SPIRITUALITY, MEANING AND SENSE
OF WELL-BEING FOR PATIENTS
WITH TERMINAL ILLNESS
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CHRISTINA L. CIESLIK
ADVISOR: MARILYN RYAN Ed.D., RN
BALL STATE UNIVERSITY
SCHOOL OF NURSING
MUNCIE, INDIANA
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ABSTRACT

RESEARCH PAPER: Spirituality, Meaning of Life and Sense of Well-being in Terminally Ill Patients

STUDENT: Christina Lynn Cieslik, R.N., B.S.N.

DEGREE: Master of Science

COLLEGE: College of Applied Sciences and Technology

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Individuals with terminal illnesses have an increased need for spiritual care. It has been found that well-being and spirituality have a positive relationship to physical responses to illness can impact an individual’s sense of well-being (Meraviglia, 2004). The purpose of this predictive study is to examine relationships among spirituality, meaning of life and prayer and a sense of well-being of physical and psychological responses after a diagnosis of a terminal illness. This study is a modified replication of Meraviglia’s (2004) study. Frankl’s Motivational Theory of Meaning is the framework. A sample will be 50 terminally ill patients recruited from two oncology/hematology physicians’ offices in Fort Wayne, Indiana. The four instruments are: Life Attitude Profile-Revised (patients’ meaning, purpose in life and motivation to find meaning), the Adapted Prayer Scale (types of prayer activity, prayer experiences, and attitudes toward prayer), Index of Well-Being (psychological well-being) and Symptom Distress Scale (degree of discomfort). Findings will provide information regarding spiritual care needs of terminally ill patients.
Chapter 1

Introduction

Medical technologies have dramatically changed the way health care is provided by shortening the length of stay in the hospital, improving patient outcomes and affecting where and how care is provided. Organizations are dramatically changing the way health care will be provided in the years to come (Joseph, 2008). Deloitte’s (2008) Survey of Health Care Consumers polled more than 3,000 Americans ages 18-75 assessing consumers’ behaviors, attitudes, and unmet needs related to health, health care and health insurance. The data provided valuable insights into ways health care providers, health plans, life sciences companies, policy makers and employers can work to close the gaps that exists between what consumers want and care consumers are currently receiving. One key was that one in three consumers want more holistic/alternative therapies in the treatment program (Deloitte, 2008).

The United States faces a critical shortage of full time registered nurses. The Health Resources and Service Administration estimates that 1 million vacancies will occur by the year 2020 (Roberts, 2008). During labor shortages employers must compete with one another by increasing wages and other compensations to attract experienced nurses. If the nurse shortage persists, then wages and compensations must continue to increase until
compensation for nursing is competitive with other occupations so that non-nurses will be attracted to nursing and providing nursing services (Elgie, 2007).

The American Nurses Association (ANA) (2008), through organizational relationships, is the leader in promoting improved work environments and the value of nurses as professionals, the essential providers and decision makers in all practice settings. ANA protects, defends and educates nurses. Variables such as flexible work hours, increased benefits, newly created professional roles, better designed hospital equipment and buildings, and an atmosphere of respect for nurses are central considerations for hospitals seeking to recruit and retain nurses (Roszak, 2006). In addition to improving the hospital environment, reducing stress provides an atmosphere where holistic care can be administered. One aspect of holistic care is spiritual care.

The Joint Commission (TJC) (2008) recommends in standards that a spiritual assessment should determine the patients’ religious denomination, beliefs, and what spiritual practices are important to the patient. This information should assist in determining the impact of spirituality on the care/services being provided. The standards require administrators to define the content and scope of spiritual assessments and the qualifications of the individual performing the assessment (TJC, 2008).

According to Bishop and Griffin (2006), work by the Center for Health Design has linked healthcare environment, self-healing with spiritual growth. Environments that promote healing produce better patient outcomes. To preserve patient autonomy and to provide a safe and comfortable environment for the expression of an individual’s beliefs, the nurse can support the patient’s choice of a particular form of prayer by providing space, privacy, and respect for sacred objects (DiJoseph & Cavendish, 2005). The most
important issue is for the patient to enter into an environment where mind-body healing can occur (Rockwood Lane, 2005). Spiritual care by nurses has increasingly been cited as an ethical obligation (Pesut, 2006). However nurses may vary on the understanding of how this is carried out in practice.

According to Sawatzky and Pesut (2005) the religious perspective of care is concerned with the holistic care of individuals in need. The authors proposed that spiritual nursing care is an intuitive, interpersonal, altruistic, and integrative expression. Spiritual care is contingent on the nurse’s awareness of the transcendent dimension of life but also reflects the patient’s reality.

At a foundational level, spiritual nursing care is an expression of self. Spiritual expressions such as love, hope, and compassion constitute the most basic and universal approach to spiritual care and can be integrated into all aspects of nursing care. More specific behavioral interventions must reflect the patient’s spiritual beliefs. Spiritual nursing care begins with “being” with that patient, and may emerge into therapeutically oriented interventions that take direction from the patient’s religious or spiritual reality (Sawatzky & Pesut, 2005).

Holistic care addresses the human person, focusing on all dimensions of the person, body, mind and spirit. One of the greatest challenges in dealing with the spiritual dimension of the human person is that the spirit is not a concrete, objective reality. It is important that nurses assess the extent to which religion is a spiritual support to the individual (McBrien, 2006; Pesut, 2006).

To provide holistic spiritually sensitive care, it is important for nurses to be self-reflective and aware of spiritual beliefs and issues so that personal beliefs or uncertainties
may be set aside when caring for the patient. Pivotal nursing care attitudes are “presence” and the “willingness to listen” (Lemmer, 2005). Nurses will achieve professional growth as holistic care providers when nurses understand the significance of spiritual care for patients and use guides for the provision of spiritual care activities (DiJoseph & Cavendish, 2005). Psychospiritual well-being is an important concept for nurses seeking a holistic approach to practice because it connects the mind and spirit with the body (Manning-Walsh, 2005).

Holistic care is intrinsic to nursing care in all practice settings throughout the life span (DiJoseph & Cavendish, 2005). Nurses are discovering ways to care for the whole person through creative interventions because art and mediation automatically put patients into the place where healing flows. Spiritual assessment and interventions are especially important for individuals at the end of life (DiJoseph & Cavendish, 2005). The incorporation of holistic care by an interdisciplinary team may improve spiritual care interventions for patients. Further study is needed on spiritual care interventions on terminally ill patients (Rockwood Lane, 2005).

**Background and Significance**

Religion and spirituality are often thought of as the same concepts (Fryback & Reinert, 1999). Spirituality however, is a broader concept than religion. Spirituality is an important aspect of the health of human beings (Fryback & Reinert, 1999). It is an innate need of human beings that provides meaning in life.

Spiritual practices are defined as specific, routinely performed activities such as prayer, mediation, and listening that may be faith-based (Cavendish, Konecny, Naradovy, Kraynyak Luise, et al, 2006). Spirituality, as it relates to health, has been discussed by
many authors over the last 15 years. Most definitions refer to spirituality as a human need and include one or more of the following concepts: a personal journey to discover meaning and purpose in life, a belief in and a relationship with a higher power, transcendence, and acting according to a higher order (Fryback & Reinert, 1999).

Policies related to spiritual care have come into conflict recently in the U.S. because federal laws and other regulations protect confidentiality in ways that countermand methods for facilitating access to pastoral care in hospitals (Erde, Pomerantz, Saccocci, Kramer-Feeley & Cavalieri, 2006). How patients’ spiritual needs will be met in contemporary healthcare settings is a concern for the nursing profession (Cavendish et al., 2006). Gadsby (2007) stated that the more medical and scientific nursing becomes, the less room there is for holistic care.

According to Meraviglia (2004) peoples’ beliefs can be challenged with a diagnosis of a terminal illness although some found that spirituality can provide them with support during a physical and psychological crisis. A complete understanding of spirituality has not been found by researchers. “Spirituality, like the physical and psychological dimensions, must be examined by assessing more than one aspect” (Meraviglia, 2006, p. E1). Prayer, communication with God, and meaning in life, the process of finding and fulfilling significance and purpose in one’s life, are two concepts that are examined by Meraviglia (2006).

**Problem**

The search for spirituality is an ongoing, dynamic process that reflects and expresses the human spirit. Prayer and having meaning in life are important aspects of the process of recovery from illness. Individuals with terminal illnesses have an increased need for
spirituality. It has been found that well-being and spirituality can impact an individual’s sense of well-being (Meraviglia, 2004).

**Purpose**

The purpose of this study is to examine relationships among spirituality, meaning in life, prayer and sense of well-being after a diagnosis of lung cancer. This is a replication of Meraviglia’s (2004) study.

**Research Questions**

1. Does spirituality, meaning in life and prayer predict a sense of well-being, physical and psychological responses after a diagnosis of lung cancer?

**Conceptual Framework**

The Framework for this study is Erickson, Tomlinson and Swain’s, (1983) Theory of Modeling and Role Modeling, and Frankl’s (1962) Motivational Theory. Spirituality is an individual concept that is defined by the person’s experiences and values. Frankl’s Motivational Theory of Meaning emphasizes that the spiritual dimension is the way that people become “fully human.” Frankl also believes that people are motivated to find and fulfill meaning and purpose in life under any circumstance (Meraviglia, 2004).

**Definition of Terms**

**Conceptual.** Meraviglia (2004) defined meaning in life as the process of finding and fulfilling meaning and purpose regardless of circumstances.

**Operational.** Meaning in life will be measured by Life Attitude Profile-Revised (LAP-R) based on Frankl’s (1962) Motivational Theory.

**Conceptual.** Meraviglia (2004) defined prayer activities and experiences as any form of communication with God or a supreme being, including verbal and contemplative.
**Operational.** Prayer activities and experiences will be measured using the Adapted Prayer Scale (APS) adapted from Poloma and Pendleton’s (1991) prayer scale.

**Conceptual.** Meraviglia (2004) defined symptom distress as the degree of discomfort related to appetite, nausea, insomnia, pain, fatigue, bowel patterns, concentration, appearance, breathing, outlook, cough and mobility.

**Operational.** Symptom distress will be measured using the Symptom Distress Scale developed by Meraviglia (2004).

**Conceptual.** Meraviglia (2004) defined psychological well-being as a sense of well-being.

**Operational.** Psychological well-being will be measured using the Index of Well-Being developed by Meraviglia (2004).

**Limitations**

*One* limitation of the study is the small sample size. A second potential limitation is that patients or nurses may define spiritual interventions from personal perspectives rather than using investigator-defined criteria, may be too subjective.

**Assumptions**

*Recent* movements such as holistic nursing care and parish nursing focus more attention on spiritual needs. Nurses caring for patients nearing the end-of-life incorporate spiritual care more effectively than nurses in other clinical settings (Meraviglia, 2004). Individuals are in need of spiritual support during a terminal illness.
Summary

Holistic care is intrinsic to nursing care in all practice settings throughout the life span. Nurses are discovering ways to care for the whole person through creative interventions because art and mediation automatically put patients into the place where healing flows. Spiritual assessment and interventions are especially important for individuals at the end of life (Meraviglia, 2004). The purpose of this study is to examine relationships among spirituality, meaning in life, prayer and sense of well-being after a diagnosis of lung cancer. Frankl’s Motivational Theory of Meaning will serve as the framework of this study. Findings will provide information about meaning in life, prayer, and sense of well-being of patients with a diagnosis of a terminal illness.
Chapter 2

Literature Review

Introduction

According to Meraviglia (2004) spirituality can impact an individual’s sense of well-being. Individuals that have been given a “terminal” or “life-threatening” diagnosis may find that during the critical life event spirituality becomes an important aspect in life. Prayer and having meaning in life are important aspects of spirituality. The purpose of this study is to examine relationships among spirituality, meaning of life and prayer and sense of well-being of physical and psychological responses after a diagnosis of a terminal illness.

The following is a selected review of literature that discusses spirituality in nursing practice and the role of spirituality with a diagnosis of a terminal illness. This chapter is divided into five sections, theoretical framework, patients’ perceptions of spirituality, nurses’ perceptions of spiritual care, effects of spirituality outcomes and coping with terminal illness.

Theoretical Framework

Frankl’s Motivational Theory of Meaning is the framework of the study. This theory emphasizes that the spiritual dimension is the way that people become “fully human.”
Frankl also believes that people are motivated to find and fulfill meaning and a positive effect on physical and psychological well-being in people with lung cancer, higher levels of meaning in life are associated with higher psychological well-being and lower symptoms distress, higher prayers scores are related to higher psychological well-being and meaning in life and prayer lessen the impact of lung cancer on well-being.

**Patients’ Perceptions of Spirituality**

Spirituality is a broad term described as prayer, meditation, refocusing on the small things in life and finding a purpose. Fryback and Reinert (1999) examined the meaning of spirituality described by people living with terminal illnesses. The aim of the study was to examine how people with a potentially terminal diagnosis view and experience the concept of health and spirituality (Fryback & Reinert, 1999).

The study took place in two southern states. Fifteen participants were selected with the inclusion criteria: age 21 or older, received a diagnosis of cancer or HIV/AIDS within the last year, ability to speak English and willing to verbalize perceptions related to the meaning of health. The eligible individuals were identified by local ministers, nurses, and from other participants. There were 13 Caucasian participants and 2 African American, all between the ages of 29-76 (Fryback & Reinert, 1999).

Data were collected through in-depth interviews lasting 60-90 minutes. Each participant was interviewed at home. The interviews were videotaped then transcribed verbatim with content analysis being performed to uncover themes. The first group had 10 women with cancer and 5 men with HIV/AIDS. Participants were interviewed regarding experiences and perceptions of spirituality. The second group had five women
with cancer. Each interview was transcribed before the next interview and the themes were then combined into broader categories (Fryback & Reinert, 1999).

The three themes that emerged from the data were: “Belief in a higher power,” “Recognition of mortality,” and “Self-actualization.” “Belief in a higher power” was described as a conviction that there is something outside oneself that is greater than the self. “Recognition of mortality” has three sub concepts: gaining a new appreciation of life, a renewed observation and appreciation of nature, and a firm resolve to live in the moment. “Self-actualization” is the living up to one’s optimal potential or having a sense of exuberant well-being. Follow-up calls were then to validate the categories (Fryback & Reinert, 1999).

Fryback and Reinert (1999) concluded that patients perceived spirituality as reflective of a higher power, immortality and as achieving self-actualization. The concepts of accepting mortality, self-actualization and belief in a higher power open up many avenues for nurses to discuss with patients and intervention. Nurses need to understand the relationship between spirituality and quality of life issues to intervene and help patients during a terminal illness.

The concept of “quality of life” is an important concept in nursing research. Enhanced quality of life is an important concept in the care of persons with dementia. “The purpose of this study was to describe the spiritual experiences of persons with early-stage dementia and to explore the relationship between personal spirituality and perceived quality of life” (Katsuno, 2003, p. 317).

The study took place in a metropolitan area of a mid-western city in the United States. The participants were identified by a clinical coordinator or a nurse-manager at a day-
care center and at an assisted-living facility. Twenty-three people with MMSE scores greater than or equal to 18 agreed to participate in the study. The mean age was 79 years with a range being from 66-91 years with 19 participants being female and 18 Caucasian. The average level of education was 11 years with no participates completing a college education. The Catholic religion was identified by 10 of the participants with 8 indentifying Protestant, and 5 Jewish; 8 were married and the rest widowed. English was the second language of three of the participants. Participants came from: Argentina, Belgium, and the Philippines. “Eighteen of the 23 participants had either probable or possible Alzheimer’s disease as diagnosed by a major facility” (Katsuno, 2003, p. 319).

Data were collected using the MMSE as a screening tool and a measure of cognitive status of participants. The possible scores range from 0 to 30, with a score of 23 or less indicated impairment of cognitive function. Quality of life and potential factors relating to quality of life was discovered using a semi-structured interview with narrative account in the respondents’ own words (Katsuno, 2003). The Systems of Belief Inventory is a 15-item tool used to measure personal spirituality, including both religious behaviors and spiritual experiences, the scale scores ranged from 0 to 45 with 0 to 30 for the Beliefs and Practice subscale. A greater number means greater spiritual and religious beliefs (Katsuno, 2003).

The Quality of Life Index (QLI) was administered verbally, however the informant was able to read along. The QLI is a 64-item tool which measures perceived quality of life of persons with early-stage dementia. The QLI measures overall quality of life as well as four concepts: health/functioning, psychological/spiritual, social/economic, and family. This scale consists of two sections: 32 items measuring satisfaction with four
domains of life, and another 32 items for measuring the importance of the domains. A 6-point Likert scale ranging from very satisfied to very dissatisfied for the satisfaction items and very important to very unimportant was used to rate each question and identify the importance of items. The total possible for score for the subscales range from 0 to 30, with a greater number indicating a higher quality of life. Questions were asked one at a time and the other sections of the questionnaire were covered from view (Katsuno, 2003).

Katsuno (2003) found that during a dementing illness a person’s personal beliefs and life values are important especially strong lifelong faith (Katsuno, 2003). For persons with dementia, religion/faith and life value emerged as an important part of life. Persons with early-stage dementia perceived that the individual receives various forms of psychological support from God identified as: help and guidance, strength, security, and comfort. Significant correlations occurred between the QLI total scores and the SBI total scores (N=21, r=0.44, p<0.05) and between the QLI total scores and the Beliefs and Practices subscale scores (N=21, r=0.51, p<0.05). Another theme that Katsuno identified was faith in God. Six categories identified were beliefs, support from God, sense of meaning/purpose in life, private practice, changes due to dementia, as part of the faith of God.

The QLI total scores and the Social Support subscale scores showed no significant association (N=21, r=0.18, p=0.42). A significant correlation was found between the SBI total score and the Psychological/Spiritual subscale of the QLI, between the Beliefs and Practices subscale and the Health/Functioning subscale of the QLI, and between the Beliefs and Practices subscale and the Psychological/Spiritual subscale of the QLI (Katsuno, 2003).
The author concluded that persons with early-stage dementia may retain a strong faith in God and still experience all areas of religiosity but personal spirituality was operationalized as religiosity. Religion was used by participants for coping with dementing illnesses and find meaning and purpose in life. Perceived quality of life is associated with personal religious, spiritual beliefs and practices (Katsuno, 2003).

Health care that people receive towards the end of life is not always consistent with personal values. One contributing factor may be the clinician’s lack of familiarity with patient’s values and care preferences. Clinicians and family members have a large part in how patients experience end of life (Vig & Pearlman, 2003). “The purpose of this study was to characterize the experience of quality of life while dying from the perspective of terminally ill men” (Vig & Pearlman, 2003, p. 1595).

The study took place at two university-affiliated medical centers in Seattle, Washington. Participants from geriatric, general internal medicine, oncology, and cardiology clinics included 26 men with an estimated 6 months or less to live (Vig & Pearlman, 2003).

Data were collected through in-person semistructured interviews. All interviews were tape recorded, conducted by one interviewer, contained two sections and took less than 60 minutes to administer. The most important aspects of life, goals, and views of the future were identified by participants during the interview. Overall quality of life with recent symptoms were rated using a 5-point Likert scale ranging from 0 (not important) to 4 (very important). Spontaneous comments made in response to the closed-ended questions were transcribed verbatim by the interviewer (Vig & Pearlman, 2003).
Two additional set of questions were included in the second section of the interview which occurred approximately 2 to 4 months after the first. The short form Yesavage Geriatric Depression Scale was included due to the possibility of the participants having a depressed mood and the influence of participants’ responses. Reactions to the first interview and identify any important life changes occurring since the first interview (Vig & Pearlman, 2003).

Living while dying, anticipating a transition to active dying, and receiving good health care were part of quality of life. Vig & Pearlman (2003) found:

- Participants had an awareness of dying in the near future with an accepted reality.
- Participants reflected on contributors to overall quality of life, which included family and friends, religious and spiritual beliefs, and aspects of good health care.
- They spoke of their priorities as they lived in the face of death. They voiced concerns about the quality of their own dying and about burdening loved ones.

(Vig & Pearlman, 2003, p. 1597).

Vig and Pearlman (2003) identified new experiences considered important to individuals facing the end of life, such as going for meals, which helped maintain a sense of meaning and normalcy. When no longer able to participate in day to day activities participants viewed themselves as moving into the final dying stage. The themes of quality of life were broadened with this new knowledge.

 Individuals living with cancer have increased or intensified spiritual needs. Knowing the perceived spiritual needs of cancer care recipients is foundational for nurses provide spiritual care. The spiritual needs of patients living with cancer or a loved one who has cancer was identified during this study (Taylor, 2003).
The study took place in inpatient units and outpatient chemotherapy clinics in a county hospital and a comprehensive cancer center, both located in a large southwestern metropolitan area. Participants included 21 patients that with a diagnosis of cancer and 7 primary family caregivers for an individual with a diagnosis of cancer. Ten patients were men, whereas all of the caregivers were women with inclusion criteria being Euro-American or African American, able to speak English, be at least 18 years old, and be a current recipient of nursing care. The sample consisted of 5 Jews, 6 Roman Catholics, 14 Protestants, 1 Mormon, and 2 nonreligious individuals and most of the informants were Euro-American with six patients and one caregiver being African-American (Taylor, 2003).

Data were collected using the “Information about You” form. The form was designed by the investigator to assess various demographic and illness-related variables, including: age, gender, ethnic background, education, religion, frequency or attendance at religious services, setting for receiving health care, perceived outcome of illness, and overall distress related to illness. Items were rated on a 5-point Likert item. The demographic form included questions about diagnosis, time since diagnosis, and current status of illness. The form was completed during semistructured interviews with data analyzed during collection. Notes were checked for accuracy after being transcribed (Taylor, 2003).

The findings provided a comprehensive listing of the spiritual needs related to living with cancer. The most prevalent spiritual needs were perceived as “quite a bit important” were: keeping a positive perspective, giving love to others, finding meaning, and understanding or relating to God. In contrast, the needs of receiving were: caring love
from others, reevaluating beliefs and life, preparing for death, and thinking about the unfairness and the “why” of having cancer a little were to somewhat important. Themes and Categories included:

1. Needs Associated With Relating to an Ultimate Other
2. Need for Positivity, Gratitude, and Hope
3. Need to Give and Receive Love from Other Persons
4. Need to Review Beliefs
5. Creating Meaning, Finding Purpose
6. Religious Needs

Taylor (2003) concluded that assessing spirituality of a patient with cancer, or a family member requires knowledge of spiritual needs. The nurses’ inability to assess spiritual needs prevents them from initiating a plan for spiritual care to promote spiritual health.

During the times of crisis and chronic illness spirituality can be understood as dynamic principles that guide a person’s view of the world and relationships with a higher life force, as well as providing a sense of hope, moral conviction, faith, love and trust and plays a vital role (Sherman, Ye, McSherry, Calabrese, Parkas & Gatto, 2005). “The purpose of this study was to examine the similarities and differences between the patient and caregiver populations and patient/family caregiver dyads as well as trends with regard to changes in spiritual well-being during the illness and dying process” (Sherman et al., 2005, p. 349).
The study took place in a healthcare system in New York City. Participants from inpatient and outpatient units included 38 patients with advanced cancer and family caregivers, and 63 patients with advanced AIDS and 43 family caregivers. Inclusion criteria included having a diagnosis with advanced cancer with metastasized, lymphoma, or chronic leukemia or AIDS. Inclusion criteria also included were:

Patients with AIDS had HIV RNA viral loads of 100,000 copies/ml or greater with or without highly active antiretroviral therapy, or a current CD4 cell count of between 0 to 200 cell/mm3, with or without HARRT and one or more hospital admissions in the last year and the presence of one or more AIDS-defining illnesses that were not responsive to therapy or multisystem organ failure” (Sherman et al., 2005, p. 351).

Inclusion criteria for patient and family caregivers were English speaking, cognitively intact according to the Short Portable Mental Status Exam Family, 18 years of age or older and a significant person who was actively involved in care that may or may not live in the same household. The average age of AIDS patients was 43.2, and the average age of cancer patients was 62.9. The average age of AIDS caregivers was 46.6 and the average age for cancer caregivers was 60.5. Most AIDS patient were African American (46.8%) and Hispanic (43.6%) while most cancer patients were Caucasian (Sherman et al., 2005).

Data were collected using the Spiritual Well-Being Scale (SWBS). This scale has 20 self-reported items that measures two components of spirituality: religious well-being (RWB) and existential well-being (EWB). RWB focuses on one’s relationship with God and EWB focuses on meaning, purpose, and satisfaction in life. A 6-point Likert-type
scale ranging from “strongly agree” to “strongly disagree” with the possible range of scores for total SWBS being 20-120 with higher scores indicating higher levels of spiritual well-being. A higher score on the RWB and EWB (10 to 60) represented a deeper sense of religious or existential well-being (Sherman et al., 2005).

AIDS patients’ findings for total SWB scores and RWB scores were higher than caregivers’ scores with the average SWB, EWB, and RWB scores for cancer patients being lower than for caregivers. AIDS and cancer patients showed no statistical difference on scores for SWB and RWB. However, the average EWB for AIDS patients was significantly higher than the average EWB for cancer patients. AIDS caregivers reported a significantly lower mean SWB and RWB compared with the mean SWB and RWB for cancer caregivers. Women with AIDS showed a lower SWB and RWB scores than men but religious affiliation was found to be a significant factor with SWB and RWB scores. Higher SWB and RWB scores were found to be with the Jewish affiliation compared with Christian religion including Protestant and Catholic affiliations. Time also was found to be a factor for cancer caregivers having a higher mean profile scores for SWB over the 12-month period than AIDS caregivers. A higher SWB was also found for cancer patients over time than AIDS patients, although no significant difference was found (Sherman et al., 2005).

The above findings included patients with cancer and advanced AIDS showed no significant differences with the total Spiritual Well Being scores but a statistical significant difference was found with total SWB scores and AIDS cancer caregivers. Family caregivers without hospice services showed lower scores on the SWB than those with hospice support (Sherman et al., 2005).
Spiritual needs vary from person to person to include universal needs such as: the need to give and receive love, to find meaning, purpose, hope, values, and faith, and to experience transcendence and beauty. Spiritual suffering or distress can occur if spiritual needs are not satisfied. “The purpose of this study was to examine the prevalence of spiritual needs and identify factors associated with spiritual needs among patients with cancer and family caregivers” (Taylor, 2006, p. 729).

The study took place in an inpatient oncology unit and outpatient radiation and proton therapy clinic at a university medical center in the southwestern United States. Participants had a diagnosis of a cancer or were a family member of a patient diagnosed with cancer. The sample included 156 patients with cancer and 68 family caregivers with the inclusion criteria of: at least 18 years of age, able to read English, and self-identified as African American or Euro-American. Exclusion criteria included a diagnosis of mental illness. White men with prostate cancer made up 67% and who had been diagnosed during the prior year and were receiving care in an outpatient clinic (Taylor, 2006). Caregivers were primarily white women, with 87% being Christians. The majority of caregivers lived with others (86%).

Data were collected using the Spiritual Interests Related to Illness Tool (SpIRT) and an Information About You form. The SpIRT was developed by (clustering 42 items into 8 categories), using a 5-point Likert response scale with 1 = not at all through 5 = a great deal. Some of the categories of items included receiving love from others and preparing for death with four items each, six items each were: needing positive perspective, needing relationship with God, practicing religion; giving love to others and reviewing beliefs having five items each and finding meaning having seven items. The SpIRT has shown:
The internal reliability for each cluster of items generated by the factor analysis was supported by coefficient alphas of 0.76-0.96. A coefficient alpha of 0.95 for the SpIRT scale shows its strong internal reliability. The eight items about a nurse helping with spirituality had a coefficient alpha of 0.98 (Taylor, 2006, p. 731).

Demographic information and illness-related variables included: age, gender, ethnic background, education, religion, frequency of attendance at religious services, setting for receiving health care, perceived outcome of illness and overall distress related to illness were found on the Information About You form (Taylor, 2006).

Taylor (2006) found that SpIRT scores found that frequency of attendance at religious services \( (r=0.50, p<0.001) \) and months since diagnosis (for patients, \( r= 0.44, p<0.001 \) ) were correlated. Taylor (2006) also found that:

Overall illness-related distress, only asking why and preparing to die subscales were correlated \( (r=0.15, p=0.03 \) and \( r=0.20, p=0.004 \) , respectively). Analyses of covariance demonstrated associations between the SpIRT (total) and gender \( (F=7.74, p=0.006) \), living situation \( (F=5.18, p=0.02) \), and setting for health care \( (F=6.7, p=0.01) \), indicating that women who lived with others, and inpatients perceived spiritual needs to be more important” (Taylor, 2006, p.734). Higher SpIRT scores were reported by Hispanic and African American participants more than Asian Americans and Euro-Americans.

The author concluded that spiritual and holistic health will be promoted by addressing spiritual needs in a caring manner by the nurse (Taylor, 2006). Factors associated with care recipients not wanting spiritual care from nurses was also identified during the study.
Taylor also discovered that patients perceived spiritual needs and expectations of nurses in meeting the needs.

*Nurses’ Perceptions of Spiritual Care*

Nurses’ attitudes are an important part of nursing care and can have an impact on the patient’s medical outcome. If spiritual issues are not addressed then the patient’s needs are not being met. The purpose of the study was to identify barriers to providing spiritual care and the influence of the nurses’ spirituality and how they deliver spiritual care (Vance, 2001).

The study took place in a large Midwest city at a 963-bed community teaching hospital. Nurses (173) responded to the survey. The nurses needed to provide direct patient care in critical care, medical/surgical, women’s health, and behavioral health. Females (155) and males (7), Caucasian with 121 nurses ranging from 30 to 49 years old. Most of the nurses (78) were Bachelor prepared and (73) were Diploma prepared. Critical care nurses completed most of the nurses being 69 with 62 nurses from medical/surgical nurses. The years in practice were mostly less than 20 years with majority 6-10 years (Vance, 2001).

The spiritual attitudes of the nurses were measured using the Spiritual Well-Being Scale and the Spiritual Involvement and Beliefs Scale. The reliability of the SWBS was \( r=0.92 \) with this retest reliability also being \( r=0.92 \) and the SWBS was \( r=0.93 \).

The spiritual care practices of nurses were examined using the two part Spiritual Care Practice Questionnaire with a reliability of \( r=0.80 \). Both the SWBS and SIBS were significantly correlated \( r=0.72, p<0.05 \), and both had significant correlation with the SCP part 1 \( r=0.19, p<0.05 \). Part II of the SIBS showed a negative correlation with barriers
and problems associated with nursing practice. The type of education, years of practice 
and attendance of religiously affiliated nursing school had no correlation with spiritual 
care delivery (Vance, 2001).

The findings were that nurses scoring higher in personal attitudes towards spirituality 
also scored higher in spiritual care practices. Barriers for providing spiritual care 
 included lack of education, lack of confidence, difference of ideals between patient and 
nurse, and the confusion over the difference between preaching and care. The nurses’ 
level of spirituality did not have a significant correlation to the number of barriers 
perceived (Vance, 2001).

The author concluded that time was the biggest barrier to providing spiritual care for 
patients was due to cutbacks and shortened stays in the hospital. Nurses also reported the 
lack of education or training in school being the second barrier to providing spiritual care. 
Other factors that limited spiritual care was lack of confidence, differences between 
patient and nurse and the confusion over providing total patient care and preaching 
religion (Vance, 2001).

Effects of Spirituality Outcomes

While caring for patients with human immunodeficiency virus (HIV) the whole person 
needs to be cared for. All aspects of well-being are impacted with the diagnosis of HIV, 
it is among the most devastating of illnesses, having multiple and profound effects upon 
all aspects of the biopsychosocial and spiritual being (Tuck, McCain & Elswick, 2001). 
Tuck, McCain and Elswick (2001) examined the spirituality and psychosocial 
relationship of adult males diagnosed with HIV.
Participants were selected from different clinic sites from a large urban medical centre, and from local churches through local newspapers. Fifty-two males with a mean age of 39 years met the inclusion criteria of 18 years of age or older, English reading and speaking, aware of the diagnosis of HIV disease, and able to participate in 6-month follow-up. The majority were African-American (61%) and single (55%). Individuals that were not eligible to participate in the study included having a significant psychiatric illnesses, cognitive impairment, severe protein-calorie malnutrition and taking steroids of immunodulatory drugs (Tuck et al., 2001).

Spiritual Perspective Scale (SpS), the Spiritual Well-being Scale (SWBS), and the Spiritual Health Inventory (SHI) were used to measure spiritual perspective, well-being, and health. Significance of spirituality and the extent to which one engages in spirituality related interactions was measured using the SpS scale which uses a Likert type scale and contains 10-items. Scoring is completed by calculating the arithmetic mean, with total scores ranging from 1.0 to 6.0 (Tuck et al., 2001).

The SWBS contains 11 positively worded items and 9 negatively worded items with scores ranging from 20 to 120 using a Likert type scale. The SHI is a 31-item Likert type scale that measures three factors: self-acceptance, relationships and hope. Total scores range from 31 to 55 (Tuck et al., 2001).

A 33 item scale, Mishel’s Uncertainty in Illness Scale, measured symptomology, diagnosis, treatment, relationships with caregivers and prognosis and showed a higher uncertainty related to the stress process. Stress levels and coping patterns were measured using the Dealing with Illness Scale (DIS) which is comprised of stress and
coping subscales. The revised 24-item SPS measured six social provisions or components or social support (Tuck et al., 2001).

The Impact of Events Scale (IES) measured the subjective impact of living with HIV disease. IES contains 15-items with higher scores indicating higher psychological distress, on the subscales of intrusive and avoidance thinking. A 55-item scale, the FAHI includes subscales of physical, social/family, emotional and functional well-being; relationship with physician; and additional concerns specific to HIV infection. Higher scores indicate greater quality of life. Correlation was used to analyze the data (Tuck et al., 2001).

Tuck et al. (2001) found that:

Spiritual Perspective Scale scores were moderately high (SpS mean= 5.08, SD= 0.84, range = 1.9-6; SWBS mean= 91, SD= 16.2; range 42-117; SHI mean= 113, SD=14.2, range 79-147). High Intercorrelations among the three spiritual measures were found. The SWBS total scores were moderately highly correlated with the SHI (r=0.70) and the SpS (r=0.72), with the SpS and SHI were more modestly related (r=0.43). The SpS was highly correlated with the religious well-being (RWB) subscale of the SWBS (r=0.80) and moderately correlated with the existential well-being (EWB) subscale (r=0.41) (Tuck et al., 2001, p.780).

Quality of life was positively related to social support, physical, social and functioning well-being, and appraisal-focused coping, while negatively related to uncertainty, perceived stress, and psychological distress in the form of avoidant and intrusive thoughts, and emotion-focused coping. Social support was positively related to effective
coping strategies and quality of life and negatively related to uncertainty (Tuck et al., 2001).

The spirituality measures that demonstrated significant relationships with the study variables were the SHI and the EWB subscale of the SWBS. Of the spirituality measures, the EWB subscale demonstrated the strongest correlations with other study variables. There were strong negative relationships between the EWB, MUIS, and emotion-focused coping subscale of the DIS (Tuck et al., 2001).

The findings indicated that moderately high Intercorrelations among the SHI, SpS and SWBS were not consistently seen in the results and may indicate measures of different aspects of spirituality as a construct. The EWB subscale was highly correlated with the study variables and in the expected directions. The SHI performed similarly but not as strongly. The SpS and RWB demonstrated limited correlations with the psychological variables and may measure the presence of spirituality or religious beliefs (Tuck et al., 2001). The authors concluded that with persons’ with HIV spirituality plays an important role of their psychosocial factors and quality of life.

Psychological well-being is important to an individual that has been diagnosed with a terminal illness. Spirituality can help answer these questions and provide support. The purpose of the study was to describe the relationships among spiritual well-being, depression and end of life issues in terminally-ill cancer patients (McClain, Rosenfeld & Breitbart, 2003).

The study took place in New York City. The population included patients that were diagnosed with cancer and had a life expectancy of less than 3 months (n=3.212). The sample was obtained from a palliative care hospital. The sample consisted of 160
participants with most having lung cancer, with a mean age of 65 years old. Participants included 91 women, and 69 men, most being Caucasian, and 80 participants reported Catholic as a religious affiliation. Participants needed to speak English and pass the cognitive screening test (MMSE) with a score of 20 or greater (McClain et al., 2003).

Seven instruments were used to measure spiritual functional well-being, depression, end of life despair, pessimism and hopelessness, social support, symptom prevalence and physical-functioning ability. The Functional Well-being Scale (FACIT-SWB) assessed the person’s spiritual well-being. This scale has two subscales that measure peace (meaning) and faith. The FACIT-SWB total score was significantly correlated with every outcome variable; with spiritual well-being the strongest predictor of each outcome variable. Depression was measured using the Hamilton Depression Rating Scale (HDRS) that was to be significantly correlated with every outcome variable but less than the FACIT-SWB total score. The Beck Hopelessness Scale (BHD) measured end of life despair, which included pessimism and hopelessness. This scale is a 20 item scale that the sum of the items produces a single score ranging from 0-20. The higher the score with this scale shows a higher level of hopelessness (Beck, Weissman, Lester & Trexler, 1974).

The Schedule of Attitudes toward Hastened Death measured the desire for a hastened death (SAHD). This scale is a 20 item scale that measures a desire for hastened death is the context of medical illness (Breitbart, Rosenfeld, Pessin et al., 2000). Social Support was measured using the Duke-UNC Functional Support Questionnaire (FSSQ). Memorial system assessment scale (MSAS) measured the symptom prevalence, frequency and distress; this scale showed that the number of physical symptoms was
significantly associated with suicidal ideation but not with hopelessness or desire for hastened death. The patient’s physical functioning scale was rated using a Karnofsky performance rating scale (KPRS) (as cited in McClain et al., 2003).

Findings from the FACIT-SWB were that spiritual well-being and desire for hastened death ($r= -0.51$), hopelessness ($r= -0.68$) and suicidal ideation ($r= -0.41$) had significant correlations. According to Hamilton depression was highly correlated with desire for hastened death in participants low in spiritual well-being ($r= 0.40$) but individuals with spirituality showed less desire for death correlation ($r=0.20$) (McClain et al., 2003).

McClain et al. (2003) concluded that a person’s spiritual well-being had a strong relationship with end-of-life despair. Understanding the importance of spiritual meaning verses faith may help nursing understand how spiritual well-being affects psychological functioning. When caring for the terminally ill the nurse needs to remember the importance of spiritual well-being and that spiritual needs and existential questions are important part of a person’s psychological functioning.

Meraviglia (2004) believed spirituality has many different meanings, and individuals with serious illnesses have a greater need for spiritual interventions. Nurses should address the spiritual needs of terminally ill patients with spiritual nursing interventions. The purpose of the study was to describe the effects of spirituality on the well-being of people with lung cancer (Meraviglia, 2004). The Framework was derived from Frankl (1962).

The study took place in Central Texas. The population included adults currently being treated for lung cancer. The sample was obtained from oncology and radiation clinics or cancer support groups by using posted informal flyers. The sample consisted of 60 adults
with a diagnosis of non-small lung cancer. Participants ranged in age 33 to 83 years old with the majority being over 50, most were female and Caucasian. Participants must be at least 21 years old or older, have a diagnosis of lung cancer within the last 2 years and able to read and write in English (Meraviglia, 2004).

Four Instruments were used to measure spirituality and well-being. Meaning and purpose in life was measured by the Life Attitude Profile-Revised (LAP-R). This instrument is a 48-item scale that uses six dimensions: life purpose, coherence, choice and responsibility, death acceptance, existential vacuum and goal seeking to obtain a total score to represent the person’s meaning and purpose in life. This scale has 48 questions with a numerical response (Meraviglia, 2004). The participants’ existential transcendence or meaning and purpose in life are defined according to the composite score from the six dimensions. The alpha coefficient for existential transcendence was 0.87 in this study, and Reker (1992) reported an alpha coefficient of 0.90 in a previous study.

Prayer was measured using the Adapted Prayer Scale (APS). This scale assessed types of prayer activities, experiences and attitudes toward prayer along with frequency, focus and length of prayers. This scale has six questions also using a numerical response with a high score indicating high degrees of prayer activities, prayer experiences, positive attitudes toward prayer and overall prayer (Meraviglia, 2004). The alpha coefficient was 0.85 in a previous study (Poloma & Pendleton) but was higher in this study, r=0.94. Discomforts such as change in appetite, nausea, insomnia, pain, fatigue and bowel patterns were measured using the Symptom Distress Scale. This scale had 14 questions
with a numerical response. The higher the number scores the more the symptom distress and physical responses to lung cancer were noted by the participants (Meraviglia, 2004).

The cognitive and affective dimensions of psychological well-being were measured using a 14-item scale Index of Well-Being. This scale used eight pairs of adjectives that the participants used to rate life at that point in time (Meraviglia, 2004). An extra item was added to this scale to rate the participants satisfaction of life as a whole. The better the psychological well-being of the participant, the higher the score on this scale was found. The alpha score for this scale was reported as 0.84.

Findings from the Life Attitude Profile-Revised were that being married was negatively related to symptom distress \((r = -0.24)\) but psychological well-being was positively related to symptom distress \((r = -0.41)\). Increased existential transcendence was related to an improved functional status but current physical health was weakly related to prayer. Findings from the Symptom Distress Scale were that the better the physical health \((r = 0.38)\) and ability to maintain usual activities \((r = 0.27)\) the better psychological well-being of the participant reported. The Index of Well-Being findings were that the higher meaning in life scores were associated with higher psychological well-being and lower symptom distress scores. Higher prayer scores were associated with higher psychological well-being scores (Meraviglia, 2004).

Meraviglia (2004) concluded that the meaning in life was associated with better psychological well-being and more meaning decreased symptom distress. Prayer also impacts psychological well-being and physical status and activities.

The physical functioning and psychological well-being can be impacted by the diagnosis of a life-threatening disease like breast cancer. All aspects of spirituality must
be examined to fully understand the impact. Spirituality has been found to help some withstand the physical and psychological problems that arise with such a diagnosis. “The purpose of the study is to examine the sense of well-being of women with a breast cancer diagnosis and the effects of spirituality” (Meraviglia, 2006, p.E1).

The studies took place in central Texas with study participants being 21 years of age or older, a diagnosis of breast cancer, able to read and write English, in a fair state of health and from oncology and radiology centers from urban and rural settings. The participants were referred to the investigator by nurses, oncologists, and radiologists. The mean age of women was 53 years with ages 34-80 with the majority of participants Caucasian, college educated, employed and married. Praying three to four times a day was reported by 51% with 71% reported having a close relationship with God and other religious preferences included Protestant (39%), Catholic (17%), nondenominational (11%), Jewish (4%), and various spiritual groups, such as 12-step programs and support groups (Meraviglia, 2006).

Demographic characteristics of age, ethnicity, education, employment, marital status, religion, satisfaction with income and economics of daily living was assessed using the Background Information Survey (Meraviglia, 2006). The Life Attitude Profile-Revised (LAP-R) measured discovered meaning, purpose in life, and motivation to find meaning in six dimensions. “The six dimensions include life purpose, coherence, choice and responsibility, death acceptance, existential vacuum, and goal seeking” using a 48-item Likert-type rating scale with each dimension ranging a score from 8-56 (Meraviglia, 2006, p. E3).
General items regarding the frequency and amount of prayer, respondents’ relationship with God, prayer activities, prayer experiences, attitude toward prayer since cancer was diagnosed, and open-ended questions were assessed using the Adapted Prayer Scale (APS). The item scores on the three subscales and then summing the three subscales create a total (Meraviglia, 2006).

The Symptom Distress Scale (SDS) measures the physical responses, using a 14-item scale. Patients’ degree of discomfort related to appetite, nausea, insomnia, pain, fatigue, bowel patterns, concentration, dyspnea, appearance, outlook, cough, and mobility. High scores represent high degrees of symptom distress and more physical responses to breast cancer (Meraviglia, 2006).

The cognitive and affective dimension of patients’ sense of well-being is assessed using the Index of Well-Being (IWB), which is a nine-item semantic differential scale showing a sense of well-being on eight pairs of adjectives and on satisfaction with life as a whole. Satisfying psychological responses to breast cancer was indicated by high scores (Meraviglia, 2006).

Lower stages of cancer ($r=0.30$) was shown in women with lower symptom distress and higher psychological well-being but employment ($r=0.30$) and no metastasis was included in women with lower symptom distress and a closer relationship with God ($r=0.37$) and a higher functional status ($r=0.32$) was reported with women having a higher psychological well-being. More meaning in life was reported by participants that were older ($r=0.32$) and had a better functional status ($r=0.35$) but women with higher prayer scores showed lower education levels ($r=-0.37$) and less income to meet their needs ($r=-$-
0.24) a closer relationship with God was reported by both groups (r=0.23) and (r=0.84) respectively (Meraviglia, 2006).

Meaning in life, personal meaning index and prayer (r=0.70, r=0.36) were positively related to psychological well-being (r=0.66). Personal meaning index (r=-0.25) and meaning in life(r= -0.27) were found to be negatively related to symptom distress but no relationship was found between prayer and symptom distress (Meraviglia, 2006).

Meraviglia (2006) concluded that spiritual concepts (meaning in life and prayer) have an influence on physical and psychological well-being. Meaning in life mediates the impact of breast cancer on the physical and psychological well-being of women.

Symptom relief is based on patients’ symptoms including spiritual, psychological and physical needs. Near the end of life the prevention of and relief from the multitude of symptoms should be addressed. “The purpose of the study was to determine to what degree the spiritual needs of patients near the end of life are met” (Hermann, 2007, p. 70).

This study took place in one inpatient hospice and five outpatient hospices in the southeastern United States. Since the interviews lasted for 15–30 minutes the participants needed to be alert and orientated. The study included 100 patients English speaking, 18 years or older with a mean age of 67 years, and a range of 21–99, with two-thirds female and Caucasian and Protestant. Sixty-nine percent believed financial status was sufficient to meet basic needs, and were residing in own or a relative’s home. Seventy-four percent had some type of cancer as a major medical diagnosis with 10% of health status judged as rapidly declining, 56% slowly declining, or 34% stable over the past month and 56% of the sample had been hospice patients for fewer than 4 months (Hermann, 2007).
Data were collected using the Spiritual Needs Inventory. This scale is a 27-item scale developed to measure the spiritual needs of individuals near the end of life. Patient’s identified a spiritual need and three different questions were asked. The first statement “In order to live my life fully, I need to (insert spiritual need here),” subjects indicated to what degree each of the 27 spiritual items were needed. Responses were measured on a 5-point Likert scale from never to always and were added to obtain a total scale score. The third question asked was “Is this need currently met in your life?” Open-ended questions were asked for patients to report any other spiritual needs that had not been included on the 27-item Spirituality Needs Inventory (Hermann, 2007).

Quality of life was measured using the Cantril ladder which is a single-item scale with a 10 = best possible life imagined, and 1 = the worst possible life. Key words from the descriptions from patients are written at the top and bottom of the ladder that measures the most important aspect of QOL-life satisfaction. Patients are asked to rate life satisfaction twice once at the present time and then immediately before receiving the diagnosis of the disease (Hermann, 2007).

The Patient Description Data form was used to collect demographic data, medical data, and patient status. Patients’ county of residence, age, medical diagnosis, length of time in hospice, race, and gender was obtained from the patients’ medical record. Religious preference, education in years, and ability to meet basic financial needs was provided by patients’ and a hospice staff member provided patients’ health status (Hermann, 2007).

Women reported a higher degree of need for spiritual aspects and more unmet needs (-X = 64.27, SD = 9.62, p = 0.0117) than men (-X = 4.32, SD = 3.21, p = 0.0406). Life
satisfaction scores, socioeconomic groups, life satisfaction, total scale score, and number of unmet needs were not significantly different were not found to be significantly different. Kruskal-Wallis technique was used to analyze relationships among education, length of time in hospice, age, and place of residence, life satisfaction, total scale score, and number of unmet needs. “A significant difference (p = 0.0353) was found in the number of unmet needs for participants with 1–8 years of education (-X = 4.97, SD = 2.98), 9–12 years of education (-X = 3.55, SD = 3.35), and 13 years or more of education (-X = 3.32, SD = 3.65)” (Hermann, 2007, p. 73).

No significant differences existed in subjects’ responses for length of time as a hospice patient and age. A significant difference (p = 0.0037) was noted for patients each of the spiritual needs on the SNI for subjects’ places of residence. Participants responded to a Likert scale of 1 (never) to 5 (always) with total scale scores ranging from 30–81 (possible range = 17–85), with a mean of 61.7 (SD = 11.7). Laughing was rated as a need by 100% of the patients and with 90% or more of the subjects needing six other items. Of the 17 items, 13 were rated as needs by 80% or more of the sample including talk with someone about spiritual issues (79%), dealing with inspirational materials, reading inspirational materials (68%), and inspirational materials (59%) (Hermann, 2007).

Scores were calculated for each subscale on the SNI. Subjects were asked whether each need currently was being met. Ninety-six patients found that the need to pray was met but not one need was met for every subject. A larger number of participants 80%–89% found that the need for music, use inspirational materials or religious phrases, talking things, see the smiles of others, were needs that perceived as met; with only 70%–79% of patients’ reported needs such as talking about spiritual issues, family and friends
information, be around children or people who share spiritual beliefs, and happy thoughts being met (Hermann, 2007). Laughing, reading a religious text, being with family, being with friends, and reading inspirational materials reportedly were met in 60%–68% of subjects’ lives and one item, the need to go to religious services, was met in only 30% of patients’ lives.

The Cantril ladder rated life satisfaction and previous life satisfaction. Ninety eight patients had a mean current life satisfaction score of 5.8 (SD = 2.8, range = 1–10) with life satisfaction scores for the time prior to diagnosis a mean of 8.1 (SD = 2.7). Previous life satisfaction for 74% participants had rating of 7 or more (Hermann, 2007).

Current life satisfaction was rated lower than previous life satisfaction by 68% (n = 66) of the subjects and 11% (n = 10) reported that life satisfaction was the same for both time periods with 21% (n = 20) reporting an increase in life satisfaction. Seven subjects (8%) rated current life satisfaction four numbers higher than previous life satisfaction of those who reported an increase in life satisfaction. Increased life satisfaction rating by three (n = 2), two (n = 6), or one (n = 4). The relationship between unmet spiritual needs and life satisfaction was r = –0.17 (Hermann, 2007).

Participants identified other spiritual needs. The top five additional needs being talk with or visit with a minister (n = 9), be prayed for (n = 5), receive communion (n = 4), visit with a hospice chaplain (n = 3), and be healed (n = 3)” (Hermann, 2007, p.75). Six other items found in the number of unmet needs reported by subjects included residing alone or in a relative’s home reported a mean of 3.3 unmet needs (SD = 3.29) with a mean of 5.35 of unmet needs (SD = 2.50), residing in a nursing home and inpatient hospice unit subjects reported a mean of 5.36 unmet needs (SD = 3.91) (Hermann, 2007).
Meeting the spiritual needs including the spiritual dimension helps patients’ achieve a better quality of life especially when they are nearing the end of life. Spiritual needs arise at anytime and since nurses spend the most time with the patients they can become an integral part of spiritual care. Personal growth can be seen prior to death which can lead to an increased life satisfaction by patients’ (Hermann, 2007). According to Hermann (2007) the facilitation of well-being near the end of life is essential in spiritual care.

*Coping with Terminal Illness*

Kloosterhouse and Ames (2002) examined families’ use of religion/spirituality and coping with the illness of a child. The conceptual framework was Antonovsky’s Salutogenic Model of Health integrated with Human Ecological Theory. Kloosterhouse and Ames (2002) used the adapted definition of religion/spirituality from the National Institute for Healthcare Research, “The feelings, thoughts, experiences and behaviors that arise from a search for the sacred, and the means and methods of the search that receive validation and support from within an identifiable group of people” (Kloosterhouse & Ames, 2002, p. 64).

Stress was measured by a two-page self-report survey developed by Kloosterhouse and Ames (1985). The survey gathered information on the families’ perceived stress, ability in coping, and importance of religion/spirituality as a resource for coping using a 5 point scale. The families’ practice of religion/spirituality, beliefs and use of religion/spirituality as a coping resource was determined by multiple regression analysis. Hypothesis two was analyzed using the multiple regression analysis (Kloosterhouse & Ames, 2002).
“Hypothesis 1 stated that there was a positive relationship between the families’ perceived ability to cope with the stress of having a child in the hospital and choosing to use religion/spirituality as a coping resource” (Kloosterhouse & Ames, 2002, p. 66). A positive relationship was not identified between the use of religion/spirituality and the ability of the family to cope with stress.

Hypothesis 2 was accepted and did show a positive relationship on the family’s belief and practice of religion/spirituality and the use of religion/spirituality as a psychosocial resource (Kloosterhouse & Ames, 2002). Importance of using supportive resources throughout the stages of stress and families identified religion/spirituality as important coping resource (Kloosterhouse & Ames, 2002).

Kloosterhouse and Ames (2002) concluded that religion was not always used to cope with stress, religion/spirituality should be considered as a psychological resource. Families in the study reported that religious and spiritual beliefs were a source of strength, which gave them a sense of meaning, purpose and hope in life.

Understanding why some individuals with a life-threatening illness consider hastening death and others do not is an important part of end of life care (Arnold, 2004). The question of the right to take a life has been debated for many years. The purpose of this study was to examine factors that contribute to consideration of hastening death among people with life-threatening illnesses.

The population targeted included individuals with a diagnosis of a life-threatening illness. Participants were recruited using several methods: publications, newspapers, advertisements, and the Hemlock society was also chosen as a resource. The sample included 148 individuals, almost equally divided between male and female, between the
ages of 19-92. The mean age is 59.46 with the majority being 65 or older. The data were collected in the person’s home. The “life-threatening illnesses” listed on the survey included cancer (18.2%) and HIV/AIDS (16.2%) which were the majority of diagnoses. When the individuals responded to the study was sent a survey package with a consent form and the questionnaire in which individuals needed fill out and return. The questionnaires were then analyzed and results were calculated (Arnold, 2004).

Five instruments were used to describe the participant’s pain, degree of depression, amount of social support available, level of hope and the clinical anxiety. The West Haven-Yale Multidimensional Pain Inventory (Arnold, 2004) is a 52 item scale with three parts that consists of 12 subscales that assess the impact of pain on people’s lives, response of others to the individual’s communication of pain and the ability to participate in daily activities. The mean score of the subscale for pain severity was used because the focus was the individual’s subjective physical experience pain. The alpha was .70 to .90 and good construct validity. The Hudson’s Generalized Contentment Scale (Arnold, 2004) is a 25 item scale that measures the degree, severity, and magnitude of depression. The coefficient alpha of .92 indicates excellent internal consistency. The scores of the GCS highly correlate with other measures depression (Arnold, 2004).

Social support was measured using the Multidimensional Scale of Perceived Social Support scale which measured 12 items from family, friends and a significant other. Internal consistency was reported as alpha of .91. The negative association with psychological distress shows good construct validity (Arnold, 2004).

Hope was measured using the Herth Hope Index (HHI). HHI is a 12-item scale that was adapted from the Herth Hope Scale. The alpha coefficient is .88 and .97 and test-
retest reliability at two weeks of .87 and .91. The Clinical Anxiety Scale was used to measure anxiety; it consists of 25 items that measure the amount, degree or severity of clinical anxiety. The coefficient alpha of .94 shows an excellent internal consistency (Arnold, 2004).

Depression was found to be the strongest predictor that contributed to the desire to hasten death. Social support, hope, pain and anxiety were positive predictors to hastening death. Depression showed contemplators (R²=34.12, p<.001) and noncontemplators (R²=22.15, p<.001), social support showed contemplators (R²=4.77, p<.01) and noncontemplators (R²=5.79, p<.001) towards hastening death. Hope showed a correlation of contemplators (R²=34.85, p<.001) and noncontemplators (R²=5.79, p<.001), pain showed a higher correlation with contemplators hastening death than (R²=1.98 and R²=1.57, p<.16) for noncontemplators. Anxiety also showed a higher tendency towards hastening death with contemplators verses noncontemplators (R²=21.12 and R²=18.78, p<.31) (Arnold, 2004).

Findings from the West Haven-Yale Multidimensional Pain Inventory were that respondents reported lower levels of pain severity, than did respondents in earlier studies of people with cancer pain and chronic pain unrelated to a life-threatening illness. Findings from the Hudson’s Generalized Contentment Scale were that if depression plays a critical role in the decision-making process of individuals contemplating hastening death, social workers who work with patients at the end of life must understand the factors that contribute to the depression and develop effective assessments and interventions (Arnold, 2004).
Findings from the Multidimensional Scale of Perceived Social Support were that social support plays a role in distinguishing contemplators from noncontemplators may be difficult to address in practice. Findings from the Herth Hope Index were that the HHI did not distinguish what factors influence a person’s level of hope. Therefore, it is unclear whether low levels of hope generally found among contemplators were the result of knowing that the illness is incurable or attributed to other factors. Findings from the Clinical Anxiety Scale were that anxiety did not play a role in the decision-making process of respondents who considered hastening death (Arnold, 2004).

The author concluded that the participant’s depression, social support and hope distinguish individuals contemplating hastening death. Without social support and hope, the desire to hasten death has been found to be stronger. Anxiety and pain levels are slightly higher for individuals that contemplated but the differences were not statistically significant (Arnold, 2004).

Hope has been associated with spiritual healing and improving physical and mental well-being. Hope helps the living to continue and the dying to die more peacefully (Felder, 2004). The purpose of the study was to explore the levels of hope and coping in patients with various cancer diagnoses to determine levels of hope and coping. Patients with cancer have identified hope as an essential element in illness (Felder, 2004).

The study took place in a large mid-Atlantic teaching institution at the hematology/oncology outpatient clinic with participants having a diagnosis of gastrointestinal, genitourinary (GI/GU), breast, head and neck, or hematologic cancer. A total of 183 patients consented and completed the questionnaires in English. Participants ranged in age from 18 to 65 with majority between 51-65 years of age, married, and a
college or graduate degree. Forty-nine percent of the participants were male and 51% were female with a majority being white (Felder, 2004).

The following cancer sites were represented in the four categories: breast cancer, colorectal, esophageal, stomach, hepatocellular, pancreatic, bladder, prostate, testicular, head and neck. The majority of the patients (51%) reported having breast, and 42% reported having colorectal cancer with the other various cancers having a low percentage of incidences (Felder, 2004).

Data were collected using a basic demographic form, the Herth Hope Scale (HHS) and the Jalowiec Coping Scale (JCS). Hope is measured using the HHS which is 30 items using a 0-3-point summated rating scale. Higher scores (<60) indicating higher levels of hope. The perception that a positive, desired outcome is realistically possible in the future is found in the subscale for the cognitive-temporal dimension. Recognition of the mutual dependence and connectedness of self and others and self and spirit is found in the affective-behavioral dimensions subscale (Felder, 2004).

Coping styles and the effectiveness of the coping style was assessed using the JCS scale. The JCS has 60-items with a Likert 0-4-point rating; each item is rated separately for its frequency of use and effectiveness. The eight coping styles described by Jalowiec are included: emotive, confrontive or constructive, fatalistic or pessimistic, evasive, optimistic, palliative or stress-reducing, self-reliant, and supportive systems. Optional open-ended question are at the end regarding other methods or coping styles used (Felder, 2004).

The groups were divided according to diagnoses: breast, head and neck, GI/GU, colorectal cancer, hepatocellular, prostate, pancreatic, esophageal, bladder, stomach and
testicular, hematological contains multiple myeloma, NHL, Hodgkin’s lymphoma, CLL, AML, and ALL. The results of the HHS total scores among the four diagnostic categories were that there were no significant differences between patients and caregivers with regard to the HHS subscales. The author found a significantly positive relationship between the overall level of hope and coping styles \( (r=0.184, P=.013) \), and the overall level of hope coping effectiveness \( (r=0.184, P=.013) \) and the overall level of hope coping effectiveness \( (r=0.375, P<.0001) \). HHS total scores and both JCS use and effectiveness scores showed a positive correlation with Group 1 (GI/GU). A significantly positive relationship between HHS total score and JCS effectiveness score only was found for the three other groups (Felder, 2004).

The authors concluded that the level of hope was high among cancer patients, even with advanced-stage cancer, and regardless of gender, age, ethnicity, level of education, marital status, or type of cancer. The more hope the individual had the better the individual coped. Nurses can enable and inspire hope by developing an awareness of life, identifying a reason for living, establishing a support system and incorporating presence, touch, active listening, values clarification, and reality surveillance into practice respectively (Felder, 2004).

With any terminal illness a psychosocial adjustment is needed. Prostate cancer can have negative effects on the quality of life long term. It was predicted that religious coping would be related to the physical, role, emotional and social functioning of prostate cancer survivors. Values and guidelines for conducting one’s life can come from various religious beliefs and practices (Gall, 2004). Gall (2004) explored the potential role of one
religious/spiritual factor, religious coping, in men’s’ long-term adjustment to prostate cancer (Gall, 2004).

The study took place over a period of 2 years. Participants were selected with the inclusion criteria of being a male with a diagnosis of prostate cancer in the past 5 years. There were 34 men, all between the ages of 47-77. The religious affiliations of the men included Protestant (52.9%), Catholic (38.2%), another religious affiliation (5.9%) and 2.9% did not include that information. Spirituality was found to be most important (61.8%) of men over religion at approximately (58.8%) of the men. Prostate cancer was perceived to be severe or very severe by 64.7% of men (Gall, 2004).

Data were collected using the Religious Coping Activities Scale; the 32-item scale assesses spirituality based, good deeds, religious discontent, interpersonal religious support, pleading, and religious avoidance coping behavior. Also used to collect data were:

Brief COPE, a 28-item scale assesses a wide range of general coping behaviors, including active coping, use of social support, positive reframing and denial coping. The Cognitive Appraisal Checklist consists of a list of 11 single-item adjectives and/or phrases including challenge, threatening, positive, and undesirable and degree of life impact (Gall, 2004, p. 456).

The Medical Outcomes Study is 36-item Short-Form Health Survey measures of quality of life and impact of ill health in various domains of life functioning (Gall, 2004).

Findings from the Religious Coping Scale were that the use of religious coping behavior was related to lower levels of role, social and emotional functioning for prostate cancer survivors. Religious coping was related to aspects of nonreligious cognitive
appraisal and coping behavior for men with prostate cancer. “All forms of religious
coping, regardless of positive or negative nature, were positively related to both
avoidance and active forms of nonreligious coping for prostate cancer survivors” (Gall,

Findings from the Cognitive Appraisal Scale were that almost all correlations between
religious coping and general functioning were nonsignificant after controlling for
avoidance in partial correlations. Men who experienced more religious discontent coping
reported poorer role and emotional functioning. Role functioning (r=0.44, P<.01) and
age were found to be significantly related with older men reporting better role
functioning than younger men with prostate cancer. “Severity of diagnosis was related to
poorer role functioning (r= -0.40, P<.05) and men who experiences more intense physical
reactions to treatment reported poorer physical functioning (r= -0.36, P<.05), role
functioning (r= -0.54, P<.001), social functioning (r= -0.57, P<.001), emotional
functioning (r= -0.55, P<.001)” (Gall, 2004, p. 457).

Seeing the illness more positively (r=0.34, p< .05) and opportunity for gain (r=0.40,
p<.05) was found to be significantly related to cognitive appraisals and spiritually based
coping. The prostate cancer having some meaning in one’s life (r=0.35, P<.05) and
religious avoidance was found to have a relation (Gall, 2004).

Pleading, coping and appraising the illness showed a positive correlation as having a
greater impact on one’s life in general (r=0.36, P<.05). Social functioning was
significantly related to spirituality based (r=0.36, P<.05) and good deeds coping (r=0.38,
P<.05) for prostate cancer survivors (Gall, 2004). The authors concluded that men have a
different developmental sense of faith (less relationally based), and thus, when men turn
to God under duress men might experience a more distant sense of this relationship (which provides less comfort) (Gall, 2004).

People with chronic illness who live in the urban areas have a lower risk for poorer health than those who live in rural settings. Differences in rural lifestyles and factors that is inherent in rural life maybe factors that increase that risk. “The purpose of this study was to explore associations among spirituality, hope, depression, social support, and well-being of people in rural settings who have one or more chronic conditions” (Craig, Weinert, Walton & Derwinski-Robinson, 2006, p. 28).

The study took place in Oregon and Montana. Participants included persons with a self-defined chronic condition who are 18 years or older. Illnesses included were arthritis (8.1%), diabetes (10.8%), cancer (8.1%), and heart problems (7.2%) with half of the sample having been ill for 8 or more years.

The sample consisted of 111 rural-dwelling people (88.8%), women making up 86.5% with median age of 58.5, Caucasians (90.1%), American Indians (3.6%), Hispanics (1.0%), African Americans (1.0%), or others (4.2%), with one or more self-defined chronic illnesses. The participants were retired or not working (69.4%), with more than half of the participants married or living with someone (55.9%) and (44.1%) living alone. Religious affiliations were Catholic (22.7%), Lutheran (20.5%), and nondenominational Christian (19.3%) (Craig et al., 2006).

Participants completed a questionnaire booklet that contained demographic questions and scales measuring spirituality, social support, hope, depression, health behaviors, quality of life, and illness management. Spirituality was measured using the Harrison Spirituality Scale which is a 38-item scale which incorporating elements of
transcendence, meaning, and connection with higher scores indicating greater spiritual feelings (Craig et al., 2006).

Personal Resource Questionnaire (PRQ) 2000 was used to measure social support, which has 15 items that are summed to produce a single score, with higher scores indicating higher levels of preserved social support. Beck Depression Inventory-II (BDI-II), a seven-item instrument measured depression with high BDI-II scores are indicating high levels of depression (Craig et al., 2006).

Miller Hope Scale, which is a 43-item instrument, measured the concept of hope with higher scores indicating higher levels of hope. Quality of life was defined as the degree of satisfaction with present life circumstances, which was measured using the Quality of Life Rating Scale (QOLRS). The QOLRS is a two-item scale that measures individuals’ perceptions concerning quality of life as a global concept, a higher scores indicating higher quality of life. The Psychological Adjustment to Illness Scale, which is a 33 item instrument, was used to assess illness management and covered illness-related issues that may have occurred in the past 30 days, with lower scores reflecting better adjustment to illness (Craig et al., 2006).

Craig et al. (2006) found that scores for spirituality, hope, depression, and social support were intercorrelated. Intercorrelations ranged from .39 between social support and spirituality to .63 between hope and social support. Social support (.26), hope (.36), and depression were all found to have a significant relationship with physical activity. Quality of life correlations were strong with hope (.60), and social support (.47) but weaker with spirituality (.33). Illnesses management had modest bivariate correlations with depression (.38). Physical activity was not significantly correlated with spirituality
-.25), sleep was significantly negatively correlated with depression (.21) and quality of life score was negatively significantly correlated with depression (.55). Illnesses management had modest negative bivariate correlations with social support (.35) but not with hope (.14) or spirituality (.21). Higher scores on illness management reflect poorer management (Craig et al., 2006).

The authors concluded that rural people with chronic illnesses and effects of spirituality on well-being were not related in this study. Findings included high levels of hope, strong illness management skills, and low levels of depression along with very high spirituality and religious affiliation. “Attention to spiritual concerns allows a nurse to attend to a very holistic aspect of nursing care” (Craig et al., 2006, p. 34).

Spirituality has become a major focus for many with the belief that spirituality and QOL are connected but little research had been conducted between the two concepts. The purpose of the study was to demonstrate the importance of spiritual well-being in coping with a chronic illness and the effects of spirituality and quality of life on the lives of HIV-positive persons (Pennington Grimsley, 2006).

A specific rural HIV clinic was designated for this study and specific days were designated for data collection. The participants were a client of the HIV clinic, able to give informed consent, able to understand and speak English, 21 years or older, non-prisoners, able to complete a questionnaire which was read aloud by the investigator. The participants also needed a diagnosis of HIV-positive status or an AIDS diagnosis (Pennington Grimsley, 2006).

The data were collected 1 day each week during the study period. The investigator administered the demographic survey, the Spiritual Perspective Scale, and the BREF to
each participant. One hundred one clients agreed to participate. It took approximately 30 minutes to complete the three instruments. To encourage participation by individuals who are reading proficiency or visual acuity might be inadequate the investigator read the questions and circled the participant’s response.

The sample included 50 men and 51 female with 84 (83.3%) black and 17 (16%) white with age ranged from 21 to 67 years and an average of 41 years old. The education level included 50% having completed high school and 6% completed college. Never being married was reported by 48% of the sample with 23% being married at the time of the study, although only 25% of the participants lived alone and 58% lived with family members (Pennington Grimsley, 2006).

Spirituality was measured using the Spiritual Perspective Scale (SPS) which has 10-items measured spiritual behaviors and beliefs. A 6-point Likert-type scale was used to measure each item with scores for each item ranging from one (low) to six (high) and a total overall score ranging from 10 to 60. The overall score is obtained by totaling each participant's scores for items 1 through 10 then divide by 10.

The questions include how frequently spiritual activities (e.g., private, prayer and meditation), were practiced and if the participant agreed with statements about spiritual aspects such as forgiveness. The BREF, a 26 questionnaire, with four domains: physical, psychological, social, and environmental health, were used to measure quality of life. Each domain includes three to eight questions with total domain scores ranging from four to twenty. A moderate to high correlation (r = .31, p = .01) was found between the BREF and SFS with spirituality and overall QOL score having a positive and significant relationship (Pennington Grimsely, 2006).
The relationship between age and spirituality was addressed in the second and third questions and found to have a positive but nonsignificant correlation. Age and QOL was also addressed with these questions. Physical well-being and health showed a lower evaluation of QOL, the older participant was. “There was a positive, significant correlation between psychological well-being and age (r = +.20, p < .05), that is, the older the participant, the bigger the rating on the psychological domain of the BREF but there was not a significant relationship between the composite BREF” (Pennington Grimsely, 2006, p. 115).

A difference between education and spirituality verses QOL was addressed in the fourth and fifth questions. Advancing education was related to bigger levels of spirituality (F =3.28, p =.23), but not statistically significant although levels of education and QOL were found to be significant (F =3.28, p .05). “The average score on QOL (mean=55.52) for patients completing less than high school was significantly different {p =.05) from the mean score on QOL (mean=62.2) for patients completing high school showing the more education, the higher the HIV-positive persons assessed their QOL” (Pennington Grimsely, 2006, p. 115).

Ethnicity and spirituality and QOL were addressed with questions six and seven. A highly (p = .001) significant relationship was found between ethnicity and spirituality between Black and White HIV patients with the average spirituality scores for Black HIV patients being higher than White HIV patients. QOL scores for Black and White participants in the study showed no significant differences.

Results of 8th and 9th research questions analysis were that no differences in levels of spirituality or QOL based on marital status were found (Pennington Grimsley, 2006).
The 10th and 11th research question investigated the difference between gender and spirituality versus QOL. Women scored higher on spirituality than men but no significance difference was found between women or men for spirituality or QOL.

Quality of life in HIV-positive participants showed that spirituality had the largest or most important direct impact. The older participants showed a lower evaluation of QOL in physical well-being and health but a higher rating on the psychological well-being. Age and psychological well-being showed a positive significant correlation with a higher the rating on the psychological domain but not between the composite BREF and age (Pennington Grimsley, 2006).

The need for nurses to address both spirituality and QOL in giving care of chronically or terminally ill patients was found to be an important. Evidence that spirituality and QOL are indeed related in HIV-positive participants was shown in this study and supported other empirical studies conducted in different geographical areas (Pennington Grimsley, 2006).

Conclusion

Patients’ perceptions of spirituality and terminal illness were well documented in the literature presented. Fryback and Reinert (1999) concluded that patients perceived spirituality as reflective of a higher power, immortality and as achieving self-actualization. Sherman et al. (2005) concluded that there was no significant difference in total Spiritual Well Being of patients with advanced AIDS and cancer, there was a statistically significant difference in total SWB scores for AIDS and cancer caregivers. In addition SWB scores for family caregivers who were not receiving hospice services were lower than scores reported by family caregivers had hospice support. Katsuno
(2003) concluded that personal spirituality was exemplified as religiosity and a person with early-stage dementia may retain a strong faith in God and still experience all areas of religiosity. The results also indicated that the participants use religion for coping with dementing illnesses and find meaning and purpose in life. Personal religious and spiritual beliefs and practices are associated with the perceived quality of life. Vig and Pearlman (2003) identified new variables considered important to individuals facing the end of life. The results broadened the understanding of how several previously identified themes contribute to quality of life at the end of life. Taylor (2003) concluded that assessing the spirituality of a patient with cancer, or a family member requires knowledge of spiritual needs. Taylor (2006) concluded that by addressing spiritual needs sensitively and intelligently, nurses undoubtedly will promote not only spiritual health but also holistic health.

Nurses’ perception of spiritual care and the use in the profession is documented in the literature presented. Vance (2001) concluded that time was the biggest barrier to providing spiritual care for patients was due to cutbacks and shortened stays in the hospital. Other factors that limited spiritual care was lack of confidence, differences between patient and nurse and the confusion over providing total patient care and preaching religion (Vance, 2001).

The effects of spirituality outcomes with terminal patients are also well documented in the literature presented. Tuck et al. (2001) concluded that spirituality needs to be considered when examining the psychosocial factors and the quality of life of persons living with HIV disease. McClain et al. (2003) concluded that a person’s spiritual well-being had a strong relationship with end-of-life despair. When caring for the terminally
ill the nurse needs to remember the importance of spiritual well-being and that spiritual needs and existential questions are important part of a person’s psychological functioning. Meraviglia (2004) concluded that the more meaning in life was associated with better psychological well-being and decreased symptom distress noted. Prayer also impacts psychological well-being and physical status and activities. Meraviglia (2006) also concluded that spiritual concepts (meaning in life and prayer) have an influence on physical and psychological well-being. Meaning in life mediates the impact of breast cancer on the physical and psychological well-being of women. Hermann (2007) concluded that care for patients near the end of life must address all aspects of individuals, including the spiritual dimension. The time prior to death can be one of personal growth that leads to increased life satisfaction. Spiritual care is essential to facilitate well-being in patients near end of life.

The coping abilities of patients with a terminal illness are documented in the following literature. Kloosterhouse and Ames (2002) identified a positive relationship between the families’ perceived ability to cope with the stress of having a child in the hospital and choosing to use religion/spirituality as a coping resource. A positive relationship was not identified between the use of religion/spirituality and the ability of the family to cope with stress. Kloosterhouse and Ames (2002) identified a positive relationship on the family’s belief and practice of religion/spirituality and the use of religion/spirituality as a psychosocial resource (Kloosterhouse & Ames, 2002). Importance of using supportive resources throughout the stages of stress and families identified religion/spirituality as important coping resource Arnold (2004) concluded that the participant’s depression, social support and hope distinguish individuals contemplating hastening death. Felder
(2004) concluded that the level of hope was high among cancer patients, even with advanced-stage cancer, and regardless of gender, age, ethnicity, level of education, marital status, or type of cancer. The more hope the individual had the better the individual coped. Gall (2004) concluded that men have a different developmental sense of faith (less relationally based), and thus, when men turn to God under duress men might experience a more distant sense of this relationship (which provides less comfort). Craig et al. (2006) concluded that the effect of spirituality on well-being among rural people with chronic illnesses independent of hope, social support, and depression were not related in this study. Pennington Grimsley (2006) findings indicated the need for nurses and other health professionals to address both spirituality and QOL in care of chronically or terminally ill patients.
Chapter 3

Methodology and Procedure

Introduction

According to Meraviglia (2004) spirituality can impact an individual’s sense of well-being. Individuals that have been given a “terminal” or “life-threatening” diagnosis sometimes find that during the critical life event spirituality becomes an important aspect in life. Prayer and having meaning in life are important aspects of spirituality. Nurses assess the spiritual needs of patients, formulate clinical diagnoses, and seek to intervene toward some goal such as well-being. This chapter contains a description of the methods and procedures for the study.

Research Questions

1. What are the spiritual concerns and needs of the terminally ill patients?
2. Are the spiritual concerns and needs of the terminally ill patients being met?

Purpose

The purpose of this study is to examine the effects of spirituality on the sense of well-being of people with lung cancer. This is a replication of Meraviglia (2004) study.

Population/Sample/Setting

The study will take place in Ft Wayne, IN. The population will include terminally ill patients from two oncology/hematology physicians’ offices. There are three physicians
in this office and see approximately 6 to 8 patients per day. The anticipated number of participants for this study will be 50 patients. The criteria for inclusion in the study will be: (a) patients diagnosed with a diagnosis of cancer and are aware of the prognosis and illness, (b) 20 years of age or older, (c) able to respond to questions appropriately and (d) will to participate in the study.

Protection of Human Subjects

The required documents of the proposed research will be submitted to the Institutional Review Board of Ball State University and the Physician’s office. Human subject’s rights and welfare would be protected by de-identifying the information gained from the surveys. Participation is voluntary and there are no risks to the welfare of the subjects. Benefits to the patients will be a chance to reflect on spiritual perspectives and the facing of a terminal illness. A documentation of review form, HIPAA, summary of safeguard statement, informed consent statement, protocol, financial disclosure and other supporting documents may be required.

Procedures

After approval of the study by the Institute Review Board of Ft Wayne area oncology physicians’ offices, the researcher will contact the office manager, the oncology/hematology nurses in the office and participating physicians. The researcher will set up an appointment to meet with the nurses and office manager to explain the purpose of the study and a separate meeting will be scheduled for the physicians that are participating in the study. A copy of the abstract and the four scales will be provided. After discussing the study the researcher will identify and select the appropriate patients for the study. The selected patients will then be mailed an information sheet and a brief
explanation about the study along with a written consent form. A stamped self-addressed envelope will also be included in the mailing for the information to be returned. The researcher will administer the questionnaire to the patients who have returned the consent during their normal visit to the physician in a private room provided in the office.

Methods of Measurement (Instrumentation)

The Life Attitude Profile-Revised (LAP-R) will be used to measure existential transcendence. The LAP-R is a 48-item scale that measures discovered meaning, purpose in life, and motivation to find meaning. Participants will respond to all six dimensions forming a composite score which shows the persons meaning and purpose in life and motivation for find meaning. The participants rate 48 statements using a seven-point scale from 1 (strongly disagree) to 7 (strongly agree).

The Adapted Prayer Scale (APS) assess types of prayer activities, prayer experiences, and attitudes toward prayer since being diagnosed with cancer. In addition, items assess frequency, focus, and length of prayers. The APS has 39 items, which include 3 general items about prayer, 1 item on perceived relationship with God, 17 items on prayer activities, 9 items on prayer experiences, 6 items on attitudes toward prayer, and 3 open-ended questions. The 3 subscales had 7 Likert-type response categories ranging from 7 = strongly agree to 1 = strongly disagree. Total scores were computed for each subscale by adding the item scores. High scores reflect high degrees of prayer activities, prayer experiences, positive attitudes toward prayer and overall prayer. The reliability was established using Cronbach’s alpha with the coefficient of 0.94 and previous alpha of 0.85 reported by Poloma and Pendleton (Meraviglia, 2004).
The Symptom Distress Scale will be used to assess the degree of discomfort related to appetite, nausea, insomnia, pain, fatigue, bowel patterns, concentration, appearance, breathing, outlook, cough and mobility. The Symptom Distress Scale is a 14-item scale with high scores representing more symptom distress and more physical responses to lung cancer. Scoring is done using 1 to 5 Likert-type scales, with 5 indicating the most distress. Items rated 3 or higher are considered to indicate serious distress. A total summed score of 25 or above indicates moderate distress; scores of 33 or above indicate severe distress that requires immediate intervention. The reliability and validity of the Symptom Distress Scale for this study was 0.84 which was consistent with the previous reported by McCorkle (Meraviglia, 2004).

Research Design

This study is an approximate replication study. The design is descriptive. According to Burns and Grove (2005) a descriptive design is used, “for the purpose of developing theory, identifying problems with current practice, justifying current practice, making judgments or determining what others in similar situations are doing.” This study will focus on identifying spiritual needs and concerns of the terminally ill and whether those needs or concerns are being met.

Intended Method of Data Analysis

Descriptive Statistics will be used to analyze the data. Burns and Grove (2005) stated descriptive statistics allow the researcher to organize the data in ways that give meaning and facilitate insight and to examine a phenomenon from a variety of angles.
Summary

The purpose of this study is to examine the effects of spirituality on the sense of well-being of people with lung cancer. The design is a descriptive design. There are four tools being used to measure meaning, purpose and motivation in life, prayer activities, degree of discomfort and cognitive and affective dimensions of psychological well-being. There are three main variables used in this study. The type of statistics used is descriptive including frequencies, means, standard deviations and range.
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