinguishable from religion in that it is:



...both the belief/awareness that there is some reality more real, more valuable, more important and more extensive than that revealed by science and to the practices by which people get in touch with this reality. I understand it as a more personal and individualistic notion than 'religion' which I use to refer to a system of more institutionally embedded beliefs and practices.

The notion that religion is associated with institutionally embedded beliefs and practices, while spirituality is more to do with a belief in a spiritual realm that underlies tangible reality.

Appears to be the one point of consensus reached by numerous authors, leading to various definitions being proposed for religion and spirituality with this as the key differentiating factor. Yet this demarcation is only useful from a theoretical standpoint and does nothing to progress efforts aimed at distinguishing spirituality from religion for the purposes of creating separate operational definitions for each. The problem remains that those who attend church describe themselves as being “religious but not spiritual”, “religious and spiritual”, and “spiritual but not religious” (Roof, 1993; Zinnbauer, Pargament, & Scott, 1999). It is the latter group in particular, that creates a conceptual quandary for researchers.

Characteristics of those who describe themselves as being “spiritual but not religious” have been identified by Roof (1993). Roof’s (1993) study of a large sample of “baby boomers” indicates that those describing themselves this way are less likely to view religiousness in a positive light, to engage in traditional forms of worship like church attendance and prayer, and to hold orthodox or traditional religious beliefs, and to be



more likely to be independent from others, to engage in group experiences related to spiritual growth, to hold non-traditional New Age beliefs, to have mystical experiences, and to differentiate religiousness and spirituality as discrete, non-overlapping concepts, than those who describe themselves as “spiritual and religious”. Reliance on single measures of religiosity like church attendance to distinguish the “religious” from the “non-religious” must inevitably lead to the “spiritual but not religious” churchgoers being assigned to a “religious” category along with traditionally oriented churchgoers, thus failing to address the non-traditional nature of this particular group’s worldview. Woodhead (1993) proposes that an individual’s conception of the sacred is a key factor in differentiating spirituality that is traditionally religious in nature from that which is non-traditional, and argues that a non-traditional approach to the divine is the central feature of what she terms the “New Spirituality”.

2.3.3 *The New Spirituality*

Woodhead (1993) proposes that the term New Spirituality refers to religious ways of thinking, as well as beliefs and practices that are distinctly different from those normally associated with traditional religious thought. These appear to have been adopted by those who are disenchanted with, and/or antagonistic towards, institutionalized religion. Woodhead (1993) identifies four specific characteristics of the New Spirituality that demonstrate how it might be differentiated from the Christian tradition. Firstly, the New Spirituality rejects the foundational Christian belief that God was made manifest in Jesus Christ. Secondly, it rejects the central Christian belief in God’s omnipotence and power, and distrusts “talk of God as



‘King’, ‘Judge’, ‘Almighty’”. Thirdly, it rejects Christian beliefs like the Trinity, or conceptions of God as transcendent or personal, and instead sees the divine as impersonal and immanent.

Fourthly, the New Spirituality rejects the belief in human sinfulness and instead takes a more optimistic view of human nature, and also rejects the anthropocentric nature of Christian belief that is grounded in the incarnation, resurrection, and existence of a personal.

It is the conception of the divine as something impersonal and immanent and different to “God” that serves to identify those whose spiritual beliefs are aligned with the New Spirituality. According to Woodhead (1993), the rise of the New Spirituality can be traced to a number of movements and groups operating inside and outside of mainstream Christian churches.

Woodhead (1993) identifies the writings on spirituality by Matthew Fox, an American Dominican friar, as having had an enormous impact both inside and outside the Church. She argues that in essence, Fox (1983) sees spirituality as panentheistic in nature, which is, viewing the world in a way that sees the whole of the cosmos as being immanent in God, and God’s creative energy as being infused in all things.

This belief in the “connectedness” of life and the universe and all within it, is also promoted by the feminist spirituality movement as a central feature of spirituality (Woodhead, 1993). Woodhead (1993) suggests that the feminist spirituality movement and the movement towards a Foxian approach to spirituality, as well as parallel movements outside the church like theosophy¹⁰ and anthroposophy¹¹, have “more or





less coalesced in the last few decades to form the New Age movement”. Woodhead (1993) notes that both the New Spirituality and New Age philosophy are characterized by radical egalitarianism, where “connectedness” and “wholeness” are regarded as the ideal, where hierarchy and dualism are loathed, and “spiritual power” is seen as the only legitimate form of power and authority. Woodhead (1993) views this particular spiritual orientation as being representative of the more counter-capitalist and “alternative wing” of the New Age movement, consistent with the theoretical stance taken by Heelas (1993).

Heelas (1993) argues that the New Age movement involves two distinct trajectories among New Age followers – and it is the characteristics of those who follow these trajectories and the activities they engage in that serve to frustrate attempts to devise a profile of a ‘typical’ New Ager. Firstly, Heelas (1993) describes the counter-capitalistic trajectory (similar to Woodhead’s “alternative wing”) as encompassing those New Ager who endeavor to “liberate themselves from institutions of modernity, in particular those involving commitment to the materialistic life” (Heelas, 1993).

New Age directly by running spiritual therapies, trainings, workshops, and those who devote themselves to applying New Age principles and practices to change mainstream institutions. Heelas (1993) sees this trajectory as representing a reaction to the mainstream and a “hankering for some premodern (perhaps, better, non-modern) sense of the natural”.

By contrast, the *pro-capitalistic* trajectory is conceived by Heelas (1993) to include those for whom the “unlocking of potential”, “controlling one’s own destiny”, and the

“gaining of higher consciousness and attainment of goals” are central concerns. While this wing of the New Age is also seen to be “self-religionist” in orientation, the nature of “self” is not envisaged in a counter-cultural fashion. This particular group of New Agers involves those who have become active in the world of big business; those who see material wealth and prosperity as being perfectly compatible with spiritual progress. Aldred (2002) identifies the Human Potential movement as sharing these same features, raising doubts that the Human Potential movement differs in any meaningful way from Heelas’ *pro-capitalist wing* of the NeAge movement.

Heelas (1993) describes this trajectory as “having the best of both worlds”, since it combines a spiritual dimension with instrumentality, and as “very much bound up with the utilitarian dynamics of capitalistic modernity”. It is the two disparate expressions of the New Age movement (pro- and counter-capitalist) that make generalizations about adherents of New Age beliefs and practices so problematic.

Heelas (1993) provides a comprehensive list of the New Age lingua franca, as formulated by William Bloom of the New Age St James’s team:

All life – all existence- is the manifestation of Spirit, of the Unknowable, of that supreme consciousness known by many different names in many different cultures

The purpose and dynamic of all existences is to bring Love, Wisdom, Enlightenment... into full manifestation. All religions are the expression of the same inner reality. All life, as we perceive it with the five human senses or with scientific instruments, is only the outer veil of an invisible, inner and causal reality. Similarly, human beings are two-fold creatures – with:



- (i) an outer temporary personality and
- (ii) a multi-dimensional inner being (soul or higher self).

The outer personality is limited and tends towards materialism. The inner being is infinite and tends towards love. Our spiritual teachers are those souls who are liberated from the need to incarnate and who express unconditional love, wisdom and enlightenment. Some of these great beings are well known and have inspired the world religions. Some are unknown and work invisibly.

All life, in all its different forms and states, is interconnected energy – and this includes our deeds, feelings and thoughts.

We, therefore, work with Spirit and these energies are co-creating our reality. Although held in the dynamic of cosmic love, we are jointly responsible for the state of ourselves, of our environment and of all life.

During this period of time, the evolution of the planet and of humanity has reached a point when we are undergoing a fundamental spiritual change in our individual and mass consciousness. That is why we talk of a New Age... This form of New Age rhetoric is common to that contained in the many publications that promote the notion of self-help, self-healing, self-empowerment, and self-actualization that take up shelf space in bookstores around the world. Indeed, Rascke (1996) identifies New Age ideology as being clearly identifiable within Bill Clinton's and Albert George Gore Junior's 1993 election campaign. He argues that most of the American electorate appeared to be hypnotized at that time by Gore's call for the total transformation of American culture and the planet, as outlined in Gore's book *Earth in the Balance: Ecology and the Human*



Spirit (Raschke, 1996). Nevertheless, it remains that the New Age movement is difficult to define.

Raschke (1996) notes that:

News analysts and armchair sociologists have struggled for more than a decade now to define the New Age phenomenon, which even in the context of its own rhetoric has eluded definition.

Considering Bloom's "New Age creed", it becomes evident that one striking feature of New Age philosophy is its inclusiveness. Different religions are viewed as "expressions of the same inner reality".

All life forms are embraced as "interconnected energy", and every human being is regarded as having an "inner being that is infinite and tends towards love". Yet there is an implicit form of hierarchy within New Age belief system. Specifically, there are the "enlightened ones", those who have no need to incarnate – those identified as "well known" among the great religions – and those who are "unknown and work invisibly". It is the belief in "enlightened ones" that gives numerous self-appointed New Age leaders the opportunity to attain guru status among proponents of the New Age. This is one of the many paradoxes of the New Age movement. Even though the notion that "the truth lies within" is held sacrosanct, all manner of products is being promoted as ways in which personal enlightenment can be achieved, with the sellers of these wares often being regarded as having superior knowledge of spiritual matters and the meaning of life.



Aldred (2002) describes the New Age movement as a “primarily consumerist movement” that “reinforces consumer capitalist values” and supports this appraisal by drawing attention to the work of Hunt and McMahon (1988). They estimated that by the 1980s, the movement already represented a “burgeoning worldwide supermarket”, a “conglomeration of business ventures for marketing spirituality” generating billions of dollars in sales in the United States, and which gave “every indication of growing faster in the foreseeable future than any other segment of the American economy” (Aldred, 2002).

The emphasis placed on self-empowerment in New Age publications and other materials acts as a double-edged sword.

With the individual being conceived as holding the power to change and achieve health, wealth and perfect happiness if they become aligned with universal forces and tap the power of the spiritual realm, the individual also shoulders the responsibility for their failure to meet these objectives. This makes New Age thought particularly attractive to those holding liberal ideals – blame for individual problems is laid on the individual rather than being attributed to anyone other than “self”. Gender, class, race, poverty, and culture do not feature as possible obstacles to personal wellbeing or success.

Raschke (1996) notes that the preponderance of New Age literature “deals with social, psychological, and political topics, generally with a slant that not too many years ago was referenced as “neoliberal””. It is this social, psychological and political content within New Age ideology that raises questions about the influence it has had, and is having on the population in terms of mental health and social behaviour.



From Woodhead's & Heelas's (1993) writings about the New Age movement, it becomes clear that the ideological underpinnings of the New Age framework of belief is that the "self" is the ultimate authority on the nature of the sacred and it is within this "self" that ultimate truth is recognized and experienced. Though the notion of "connectedness" is also emphasized, this connection is depersonalized in nature and conceived to exist at the non-corporeal level. Campbell (2001) draws particular attention to the individualistic nature of new age spirituality. He argues that the individual remains the basic unit within the New Age theodicy and that there is "little self-transcendence through identification with collectivities" (2001:79). Indeed, his assessment of the New Age worldview suggests that it is anti-establishment in nature through its position involving:

...a condemnation of contemporary, materialist, scientist and Christian-dominated Western civilizations inimical to true spiritual awareness, and hence as being the central obstacle to enlightenment and true spiritual progress (2001:78).

Despite his reference to the condemnation of materialism within a New Age worldview, Campbell (2001), in agreement with Heelas, acknowledges the pro-capitalist orientation of some New Agers. This apparent contradiction is one that pro-capitalist New Agers themselves appear to have little trouble justifying. There appears to be a tendency for New Agers to be able to separate their own pro-capitalist leanings from the pro-capitalistic nature of Western civilization by rationalizing that money is for them just one form of "spiritual energy" (Aldred, 2002). Some have argued that contemporary religiosity in general is consumeristic in nature and that this is a characteristic of post modernity. For example, Davie (2004) suggests that one key difference between religion



in post modernity and religion in modernity is that the former is based on consumption, while the latter is based on obligation. However, the promotion of others' interests over self-interest and social obligation is a cornerstone of Christianity and other mainstream religions. By contrast, New Age philosophy seems to give obligation little consideration, and instead emphasizes self-empowerment, self-actualization, and the "self" as the primary arbiter of truth and reality. Findings from qualitative research conducted by Possamai (2000) lend support to this view. From analysis of interviews with 39 informants described as proponents of New Age spirituality, Possamai (2000:369) notes that "nearly all my informants locate authority in the religious quest in the inner self" and that informants tended to have an aversion to "any dogmatic message from any authority beyond the self". Campbell (200) summarizes the New Age theodicy as endorsing "a remarkably individualist, a-social ethic".

It is noteworthy that Campbell's assessment of the New Age theodicy as being a-social and individualistic, parallels that made by Georg Simmel in regard to Buddhism. Simmel (1997) argued that Buddhism, unlike most Christian culture, lacks social norms because there is an absence of any "correlation between social and religious obligation".

This lack of a correlation between social and religious obligation is the rationale used by Simmel (1997) to conclude that Buddhism is "not a religion". It is interesting to note that Buddhist beliefs such as a belief in reincarnation and the belief that self-enlightenment removes the need for any future incarnation are both characteristic of the New Age lingua franca as identified by Heelas (1993). Meditation is also promoted strongly within New Age circles. Indeed, New Age beliefs and Buddhism have been grouped together as representative of a specific sub-category under "alternative



spiritualities” in the Australian study of spirituality by Kaldor et al. (2004). Yet the systems of belief promoted by Buddhism and the New Spirituality are not one and the same. Overall, the Buddhist-like beliefs adopted among Westerners are not linked to familial, ethnic or cultural background, or notions of asceticism, but represent one part of an eclectic mix of various beliefs and practices, borrowed at will from multiple and diverse religious traditions. Woodhead (1993) notes that “myths, rituals, gods and goddesses are apparently plucked at random from available sources” by those who are part of the post-Christian feminist spirituality movement. Yet, self-selection of specific beliefs and practices is not unique to feminist spirituality and is commonplace within the New Age movement more generally. In essence, the New Spirituality is akin to a mass conversion from Christianity to a “self-religionist” state.

Any belief and/or practice from any religious tradition can be legitimately adopted, “tried out”, and replaced for some other belief or practice at any time – since “all religions reflect the same inner reality” and individuals are seen as having ultimate authority over what they believe and do. Lyon (1993:117) describes the New Age approach as having:

...little to do with the conventional transcendent monotheism of Christianity and much to do with a marketplace – shopping mall or circus – of religious and quasi-religious elements focused on self and on choice.

Having identified characteristics of the New Spirituality, the eclectic approach to beliefs and practices that is associated with this form of spirituality, the individualistic,



consumeristic, and a-social ethic that permeates this non-religious approach to the sacred, the following section identifies the theoretical underpinnings of this thesis.

2.3.4 *Durkheimian theory*

Religion was a central focus for Emile Durkheim in the development of his theory of society. He perceived religion to be a means by which moral frameworks were created, social norms were reinforced, and group solidarity was promoted (Durkheim, 1968). The central thesis of Durkheim's (1968) work entitled *The Elementary Forms of the Religious Life*, in which Australian Aboriginal religions were used as an example of his theory of religion, was that religious beliefs and rites are developed by groups as a means to preserve social order and that religion is fundamental to the preservation of society itself. He referred to the "totemic principle" as being representative of the clan itself:

The god of the clan, the totemic principle, can therefore be nothing else than the clan itself, personified and represented to the imagination under the visible form of the animal or vegetable which serves as totem (Durkheim, 1968 [1915]:206).

For Durkheim (1968), the totemic principle was not just applicable to what he regarded as 'primitive' religions. Rather, he saw it as something that must always "penetrate and organize itself within us" to ensure the survival of individuals and of society.

We now see the real reason why the gods cannot do without their worshippers any more than these cannot do without their gods; it is because society, of which the gods are only a symbolic expression, cannot do without individuals any more than these can do without society (Durkheim, 1968 [1915]:347).



Thus, according to a Durkheimian perspective, religious beliefs are not just important for individuals, but are of paramount importance to the clan,

Group or society to which an individual belongs. Durkheim (1968) argued that religious beliefs and rites are those that are associated with membership to formal organizations, where norms, values, beliefs and practices are shared; giving rise to moral communities to which individuals belong. Durkheim (1968) held that religious beliefs and practices are “collective representations” that require “immense cooperation”, and that they form the basic components of religion. These collective representations were conceived by him as promoting a “collective conscience”. Durkheim (1968) distinguished the rites and beliefs that took place within these moral communities from those that exist without the support of a cohesive group or formal organization, and termed the latter magic. Durkheim (1968) regarded magic as lacking any “binding effect” between individuals, even if it involved as many adherents as those involved in a “real religion”, arguing that no lasting bonds were formed between both the “magician” and the individual, or between these individual adherents. Durkheim (1968) likened these individuals to the “sick clientele of a physician”, since they might not even know one another or have relations with one another at all. Thus, from a Durkheimian perspective, institutionalized forms of religion serve to strengthen society and the individuals living within it, while “magic” provides neither of these benefits. He justified this argument by highlighting that there is no church of magic.

Even though Durkheim’s theory of religion has been strongly criticized as involving a circular argument (the sacred is the social and the religious is the sacred, and so the religious is the social), and for being too reductionistic (Pals, 1996), his study of suicide



provided support for his view that religion and societal wellbeing are inextricably linked. His study involved analysis of national European data on cases of suicide and mental illness per 100,000 inhabitants from the latter part of the 1800s. Durkheim (1952) found that rates of mental illness and suicide differed according to religious faith.

Durkheim observed that Jews had the highest rates of mental illness, that Protestants had slightly higher rates of mental illness than Catholics, but that there was no direct and positive relationship between rates of mental illness and suicide. Durkheim (1952) showed that although Jews had the highest rates of mental illness, their rates of suicide were the lowest. He found this especially interesting given that Judaism was the one religious faith of those he examined that did not proscribe suicide (1952). Durkheim (1952) also found that Protestants had disproportionately higher rates of suicide than Catholics given their relative rates of mental illness and thus concluded that suicide must be more linked to group norms, experience and ideology than it is to individual mental states. These findings led him to devise a typology of suicide, including four separate suicide types that reflected differing levels of social integration and moral regulation. This seminal work remains foundational to contemporary theories that address the social origins of suicide, mental illness and antisocial behaviour, since Durkheim succeeded in showing that a highly individual and personal phenomenon is explicable through the social structure and its ramifying functions.

More recently however, Thomas Luckmann (2003) has dealt with this very issue. He tracks religion from archaic times to the present, and in doing so, provides a way of explaining declining levels of institutionalized religion and increasing levels of privatized religion.



The emphasis on religion as presented by Durkheim affirms the importance of religion and for that the spiritual life of the individual and this does not exclude the patient's life.

2.3.5 *Spirituality and religion: the theoretical 'crisis'*

With spirituality becoming a whole new focus for investigation within the psychology of religion, Pargament (1999) warned at the end of the 20th century that approaches to the study of both religion and spirituality lacked grounding in either theory or research and that this posed serious dangers for the psychology of religion. Since this time, the empirical literature which examines associations between religion, spirituality, and health has grown, and there is also evidence to suggest that psychiatric patients want clinicians to consider their religious and spiritual beliefs when devising treatment plans (D'Souza, 2002). The growing empirical literature on links between religion/spirituality and mental health, as well as patient demand, both appear to be instrumental in religion and spirituality gaining increasing recognition as a new frontier for research within the mental health domain. Blass (2001) for example, has proposed a conceptual framework to facilitate an interaction between the fields of psychiatry and religion in order to "further the care of individuals, as well as to promote research into and teaching of the psychiatry-religion interaction". However, it remains that research into religion/spirituality is largely evidence-driven, leaving the psychology of religion without solid, coherent theories upon which to base strategies that are aimed at meeting the objectives outlined by Blass. It would seem no exaggeration to suggest that the psychology of religion is undergoing a theoretical 'crisis'. The development of sound theoretical frameworks for religion and spirituality is frustrated by two major obstacles.



Firstly, the myriad ways in which spirituality is conceptualized serve to block consensus on how to define religion and spirituality for research purposes. Unruh, Versnel, & Kerr (2002) examined the ways in which spirituality had been defined within the health literature using electronic databases including Medline, CINAHL, PsychInfo and Sociofile, and found that more than 80 different definitions for spirituality had been used since 1980. The current lack of consensus on how religion and spirituality might best be defined serves to exacerbate the difficulties encountered in interpreting research evidence related to religion, through the need to interpret evidence with not just religion or religiousness in mind, but spirituality as well.

The lack of conceptual uniformity means that findings based on singular measures of religion/spirituality may be largely un-interpretable because there is no clear theoretical basis from which to assess the types of mechanisms that might be involved.

Secondly, religion is an emotive topic. Blass (2001) notes that “psychiatric theories about religion have often been founded [more] upon values and beliefs than upon scientific facts”. The threat to objectivity that personal beliefs and values pose to the scientific study of religion and spirituality has also been highlighted by Pargament (1999) and Zinnbauer (1999).

More recent research published by Saucier and Skrzypinska (2006) however, appears to have made substantial headway in progressing understanding of the distinctive aspects of religiousness and spirituality, as a means of addressing the conceptual overlap between these two terms. Saucier and Skrzypinska (2006:1259) defined religion as “a system of beliefs in a divine or superhuman power, and practices of worship and other rituals directed at such a power” and subjective spirituality (SS) as “a subjective



experience of the sacred” (Vaughan, 1991). Saucier & Skrzypinska (2006) differentiate SS from religion in this way because they conceive SS as being “closer in meaning to the natural-language term mysticism” and “a narrower and less inclusive and ambiguous notion than spirituality”, and argue that “the term mystical is more distinct in meaning from religious than is the term spiritual”. The sample comprised 160 males and 215 females (with a mean age of around 51 years) from the Eugene-Springfield community sample. A one to nine rating scale was used to assess the extent that participants identified with being Religious in 1993, and a one to seven rating scale was used to assess whether participants were Mystical or Spiritual in 2002. A battery of instruments was administered, including 24 items from the Expressions of Spirituality Inventory (ESI) (MacDonald, 2002), the 48-item Survey of Dictionary-Based Isms (SDI) which measures social attitudes (Saucier, 2000), supplementary attitude scales (42 items), and various other instruments. Saucier’s & Skrzypinska’s research indicates that tradition-oriented religiousness (TR) and subjective spirituality (SS) represent two independent dispositions, leading them to conclude that unitary concepts of religiousness/spirituality mask two divergent constructs. TR was observed to be highly associated with authoritarianism and traditionalism, and moderately correlated with collectivism (versus individualism), low levels of openness to experience, as well as reliance on tradition-hallowed sources of authority that provide shared practices like rituals, and rules for controlling social and sexual behaviour. By contrast, SS correlated strongly with fantasy proneness, dissociative experiences, superstitious and magical beliefs, as well as eccentricity, and high levels of openness to experience. These findings led Saucier and Skrzypinska (2006) to conclude that individual differences in R/S beliefs cannot be



captured by a single dimension like religion/spirituality and that to date; psychology has paid too little attention to the two independent dispositions revealed by their research.

2.4 Conceptual Frame work

The relevant concepts identified to guide this study were “spirituality”, “spiritual care”, and “factors influencing spiritual care-giving in practice.” It is important that these concepts and their possible inter-relationships are identified (See Figure 2.1).

The conceptual framework outlines variables and relationships among variables to be investigated.

The concept, Spirituality, is proposed to include domains such as the nature and characteristics of spirituality; defining factors which influence and shape individuals’ spiritual perceptions; and the importance of spiritual well-being. Spiritual care includes the meaning of spiritual care; types of spiritual care activities;

Competencies associated with spiritual care; and nurses’ role in spiritual care. Factors influencing spiritual care-giving fall into two main categories: enablers and barriers whereby they were further categorized into system, individual (healthcare professional), patient, and family-related factors.

Central to this conceptual framework is to understand the relationships among concepts as shown in Figure 2.1. It appears that a logical and implied relationship between understanding spirituality, spiritual care, and its application in practice exists. Researchers such as McSherry (2007) and Narayanasamy (2004a; 2004b; 2006) explored individuals’ perceptions, understandings and meanings of spirituality and spiritual care to reach a consensus of these meanings in nursing. They maintained that



without a common understanding of what spirituality means, it would be difficult to define and understand the scope of spiritual care (Pesut, 2002; 2003; 2008a; 2009; McSherry, 2007).

Spirituality is acknowledged to be elusive and subjective because nursing leaders like McSherry believed that it is universal and innate. Thus, spirituality is ethno-culturally and individually dependent which many philosophers such as Paley and Clarke find difficulty to define as well as achieving a consensus.

Despite these difficulties, nursing and medical professionals such as Miner- Williams, Oldnall, Koenig, Pulchaski, & Anandarajah contended that spiritual well-being is important for one's health and is one of the basic human needs. It is, therefore, important that the different spirituality domains such as its meaning, nature, and characteristics are derived from participants so that a culturally contextualized meaning and understanding of the nature and characteristics of spirituality can be described and defined.

As iterated, conceptualizing spirituality helps to clarify the meaning and scope of spiritual care activities. Nursing authors and leaders have sought to define the parameters for spiritual care. Without these, nurses will continue to be confused about their roles and responsibilities in the provision of spiritual care, let alone defining and developing competencies in this area (McSherry & Ross, 2002; van Leeuwen & Cusveller, 2004; Gordon & Mitchell, 2004; McEwen, 2005; Lantz, 2007; Carr, 2008). Similarly, policy makers will find difficulty drafting policies and guidelines governing this practice if the meaning and characteristics of spirituality and spiritual care are not well defined (Chan, 2009; McSherry & Ross, 2002).



It can be concluded from the review of the literature that individuals' understanding and perspectives of spirituality serve to inform spiritual care, nursing's role and inevitably, the attributes and competencies associated with it. Similarly, one's perceptions and understanding of what spiritual care means can shape one's perspective about spirituality. Hence, the inter-relationship between spirituality, nursing role and personal attributes should be included when exploring the concept of spiritual care.

For the purpose of this research, a conceptual framework has been adopted and revised for the study. The framework is based on several assumptions. It is assumed that spirituality should not be precisely defined. Although common elements are recognized and can be measured, the meaning of spirituality is unique to the understanding of each individual. Similarly, spiritual care is influenced by contributory systems, individual, patient, and family factors that may enable or hinder integration of spiritual care in practice. The study need to explore the extent to which these factors enhance or inhibit spiritual care in context.

Identification of the various domains of spirituality and spiritual care can contribute to our knowledge and understanding of these important factors in the delivery of quality care.

Relevant concepts and their relationships as illustrated in the conceptual framework are presented in Figure 2.1.



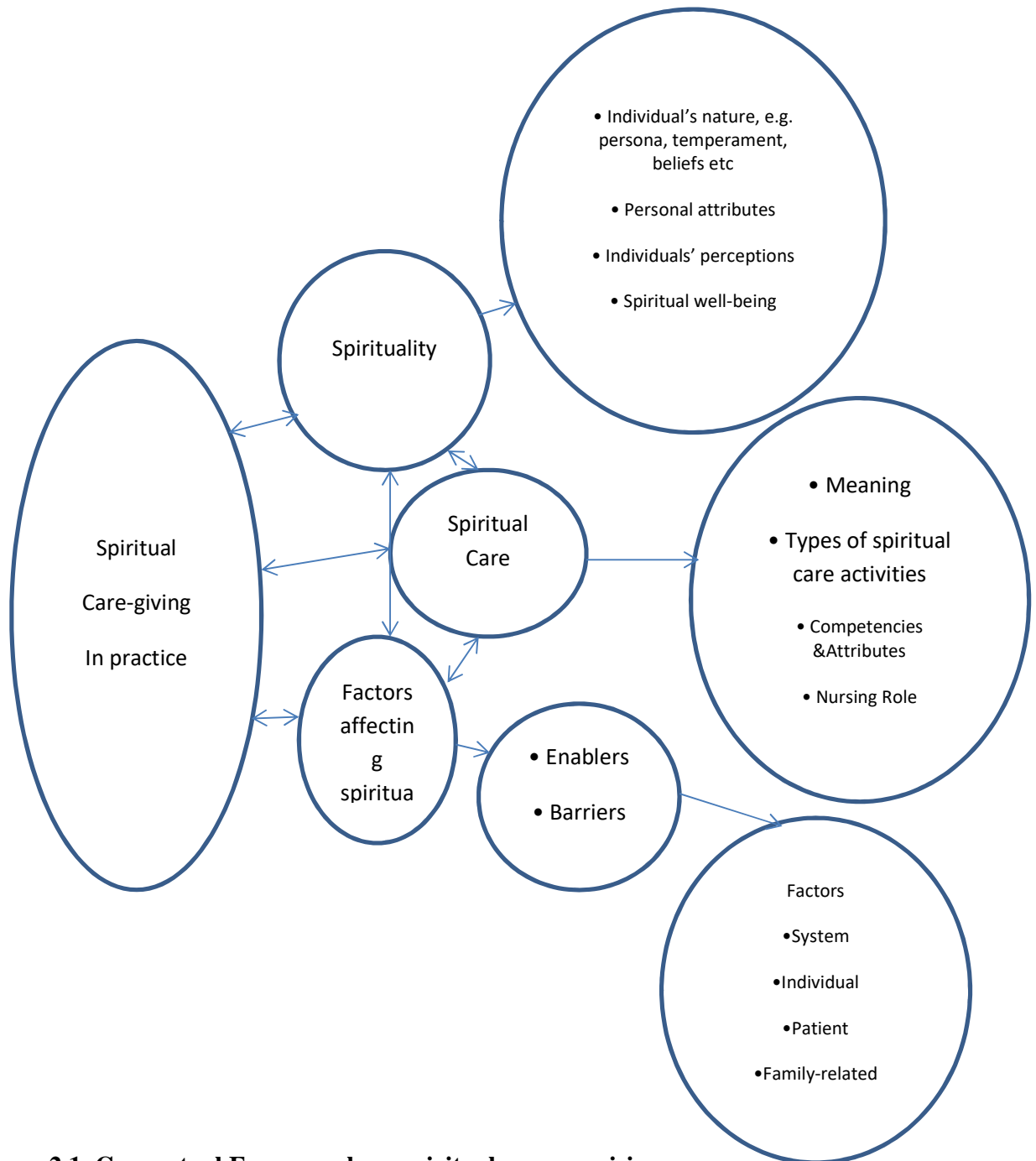


Figure 2.1 Conceptual Framework on spiritual care provision

Source: McSherry, (2007)



CHAPTER THREE

METHODOLOGY

3.1 Introduction

The issues considered under this chapter involve the study area, research design, study population as well as the sampling procedure used in the study. The chapter also discussed the research instruments, pre-testing, and data collection procedure, data analysis and ethical considerations of the study as well.

3.2 Study Setting

Tamale Central Hospital (popularly known as old hospital) formally served as the Regional Hospital of Northern Region also a referral point for the upper Region until 1974 when it was closed down following the commissioning of the current Tamale Teaching Hospital. The structure then metamorphosed into offices for disease control activities, Guinea Worm eradication programs, places of worship and schools.

However, the former Regional Director of Health Services with the aim of improving accessibility to health care services within the Tamale Metropolis took a bold decision to renovate the Tamale Old hospital to be upgraded to a Regional hospital. Health care delivery services were commenced in January 2005 with the provision of Reproductive and Child health Services as well as Outpatient Services. Tamale Central Hospital became an autonomous institution when the Management of the hospital was handed over to a Management Team in April 2007.

Category of services in the hospital include reproductive and child health services, laboratory services, pharmaceutical services, in-patient services, out-patient service,



ART Clinic, ANC Clinic, NHIS claims office, Eye Clinic, theatre, ENT and ultrasound (Tamale Central Hospital, 2016).

The Tamale Central Hospital is bounded to the north by Queen Elizabeth School complex, to the south by the Northern Regional Health directorate, to the East by Ghana Water Company Regional office and to the West by the Police barracks.

The hospital is one of the public hospitals in the Tamale metropolis providing health care service to everybody. It is an accredited facility of the NHIS and most private Health Insurance companies.

3.3 Study design

The research method adopted for this study was the Mixed Approach. This generates objective, qualitative and quantitative data for high valid and reliable results. It involves the use of closed and open-ended questions as well as allow statistical and text analysis of multiple data drawn from all possibilities (Creswell, 2009). Based on the nature of this study of which our target population is adult patients in Tamale Central Hospital it was necessary employing a quantitative component to study a sample of the population. This allowed for a numeric description of opinions of the population to be made from the sample results.

However, the nature of the study also requires an emergent design in which data is gathered at ward level where patients' hourly experiences and interaction with healthcare providers necessitates the integration of a qualitative approach. This approach allowed for the collection of data from all sources possible such as face-to-face



interviews, observation, and review of facility annual reports or other documents of Tamale Central Hospital.

This mixed method called concurrent triangulation in general used quantitative sampling approach, qualitative data collection and quantitative plus qualitative data analysis.

3.4 Study population

The target population of this study was hospitalized adult patients (18years+) of Tamale Central Hospital.

3.5 Inclusion criteria

Primarily only adult patients on admission in to the adult wards of the Tamale Central Hospital between February, 2016 and February, 2017, were included in this study. This also included the unit head of the hospital, hospital management, and prescribers as key informants.

3.6 Sampling size determination

For the Quantitative data, Taro Yamane (1967) formula was used to calculate the sample size as follows,

$$n = \frac{N}{[1 + N(e)^2]}$$

Where n is the sample size, N is the population size, and e is the level of precision.

When this formula is applied using a 95% confidence level, with 0.05 margin of error and a population size of 494

$$\text{Sample size} = N / ([1+N (0.05)^2]$$



$$\text{Sample size} = 494 / (1 + 494 (0.05)^2) = \underline{\underline{221}}$$

Sample size = 221

A sample size of 15 was used for the qualitative data

3.6.1 Sampling Technique

Purposive sampling was used to select respondents from hospital management and prescribers as well as unit head that have had a considerable experience and knowledge required for the interview. Using this technique, the researcher selects a sample based on her or his knowledge of the population and type of sample that best suits her or his research goals (Loreen, 2007). The hospital management of the Tamale Central Hospital constituted the medical superintendent, the administrator, the unit heads and the senior executive officer.

All patients that came on admission to the adult wards of the hospital and had spent seventy two hours or more within the period of the study (2nd February 2016 to 16th February 2016) were interviewed. The interview went on until the sample size target was met.

3.7 Data collection techniques

3.7.1 Key Informants Interviews

This technique among others was used to collect the qualitative data. In this regard, key persons such as hospital management, nurses and prescribers were interviewed. During this process, the interviewer read out questions, explained questions clearly after which



these key persons were given the opportunity to freely express themselves as much as possible.

3.8 Data Collection Tools

The data collection tools include questionnaire and interview guide. There are two methods to have a valid and reliable tool for the research with the first method being to develop a new instrument and test it for validity and reliability whereas the other method is to adopt an existing instrument either wholly as it is or with some modification, (Neuman, 2006).

This study employed the later. The tool used was previously developed by Musa (2007) and used by Mysoon (2012) in his study.

This tool was used to collect quantitative and qualitative data from adult patients on admission to the adult wards of the Tamale Central Hospital and staff of the hospital respectively. The Tool used to collect quantitative data from adult patients admitted to the adult wards of the Tamale Central Hospital had two (2) sections; a demographic sheet and the Spiritual Care Rating Scale (SCRS)-domain frequency.

Section one is the demographic data. In this section questions about patient's background information were asked with the related illness factors. This enabled the researcher group the response with those persons with similar or same background information during the analyses. The instrument, made provision for respondents to add any comments if need be. The items covered the demographic data such as age, sex, marital status and educational background



Some modifications were made in the demographic section of the tool to suit the purpose of the study. The Section two aspect of the Tool is the Spiritual Care Rating Scale (SCRC).

This part consists of a list of questions seeking to ask about the provision of spiritual care to the patient by the health care providers throughout the patient's admission period. Respondents were required to select a response that best described the provision of spiritual care to him/her by the health care providers for each question. A six point Likert Scale was used to enable respondent do the selection as below.

- A. not at all
- B. not often
- C. occasionally
- D. regularly
- E. at all times
- F. Do not know

The qualitative data was collected using interview guide to study the perception of ward in-charges (head nurses of the wards), nursing managers, prescribers (Physician Assistant-Pas and Nurse Practitioners –NPs) medical officers and medical superintendent about the provision of spiritual care to the patients on admission. Under this, emphasis on the provision of spiritual care centered on the provision of spiritual care, the one responsible for the provision of the care to clients, the barriers/challenges to the provision of spiritual and possible suggested solutions to curb the barriers.



The interview guide was pretested at the Tamale West Hospital among staff with similar characteristics. This pretest enabled the researcher to fine-tune the interview guide to achieve the set objective of the study.

3.9 Techniques of data analysis and presentation

Data analysis was both qualitative and quantitative. It was necessary in both descriptive and analytical studies to look for and to establish relationship between and among phenomena and events. Statistical methods are one of the means to this end.

Qualitative data generated from interviews were analyzed using cross-case analysis. In this approach, responses to a common question from all interviewees in each category are analysed together. Thus, each question was analysed separately for patients, hospital management of Tamale Central Hospital.

Patton (1990) posits that it is easy to do a cross-case analysis for each question in the interview when a standardized open-ended approach is used. In a cross-case analysis, participants' responses to a particular question/item are combined. Common themes across participants (cases) are then identified, analyzed and interpreted item by item.

3.10 Validity and Reliability

Validity, according to Seidu, (2015), generally considers whether the measurement actually measures what is supposed to measure. Thus the term validity implies how well the measuring instruments in the study are able to measure what is to be measured. Poor memory of a researcher can affect the validity of the study. To avoid this challenge as much as possible, the researcher made summary on key findings identified in his field notebook.



Reliability on the other hand describes the stability of your measurement technique Seidu (2015). Thus reliability addresses the important issues of how the same thing can be measured in the same way in repeated tests. Seidu (2015). For example, registers, stopwatches, and weighing scale are reliable tools for measuring school attendance, speed and newborn infants, respectively.

3.11 Ethical Consideration

The following measures to ensure that this study did not subject respondents to any kind of embarrassment or put them in any disadvantaged situation:

1. An introductory letter was obtained from the department , permission was sort from Regional Health Directorate, management of Tamale Central Hospital & respondents
2. The choice of topic for this study was governed by ethics of the target population and the general public.
3. The privacy and confidentiality of respondents were considered in the design, choice of questions and administration of the questionnaire.



CHAPTER FOUR

RESULTS

4.1 Introduction

The main objective of this study is to assess the role of health care providers in providing the emotional and spiritual needs to the patients in the adult wards of the Tamale Central Hospital. The study presents the findings of the study in six sections. Section one present respondents characteristics such as sex, age, and educational status, Section two, assess the extent to which emotional/spiritual care is provided to hospitalized patients in the adult wards of the Tamale Central Hospital, Section three establish the burden of providing emotional/spiritual care to hospitalized patients in the adult wards of the Tamale Central Hospital, Section four, establish the barriers in providing emotional/spiritual care to patients admitted to the adult wards in the Tamale Central hospitals and Section five establish possible solutions to the barriers in providing emotional/spiritual care to patients admitted to the adult wards of the Tamale Central Hospitals.

4.2 Socio-Demographic Characteristics of Respondents

This section presents demographic characteristics of respondents who participated in the research work, their age and other relevant socio-cultural data pertinent to the study were looked at. This information is very important for the interpretation of the results emanating from the analysis made in respect of the role of health care providers in providing the emotional and spiritual needs of the patients in the adult wards of the Tamale Central Hospital.



For the patients, females dominate (72.4%) as compare to male (27.6%). On staffs who manage the Tamale Central Hospital female made up of 66.7% while 33.3% of the staffs are males (See table 4.1).

From the study, data on age distribution of patients revealed that 14.9% of the patients were 20 years and below, 23.5% of the patients were between the ages of 21-30 years, 26.2% of the patients were between the ages of 31-40 years, 20.4% of the patients were age 41-50 years, 9.5% of the patients were between the ages 51-60 years and 5.4% of the patients were ages 61+ years. Also for age distribution of the management of the Tamale central hospital shows that 73.3% of the staffs were between the ages 21-30 years, 26.7% of the staffs were between the ages 31-40 years (See table 4.1).

The level of education of Staff who manages the patients plays a vital role in terms of health delivery and, understanding of content of spiritual care provision and promotion by the health professionals in the hospital. For the patients the study reveals that, patients with no formal education constitute 29.9% of the respondents, Primary constitute 23.5%, JHS constitute 21.3% of the respondents, SHS constitute 19.0% of the adolescent, and 6.3% is educated up to the tertiary level. With the staff of Tamale central hospital 6.7% of them is educated to SHS, and 93.3% of them are educated up to the tertiary level. On marital status of patients, data from the study reveal that 32.1% of the patients were single, 51.1% of the patients were married, 6.3% of the patients were Divorce, and 10.4 percent of the patients were widow (See table 4.1). The marital status of staff was not sort for in the questionnaire.



Table 4.1: Socio-Demographic Characteristics of Respondents

Categories of Respondent	Patients	Percent %	Staff of Tamale Central Hospital	Percent %
Sex Distribution of Respondents				
Male	61	27.6	5	33.3
Female	160	72.4	10	66.7
Total	221	100	15	100
Age of Respondents				
20 and below years	33	14.9	0	0.0
21-30 years	52	23.5	11	73.3
31-40 years	58	26.2	4	26.7
41-50 years	45	20.4	0	0.0
51-60 years	21	9.5	0	0.0
61+ years	12	5.4	0	0.0
Total	221	100	15	100
Level of Education of Respondents				
No formal education	66	29.9	0	0.0
Primary	52	23.5	0	0.0
JHS	47	21.3	0	0.0
SHS	42	19.0	1	6.7
Tertiary	14	6.3	14	93.3
Total	221	100	15	100
Marital Status				
Single	71	32.1	-	-
Married	113	51.1	-	-
Divorce	14	6.3	-	-
Widow	23	10.4	-	-
Total	221	100	-	-

Sources: Field Survey, 2017



4.3 Extent to which emotional/spiritual care is provided to patients.

This section assesses the extent to which emotional/spiritual care is provided to hospitalized patients in the adult wards of the Tamale Central Hospital by the health care providers. The results show a mean value of 4.04 meaning nurses regularly listen actively to patients talk about their religious/spiritual beliefs, strengths, and beliefs about God. This is often done at the time is presenting his/her complaints to the care giver. In the presenting complaints, the care provider would listen to the patient talk about their religious beliefs and about God

Data from the study further shows a mean value of 1.36, which means not at all, some nurses do not give patients the opportunity to talk about God and support coming from God. Patients listen actively to stories from their spiritual life was also found not to be done at all by the patients in the Tamale central hospital. Offer to read from the Qur'an/Bible on their own to share prayer and meditation in the hospital had mean values of 4.11, meaning patients regularly are allowed to read from the Qur'an/Bible on their own to share prayer and meditation in the hospital.

Data from the study also reveal a mean response value of 3.96 which is 4 meaning regularly nurses help patients to have suitable place to pray, to read from Qur'an/Bible, or to meditate in the hospital. Also facilitate utilization of religious/spiritual resources is available in the hospital that patients can use (e.g., common prayer room, the Holy book- Qur'an/Bible, or other religious materials) had a mean value of 1.33, meaning not at all, nurses do not facilitate utilization of religious/spiritual resources in the hospital that patients can use (e.g., common prayer room, the Holy book- Qur'an/Bible, or other religious materials). The study also reveals a mean value of 1.27 meaning not at all,



nurses do not help patients listen to religious programs on radio or TV if available. However, data from the study reveal a mean value of 3.03 meaning occasionally nurses give patients the opportunity to participate in religious or spiritual events arranged in the ward (e.g., praying with others or visit other patients in the hospital). The study further reveals a mean value of 3.01 for offer to discuss with nurses the difficulties of practicing prayer when sick.

Additionally, arranging visit by the hospital Imam/Pastor to comfort and support patients if requested by patients had a mean value of 3.71, which is meaning not all the time do care providers regularly arrange visit by the hospital Imam/Pastor to comfort and support patients if requested by patients in Tamale central hospital. The study further revealed a mean value of 2.94 meaning, regularly patients' privacy, dignity, religion, and religious and spiritual beliefs and rituals are respected by the hospital nurses.

Data from the study again revealed a mean response value of 3.06 meaning occasionally, nurses give patients family the opportunity to visit them and to share prayer, reading from Qur'an/Bible, and mediation with them, meaning patients family are not regularly given the opportunity to visit and share prayers with their patients in Tamale central hospital. Also nurses give patients close friends the opportunity to visit them and to share prayer, reading from Quran/Bible, and meditation with them had a mean value of 1.32, meaning not at all does nurses give patients close friends the opportunity to visit them and to share prayer, reading from Quran/Bible, and meditation with them in Tamale central hospital.



The study also revealed a mean value of 2.35 meaning not often nurses help patients to become aware of meaning and purpose of life in facing illness and suffering that have come with their condition. However, data from the reveal a mean value of 5.23 meaning at all times nurses spend time giving comfort, support, and reassurance when needed by patients in the Tamale central hospital. The study further reveals a mean value of 1.17 for creating a feeling of kindness, cheerfulness, and intimacy when giving care to you, meaning not at all nurses create a feeling of kindness, cheerfulness, and intimacy when giving care to patients in the Tamale central hospital.

Additionally, Nurses helping patients to feel hopeful and to keep a positive outlook had a mean value of 3.44, which mean occasionally; nurses do help patients to feel hopeful and to keep a positive outlook in Tamale central hospital. The study further revealed a mean value of 2.63 which equivalent to 3 meaning occasionally, nurses help patients to complete unfinished business or activities regarding their treatment (See table 4.2 below).



(Likert Scale -Not at all = 1, Not often = 2, occasionally = 3, regularly = 4, at all times = 5, Do not know = 6)

Table 4.2 Hospitalization and Provision of spiritual health care

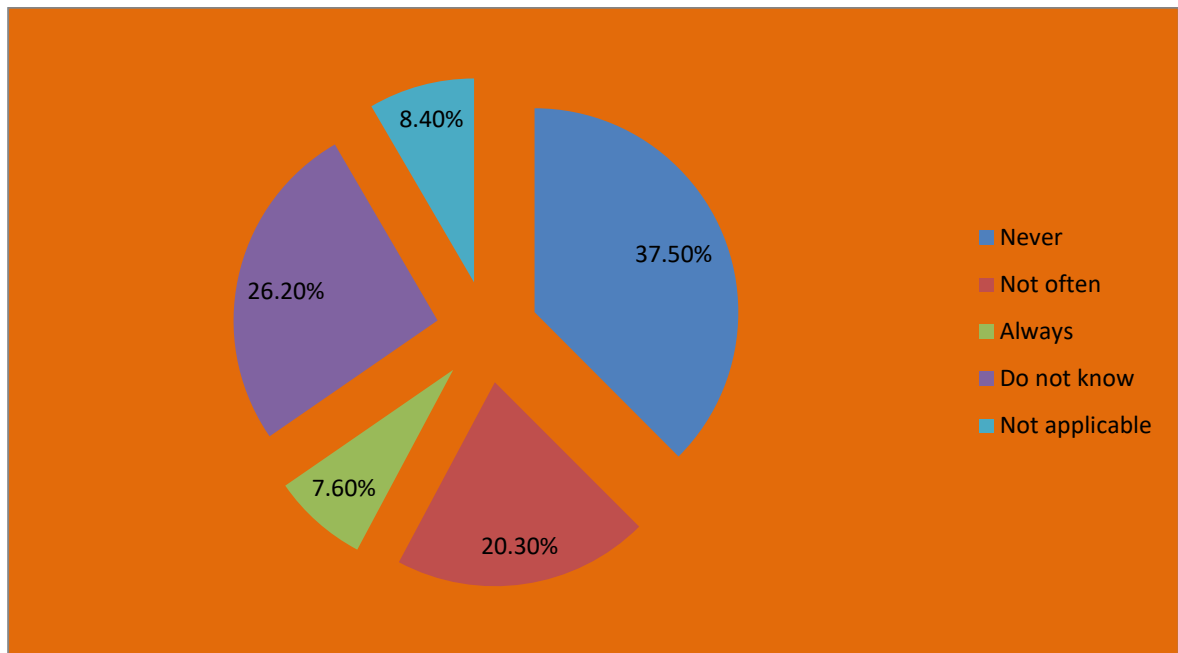
<i>Hospitalization and Provision of spiritual health care</i>	N	Mean	Std Dev.
Listen actively to you talk about your religious/spiritual beliefs, strengths, and your beliefs about God	221	1.36	1.345
Give you the opportunity to talk about God and support coming from God	221	1.08	1.015
Listen actively to stories from your spiritual life	221	1.16	1.196
Offer to read from the Qur'an/Bible on you or to share prayer and meditation with you	221	4.11	0.655
Help you to have suitable place to pray, to read from Qur'an/Bible, or to meditate	221	3.96	0.563
Facilitate utilization of religious/spiritual resources available in the hospital that you can use (e.g., common prayer room, the Holy book-Qur'an/Bible, or other religious materials)	221	1.33	1.24
Help you listen to religious programs on radio or TV if available	221	1.27	1.543
Give you the opportunity to participate in religious or spiritual events arranged on the ward (e.g., praying with others or visit other patients in the hospital)	221	3.03	0.586
Offer to discuss with you the difficulties of practicing prayer when sick	221	3.01	0.522
Arrange a visit by the hospital Imam/Pastor to comfort and support you if requested by you	221	3.71	0.602
Respect your privacy, dignity, religion, and religious and spiritual beliefs and rituals	221	2.94	1.177
Give your family the opportunity to visit you and to share prayer, reading from Qur'an, and mediation with you	221	3.06	0.783
Give your close friends the opportunity to visit you and to share prayer, reading from Quran/Bible, and meditation with you	221	1.32	1.570
Help you to become aware of meaning and purpose of life in facing illness and suffering that have come with your condition	221	2.35	1.106
Spend time giving comfort, support, and reassurance when needed	221	5.23	0.768
Create a feeling of kindness, cheerfulness, and intimacy when giving care to you	221	1.17	1.264
Help you to feel hopeful and to keep a positive outlook	221	3.44	0.858
Help you to complete unfinished business or activities	221	2.63	1.056

Sources: Field Survey, 2017



4.3.1 Listening to Music or Practicing another Art if Requested by Patients

The study furtherer reveals that 37.5% of the patients said they never had help in listening to music or practicing another art when asked for it, 26.2% of the patients do not know whether they received help in listening to music or practicing another art if requested by them, 20.3% of the respondents said not often do they had help in listening to music or practicing another art if requested by patients in the hospital, additionally, 8.4% of the patients indicated that it's not applicable for them to received help by listening to music or practicing another art if requested by you, and 7.6% of the patients agreed that they always received help in listening to music or practicing another art if requested by them (See figure 1 below).

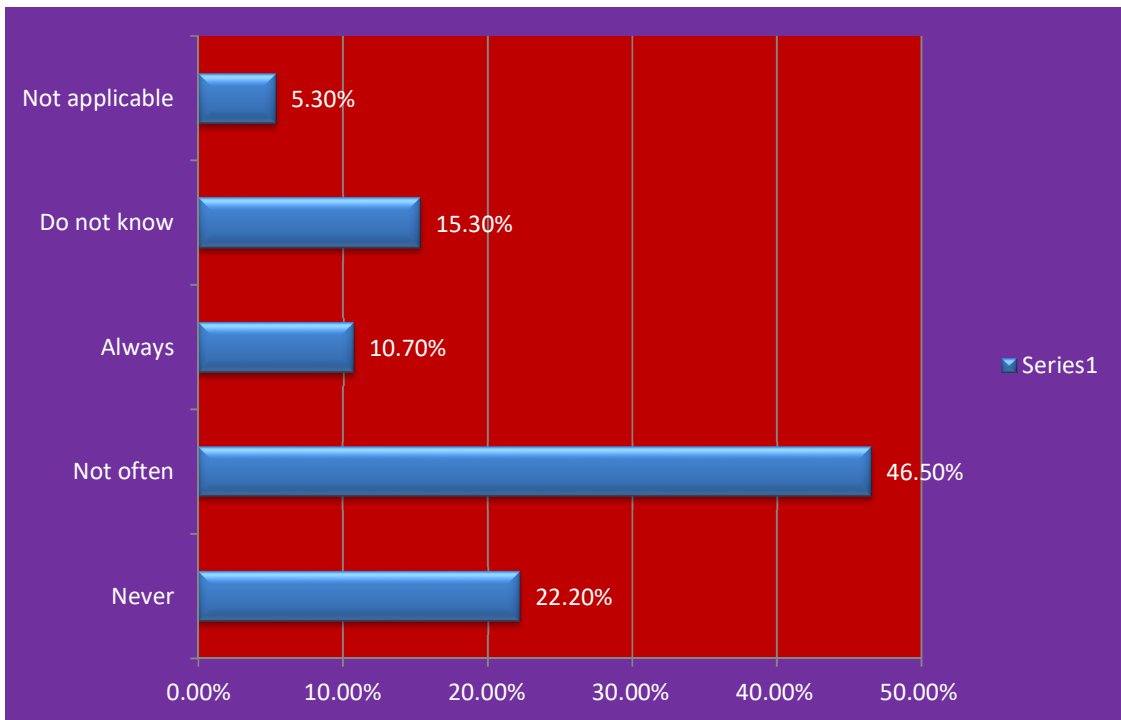


Sources: Field Survey, 2017

Figure 4.2: Listening to Music or Practicing another Art if Requested by Patients

4.3.2 Entertaining patients with the Appropriate Humor by Nurses

Further investigation indicates that 46.5% of the patients said nurses do not often make them laugh or introduce appropriate humor to them, 22.2% of patients said they are never made to laugh or introduce appropriate humor to them, 15.3% of the patients indicates that they do not know whether nurses make them to laugh or introduce appropriate humor for them, 10.7% of the patients said they are always make to laugh or introduce appropriate humor for them, and 5.3% of the patients indicated that it's not applicable that nurses make them laugh or introduce appropriate humor (See figure 4.2 below)



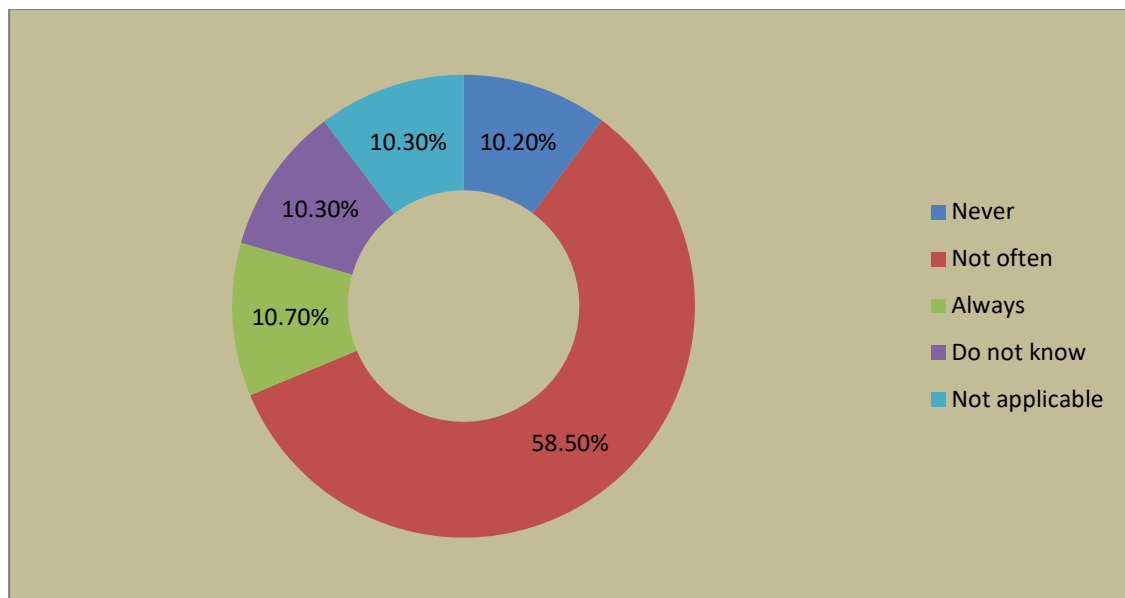
Sources: Field Survey, 2017

Figure 4.3: Make Patients Laugh or Introduce Appropriate Humor by Nurses



4.3.3 Giving support and reassurance

Also the study reveal that 58.5% of the patients indicated that not often that nurses held their hand or put his hand over patients shoulders to give them support and reassurance of recovery, 10.7% of the patients said that nurses held their hand or put their hand over patients shoulders to give them support and reassurance of recovery, 10.3% of the patients said they did not know whether nurses held their hand or put his hand over patients shoulders to give them support and reassurance of recovery, another 10.3% of the patients indicated that it's not applicable that nurses hold their hand or put his hand over patients shoulders to give them support and reassurance of recovery, and 10.2% of the patients said nurses never hold their hand or put his hand over patients shoulders to give them support and reassurance of recovery in Tamale central hospital (See figure 3 below).



Sources: Field Survey, 2017

Figure 4.4: Giving you support and reassurance

4.3.4 The most appropriate person to provide spiritual care during hospitalization

On the question of who will be the most appropriate to provide spiritual care to patients, the study reveal that 33.0% of the patients indicated that imams are the most appropriate persons to provided spiritual care during hospitalization period, 22.6% of the patients also indicated that nurses are the most appropriate person to provided spiritual health care during hospitalization period, 18.6% of the patients are of the view that none of the various professionals including imams and pastors are the most appropriate person to provided spiritual health care during hospitalization period, 14.5% of the respondents argue that family members are the most appropriate person to provided spiritual health care during their hospitalization period in Tamale central hospital, 4.1% of the patients said its Doctors who are the most appropriate person to provided spiritual health care during their hospitalization period, 3.6% of the patients indicated that its close friends who are the most appropriate person to provided spiritual health care during hospitalization period, and another 3.6% of patients said that pastors are the most appropriate person to provided spiritual health care during their hospitalization period (See table 4.3 below).



Table 4.3: The most appropriate person to provide spiritual care to Hospitalized patients

Person	Frequency	Percent
Doctors	9	4.1
Nurses	50	22.6
Family members	32	14.5
Close friends	8	3.6
Imam	73	33
None /other	41	18.6
Pastor	8	3.6
Total	221	100

Sources: Field Survey, 2017

Activities and issues engage in providing emotional/spiritual care to hospitalized patients. This section establishes the activities and issues engage in providing emotional/spiritual care to hospitalized patients in the adult wards of the Tamale Central Hospital. The results show a mean value of 1.07 meaning not at all that the duration of patient's current admission, do their health care providers ask them about their spiritual/religious beliefs.

Data from the study further shows a mean value of 1.33, which means not at all the duration of patient's current admission, do their health care providers ask them about their relationship with God. About your relationship with yourself, and significant others was also found to have a mean of 2.05 meaning not often that on the duration of patient's current admission, do their health care providers ask them about their relationship with themselves, and significant others.

The result showed patients religious practices that they will like to do had mean of 4.11 meaning regularly that on the duration of patient's current admission, do their health



care providers ask them about their religious practices that they will like to do in the hospital. How patients spiritual/religious practices (e.g., prayer, reading from Qur'an/Bible, and/or meditation) and beliefs help you to cope with the new situation after being diagnosed with cardiac disease had a mean values of 1.44, meaning not at all the duration of patients current admission, do their health care providers ask patients spiritual/religious practices (e.g., prayer, reading from Qur'an/Bible, and/or meditation) and beliefs help them to cope with the new situation after being diagnosed with cardiac disease in the hospital.

Data from the study also reveal a mean value of 2.37 meaning not often the duration of patient's current admission, do their health care providers ask patients about their religious books, articles, or symbols that they will like to have with them in the hospital.

Also on the question of about patient favorite places to practice their religious activities had a mean value of 3.72 meaning on the duration of patient's current admission, do their health care providers ask patients occasionally about their favorite places to practice their religious activities in the hospital.

The study also reveals a mean value of 1.07 meaning not at all that there are changes in patient's spiritual/ religious practices, and feelings about their condition on the duration of patient's current admission, do their health care providers. Data from the study reveal a mean value of 1.25 meaning not at all that nurses asked how they can help patients to maintain their spiritual/religious strength after being admitted with their condition the duration of patient's current admission. The study further reveals a mean value of 3.41 for the question what gives meaning and purpose to patient's life, meaning occasionally



patients are asked about what gives meaning and purpose to their life after being admitted with their condition in the hospital.

Additionally, on the question of about patient life story and their future had a mean value of 1.42, meaning not at all that patient's life story and their future are asked by nurses after being admitted with their condition in the hospital. The study further reveals a mean value of 3.06 which equivalent to 3 meaning occasionally, nurses asked patients about their sources of strengths and hope after they have been admitted with their condition in the hospital.

Data from the study reveal a mean value of 2.35 meaning not often patients are asked about their most important relatives and/or friends to them after they have being admitted with their condition in the hospital. Also What brings joy, pleasure, and peace to patient life had a mean value of 1.23, meaning not at all does nurses asked patients what brings joy, pleasure, and peace to their life after they have been admitted with their current condition in the hospital.

The study also reveals a mean value of 1.17 meaning not at all nurses asked patients about their forgiveness for others and how to show forgiveness for themselves after they have being admitted for their current condition in Tamale central hospital. However, data from the reveal a mean value of 3.44 meaning occasionally, nurses asked patients about the most loving things that they do for others or receive from them after they have being admitted in the hospital. The study further reveals a mean value of 2.63 for the appropriate time to ask and discuss with patients' spiritual/religious issues, meaning nurses occasionally, asked patients the appropriate time to ask and discuss with them spiritual/religious issues (See table 4.4 below).



(Liker scale - Not at all = 1, Not often = 2, occasionally = 3, regularly = 4, at all times = 5, Do not know = 6)

Table 4.4: The frequency of health care providers' questions on patients' spirituality.

How often did your care provider asked you	N	Mean	Std Dev.
About your spiritual/religious beliefs	221	1.07	0.717
About your relationship with God	221	1.33	0.655
About your relationship with yourself, and significant others	221	2.05	1.066
About your religious practices that you like to do	221	4.11	0.065
How your spiritual/religious practices (e.g., prayer, reading from Qur'an/Bible, and/or meditation) and beliefs help you to cope with the new situation after being diagnosed with cardiac disease	221	1.44	0.563
About religious books, articles, or symbols that you like to have	221	2.37	1.533
About your favorite places to practice your religious activities	221	3.72	0.572
About changes in your spiritual/ religious practices, and feelings about your condition	221	1.07	0.586
How they can help you to maintain your spiritual/religious strength after being admitted with this condition	221	1.25	0.522
What gives meaning and purpose to your life	221	3.41	0.602
About your life story and your future	221	1.42	1.177
About your sources of strengths and hope	221	3.06	0.783
About the most important relatives and/or friends to you	221	2.35	1.704
What brings joy, pleasure, and peace to your life	221	1.23	
About your forgiveness for others and how to show forgiveness for yourself	221	1.17	1.403
About the most loving things that you do for others or receive from them	221	3.44	0.786
The appropriate time to ask and discuss with you spiritual/religious issues	221	2.63	1.086

Sources: Field Survey, 2017



4.4 Barriers in providing emotional/spiritual care to patients

This section looked at the barriers in providing emotional/spiritual care to patients admitted to the adult wards in the Tamale Central hospitals. It started with the understanding of the term spiritual care by respondent with the question---When you hear of spiritual care, what comes to mind? What does—spiritual care mean to you?

Various definitions were giving by respondent as to their understanding to the term spiritual care in health provision as follows;

“Spiritual care is a care given based on the patients religious believe”

“Spiritual care means caring for the believes of the patient”

“Spiritual care means how I belief in superstition as a nurse”. There are some diseases that the patients will come with that cannot be treated medically unless through spiritual ways. For example “Jin” possession.

Jin is a spiritual illness that comes as a result of demons possession. They can make the individuals behave abnormally like a mad person, sometimes it will just be sickness and the person will attend hospitals till such a time that, the person will realize that problem cannot be solved medically.

“Spiritual care means meeting the patients’ needs in terms of what he beliefs in”

“Spiritual care means believing in the unseen and its effects on the society”

“Spiritual care means prayers or traditional care for patients”



“Spiritual care means taken care of the religious beliefs of patients by understanding his or her needs”

“Spiritual care is about allowing the client practice his religion and follow his beliefs- that is belief in God and the practice of one's religion”

“Spiritual care refers to the intervention given to a client aside the nursing care. Like praying for patients being it Muslim, Christian or traditional prayers”

“Spiritual care is about taking care of patients taking into consideration their beliefs, norms and values” (Field Survey, 2017)

Respondents further argue out the importance in the provision of spiritual care to patients as follows;

Spiritual care is very important because some of the patients come to the hospital and thinks that their conditions are due to God. For me I am a Muslim. We believe that a Muslims illness is a period of test for him. If he should take the illness as coming from Allah and not from any worldly creation, he is rewarded and the pain he goes through is used to wipe his/her sins.

This is stated in the Holy Quran but I cannot remember the chapter outright. You may come back later for it. So in this case if you don't understand the patient's spirituality, you may not be able to help that patient well. (A staff nurse in the male ward of the Hospital)

Spiritual care helps in meeting patient's beliefs and superstition



Spiritual care helps in their healing because most of them believe that whatever that suffering they go through is from God

Spiritual care facilitates patient speedy recovery.

Spiritual care helps in their fast recovery especially when they feel that the sickness is spiritually inclined

Spiritual care strengthens patients' belief and hope of recovery

Spiritual care is very important because some of the conditions are more of spiritual than medical example, spiritual poisoning, jinn, possession

Spiritual care is very important because, some patient's conditions need spiritual intervention than just nursing intervention, example when a client is possessed and is being brought to the health sector. There are several times that patients are brought to us here and later the relatives will ask for discharge against medical advice just because they think the patient is possessed. They normally take such patients to spiritual healers of their choice.

Yes, I understand there is one at FUO, another healer at Mba Naayili, another at Gumani and Sinsina. I can direct you to the Gumani and the Fuo. There are the only places I know. I have taken patients there personally. We were treating her for psychosis. Yes she got better. I wish I knew what they normally do for the patients; I would have added that to the care of my patients. (Field Survey, 2017).

Respondent's views as to the barriers in providing emotional/spiritual care to patients admitted to the adult wards in the Tamale Central hospitals as follows;



Because of different beliefs of the staffs and the patients. *Sometimes a patient will come and is a Muslim but the nurse is a Christian, the nurse may not know if the patient will even accept whatever the nurse will want to do for him/her. On the other hand since there is religious difference it is even the question of whether the nurse can even help the patients achieve her spiritual needs. (A respondent said)*

Most of patients do not believe in superstition and lack of communication skills in giving this care. For some patients they don't believe in spirituality. The lack of communication skills has to do with some of us health care workers. Some of us think one must belong to a religion but it is not by force. Some if they find someone who does doesn't believe in superstition, the way they may talk to the person may not be good. Or even sometimes it is not about believing in superstition but some generally do not know how to talk.

Lack of pastors and imams in the hospitals. *Before I came to nursing, there used to be a man –Pastor, who used to go round at Tamale Teaching Hospital to pray or the patient. In our training we are told about the hospital chaplain, but since I started practice I am yet to see one. I have been practicing for about six (6) years now ((Field survey, 2017).*

Multiple beliefs of the patients sometimes too you find a client that is either a Muslim or Christian but still have faith in another religious practices

Lack of chaplains within the hospital

Difference in beliefs and how to approach it with the context of health care provision in the hospital

Lack of regulations and time for spiritual care provision



Forgetfulness on the need to provide spiritual care to our patients

Lack of policy to mandate the provision of spiritual health care in the hospital

Work load and health care providers do not get enough time to give spiritual care to clients (Field Survey, 2017).

On the question of who is responsible for the provision of spiritual care to patients in the hospital, respondents argue out the following points as to in their view those responsible for the provision of spiritual care to patients in the hospital;

Chaplain in the hospital because they are well versed in the scriptures.

Hospital chaplain because they are the men of God

Imams, pastors and traditionalist, because they know the scriptures very well

Depending on the religious background of the patient, either a Mallams or pastor

The nurses, they are always with the patient

Nurses because it is part of their trying and they spend more time with the patient than any other category of the health staff

All health care providers can give spiritual care. Because one way or the other, we all belong to one religion or the other (Field Survey, 2017).



4.4 Respondents suggested solutions to the barriers in providing emotional/spiritual

care. This section looked at the views from respondents as to the solution to the barriers in providing emotional/spiritual care to patients admitted to the adult wards of the Tamale central hospital. Respondents in their view gave the following suggestion as to the solutions to the barriers in providing emotional/spiritual care to patients admitted to the adult wards of the Tamale Central Hospitals;

- ✚ Health education on spiritual health care provision in the hospital. A nurse manager suggested that health education should be intensified in the hospital on topics related to patients' spirituality and their spiritual beliefs. She added that she had worked with the Tamale Teaching Hospital (TTH) before joining the Tamale Central Hospital about eight (8) years ago. According to, *her when we were at the TTH, we used to have morning devotion with our patients, but it stopped for no apparent reason. But for this place I tried it but it didn't work.*
- ✚ Health workers should be educated more to provide spiritual needs of the patient in hospital. *Actually some of us (nurses) may not know what the patient might consider as his/her spiritual needs. So it will be very difficult to meet them.* This response is supported by an observation that was made by the researcher during one of the data collection days where a female client/patient was playing a gospel music from her phone whilst on admission and a nurse asked her to shut it off with the reason that she was disturbing the other patients.
- ✚ The policy makers should be encouraged to capture the spiritual needs of patients in the management protocols.



The books for the training of care givers –Nurses, Doctors alike have as part of their course outline spirituality and spiritual care but a policy document is yet to be made available for use at the various hospitals.

This makes care givers see rendering this specialized care as an option rather than a rule. More education should be done to help meet the spiritual needs of the patients. Policy makers should include it their policies.

- ✚ More health talk should be done when the patients are in the hospital and make them understand that they can somehow practice their beliefs. Some of the patients nurse the fear of expressing their desire to practice their faith. If made clear to them, they would ask for even if patients do not initiate it.
- ✚ Get Religious leaders to visit patient daily
- ✚ They should be a constant reminder to nurses on their responsibility to provide spiritual care
- ✚ Health care providers must see it as one of their responsibility for their patients and not just a study
- ✚ The hospital should employ an Imam and a Pastor to compliment the nurses role in taking care of the spiritual needs of the patient"
- ✚ It should be added to the daily assignment of nurses, so that some health care providers will be assigned to it daily, and it should be rotating daily.
- ✚ Routine in-service training for healthcare providers (Field Survey, 2017).



CHAPTER FIVE

DISCUSSION OF RESULTS

5.1 Introduction

Chapter five is a detailed discussion of study results as they relate to other items within the current study and findings from other relevant literature.

5.2 Discussion of Results

5.2.1 Demographic characteristics

Demographic characteristics of respondents who participated in the research work, their age and other relevant socio-cultural data pertinent to the study were looked at. The study revealed that Female is made up of 72.4% of the patients' care takers who took part in the study. This shows that female out number males in terms of people who were to assist their patients on admission, and also with the staffs who manage the Tamale Central Hospital female made up of 66.7% of the staff as compare to their male counterparts. This means that for the staff who manages and take care of the patients in the hospital female are more than males which thus means that more males should be employ by the hospital to make up for the short fall of men in the hospital. More than half of the patients that is 70.1% of patients or care takers who were on admission ages are between the ranges 21-50 years. This means that majority of the patients are within the very active working group who should have been in their various field of work. For the staff, almost all of them, that is 100% are between the ages 21-40 years, an indication that the staffs are still young and energetic who can still work for the next 20 years.



On education, the study reveals that, patients with no formal education constitute 29.9% of the respondent and with the staff of Tamale central hospital 93.3% of them are educated up to the tertiary level.

This means that almost all the staffs has tertiary certificate which is best for the operation of the hospital in terms of application of professionalism and work ethics. This finding means that the understanding in terms of spiritual care in the health profession will be easy since almost all the staff had their education to tertiary level. It will also enhance their productivity and ease of doing things in the hospital.

5.2.2 Provision of spiritual care

On the extent to which emotional/spiritual care is provided to hospitalized patients in the adult wards of the Tamale Central Hospital, the study revealed a mean value of 4.04 meaning nurses regularly listen actively to patients talk about their religious/spiritual beliefs, strengths, and beliefs about God when requested by patients. However care providers themselves do no initiate such activities. This implies that patients or care takers/family talk about their spiritual beliefs within the hospital if need be but nurses actual do not participate in adding them some advice or knowledge in the area of spiritual care. This finding is not in line with Wehmer et al. (2010) who reported that nurses also used other spiritual practices such as playing or listening to music (99.2%), helping others (95.2%), exercise such as walking (92.9%), family activities (88.9%), praying alone (87.3%), relaxation (81%), recall of positive memories (81.5%), praying with others (70.6%), visiting a house of worship or quiet place (70.6%), reading spiritual material (51.6%), meditation (31.7%) and yoga (31.7%). The three most commonly used practices was playing or listening to music, exercise such as walking and praying alone.



Data from the study further revealed that nurses do not initiate discussions with patients or care takers about God and support coming from God.

Clients however often do this with colleague patients or family members on visit. In terms of prayers, they do their own prayers on the ward in accordance with their faith. They chose to listen to the word of God from the visiting religious scholars. They also receive more reassurances from the pastors and Imams that comes on visit since the hospital has no chaplain. This means that clients are able to pray and talk about God in their own way but not from the nurses or health professionals teaching or advice. Thus, outside helps from imams and pastors are allowing since it's from God intervention. This finding is not in line with the basic assumption which indicate 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).

Patients listen actively to stories from their spiritual life was also found to be done by the patients themselves provided they were in the position to be engage in their spiritual activities in the Tamale central hospital. The result showed that nurses allow patients to engage in spiritual activities provided they are interested and are able to engage with their spiritual world. Muslim patients that ambulatory were directed to the Mosque when requested. Christian patients had no designed place of worship in the hospital so they often offered their devotional service in the ward. Both religious groups often are faced with some challenges in areas of place of worship on admission and the use of some



religious articles. The adult's wards had no such religious articles like Bible/Quran, rosary/Tasbeeh, etc. as showed by findings from the study which added that patients or care providers do not read the Qur'an/Bible on their own to share prayer and meditation in the hospital.

Meaning patients are not allowed to read the Qur'an/Bible on their own to share prayer and meditation in the hospital, which is an indication of disagreement by the respondents that patients read their Quran/Bible in the hospital to sick for God intervention. It also reveals that, though there is no specific unit designated for religious activity in any of the adult wards, nurses help patients to have suitable place to pray, to read from Qur'an/Bible, or to meditate in the hospital-mostly in bed and the hospital Mosque. This implies that nurses facilitate utilization of religious/spiritual resources in the hospital that patients can use (e.g. The Holy book- Qur'an/Bible or other religious materials. Also nurses do not at all give patients the opportunity to participate in religious or spiritual events arranged in the ward (e.g., praying with others or visit other patients in the hospital). This does not give opportunity to both patients and their spiritual leaders to be in contact with one another for spiritual engagement. This finding is not in line with 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. The study further reveals that patients or care takers do not offer to discuss with nurses the difficulties of practicing prayer when sick. This means that not at all, patients offer to discuss with nurses the difficulties of practicing prayer when sick in the Tamale central hospital. This finding is supported by the argument in empirical literature which examines associations between religion, spirituality, and health has grown, and there is



also evidence to suggest that psychiatric patients want clinicians to consider their religious and spiritual beliefs when devising treatment plans (D'Souza, 2002).

Additionally, the study reveals that arranging visit by the hospital Imam/Pastor to comfort and support patients if requested by patients do not exist at all in the hospital.

The hospital has neither Pastor nor Imam.

The hospital had no system in place that allows the bringing of external Imams or pastors to offer prayers for patients. However, during visiting hours, patients' friends and family and other religious men that often come to visit patients are not prevented from offering religious services such as prayers, reassurance and talking about support from God. Also there is regularly patient's privacy, dignity, religion, and religious and spiritual beliefs and rituals are respected by the hospital nurses.

5.2.3 Activities engaged in the provision of spiritual care to patients

On the activities and issues engage in providing emotional/spiritual care to hospitalized patients in the adult wards of the Tamale Central Hospital. The results show that there is relationship with patients and health care providers and significant others in providing spiritual care. The result showed that health care providers ask patients about their religious practices that they will like to do in the hospital but not often. This often starts at the records where the patients obtain his/ her folder. The patients' particulars includes: name, home address, telephone number, RELIGION, among other information (see appendix 2). This finding is in line with the caution that nurses should know their boundaries in the provision of spiritual care to clients. Knowing the person religious background will permit the care giver to be advised even when he/she wants to render



that care. First, don't prescribe religion to non-religious patients. Even though religious involvement may be good for health, non-believers should not be encouraged to become religious. Furthermore, the spiritual assessment should be conducted in such a way that patients who do not consider themselves spiritual do not feel devalued. Second, and related to the latter, don't force a spiritual assessment if the patient is not religious.

In that case, quickly switch to asking about what gives life meaning and purpose in the context of illness and how this can be supported. For these individuals, issues related to demoralization or death anxiety should be dealt with in a broad way using a holistic model grounded on humanistic beliefs and values.

Finally, in order for the physician and other team members to deliver whole-person spiritual care to patients, they need to be whole-persons themselves. The difficult task of caring for sick challenges the physical, emotional and spiritual resources of most providers. For that reason, one major task of the spiritual care team is to support each other's spiritual needs that arise during the course of providing healthcare. Part of the role of the spiritual care coordinator and the chaplain is to ensure that the spiritual needs of team members are met. There are numerous spiritual resources that may help in this regard, depending on the provider's faith tradition (Chambers 1963; Kugle, 2013). It means nurses are not compelling to asked patients about their religious practices which are one of the means to providing spiritual care. However, Glasper and Taylor hold different view. That is nurses should provide spiritual care simply by their caring presence and empathic approach, irrespective of their own personal spiritual beliefs and faiths. Setting standards for spiritual care practice will help nurses not only to recognize the spiritual needs of their patients, but also to develop the necessary skills, knowledge



and attitudes to deliver spiritual care whenever and wherever it is needed (Glasper, 2011). Since nurses are in a position to work closely with human beings they have access to their most intimate elements of human experience. Many nurses, however have difficulty addressing spirituality with their clients. (Taylor, 2007).

Data from the study also reveal health care providers seldom ask patients about their religious books, articles,

Or symbols that they will like to have with them in the hospital but not often and also health care providers ask patients occasionally about their favorite places to practice their religious activities in the hospital. It was observed however during one of the visiting hours where religious men from 'Jehovah Witness' came to distribute their books to patients as they came to pray with the patients. The study further reveals that occasionally patients are asked about what gives meaning and purpose to their life after being admitted with their condition in the hospital. It added that occasionally, nurses asked patients about their sources of strengths and hope after they have been admitted with their condition in the hospital. They also reveal that occasionally nurses asked patients about the most loving things that they do for others or receive from them after they have being admitted in the hospital. The study further reveals that nurses ask and discuss with patients' spiritual/religious issues, meaning nurses occasionally, asked patients the appropriate time to ask and discuss with them spiritual/religious issues.

Data from the study reveal a mean value of 2.35 meaning not often patients are asked about their most important relatives and/or friends to them after they have being admitted with their condition in the hospital.



5.2.4 Barriers to the provision of spiritual care to patients

On the issue of barriers in providing emotional/spiritual care to patients admitted to the adult wards in the Tamale Central hospitals. The study reveal the following as the barrier to providing emotional/spiritual care to patients admitted to the adult ward of the hospital; Because of different beliefs of the staffs and the patients, Most of patients do not belief in superstition, lack of communication skills in giving this care, Lack of pastors and imams in the hospitals, Multiple beliefs of the patients, Lack of chaplains within the hospital, Difference in believes and how to approach it with the context of health care provision in the hospital,

Lack of regulations and time for spiritual care provision, Forgetfulness on the need to provide spiritual care to our patients, Lack of policy to mandate the provision of spiritual health care in the hospital, Work load and health care providers do not get enough time to give spiritual care to clients. This finding is supported by the finding of the Harvard oncology group at the Dana Farber Institute (Michael et al, 2014). They asked oncologists and oncology nurses why they did not routinely assess and address the spiritual needs of patients and find the following as the barriers; Lack of Time, Discomfort, Making Patient Uncomfortable, Spirituality Not Important, Topic Too Personal, Patients Don't Want Spiritual Care from Doctors/Nurses, Power Inequality, and Religious Beliefs Differ.

5.2.5 Suggested solutions

The study revealed the following in their view as to the suggested solutions to the barriers in providing emotional/spiritual care to patients admitted to the adult wards of the Tamale Central Hospitals; training institution should reinforce the education on



spiritual health care provision in the hospital. Health care providers should be educated more to provide spiritual needs of the patient in hospital. Though spirituality and spiritual care is thought in school, more attention should be given to the practices of spiritual care provision.

The policy makers should be encouraged to capture the spiritual needs of patients in the management protocols. There is no known policy document yet on spiritual care in the hospital. Policy makers should include spiritual care in the Ghana Health Service policy document. Nurses should also undertake health talk on the ward to include patient's spirituality when the patients are in the hospital and make them understand that they can somehow practice their beliefs.

The chaplain system should be reinstated. But until then, the hospital can liaise with Religious leaders to visit patients daily to offer some prayers to them.

According to Mysoon 2012, the role of a clergyman or a chaplain in the health care team to provide spiritual care for patients who suffer from emotional and spiritual crisis is well recognized. Again, Vande Creek & Lyon (1997), Hunt et al. (2003), and Kliewer & Saultz (2006) in Mysoon 2012 said that chaplains are the specialist professionals who can provide in-depth spiritual care to their patients, which will result in improved satisfaction and emotional comfort. This is in line with the findings from the study

There should be a constant reminder to nurses on their responsibility to provide spiritual care. A refresher programs can be organized for care providers. Routine in-service training for healthcare provider. This is in line with the findings from (finish the sentence)



CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter presents a summary of the findings of the study. The conclusions that have been drawn based on the findings and the recommendations are presented in this chapter.

6.2 Summary of Findings

6.2.1 Extent to which emotional/spiritual care is provided to hospitalized patients in the adult wards of the Tamale Central Hospital

On the extent to which emotional/spiritual care is provided to hospitalized patients in the adult wards of the Tamale Central Hospital, the study reveals a mean value of 4.04 meaning nurses regularly listen actively to patients talk about their religious/spiritual beliefs, strengths, and beliefs about God. Data from the study further reveal that nurses regularly give patients or care takers the opportunity to talk about God and support coming from God. Patients listen actively to stories from their spiritual life was also found to be done by the patients provided they were in the position to be engage in their spiritual activities in the Tamale central hospital. The result showed that nurses allow patients to engage in spiritual activities provided they are interested and are able to engage with their spiritual world. The study also found that patients or care providers read the Qur'an/Bible on their own to share prayer and meditation in the hospital. It also reveals that nurses help patients to have suitable place to pray, to read from Qur'an/Bible, or to meditate in the hospital. However occasionally nurses give patients



the opportunity to participate in religious or spiritual events arranged in the ward (e.g., praying with others or visit other patients in the hospital).

The study further reveals that patients or care takers offer to discuss with nurses the difficulties of practicing prayer when sick. Additionally, the study reveals that arranging visit by the hospital Imam/Pastor to comfort and support patients if requested by patients is regularly arranged by the hospital. Also there is regularly patient's privacy, dignity, religion, and religious and spiritual beliefs and rituals are respected by the hospital nurses.

6.2.2 Activities and issues engage in providing emotional/spiritual care to hospitalized patients in the adult wards of the Tamale Central Hospital

On the activities and issues engage in providing emotional/spiritual care to hospitalized patients in the adult wards of the Tamale Central Hospital. The results show that there is relationship with patients and health care providers and significant others in providing spiritual care. Also the study showed that health care providers ask patients about their religious practices that they will like to do in the hospital but not often. Health care providers ask patients about their religious books, articles, or symbols that they will like to have with them in the hospital but not often and also health care providers ask patients occasionally about their favorite places to practice their religious activities in the hospital. The study further reveals that occasionally patients are asked about what gives meaning and purpose to their life after being admitted with their condition in the hospital. It added that occasionally, nurses asked patients about their sources of strengths and hope after they have been admitted with their condition in the hospital. They also reveal that occasionally nurses asked patients about the most loving things that they do



for others or receive from them after they have being admitted in the hospital. The study further reveals that nurses asked and discuss with patients' spiritual/religious issues, meaning nurses occasionally, asked patients the appropriate time to ask and discuss with them spiritual/religious issues.

Data from the study reveal not often that patients are asked about their most important relatives and/or friends to them after they have being admitted with their condition in the hospital.

6.2.3 Barriers in providing emotional/spiritual care to patients admitted to the adult wards in the Tamale Central hospitals

On the issue of barriers in providing emotional/spiritual care to patients admitted to the adult wards in the Tamale Central hospitals. The study reveal the following as the barrier to providing emotional/spiritual care to patients admitted to the adult ward of the hospital; Because of different beliefs of the staffs and the patients, Most of patients do not belief in superstition, lack of communication skills in giving this care, Lack of pastors and imams in the hospitals, Multiple beliefs of the patients, Lack of chaplains within the hospital, Difference in believes and how to approach it with the context of health care provision in the hospital, Lack of regulations and time for spiritual care provision, Forgetfulness on the need to provide spiritual care to our patients, Lack of policy to mandate the provision of spiritual health care in the hospital, Work load and health care providers do not get enough time to give spiritual care to clients.



6.2.4 Possible solutions to the barriers in providing emotional/spiritual care to patients admitted to the adult wards of the Tamale Central Hospitals

On the solution to the barriers in providing emotional/spiritual care to patients admitted to the adult wards of the Tamale central hospital. Respondents in their view give the following suggestion; Health education on spiritual health care provision in the hospital, Health workers should be educated more to provide spiritual needs of the patient in hospital, The policy makers should be encouraged to capture the spiritual needs of patients in the management protocols, More education should be done to help meet the spiritual needs of the patients .policy makers should include it their policies.

By employing health provisional who are well verse in spiritual health care provision in the hospital, More health talk should be done when the patients are in the hospital and make them understand that they can somehow practice their beliefs, Health education should be done on the need for spiritual care and also policy makers should include spiritual care in the policies, By involving traditional and spiritual leaders in our health facilities, Get Religious leaders to visit patient daily, They should be a constant reminder to nurses on their responsibility to provide spiritual care, Health care providers must see it as one of their responsibility for their patients and not just a study, The hospital should employ an Imam and a Pastor to compliment the nurses role in taking care of the spiritual needs of the patient, It should be added to the daily assignment of nurses, so that some health care providers will be assigned to it daily, and it should be rotating daily, Routine in-service training for healthcare providers.



6.3 Conclusion

Based on the findings of the study it can be concluded that there is relationship with patients and health care providers and significant others in providing spiritual care though not to the expectation of patients. Also health care providers ask patients about their religious practices that they will like to do in the hospital but not often. Health care providers ask patients about their religious books, articles, or symbols that they will like to have with them in the hospital but not often and also health care providers ask patients occasionally about their favorite places to practice their religious activities in the hospital. Additionally, on occasional situations patients are asked about what gives meaning and purpose to their life after being admitted with their condition in the hospital, nurses asked patients about their sources of strengths and hope after they have been admitted with their condition in the hospital.

Nurses also asked and discuss with patients' spiritual/religious issues, meaning nurses occasionally, asked patients the appropriate time to ask and discuss with them spiritual/religious issues, and not often thus patients are asked about their most important relatives and/or friends to them after they have being admitted with their condition in the hospital.

The study further concludes that all the care provides are aware of the importance of and the need to provide spiritual care to the clients on admission in to the adult wards of the hospital but admitted that the provision is infrequent. However some barriers were identified as the reason for infrequent provision.



The study also concluded on the following as the barrier to providing emotional/spiritual care to patients admitted to the adult ward of the hospital; because of different beliefs of the staffs and the patients, most of patients do not believe in superstition, lack of communication skills in giving this care, lack of pastors and imams in the hospitals, Multiple beliefs of the patients, lack of chaplains within the hospital, difference in beliefs and how to approach it with the context of health care provision in the hospital, lack of regulations and time for spiritual care provision, Forgetfulness on the need to provide spiritual care to our patients, lack of policy to mandate the provision of spiritual health care in the hospital, work load and health care providers do not get enough time to give spiritual care to clients.

The study also uncovered some suggestions regarding the provision of spiritual care and its improvement to the patients on admission to the adult wards of the hospital to include the reintroduction of the hospital chaplain system, the adoption of the nursing process and strengthening education and in-service training for staff to remind them of the need to render this care to clients.

6.4 Recommendations

Based on the findings and the objectives of this study, the following recommendations are made;

- ✚ There should be health education on spiritual health care provision in the hospital by management of the Hospital. This can be done on Tuesday and Thursdays since these days currently serve as the consultation days for chronically ill patients and there is high OPD attendance on those days.



- ✚ Health workers should be educated more to provide spiritual needs of the patient in hospitals by Health training institution and hospitals. Some health care providers limit spiritual care of the patient to the clergies. They still do not appreciate their role in the provision of the spiritual care and therefore find reasons for their inability to meet this demand from their clients.
- ✚ There should be a clear policy on spirituality and spiritual care. Again policy makers like the government and the Ghana health service should be encouraged to capture the spiritual needs of patients in the management protocols.
- ✚ Health care professionals should show more interest in clients' spirituality and be encouraged to learn more on the job regarding the diverse spiritual and religious beliefs so as to have a fair idea to enable them meet their clients' spiritual needs.
- ✚ Health education on the ward should include spirituality and its role in the treatment process to make clients understand that they can practice their beliefs on the ward as long as their conditions permit so.
- ✚ Once a while, hospital management should involve clergies in the hospital programs and also ward activities.
- ✚ Health care providers must see spiritual care of the patient as one of their responsibilities for their patients and not just a study. Therefore, Spirituality and activities involved in rendering spiritual care to the patient should be added to the 'daily assignment list ' of the various wards so as to constantly remind nurses on their responsibility to provide spiritual care



- ✚ The Tamale Central Hospital should employ health professionals who are well versed in spiritual health care provision in the hospital.
- ✚ The hospital should employ an Imam and a Pastor to compliment the nurses' role in taking care of the spiritual needs of the patient. The hospital chaplain system should be reintroduced and strengthened.

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APPENDIX: Questionnaire on the provision of patients spiritual needs.

UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF ALLIED HEALTH SCIENCES

DEPARTMENT OF COMMUNITY HEALTH AND DEVELOPMENT

Questionnaire on the provision of patients spiritual needs.

SECTION ONE- DEMOGRAPHIC DATA

In this section questions about your background information are asked with the related illness factors. This will enable me group the response with those persons with similar or same background information when the results of this study are analyzed.

1. Age (in years)-----

2. Sex

A. Male []

B. Female []

3. Marital Status

A. Single []

B. Married []

C. Divorced []

D. Widow []



4. Educational background
- A. No Formal Education []
 - B. Primary []
 - C. JSS/ Middle School []
 - D. SSS []
 - E. Tertiary []

SECTION TWO

This part consists of a list of questions seeking to ask about the provision of spiritual care to you by your health care providers throughout your admission period. Please select a response that best describes the provision of spiritual care to you by your health care providers for each question.

Please provide the best answer as much as you can if you are not sure as to how to answer any question.

- A. Not at all
- B. Not often
- C. Occasionally
- D. Regularly
- E. At all times
- F. Do not know





For the duration of your current admission , how often did your health care provider ask you:		Not at all	Not often	Occasionally	Regularly	At all times	Do not know
1.	About your spiritual/religious beliefs						
2	About your relationship with God.						
3	About your relationship with yourself, and significant others						
4	About your religious practices that you like to do						
5	How your spiritual/religious practices (e.g., prayer, reading from Qur'an/Bible, and/or meditation) and beliefs help you to cope with the new situation after being diagnosed with cardiac disease?						
6	About religious books, articles, or symbols that you like to have						
7	About your favorite places to practice your religious activities						
8	About changes in your spiritual/religious practices, and feelings about your condition						
9	How they can help you to maintain						



	your spiritual/religious strength after being admitted with this condition						
10	What gives meaning and purpose to your life						
11	About your life story and your future						
12	About your sources of strengths and hope						
13	About goals and wishes that you have not met them yet						
14	About the most important relatives and/or friends to you						
15	What brings joy, pleasure, and peace to your life						
16	About your forgiveness for others and how to show forgiveness for yourself						
17	About the most loving things that you do for others or receive from them						
18	.The appropriate time to ask and discuss with you spiritual/religious issues						

During your current hospitalization, how often did the health care provider:

19. Listen actively to you talk about your religious/spiritual beliefs, strengths, and your beliefs about God
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
20. Give you the opportunity to talk about God and support coming from God
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
21. Listen actively to stories from your spiritual life
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
22. Offer to read from the Qur'an/Bible on you or to share prayer and meditation with you
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []





23. Help you to have suitable place to pray, to read from Qur'an/Bible, or to meditate
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
24. Facilitate utilization of religious/spiritual resources available in the hospital that you can use (e.g., common prayer room, the Holy book- Qur'an/Bible, or other religious materials)
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
25. Help you listen to religious programs on radio or TV if available
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
26. Give you the opportunity to participate in religious or spiritual events arranged on the ward (e.g., praying with others or visit other patients in the hospital)
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
27. Offer to discuss with you the difficulties of practicing prayer when sick
- A. Never []
 - B. Not often []
 - C. Always []

D. Do not know []

E. Not applicable []

28. Arrange a visit by the hospital Imam/Pastor to comfort and support you if requested by you

A. Never []

B. Not often []

C. Always []

D. Do not know []

E. Not applicable []

29. Respect your privacy, dignity, religion, and religious and spiritual beliefs and rituals

A. Never []

B. Not often []

C. Always []

D. Do not know []

E. Not applicable []

30. Give your family the opportunity to visit you and to share prayer, reading from Qur'an, and mediation with you

A. Never []

B. Not often []

C. Always []

D. Do not know []

E. Not applicable []

31. Give your close friends the opportunity to visit you and to share prayer, reading from Quran/Bible, and meditation with you

A. Never []

B. Not often []

C. Always []

D. Do not know []

E. Not applicable []





32. Help you to become aware of meaning and purpose of life in facing illness and suffering that have come with your condition
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
33. Spend time giving comfort, support, and reassurance when needed
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
34. Create a feeling of kindness, cheerfulness, and intimacy when giving care to you
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
35. Help you to feel hopeful and to keep a positive outlook
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
36. Help you to complete unfinished business or activities
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []



37. Help you in listening to music or practicing another art if requested by you
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
38. Make you laugh or introduce appropriate humor to you
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
39. Hold your hand or put his hand over your shoulders to give you support and reassurance
- A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
40. During you current hospitalization period, who do you think is the most appropriate person to provide spiritual care for you? (Please select the best one)
- A. A. Never []
 - B. Not often []
 - C. Always []
 - D. Do not know []
 - E. Not applicable []
- Other, please specify -----

COMPONENT OF SEMI-STRUCTURED INTERVIEW FOR HEALTHCARE PROVIDERS

PART A:

Demographic Data:

Please fill out the following sheet about yourself

1. What is your age? ----- (Please write your age in years).
2. What is your sex? (Please circle one choice only)
3. What is your highest degree of education? Please specify the field?
4. At which school/college and country did you receive your education?
5. What is your current position?
6. For how long you have been practicing in your current position?
7. For how long you have been working in the health care sector?
8. Which ward do you work (please write down the name of your ward)



PART B:

Questions to be asked by the Interviewer

1. I would like to learn about how your education (formal and non-formal) addressed spirituality and spiritual care.
2. When you hear of spiritual care, what comes to mind? What does —spiritual care mean to you?
3. How important do you think is the provision of spiritual care to your patients?
4. Who do you think is responsible for the provision of spiritual care to your patients? And why?
5. What do you think are the barriers and/or challenges that hinder the provision of spiritual care to your patients?
6. What do you think can be done to overcome barriers and challenges to providing spiritual care to cardiac patients at the levels of?
 - a. Institution []
 - b. Health education []
 - c. Health care policy makers []
 - d. Others
7. Is there anything else that you would like to say about spiritual care that we have not talked about?

