SPIRITUALITY IN THE TERMINALLY ILL HOSPITIZED PATIENT

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ABSTRACT

RESEARCH PAPER: Spirituality in the Terminally Ill Hospitalized Patients
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Spiritual and religious beliefs influence how individuals view death and dying. Nurses focus on the physiological, safety, and emotional needs of the patient, and sometimes the spiritual needs may be neglected (Reed, 1987). Nurses need to identify the spiritual needs to delivery holistic care. The purpose of this study is to compare perspectives of the spirituality and well-being of the non-terminally ill hospitalized and terminally ill hospitalized adults and to determine if there is a relationship between spirituality and well-being. This is a replication of Reed’s (1987) study. The Systemic Organization (Friedemann, Mouch, & Racey, 2002) is the framework that guides the study. All terminally ill patients hospitalized on the oncology or hospice units from two hospitals in the Lafayette, Indiana will be evaluated during a 6 month period. The seriously ill patients will be patients admitted to the intensive care units and step-down units. The anticipated number of participants is 50 terminally ill patients and 50 seriously ill patients selected from an anticipated 100 terminally ill patients and 100 seriously ill patients. The Spiritual Perspective Scale (SPS) and Index of Well-Being (IWB) will be used to measure the spirituality and well-being of the participants. Findings will provide information for nurses about the perspectives on spiritual care.
Chapter 1

Introduction and Background

Introduction

Healthcare today is a complex, technology driven industry, which has made the United States health care system one of the best in the industrialized world (AHA, 2007). Financial and business information and support, biomedical monitoring devices, patient safety monitoring, connectivity and communication links, and educational and reference information have become commonplace in the health care environment (Smith, 2004). The delivery of patient care depends on the vast and ever changing technologies in order to provide safe, efficient, quality care. Physicians, nurses and all healthcare providers need to acquire the ability to use technologies, yet keep a personal, holistic approach with patients and families. The advantages of technology must be weighed within the personal issues of care.

Technology can distract from the humanistic care of the patient. Medical technology has caused the “dehumanization, depersonalization, and objectification of patients and of nursing care” (Barnard & Sandelowski, 2001, p. 367). The patient can be viewed as an extension of machines and technology resulting in loss of identity, individuality, and dignity as a human being. The nurse can become a robotic deliverer of patient care, treating the machine, unless re-oriented to holistic care.
Nursing is described as the art of caring. The goals of nursing have been to promote well-being and optimal health. The nurse’s caring behaviors are reflected through presence at the patient’s bedside. Presence is not only a physical attendance, but “a willingness to focus on really being there and being involved when with another” (Meinechenko, 2003, p. 19). Presence helps the nurse to develop an understanding of the patient’s lived experiences, and through the patient’s lived experience the nurse can help the patient to explore and find meaning.

Finfgeld-Connett (2008) defined the art of nursing as the expert use and adaptation of empirical and metaphysical knowledge and values. Empirical knowledge is the evidence-based practice of nursing. It is the science of what and why nurses practice. The metaphysical knowledge is the “awareness of things that are not always visible, audible, or palpable; and which are often thought of as intuitive” (Finfgeld-Connett, 2008, p. 383).

Values are the principles that guide practice. Values inherent to nursing are holism, care for individuals in need, respect for self and others, right to personal choice, and empowerment through patient advocacy. The attributes of the art of nursing are relationship-centered practice (kindness, compassion, healing touch, humor, and thoughtful doing); expert practice (experience at assessing, planning, intervening, and evaluating care); and outcome (improve the welfare of humankind) (Finfgeld-Connett, 2008). The goals of the art of nursing are to promote professional satisfaction and personal grow of the nurse.

Holism views the patient as an integration of body, mind, and spirit and requires not only care of the physiological, social, and psychological aspects, but also the
spiritual. Nurses are expected and mandated to provide spiritual care to patients as outlined in the International Code of Nursing (2000) and by the Joint Commission on the Accreditation of Healthcare Organizations (JACHO, 2004). JACHO recognized that psychological, spiritual, and cultural values affect the patients’ response to care. Spiritual assessment is defined as a minimum of the “patient’s denomination, beliefs, and what spiritual practices are important to the patient” (JACHO, 2004, p. 1).

Anandarajah and Hight (2001) found that 77% of patients would like spiritual issues considered as part of medical care, and only 10 to 20% reported that the physician discussed spirituality. Hospitalized patients are often left to pastoral services for spiritual care. However, it is estimated that approximately 20% of patients are left spiritually grieving because of lack of having the same theological affiliation with the pastoral care personnel (McEwan, 2004).

Taylor and Mamier (2003) studied 156 cancer patients and 68 primary family caregivers to determine what spiritual care patients want from nurses. It was determined that nurses should be prepared to provide spiritual care that is patient-centered and acceptable to the patient, which detailed less intimate care and not overtly religious (Taylor & Mamier, 2003). Kuuppelmaki (2001) determined that 50% of hospital-based nurses reported problems with spiritual care and 33% reported not being willing to provide spiritual care. Reasons given for the lack of spiritual care were lack of time, knowledge, and personal sense of adequacy.

McSherry (1998) examined 559 nurses’ perceptions of spirituality and spiritual care. It was determined that 71.4% were able to identify spiritual needs, but only 32.9% addressed needs in giving care. In addition, 52.8% reported not receiving any
educational preparation about spirituality or spiritual care (McSherry, 1998). Stranahan (2001) examined the relationships among spiritual perceptions, attitudes about spiritual care, and spiritual care practices of nurse practitioners. More than 50% of advanced nurse practitioners rarely or never provided spiritual care.

Several nurse theorists developed definitions of spirituality. Nightingale (1969) recognized the need for spirituality and stated that it “involved the evolution of the human consciousness” (Gray, 2006, p. 59). Pender viewed spirituality as the individual’s interpretation of life events and how life events affected health behaviors. Neuman viewed spirituality as the energy what develops if the environment is nourished. Roy defined spirituality as “one’s relationship with the universe” (Gray, 2006, p. 59). However, King and Watson did not specifically defined spirituality, but King referred to “the process of making meaning” and Watson addressed caring factors of faith-hope (caring for the whole person) and existential phenomenological factors (meaning in life) (Gray, 2006, p. 59). Nurse theorist have contributed to the definitions that help define the nursing profession, however a consistent definition of spirituality needs to be examined to bridge the gap between theory and practice.

Spirituality is essential to providing holistic care and can affect health and healing. Patients, especially patients that experience pain, suffering, terminal illness, life events, and aging have been shown to turn to spiritual beliefs and practices (Albaugh, 2003; Buck, 2006; Dobratz, 2002; Fryback & Reinert, 1999; Gray, 2006; Hermann, 2007; Kelly, 2004; Logan, Hackbusch-Pinto, & De Grasse, 2006; McClain, Rosenfeld, & Brietbart, 2003; Meraviglia, 2005; Reed, 1987; Tan, Braunack-Mayer, & Beilby, 2005). Nurses with a higher level of spiritual well-being and development of spirituality are
more sensitive to spiritual needs and spiritual care (Gray, 2006). Thus, research and
theory development on spirituality needs to continue to support the delivery of holistic
care to patients and families in complex care environments.

*Background and Significance*

The definition of spirituality has evolved to embody the concepts of
transcendence or beyond the self (Buck, 2006; Reed, 1987), connecting with the self,
others, or a higher power (Buck, 2006; Meraviglia, 2005; Tan et al., 2003); a personal
quest for meaning in life or purpose (Buck, 2006; McClain et al., 2003); value or belief
(Buck, 2006); and becoming or the life journey (Buck, 2006). Spirituality incorporates
faith in God or a Supreme Being and connectedness with nature (Buck, 2006; Dobratz,
2005; Fryback, & Reinert, 1999; Gray, 2006; Reed, 1987).

One theme that is consistent in the literature is that spirituality and religion have
distinct meanings. Religion is viewed as a mode of spiritual expression or practice (Tan
et al., 2003). Religion is a choice of how spirituality is expressed and may not be a part of
every human being’s personal experience. However, spirituality is a part of every human
being. Buck (2006) further explained the concept of spirituality based on five criteria of
an experience that: (a) is intrinsically human, but not limited by cognitive ability; (b)
incorporates the metaphysical components of ontology (the nature of being) and
teleology (the ultimate purpose or end); (c) identifies self as transcended; (d) involves a
connection with the corporeal and incorporeal, and (e) may or may not involve religious
involvement. Buck (2006) concluded that spirituality is “the most human of experiences
that seeks to transcend the self and find meaning and purpose through connections with
others, nature and/or a Supreme Being, which may or may not involve religious structure or traditions” (p. 289-290).

Spirituality has appeared in nursing literature since the early 1980s. One study from a nursing perspective was completed by Reed (1987), who examined the spirituality and well-being of the terminally ill, the non-terminally ill, and healthy patients to gain an understanding into how spirituality affected individuals. Since Reed’s study, many other nursing professionals have explored the realm of spirituality in various patient populations. Spirituality has been studied in patients with life-threatening illness (Albaugh, 2006); who are liver transplant recipients (Bean & Wagner, 2006); in hospice care (Dobratz, 2005); with potentially fatal diagnosis (Fryback & Reinert, 1999); undergoing breast diagnostics (Logan et al., 2006); and with cancer (Meraviglia, 2006). Other studies have examined nurses’ perceptions of spirituality in nursing practice (Van Dover & Bacon, 2001); the impact of the environment on spirituality (Tan et al., 2005); and spiritual needs of patients (Hermann, 2007). All studies have contributed to the developing body of knowledge on spiritual care.

As the dying patient comes closer to the end of life, spiritual needs tend to be a prominent defense in transcending the meaning of life and beyond. Reed examined two hypotheses: (a) terminally ill hospitalized patients have a greater spiritual perspective than non-terminally hospitalized patients and healthy non-hospitalized adults, and (b) there is a positive relationship between spirituality and well-being in terminally ill (1987, p 339). Through the use of the Spiritual Perspective Scale (SPS) and Index of Well-Being (IBW) instruments, Reed (1987) concluded that spirituality was a significant aspect of the dying person’s life and that there was a higher sense of spiritual well-being
reported in the terminally ill patients. The relationship between spirituality and well-being for the other groups was not significant. Reed’s study laid the foundation for further studies by other nurse researchers. The researchers discovered that for the terminally ill and the seriously ill patient, spirituality becomes a means of gaining control, finding meaning in life and disease, transcendence, and well-being.

Problem Statement

Spirituality and religious beliefs influence how the patient views death and dying. Nurses focus on the physiological, safety, and emotional needs of the patient, sometimes the spiritual needs may be neglected. The nurse needs to explore personal beliefs and feeling with regard to death and dying to provide care for the terminally ill patient (Reed, 1987).

Purpose of the Study

The purpose of this study is to identify the spiritual needs perspectives of the hospitalized patient by determining the difference in spiritual perspectives between the seriously ill and the terminally ill hospitalized adult, and to determine the relationship between spiritual perspectives and well-being in the terminally ill patient.

Research Questions

1. What are the spiritual needs perspectives of the hospitalized patient?
2. Is there a difference in spiritual perspectives between seriously ill hospitalized adults and terminally ill adults?
3. Is there a relationship between spiritual perspectives and well-being?
Organizing Framework

The Framework of Systemic Organization (Freidemann, 1995) is the framework for this study and a means of organizing the relationships of how nurses engage in the nurse-patient relationship to explore patient’s spiritual needs. The framework is based on the open system theory and social ecology. The key concepts of the Framework of Systemic Organization are: congruence, control, system maintenance, system change, spirituality, coherence, individuation, and health. The ideal situation of all systems is congruence, which is that the system is in harmony with each other and the universe. Tension is felt in the system that experiences incongruence. The system maintains congruence through the use of two defense mechanism, control and spirituality (Friedemann, Mouch, & Racey, 2002). This framework is appropriate for this study because it provides a logical representation of how the patient maintains congruence in life through the use of control and spirituality from the tension of a terminal illness. Control is maintained through system maintenance and system change, which may be difficult for the terminally ill patient to achieve. Spirituality offers an alternative means of the patient maintaining congruence when control is of little or no benefit.

Definition of Terms

Terminally Ill.

Conceptual Definition: Terminally ill patient are defined as patients facing a life-threatening illness that is incurable and death is the expected outcome (Reed, 1987).

Operational Definition: Terminally ill patients will be cancer or end-stage disease patients on the oncology and hospice units.
Seriously Ill.

**Conceptual Definition:** Seriously ill patients are defined as patients facing the potential of a life-threatening illness that has a potential of being curable with appropriate treatment and lack of complications (Reed, 1987).

**Operational Definition:** Seriously ill patients will be patients from the intensive care and step-down units.

Spiritual Perspective.

**Conceptual Definition:** The saliency of spirituality is the extent to which spirituality permeates life and the engagement in spirituality-related interactions (Reed, 1987, p. 337).

**Operational Definition:** The measure of spiritual perspective will be the Spiritual Perspective Scale (Reed, 1987). Connectedness with a higher being (transpersonal), others (interpersonal), and self (intrapersonal).

Spiritual Well-being.

**Conceptual Definition:** Satisfaction with life as experienced with cognitive and effective dimensions of well-being (Reed, 1987, p. 338). Spiritual well-being is the degree in which a person experiences satisfaction with life and life purpose.

**Operational Definition:** The measure of spiritual well-being will be the Index of Spiritual Well-Being scale (Reed, 1987).

Limitations

The limitations of this study are: (a) small sample size of terminally ill and seriously ill patients, and (b) location in one city and state.
Assumptions

The assumptions of the study are: (a) terminally ill and seriously ill patients are aware of spirituality and have a belief in a higher power and (b) spiritual care by nurses will assist the patient to recover or to a peaceful death.

Summary

Terminally ill and seriously ill patients use spirituality as a significant human experience and resource during the terminal or serious illness (Reed, 1987). Understanding the spiritual perspective of the terminally ill or seriously ill patient can provide nurses with information that can help facilitate healthy spiritual well-being in patients. The purpose of this study is to understand the differences in spiritual perspectives and spiritual well-being in two groups of individuals, the terminally ill and the seriously ill. The Framework of Systematic Organization will be used to rationalize the study. Findings will provide information for nurses on spiritual well-being of these patients in an attempt to increase awareness toward providing holistic care.
Chapter II

*Literature Review*

*Introduction*

Spirituality is a complex concept and has been described “in terms of personal views and behaviors that express the sense of relatedness to a transcendent dimension” (Reed, 1987, p. 336). The concept of the whole or holism has been embraced by nursing as the individual is an integration of the body, mind, and spirit. Nurses caring for seriously and terminally ill patients need to have a heightened awareness of treating the “whole” individual. Serious and terminal diagnoses threaten mortality, and the patient attempts to maintain health within the illness through spiritual and religious practices (Reed, 1987).

*Purpose*

The purpose of this study is to explore the spiritual needs and perspectives of hospitalized serious and terminal ill patients in order to gain in increased understanding of spirituality.

*Organization of Literature*

The literature review consists of selected research studies with regard to spirituality, relating how spirituality is expressed, how the environment impacts spirituality, how health and well-being can be achieved, and how nurses identify and
address spiritual needs. The literature review is divided into six sections: (a) organizing framework, (b) meta-analysis, (c) patients’ perception of spiritual care, (d) nurses’ perception of spiritual care, (e) factors affecting spiritual care, and (f) instrumentation.

Organizing Framework

The Framework of Systemic Organization is the organizing framework for this study. In 2002, a study by Friedemann, Mouch, and Racey used the conceptual model of the Framework of Systemic Organization (Freidemann, 1995) as a means of describing relationships between the nurses and patients to explore the patient’s spiritual needs. The framework is based on the open system theory and social ecology. The key concepts of the Framework of Systemic Organization are: congruence, control, system maintenance, system change, spirituality, coherence, individuation, and health. The ideal situation of all systems is congruence, which is that the system is in harmony with each other and the universe. Tension is felt in the system that experiences incongruence. The system maintains congruence through the use of two defense mechanism, control and spirituality (Friedemann et al., 2002).

Control is the process of altering what interferes with the system’s process to return to a status quo. System maintenance and system change are two processes in achieving control. The individual practices system maintenance through self-care to meet needs. When system change is experienced, the individual seeks strategies to adapt to changes in the system, thus seeking to gain control. When control is not successful, then the congruence of the system is affected and can manifest in anxiety, hopelessness, and helplessness (Friedemann et al., 2002).
Spirituality is a mechanism used to help alleviate the anxiety and tension created when control has failed. Spirituality is the transcendence beyond the physical environment and beyond the logical reasoning. It leads to congruence through a sense of unity with the universe and inner peace. Spirituality involves the mind and emotions, where as control utilizes the physical and behavioral strategies to achieve congruence. Individuals strive for spirituality through coherence and individuation. Coherence is the sense of unity within, gained through activities that nurture the mind and spirit. This can be accomplished through religious practices, meaningful relationships, music or art, or observing beauty or nature. Individuation is the human striving to connect and become part of something outside oneself. It is the expansion of one’s consciousness and sharpening or changing perceptions (Friedemann et al., 2002).

Health, then, is defined as the experience of congruence in the system. It is the balance of control and spirituality. Health is evidenced in the absence of anxiety and therefore is not the absence of physical disease. Mortality of the individual is inevitable, and disease or body system failure is congruent with the universal order of life. Therefore, the system is congruent when spirituality and control are utilized to reduce the anxiety that can be experienced with physical disease processes (Friedemann et al., 2002).

The Framework of Systemic Organization was used to define the concepts in relation to a case study of a patient’s experience with a terminal illness. As the client experienced the forced retirement related to a heart condition, the client experienced anxiety about new life circumstance. When the client was not able to control through prior system maintenance, the client utilized system change to gain congruence. Further,
System congruence was achieved as the nurse guided the client to use of spirituality to gain control. Coherence was utilized as the client sought forgiveness for a past indiscretion. Through the modeling of a nurturing relationship by the nurse, the client was able to express feelings and achieve congruence with spirituality (Friedemann et al., 2002).

Control remains an important aspect of a person’s life. Spirituality becomes increasingly necessary in maintaining emotional health, seeking forgiveness, and maintaining family relationships. The relationship of the nurse-client can be an effective instrument in finding a balance of control and spirituality for the client (Friedemann et al., 2002).

Spirituality needs to be included in the care of the terminally ill patient and for all patients throughout the lifespan. “Nurses who have explored and reconciled their own spiritual beliefs can learn to address their patient’s unique needs within the broad context of family and environment” (Friedemann et al., 2002, p. 325). The Framework of Systemic Organization is a patient-centered and patient-directed process that can lead to growth in both the patient and the nurse.

**Meta-analysis**

Sulmasy’s (2002) meta-analysis of spirituality in the dying patient examines the medical community’s biopsychosocial model of humans and found that the care of the spiritual aspects of the person was missing. The biopsychosocial model categorizes the person into three dimensions: the biological, psychological, and social dimensions. Holistic care of the person is meant to treatment the whole person and not just its parts. Sulmasy (2002) proposed to expand the biopsychosocial model to include the spiritual
dimension of care, calling the new model the biopsychosocial-spiritual model. The dying patient has a spiritual and biopsychosocial history that affects and manifests itself in the current spiritual and biopsychosocial state. Spiritual interventions can support and strength the present state and lead to a modification in the spiritual state and biopsychosocial state, with each state affecting the other. Quality of life is manifested through the process of interaction of the spiritual intervention and the modification of the spiritual and biopsychosocial states. Death of a patient can occur at any time and hopefully the patient enters death with a feeling of peace and good quality of life.

Humans are beings-in-relationships with each other and each person has a complex set of relationships. Relationships can be intrapersonal or extrapersonal. Intrapersonal relationships are the physical relationship with the body, and organs, or body parts; and the physiological or biochemical processes of mind-body relationships, which include multiple relationships among symptoms, moods, cognitive understandings, meanings, and a person’s physical state. Extrapersonal relationships are relationships with the physical environment; interpersonal environment, which include family, friends, communities, political order; and with the transcendent. The patient interacts with intrapersonal and extrapersonal relationships throughout the illness. Relationships are altered and previous patterns of coping may be disrupted. Through the disturbed relationships, questions arise between the patient and the environment and the patient and the transcendent (Sulmasy, 2002).

Disease is the disruption of the right relationships that strive to maintain homeostasis. Healing then is to restore the right relationships to all dimension of the person, since each dimension can affect the others. Healing the whole person in a holistic
manner requires attention to biological, psychological, social, and spiritual disturbances. Healing can occur at the end of life. Death is a natural process and spiritual issues can arise at the close of life. The quest to find value and meaning in life, suffering, and death leads the person to ask question about values which are: dignity; meaning which is summed under hope; and relationships which can lead to the need for forgiveness. “Each person must live and die according to the answer that each gives to the question of whether life or death has a meaning that transcends both life and death” (Sulmasy, 2002, p. 26).

A spiritual assessment must be performed to complete the holistic treatment of the person. Sulmasy (2002) discussed the spiritual domains that can be measured. Four categories of spiritual domains were addressed: measures of religiosity, spiritual/religious coping and support, spiritual well-being, and spiritual needs. Religiosity refers to the way in which spirituality is expressed through a religious practice or belief system. It has been well studied and consists of measurements exist in the strength of belief, prayer and worship practices, and intrinsic versus extrinsic factors.

Spiritual/religious coping and support refers to how spiritual or religious beliefs, attitudes, and practices affect the response to a stressful life event. Measurements for spiritual/religious coping exist and the two instruments with any merit are RCOPE, which measures religious coping, and INSPIRIT, which measure general spiritual coping. The construct of spiritual/religious support has no validated instruments.

Spiritual well-being refers to the quality of life based on spiritual aspects of the person. Measurements exist that assess the spiritual state or level of spiritual distress as a dimension of quality of life. The most reliable instrument in regard to the dying patient is
the FACIT-SP, which measures spiritual well-being. Other instruments are the Spiritual Well-Being Scale, Meaning in life scale, the McGill Quality of Life Questionnaire, which has a useful spiritual well-being subscale, and the Death Transcendence scale, which is specific to the dying patient. Spiritual needs are the spiritual practices, conversations, prayer, rituals, that a patient utilizes to meet spiritual needs. For the dying patient, this may be the most important aspect of the patient’s care. Qualitative studies suggest that patients have many spiritual needs, and few instruments are available (Sulmasy, 2002).

Patients with end-of-life issues wish that healthcare providers would address spiritual needs without proselytizing. Sulmasy (2002) concluded that further research needed to address: improving measurements of the spiritual states of religiosity, spiritual coping, spiritual well-being, and spiritual need; better defining who is best to address spiritual issues with patients; studying the interactions between measurable spiritual dimensions with traditional health measures; designing and measuring the effectiveness of spiritual interventions; refining and testing of spiritual tools to take spiritual histories; and assessing the impact of the health professional’s own spirituality on the end-of-life care of the patient (Sulmasy, 2002).

Patients’ Perception of Spiritual Care

One study on spirituality and the terminally ill was conducted by Reed (1987). As the dying patient comes closer to the end of life, the spiritual needs tend to be a prominent defense in transcending the meaning of life and beyond. Reed examined two hypotheses: (a) terminally ill hospitalized patient have a greater spiritual perspective than non-terminally hospitalized patients and healthy non-hospitalized adults, and (b)
terminally ill hospitalized patient have a positive relationship between spirituality and well-being (1987, p. 339).

The sample consisted of 300 adults from the southeastern United States. There were 100 patients from three groups of patients, terminally ill hospitalized patients, hospitalized patients, and healthy adults. Each group varied on race and religious beliefs with the majority being white and Protestant. The participants were 45% male and 55% female, with an average age of 60 years. Most of the terminally ill and hospitalized group members were married or widowed, however the majority of the health adult group were divorced or single. The terminally ill hospitalized and non-terminally ill hospitalized were in the hospital for at least 5 days prior to the study. The healthy adult group was selected from a community setting or shopping mall setting (Reed, 1987).

Reed used the Spiritual Perspective Scale (SPS), a 10-item questionnaire addressing perceptions of spirituality, and how spirituality influences life and how individuals engage in spiritual based activities. The questions are rated on a 1 to 6 scale with 6 indicating greater spiritual perspective, and 1 no spiritual perspective (Reed, 1987).

The Index of Well-Being (IBW) was used to measure the patient’s satisfaction with life. The tool is a nine-item questionnaire that is scored using a 6-point Likert scale, with 6 indicating the greatest satisfaction, and 1 indicating dissatisfaction. The scoring of the IBW is based on a sum of two weighed scores: an overall score of a life satisfaction item weighed by 1.1, and then the mean score of the remaining eight items weighed by 1.0. The potential score ranges from 2.1 to 12.6, with the higher score indicating satisfaction with life. The participants were asked how individuals perceived health on a
scale of 1 to 5, with 1 indicating poor, and 5 indicating excellent health. An open-ended question asked about any changes that have occurred in spiritual views.

Both the SPS and IBW had established reliability and validity. For this study the reliability of the SPS was measured by the Cronbach’s alpha coefficient and ranged from .93 in the non-terminally ill hospitalized group, to .95 in the terminally ill hospitalized and the healthy adult groups. Inter-item correlations ranged from .57 to .68 across all groups. Validity was evidenced by women who reported having a religious background, and who scored higher on the SPS (1987, p. 337). For the IBW, the reliability was measured by the Cronbach’s alpha coefficient of .90. Inter-item correlations ranged from .51 to .61. Validity was estimated to be moderate with a Pearson correlations of .35 between well-being and self-esteem and self-confidence (Reed, 1987, p. 338).

The findings supported the two hypotheses: (a) terminally ill hospitalized patients would have a greater spiritual perspective than the non-terminally ill and healthy groups, and (b) terminally ill hospitalized patients would have a positive spiritual perspective related to well-being. The mean scores on the SPS were 4.530 for the terminally ill hospitalized group, 4.137 for the non-terminally ill hospitalized groups, and 4.160 for the healthy adult group. The Pearson correlation for the positive relationship between spirituality and well-being was $r = .22$ ($p<.02$) and was not significant in the non-terminally ill or healthy adult groups (1987, p. 339). In regard to the question about perceived health, the terminally ill patients rated health lower than the other two groups. Also, the question about changes in spiritual views, the terminally ill patients and the non-terminally hospitalized patients reported a move toward greater spirituality. When a
spiritual view change was reported in the healthy adults group, it was related to aging or the death of a family member (Reed, 1987).

Reed (1987) concluded that spirituality was a significant aspect of the dying person’s life and that there was a higher sense of spiritual well-being reported in the terminally ill patients. The relationship between spirituality and well-being for the other groups was not significant. The assumption was made that dying is a developmental phases that the individual passes through, and increased spirituality is the developmental change that is evidenced in this developmental stage. Reed concluded that the terminally ill have a greater spiritual perspective.

Spirituality is viewed as the bridge between hopelessness and helplessness to finding meaning and purpose, and is separate from, but part of the physical aspect of health (Fryback & Reinert, 1999). Fryback and Reinert (1999) examined the concept of spirituality from the perspective of patients living with a potentially terminal diagnosis was explored through the view and experience of the concept of health. This was a qualitative, phenomenological study.

The study took place at two different sites in two different states. A convenience sample of 15 participants was identified by ministers, nurses, and from other participants. The criteria to be included in the study were that the participants were 21 years of age or older; had received a diagnosis of cancer or HIV/AIDS within the last year; were able to speak and understand English; and were able to verbalize perceptions related to the meaning of health. The sample included five women with cancer and five men with HIV/AIDS from the first site, and then five additional women with cancer from the second site. There were 13 Caucasians and two African Americans, and all were between
the ages of 29 to 76; half of the women were married and three women were widowed; none of the men were married, but three of the men lived with a partner; and three of the women and two of the men were still working with eight of the women and all of the men had worked prior to their diagnosis (Fryback & Reinert, 1999).

The data were collected through in-depth interviews that lasted 60 to 90 minutes and were audio-taped. The tapes were transcribed verbatim and then content analysis was performed. Each interview was analyzed for themes before the next interview. The emerging themes were categorized and the categories were validated via a follow-up phone interview. Field notes were taken by the interviewer to document non-verbal cues during the interview. Three main concepts or categories came through in the interviews: “belief in a higher power,” “recognition of mortality,” and “self-actualization” (Fryback & Reinert, 1999, p. 15).

“Belief in a higher power” is the connectedness with a power greater than the self and has been seen as a critical attribute of spirituality. This concept consisted of two sub-concepts of church attendance/religion and transcendence. Ten participants specifically mentioned church attendance, three did not trust organized religion, and two did not attend church. For the men with HIV/AIDS, religion was associated with satisfaction and conflict. Despite the negative experiences with organized religion, the participants discovered that spirituality was not dependent on a particular religion or church. Spirituality was strengthened though the search for spiritual connection, which made the individuals feel healthier (Fryback & Reinert, 1999).

“Recognition of mortality” had three sub-concepts: gaining a new appreciation of life, renewed observation and appreciation of nature, and a firm resolve to live in the
moment. The participants did not give up hope, but the illness and process of exploration lead to give up the illusion of living forever (Fryback & Reinert, 1999).

“Self-actualization” was the last concept of spiritual health, and refers to having a sense of exuberant well-being, described as learning to accept and love oneself, find meaning in life, and have the disease became the focus of health. Increasing self-awareness gave the participants a true sense of oneness or wholeness through exploration of the issues that led to be unhappy. The existential dimension of spiritual well-being focuses on the purpose and meaning of life, that allows the patient to gain health within illness. Fryback and Reinert (1999) indicated that nurses can help patients deal with spiritual conflicts, especially nurses who work on the night shift. Patients are often along at night to contemplate the situation, fears and hopes. Caring and compassion with patient-centered skills are needed by the nurse more than technical skill. Fryback and Reinert (1999) concluded that the dying patient had a belief in a higher power and recognized mortality.

Albaugh (2003) conducted a qualitative phenomenologic study with seven individuals to explore the lived experience of confronting a life-threatening illness during the treatment process. The participants were selected from various groups and religious affiliations through flyers and word of mouth. The inclusion criteria were to be 18 years of age or older, English speaking, willing to discuss the present illness, and have “a personal belief in a higher power or being that guides life” (Albaugh, 2003, p. 594). Data were collected via interviews. The framework was based on Frankl’s (1995) theory of logotherapy, which states that the goal of life is to find meaning and that life holds potential meaning under any circumstance, including during suffering.
Albaugh (2003) revealed that all the participants found a sense of meaning in life during the journey through illness. Spirituality provided comfort throughout the journey, strength in facing the life-threatening illness, blessings despite the hardships, and trust in a higher power to get through the journey. Albaugh (2003) concluded that spirituality greatly affected the patient’s journey through a life-threatening illness and provided a sense of meaning.

Dobratz (2005) conducted a study to explore hospice patients’ expressions of spirituality. The purpose of the study was to explore the differences in psychological well-being and adaptation, and social support, physical function, and pain. The design was a secondary analysis of a quantitative study of home hospice patients that sought to describe the meaning of spirituality to persons who want to die at home.

The sample was a convenience sample of 97 home hospice patients that were 30 years of age or older, had intact mental status, English speaking, signed consent, and willingness to participate. The mental assessment was made through an interviewing process during the consent phase of the selection process (Dobratz, 2005).

The demographic characteristics of the sample were as follows for the expressed spirituality group: average age 66.1 years; females 17, males 27; white 38, Mexican American 4, African American 2; cancer 35, HIV/AIDS 4, ALS 2, other diagnoses 3; and Protestant 26, Roman Catholic 12, Jewish 1, and other religious affiliation 5. For the non-expressed spirituality group the demographic characteristics were: average age 65 years; female 20, male 33; white 49, Mexican American 1, other race/ethnicity 3; cancer 41, HIV/AIDS 6, ALS 4, other diagnoses 2; and Protestant 30, Roman Catholic 12, Jewish 1, and other religious affiliation 10 (Dobratz, 2005).
The participants from the original study were divided into two groups: expressed and non-expressed spirituality. This determination was made if the participant disclosed any content relative to spirituality. Using a cross-sectional design, groups were compared on psychological well-being and adaptation, and social support, physical function, and pain, as well as selected demographic variables (Dobratz, 2005).

Measures for psychological well-being were the Affect Balance Scale (ABS), with the scale having either a positive or negative affect to five responses. Scores ranged from 0 to 5 and were calculated as the sum of the positive affects minus the negative affects. Correlation coefficient of .76 was established for the total ABS score and .83 for the positive affects and .81 for the negative affects (Dobratz, 2005).

Measures for psychological adaptation were the Life Closure Scale (LCS), which contained two sub-scales, self-reconciled and self-reconstructing. The LCS is grounded in Roy’s adaptation nursing theory. Reliability was demonstrated with a Cronbach’s alpha of .87 for the total scale, .80 for the self-reconciled scale, and .82 for the self-reconstructing scale. Validity of \( r = -.59 \) was significant for the negative correlation of the LCS with the ABS items that measured a negative affect and \( r = .36 \) was a significance for positive correlation with the LCS with the ABS items that measured a positive affect (Dobratz, 2005).

The Karnosky Performance Status Scale (KPS) is a tool to measure physical functions with 11-items that range from 100 points for normal function to 0 points for death. Construct validity with home hospice patients obtained a .44 Kendall’s tau with the KPS and a severity scale. The reliability was demonstrated with variables of functioning with an \( r = .61 \) with balance and \( r = .63 \) with stairs (Dobratz, 2005).
The McGill-Melzack Pain Questionnaire (MPQ) was utilized to measure pain intensity and quality. A 5 point word descriptor scale was used with 1 indicating mild pain and 5 indicating excruciating pain. Seventy-eight words, with 20 words per grouping, represented the four components of pain quality: sensory with 42 words, affective with 14 words, evaluative with 5 words, and miscellaneous with 17 words. The MQP was scored for the total number of the 78 word descriptors and on the rank value of the words selected and a score for each of the four components. Reliability and construct validity alpha coefficients for the sensory, affective, and evaluative components of .46 to .78 were established. High correlations between the pain rating index and the number of words chosen were demonstrated with an $r = .97$ (Dobratz, 2005).

The Personal Resource Questionnaire 85 (PRO-85) Part 2 measured perceived social support. A 7-point Likert scale of 25-items ranging from 7 indicating strongly agrees to 1 indicating strongly disagrees was used for the PRO-85. Four subscales existed within the scale: intimacy, social interaction, worth, and assistance. The reliability for the total scale was an alpha of .87, and the validity measured with depression was $r = -.33$ and with anxiety was $r = -.30$. The psychosocial adaptation portion of the LCS and the PRO-85 correlated with an $r = .53$ (Dobratz, 2005).

A secondary analysis by the examination of the verbatim content of the participants who referenced spirituality of an earlier study conducted by Dobratz was completed. Content phrases related to spirituality were extracted, coded and grouped into themes. Measurement tools were then completed at the residence of the participant that consented to the study. Interesting to note is that 54% of the spirituality that was referenced did not related to God, religion, or a higher power (Dobratz, 2005).
The results revealed that the expressed and non-expressed spirituality groups showed no significant differences for the measure of psychological well-being (ABS), physical function (KPS), and social support (PRO-85). Significant differences were found in the three components of the MPQ in the affective component, the pain rating index, and the number of words chosen. Pain was rated as mild for the expressed spirituality group (1.61) and also for the non-expressed spirituality group (1.71). The total MPQ score was lower for the expressed spirituality groups, with fewer words chosen to describe the quality of the pain and a lower mean score on the affective component (Dobratz, 2005).

The participants did not differ in psychological well-being and adaptation, social support, and physical function between the two groups of expressed and non-expressed spirituality. Dobratz (2005) reported that this was not an anticipated finding. Social support did not differentiated between the two groups. Dobratz’s earlier qualitative study reflected that patients with expressed spirituality indicated a connectedness to other believers and related social support. Dobratz believed that the tool used may not have been refined enough to capture examples or spiritual or religious support. The physical function was not different between the two groups and Dobratz believed that the tool was not precise enough to detect differences (Dobratz, 2005).

The expressed and non-expressed spirituality groups both had overall similar pain rating scores, but that the expressed spirituality group had a lower number of words chosen on the affective component of the MPQ. Dobratz (2005) concluded that fewer words chosen to rate the pain in the expressed spirituality group, supported the Yates’ study.
Dobratz (2005) related that further study is needed with relate to pain and spirituality in the psychological adaptation in life closure. Hospice nurses are competent in assessing pain intensity, location, and pain relief; however, are less skilled in assessing other symptoms such as spiritual distress. Controlling spiritual distress is essential in the physical pain of the dying patient (Dobratz, 2005).

Tan et al. (2005) conducted a qualitative study to define spirituality as the search for meaning in life and to determine if religion may be an expression of spirituality for the palliative patient. The purpose of the study was to describe how hospice inpatients express spirituality and to investigate the impact of the hospice environment. The researchers used Heidigger’s Phenomenological Hermeneutics, which combines phenomenology with hermeneutic analysis or the interpretation of the observer that is used to develop understanding of the situation (Tan et al., 2005).

The participants were from an Australian inpatient palliative care unit, and had been a resident for at least 4 days. Twenty-eight patients were referred for the study; however seven of the patients were not entered in the study due to discharge, death, and deterioration of condition. The 13 patients consented to the study, but only 12 patients were interviewed. One patient died before the interview could be completed. The mean age of the participants was 73 (range 54 to 92); seven were male and five were female; seven had no religious affiliation, two were Catholic, two were Protestant, and two were pagan. Seven were born in Australia, three in the United Kingdom, one in Italy, and one in Romania (Tan et al., 2005).

The researchers worked as a pastoral care worker and counselor. The study was conducted using semi-structured interview questions with the aims of understanding how
the participants expressed spirituality and how the hospice environment impacted spirituality. Each participant was given a list of social worker, chaplains, and counselors to assist in any issues that arose during the interview. Interviews were audio-taped and the dates were evaluated by using theme analysis (Tan et al., 2005).

The major themes identified of hospice influences on spirituality were: “relationships,” “that which uplifts,” “spiritual practice,” and “having hope.” None of the participants had difficulty in discussion of the topics. The findings revealed that for the theme of “relationships,” the hospice environment facilitated the spiritual expression by deepened relationship through facing death together, bonding with the family, freedom of family and friends coming and going at any time, freedom to worship, and staff recognizing significant others. The environment may have helped in the relationship theme by each patient having a private room as an option, sensitivity to the patient needing time-out from visitors, room to entertain larger groups, and more continuity of care by the same nurse (Tan et al., 2005).

The findings revealed that which uplifts the hospice environment facilitated spiritual expression by providing music and garden areas, allowing pets to visit or stay, compassion and caring behaviors exhibited by the staff, and the staffs’ appreciation of and participation in humor. The environment may have helped in that which uplifts by a greater sensitivity to the music that the patient enjoyed and a greater awareness that humor can be used as an attempt to hide pain and fear (Tan et al., 2005).

The findings revealed that the theme of “spiritual practice” facilitated spiritual expression by having interdenominational services, by not having evangelizing, an atmosphere of peace and quiet, and that the patient’s priest could visit. The environment
may have aided in spiritual expression by more nurses being trained in listening skills and dealing with views that are different from nurses and having more awareness of the patient’s individual needs (Tan et al., 2005). The findings revealed that the theme of “having hope” facilitated spiritual expression by giving the impression of hope when needed, willingness to listen, giving patients some sense of control, and providing normality. The environment may have helped in spiritual expression by the nurses having more training in the awareness of the patient’s individual needs (Tan et al., 2005).

The authors concluded that relationships, hope, and spiritual practices were important to the patients. The findings revealed important insights into the spiritual expression of the palliative care patients and that the hospice environment does have an impact on the patient’s spiritual expression. Tan et al. (2005) recommended that further research for inappropriate burdens on the nurse in being able to provide individualized spiritual care and to whether or not additional training in listening skills is needed for nurse with the effectiveness of the training.

Breast cancer has become the most common problem that women face and a diagnosis of breast cancer can lead to distress. Logan et al. (2006) explored the lived experience of spirituality in women who were undergoing the diagnostic experience of breast cancer. This qualitative, phenomenological designed study using Giorgi’s approach enabled the exploration of the participant’s perspective on spirituality. The research was conducted in-depth, semi-constructed interview, which were tape-recorded and transcribed. The sample consisted of 20 Caucasian women ranging in age from 30 to 89 in a Canadian outpatient breast assessment center. Sixty percent of the women were
between the ages of 40 and 60; 85% spoke English; 70% were married; 50% were Catholic; and 80% ended with a diagnosis of breast cancer (Logan et al., 2006).

The results revealed two themes: creating a focused isolation and seeking connections. The participants related the need to isolate themselves from the distraction that would prevent concentration on the things that needed to be done during the diagnostic phase. It was a strategy that helped to focus on life, both past and present. The values and actions of women as nurturers, who care for others through kindness and lovingness, were set aside. Many women sought nurturing from God. Physically withdrawing provided a place to be nurtured and find inner strength and peace. When physical isolation was not possible, the women would perform normal routines and be present but would be emotionally and mentally detached. The isolation became a protection from unwanted emotional display that may be possible from contact with others who would wish to talk about the situation (Logan et al., 2006).

In contrast, the theme of seeking connection prevented deep sadness and overwhelming depression. The women sought support from family members like husbands, sister, or children, and also from spiritual connections. Praying and talking with God and being in nature were cited most often along with seeking out sources of enjoyment such as music, shopping, and things considered treats. Also the staff and chaplain at the outpatient center provide support and connections (Logan et al., 2006).

Logan et al. (2006) concluded that women need to handle the stress of breast cancer alone, and the reliance on spirituality and God was a need that was balanced with the connections with family and others. Nurses can help women undergoing breast
diagnostics to be focused on spirituality and help family and friends to understand their role during this distressing time.

A breast cancer diagnosis impacts every aspect of the patient’s life. The physical and psychological impact of breast cancer has been well studied, however little is known on the impact of spirituality. Meraviglia (2006) examined the effects of spirituality on a sense of well-being among women who have had breast cancer. According to Meraviglia (2006), spirituality can be defined “as the experience and expression of the spirit in a unique and dynamic process reflecting faith in God or a supreme being; connectedness with oneself, others, nature, or God; and integration of the dimensions of mind, body, and spirit” (2006, p. E2). The concepts of meaning in life and prayer were the organizing framework. The impact of cancer was evaluated through the background characteristics of the women and characteristics of cancer which affect well-being, and were evaluated through the physical and psychological responses.

The descriptive, correlational, cross-sectional study took place in rural and urban Texas. Participants were referred by nurses, oncologist, and radiologist and had to be 21 years of age or older, diagnosed with breast cancer, able to read and write English, and in a fair state of health. A sample size of 80 was determined to be adequate for a regression model. The final sample size was 84 women with various stages of breast cancer, 68% with metastasis at diagnosis, time of less than 6 months since diagnosis to greater then 5 years, various stages of treatment with 68% receiving no treatment, 49% rated health at good and 32% rated at very good, and 51% able to do usual activities and 35% able to do usual activities with effect. The majority of the participants were Caucasian, married, college educated, and employed (Meraviglia, 2006).
The data were collected utilizing six instruments: the Background Information Survey (BIS), the Characteristics of Cancer Survey (CCS), the Life Attitude Profile-Revised (LAP-R), the Adapted Prayer Scale (APS), the Symptoms of Distress Scale (SDS), and the Index of Well-being (IWB). The BIS was utilized to collect demographic characteristics. The CCS assessed the type of breast cancer, the presence of metastasis, length of the illness, past and present treatment, current physical health status, perceived functional status, the presence of other diseases, and medication regimens for daily use and to control symptoms (Meraviglia, 2006).

The LAP-R is a 48-item instrument based on Frankl’s Motivational Theory of Meaning and is used to discover meaning, purpose in life and motivation to find meaning in six dimensions of life: purpose, coherence, choice and responsibility, death acceptance, existential vacuum, and goal-seeking. The instrument utilizes a Likert scale and each dimension is scored by summing the items. Each dimension provides a subscale score and two composite scales, personal meaning index and existential transcendence. Personal meaning index focuses on purpose and coherence subscales. Existential transcendence focuses on purpose, coherence, choice and responsibility, and death acceptance minus the sum of existential vacuum and goal-seeking subscales. Construct validity was validated from others studies, and internal consistency reliability were acceptable with reliability ranging from 0.70 – 0.85 for the subscales and 0.77 – 0.88 for the two composite scales (Meraviglia, 2006).

The APS is a 39 item instrument that includes three general items related to the amount and frequency of prayer, 1 item related to the participant’s relationship with God, 17 items related to prayer activities, 9 items related to prayer experiences, 6 items related
to attitudes toward prayer since the cancer diagnosis, and 3 open-ended questions. Total scores are computed by the sum of the items from three subscales, and then summing the three subscales. Internal consistency reliability for the APS were acceptable and were 0.96 with range of 0.77 – 0.95 for the subscales (Meraviglia, 2006).

The SDS is a 14 item scale that assesses the participant’s degree of discomfort. Assessments of appetite, nausea, insomnia, pain, fatigue, bowel patterns, concentration, dyspnea, appearance, outlook, cough, and mobility are evaluated twice: once to assess discomfort since the diagnosis of breast cancer, and then again within the last month. The higher the score the higher the symptom distress. Face, content, and convergence validity have been established. Internal consistency reliability was 0.90.

The IWB is a nine item instrument used to assess satisfaction with life. This instrument was used by Reed (1987) and was discussed earlier. Higher scores represent the greatest satisfaction with life. Cronbach’s alpha was 0.95 (Meraviglia, 2006).

The data analysis was conducted through a mediator research model that examined the outcome variables of background information and characteristics of cancer with the mediator variables of meaning in life (LAP-R) and prayer (APS). The outcome variables were compared with the predictor variables of physical response (SDS) and psychological responses (IWB), and finally the mediator variables with the predictor variables.

The findings revealed that 71% of women had a close relationship with God, 51% prayed three to four times daily, and the largest religious group was Protestant (39%). Correlational analysis of outcome variable with sample characteristics revealed that women with lower symptom distress were employed, had lower stages of cancer, and has
no metastasis at diagnosis. Women who reported higher psychological well-being reported lower stages of breast cancer, higher functional status, and a closer relationship with God. Mediator variables compared to sample characteristics revealed the women with more meaning in life were older, had better functional status, a closer relationship with God, and greater satisfaction with income. Women with higher prayer scores reported a closer relationship with God, lower educational levels, and less income to meet needs. Mediator and outcome variable comparison revealed that meaning in life was positively related to psychological well-being and negatively related to symptom distress. The personal meaning index was positively related to psychological well-being and negatively relate to symptom distress. Prayer was positively related to psychological well-being and not significantly relate to symptom distress (Meraviglia, 2006).

Since prayer subscales and total scores were not significant, the mediator analysis was not analyzed for this spiritual variable. However, functional status was significant in predicting meaning of life, and predicting psychological well-being. Meaning in life mediated the relationship between functional status and symptom distress, but was not significant for physical well-being. Therefore, the authors concluded that meaning in life mediates the impact of breast cancer on the physical and psychological well-being of women (Meraviglia, 2006).

Hermann (2007) conducted a descriptive study to explore spiritual needs of the patient. The purpose of the study was to determine to what extent the spiritual needs of patients near the end of life were met. The setting was one inpatient and five outpatient hospices. The sample included 62 females and 38 male hospice patients with a mean age of 67. Seventy-four of the patients were dying from cancer with 56 of the participants
were in hospice for less than 4 months. The sample was predominantly Protestant and Caucasian.

The goals of end of life care can include the relief and prevention of many physical symptoms, however spiritual and psychosocial needs may require special attention. All dimensions of the patient need to be addressed when providing quality end of life care. Hermann (2007) measured spiritual needs and life satisfaction with the Spiritual Needs Inventory (SNI) and the Cantril ladder, respectively. The aim of the study was to describe to what degree patients near the end-of-life have spiritual needs, what spiritual needs are not met, how patients rate life satisfaction and how life satisfaction is related to spiritual needs.

The Spiritual Needs Inventory (SNI) is a 17-item scale developed to measure the spiritual needs of patients near the end-of-life. Each item is measured on a 5-point Likert scale from never (1) to always (5). The Cronbach's coefficient alpha was 0.85 and reliability was supported because of the item-to-total correlation range from 0.33 to 0.67. The correlation between unmet spiritual needs and life satisfaction was 0.17 for the SNI (Hermann, 2007).

The Cantril ladder is a single-item scale that measures the most important aspect of quality of life, life satisfaction. It was chosen because it provides a global rating of quality of life from the patient’s perspective, is appropriate to use with end-of-life patients, and evokes a significant ease of response. The Cantril ladder consists of 10 steps with the top rung of the ladder representing the best possible life imagined and the bottom rung representing the worst possible life. Each participate was asked what the best imagined life and what the worst imagined life would represent. The best and worst
represented the end points of the scale and then the participants rated current life satisfaction on a 10 step scale (best being 10 and worst being 1). The Cantril ladder evaluated quality of life based on the participant’s perceptions (Hermann, 2007).

The results from the SNI revealed that all the participants believed that laughter was a perceived need. Of the remaining 16 items, 6 items were perceived as needs by greater than 90% of the participants and included being with family, being with friends, praying, thinking happy thoughts, talking about day-to-day things, and seeing the smiles of others. Items rated by greater then 80%, but less than 90% of the participants, were singing or listening to music, reading a religious text, having information about family or friends, being around children, being with people who share spiritual beliefs, and going to religious services (Hermann, 2007, p. 74). However, not one need was met for every participant, although 96% of the participant believed that the need for praying was met. The next highest spiritual need that was met included using inspirational material (86%) and using phases from religious text (86%), although the participants only rated the needs as perceived needs at 59% and 65% respectively (Hermann, 2007, p. 74).

The final item on the SNI was to identify other spiritual needs that were experienced. The needs included talking with or visiting with a minister, being prayed for, receiving communion, visiting with a hospice chaplain, and being healed (Hermann, 2007, p. 75).

The Cantril ladder revealed that 98 of the 100 participants rated current life satisfaction and 95 participants rated past life satisfaction as a need. The mean current life satisfaction was a mean of 5.8 with a standard deviation = 2.8 and range = 1 to 10. Past life satisfaction was related to the time prior to diagnosis, with a mean of 8 and a
standard deviation = 2.7, and range from 1 to 10. Seventy-four percent of the participants rated previous life satisfaction at 7 or greater. When comparing the current life satisfaction and past life satisfaction, 68% of the participants rated current life satisfaction lower than past life satisfaction, while 11% reported the same level for both periods and 21% reported an increase in life satisfaction. The relationship between unmet spiritual needs and life satisfaction was r = -0.17 (Hermann, 2007, p. 75).

Hermann (2007) found that female patients residing in a nursing home or on an inpatient hospice unit, and patients with lower levels of education, reported a higher number of unmet spiritual needs. Spiritual needs that were dependent on others and on functional status were rated at the lowest level; however independent spiritual needs were met at the highest rate. Higher levels of religiosity and spirituality were also found in women than men, supporting Reed’s (1986) findings. Hermann (2007) concluded that spiritual needs are important to patients who are near the end of life, but the patients may have a variety of unmet needs that depend on many factors like other people and the care setting.

Nurses’ Perception of Spiritual Care

Nurses should give greater attention to the spiritual dimensions of the patient. A picture of what is happening in spiritual care encounters is needed. Van Dover and Bacon (2001) conducted a study to describe the experiences of nurses and patients engaged in spiritual care encounters utilizing a grounded theory method.

The sample was selected by 10 faculty and graduate students who interviewed 20 nurses who gave spiritual care to patients in a clinical setting. The nurses worked in all clinical settings and varied in age. Interview questions were utilized to guide the
interviews that explored one spiritual care experience. The interviews lasted about 20 to 60 minutes and were audio-taped. The interviews were transcribed verbatim. The initial data analysis was conducted by the 10 interviewers and then the authors of the study performed a more detailed analysis, using constant comparison and multiple reviews of data. The features of each interview were examined for themes and commonalities as well as differences in both content and process (Van Dover & Bacon, 2001).

The care giving settings were inpatient hospital settings, home or community settings, parish or congregational settings, or hospice settings. The duration of the relationships between the nurses and patients varied from short to long. In the hospital setting the nurses took limited time with the patients but attended to the physical needs of the patient. Examples reflected that many times nurses were attending to the spiritual needs of the patient with only a few hours of total contact with the patient. Prayer by the nurses for guidance in how to respond to the patient’s needs, and for help in resolving the patient’s illness was evidenced. Outcomes varied and occurred immediately or over the course of hours or days. Acceptance, a feeling of peace, and a normal heart rhythm were a few outcomes experiences. Other patient outcomes were that a comatose patient later regain consciousness and dysphasic patient regained speech after a nurse prayed. The nurse’s ability to actively give spiritual care may enable the patient to move from spiritual distress to well-being in a relatively short time. Nurses found meaning in caring (Van Dover & Bacon, 2001).

Van Dover and Bacon (2001) concluded that spiritual care is practiced in many nursing care settings. Nurses develop a comfort level with practicing spiritual care. Experienced nurses had a great sensitivity to assessing the spiritual needs and then
providing an intervention. It was also concluded that “spiritual care addresses the core of human beings, the human spirit” (2001, p. 28). Nurses who provide spiritual care not only help the patients and families create meaning and memories but also add meaning and memories to their own spirituality.

Factors Affecting Spiritual Care

The importance of spirituality is becoming more recognized as a central component to the health and well-being of patients. Terminally-ill patients face mortality issues. The despair and psychological distress the terminally ill patient experiences at the end of life may be addressed through a sense of spiritual well-being. The research has also shown that there is a link between depression, desire to hastened death, suicidal ideation, and hopelessness in the terminally ill patient. The purpose of McClain et al.’s (2003) study was to examine the relationship between despair in the terminally ill patient to spiritual well-being.

The participants were selected from individuals admitted to palliative care hospital in New York over 18 months. The patients had cancer as a diagnosis, and had less than 3 month’s life expectancy. Participants had to be fluent in English and not exhibit any psychotic mental disorders. The hospital had 3,212 patients admitted for end-of-life care, with 2,352 patients ineligible due to the severity of the condition. The remaining patient population was screened with the Mini-Mental Screening Examination (MMSE) to evaluate the cognition of the patients. Patients who scored 19 or less on the MMSE were excluded from the study. After the screening and consent was completed, only 160 patients were accepted into the study. The study participants were 57% women and 43% male; mean age 5.7 years. Participants were 71% white, 21% African-
American, 6% Hispanic, 1 Asia and 1 non-specified ethnicity. Participants were 50% Catholic, 21% Protestant, 11% Jewish, and 18% none or other religious affiliation (McClain et al., 2003).

The assessment tools used in the study were: the Functional Assessment of the Chronic Illness Therapy-Spiritual Well-Being (FACIT-SWB), which measures spiritual well-being in two subscales of meaning and faith. The Beck Hopelessness Scale (BHS), which measures pessimism and hopelessness. The Schedule of Attitudes toward Hastened Death (SAHD) measures the desire to hastened death in the context of medical illness. The Functional Social Support Questionnaire (FSSQ) measures perceived social support. The Memorial Symptom Assessment Scale (MSAS) measures symptom prevalence, frequency, and distress. The Karnofsky Performance Rating Scale (KPRS) measures physical functioning ability of cancer patients. The inter-rater reliability was high for the KPRS and the HDRS scales. The other assessment scales have been widely used in other research and had established reliability and validity (McClain et al., 2003).

The results from the FACIT-SWB were divided into two categories: one with high spiritual well-being (a mean score >3) and one with low to moderate spiritual well-being (a mean score < 3). The results of the FACIT-SWB were compared with the dependent variables of hopelessness (BHS), desire to hastened death (SAHD), and suicidal ideation, and then, with the covariates of depression (HDRS), social support (FSSQ), physical functioning (KCRS), and the number of symptoms (MSAS). Depression significantly correlated with every outcome variable. The spiritual well-being showed significant correlations with all variables. The regression model showed that spiritual well-being and depression had significant effects, with depression having a
weaker effect than spiritual well-being. Social support and physical functioning had no significant contribution to the model. Physical symptoms had a significant association with suicidal ideation, but not on hopelessness and desire to hastened death (McClain et al., 2003).

In the second analysis of the FACIT-SWB, the FACIT-SWB was further subdivided into meaning and faith. Meaning was significantly related with end-of-life despair, and faith was significantly related with hopelessness. Then in the final analysis, the interaction between the level of depression and the level of spiritual well-being in prediction of hopelessness, desire to hastened death, and suicidal ideation revealed that depression and spiritual well-being predicted the desire to hastened death but was not significant for hopelessness and suicidal ideation. The high spiritual well-being group the measure was considerably weaker than for the low-moderate spiritual well-being group (McClain et al., 2003).

McClain et al. (2003) concluded that spiritual well-being was strongly related to end-of-life despair. Specifically, that meaning has more significance than faith, which in a reflection of religion. Spiritual well-being buffered the effects of hastening death, but did not effect the depression and hopelessness and suicidal ideation. Interventions that instill a sense of purpose and strengthen meaning help to alleviate the despair and distress that comes in the terminal illness of cancer.

Liver transplant recipients face the reality of mortality related to the disease process that leads up to the need for a liver transplant, and the possibility of organ rejection and other complications of the transplant. The liver transplant recipient’s struggle to preserve life has an increased awareness of spirituality and is challenged to
find meaning and purpose in the transplant experience. Bean and Wagner (2006) examined liver transplant recipients for the relationships among self-transcendence, illness distress, and quality of life. The authors wanted to describe the level of self-transcendence post-transplant; the relationship between self-transcendence and quality of life, illness distress, and related demographic variables; the difference in scores from the Self-Transcendence Scale (STS) from the time since transplant groups and gender; and factors and experiences related to self-transcendence. The conceptual framework was a proposed model of “a developmental process of self-transcendence that is positively correlated with quality of life” (Bean & Wagner, 2006, p. 48). Bean and Wagner synthesized the framework from Reed’s (1991) Theory of Self-transcendence and Ferrans and Powers’ (1992) conceptualization of quality of life.

The design of the study was correlational, cross-sectional and included a qualitative strategy of narrative analysis from written responses to open-ended questions. The sample was 18 years of age or older, had one liver transplant, and willing and able to complete a questionnaire. The sample was selected from 1,458 qualified liver transplant recipients from two transplant centers, one in southwestern and one in the midwestern United States. Participant responses included 471 subjects (354 from the southwest and 117 from the midwest). The participants were 53.5% male; 85.6% Caucasian; 97.6% well-educated; 73.5% married; 93.6% had a religious affiliation; 38.2% working full-time and 7.9% working part-time; and 25.5% had Hepatitis C, which was the leading cause of the liver transplant (Bean & Wagner, 2006, p. 50).

The Self-Transcendence Scale (STS) is a 15-item questionnaire that quantifies the intrapersonal, interpersonal, and transpersonal aspects of transcendence. The STS
utilizes a 4-point scale ranging from 1 (not at all) to 4 (very much). Each item was scored by totaling the responses for items 1 to 15. The total score was divided by the number of items answered. The Cronbach’s alpha ranged from .72 to .94 with a test-retest reliability of 95. The current study has $r = .81$ (Bean & Wagner, 2006, p. 49).

Quality of Life Index (QLI) is a 72-item questionnaire divided into two sections of satisfaction and importance. Each satisfaction item has a corresponding importance item. The QLI is further divided into four domains: health and functioning; social and economic; psychological and spiritual; and family. The satisfaction measures range from 1 (very dissatisfied) to 6 (very satisfied) and the importance measures of 1 (very unimportant) to 6 (very important). The satisfaction scores are multiplied by the importance scores for each item. A total life mean score is obtained by adding each item score and dividing by the total number of answered items. A score for each domain is also obtained by adding the multiplied satisfaction and importance scores and dividing by the total number of answered response for that domain. Internal consistency reliability for the QLI using the Cronbach’s alpha is 0.84 to 0.98. The current study has $r = 0.97$ (Bean & Wagner, 2006, p. 49).

The Illness Distress Scale (IDS) is a 22-item scale to assess the extent each item (loss of energy, depending on others, thinking about death, etc.) is experienced. The responses are scored with a 5-point Likert scale that ranges from 0 (none) to 4 (extremely) and then summed with a range of 0 to 88. This scale has only been utilized in one study of 400 cancer patients. No reliability was reported for this scale (Bean & Wagner, 2006).
The findings revealed that self-transcendence post-transplant had a mean score of 3.36 with a standard deviation of .37. Females had a mean score of 3.41 compared to the males, which were 3.31. The STS scores had a significantly positive correlation with QLI (r = -51). Health status had a Kendall tau = .28 (p = .01); female gender had a Kendall tau = .11 (p = .05); and being employed had a Spearman rho = .11 (p = .01). STS and IDS scores had a significant negative correlation of r = -.36 (P = .01). The differences between gender and time-since –transplant groups on the STS scores were calculated using the analysis of variance. No significant interaction was found between gender and time-since-transplant groups. However, a significant difference in STS and genders groups was noted. Females had higher STS scores than males in all four time-since-transplant groups (Bean & Wagner, 2006, pp. 50-51).

Factors and experiences that suggested self-transcendence were categorized into interpersonal, intrapersonal, and transpersonal relationship groups. The themes that were reported for the interpersonal relationships were appreciation for family and friends; stronger bonds with family and friends; more relaxed and closer relationship with family and friends; not taking others for granted; and the importance of showing feelings to others. Intrapersonal relationship themes were: more awareness of health and body needs; increased personal strength; increased awareness of life and realignment of priorities; becoming a more mature and balanced person with appreciation for each day; and ability to enjoy activities. Transpersonal relationship themes included: caring more about spiritual life; being much closer to God; increased faith in God and overall peace; and increased dependence on God for strength and recovery (Bean & Wagner, 2006, p. 51).
Bean and Wagner (2006) concluded that the findings supported the framework. Self-transcendence may develop during the crisis of a liver transplant, interaction with illness distress, and facilitate a positive outcome of high perceived quality of life. The findings also supported Reed’s (1991) theory that end-of-life self-transcendence is characterized by interpersonal, intrapersonal, and transpersonal relationships (Bean & Wagner, 2006, p. 52).

Instrumentation

Chronic illness is an irreversible disease state in which no cure exists. The focus of care is symptom management to reduce the impact of the illness and enhance health. The chronically ill strive to balance the bio-psycho-social-spiritual health and well-being through a variety of strategies. Adegbola (2006) proposed that theoretical and research instrumentation support the inclusion of spirituality and quality of life assessments as essential elements in the care of the chronically ill patient. It has become essential for health care providers to justify interventions that promote quality of life; are holistic; include spiritual aspects of the patient; and are cost effective. Quality of life has been shown to predict survival and well-being.

Quality of life is defined as the “feeling of overall life satisfaction, as determined by the mentally alert individual whose life is being evaluated” (Adegbola, 2006, p. 42). Self-care management and health status have been show to affect quality of life; however the individual’s ability to adjust to illness and maintain quality of life requires the individual’s subjective and personal valuation. Measurement of quality of life exists.

Adegbola (2006) discussed the current instruments that are available: the Functional Assessment of Chronic Illness Therapy (FACIT), the Functional Assessment
of Cancer Therapy General (FACT-G), and the Functional Assessment of Chronic Illness Therapy Spiritual (FACIT-SP). The FACT-G measures quality of life in the four areas of physical well-being, functional well-being, emotional well-being and social well-being. The FACT-G was validated with a sample of 545 patients and showed an internal consistency of 0.89 and test-retest reliability coefficients ranging from 0.82 to 0.93. It has been utilized in additional studies of cancer and chronically ill patients (Adegbola, 2006, p. 43). The FACIT-SP was a separate subscale that was developed from the FACIT, which assesses the role of spirituality in quality of life. This 12 item scale is measured using a 5-point Likert scale ranging from not at all (1) to very much (5). The Cronbach’s alpha ranged from 0.81 to 0.88.

Health involves the unity and harmony of the body, mind, and soul (Adegbola, 2006, p.43). Spirituality is an important aspect of life and enables the individual to cope and make sense of adversity. It helps the individual find meaning and purpose in life and strengthens the individual in organizing and valuing life. Medical care and health care providers avoid the spiritual aspect of the patient’s care, and view spirituality as a personal religious preference, giving little therapeutic value to spirituality. However, studies have indicated that spirituality can provide influencing adaptation to illness and dying (Adegbola, 2006).

Health care providers and especially nurses need to treat the patient’s body, mind, and spirit, a holistic being. The philosophy of caring and holistic nature is a perfect environment for implementation of spiritual practices, by nurses. The development of theory and the building of a body of knowledge that promotes quality of life for the chronically ill patients is needed. Nurses that do provide spiritual care with an attitude of
caring, sensitivity and competence not only help the patient, but also increase the nurse’s spirituality and fulfillment in caring for patients (Adegbola, 2006).

Adegbola (2006) concluded the discussion of spirituality and quality of life with the charge to incorporate spiritual care into practice, especially as new research findings provide evidence of the effectiveness of spiritual interventions. Further research is needed into what exactly the relationships are between health related issues, spirituality, and quality of life. Since spirituality reflects the diversity of people and spiritual needs, research needs to explore the many different faiths and cultures (Adegbola, 2006).

**Summary**

Sulmasy’s (2002) expansion of the biopsychological model incorporates the spiritual dimension of the patient so that the dying patient’s spiritual needs can be addressed. Further study of religiosity, spiritual coping, spiritual well-being, and spiritual needs of the dying patient can help healthcare providers to impact the health of the dying patient (Sulmasy, 2002).

The patient’s perspective on spirituality were demonstrated through the patient’s quest for meaning in life; relationships with others and a higher power, and spiritual practices. Reed’s (1987) study supports a higher sense of spiritual well-being in the dying patient, and that spirituality and well-being are significant to terminally ill patients. Fryback and Reinert (1999) found that the dying patient has a belief in a higher power and recognizes mortality. Spirituality provides a method of finding meaning in life (Albaugh, 2003) and mediates physical and psychological well-being (Merviglia, 2006). Breast cancer patients were found to balance the need for isolation and connection to others, with isolation providing a means to seek connection with a higher power and to
finding meaning in life and connection with others providing the needed support and strength to endure the disease (Logan et al., 2006). Hermann (2007) found that spiritual needs were important to end of life care.

Nurses can have an impact on the spirituality. Van Dover and Bacon (2001) found that nurses do practice spiritual care in many ways. Spiritual care addresses the core of the human being, and providing spiritual care can not only help the patient but also the nurse define personal, spiritual significance. The nurse who knows and practices spiritual care with comfort and sensitivity can provide patients and families opportunities to move from spiritual distress to spiritual well-being.

Factors that can affect spiritual care are spiritual well-being and self-transcendence. McCain et al. (2003) found that spiritual well-being has a strong correlation to end-of-life despair. The importance of meaning in life and disease was greatly than faith. Interventions that support the exploration of meaning and decrease psychological distress of the terminally ill patient can increase a sense of spiritual well-being. Self-transcendence was also found to affect the spirituality of liver transplant recipients (Bean & Wagner, 2006). The interpersonal, intrapersonal, and transpersonal relationship characteristics of self-transcendence help to facilitate higher perceived quality of life.

The studies clearly demonstrated that as the patient faces terminal and serious illness and end-of life issues, spirituality becomes a buffer to maintaining health within the disease. Congruence cannot be achieved through control. However, anxiety and tension can be alleviated through religious practices, meaningful relationships, forgiveness and reconciliation, increased appreciation for nature, music, and art, and
transcendence. Thus, congruence can promote health through coherence and individuation. Nurses can greatly impact the patient’s spirituality and spiritual needs by listening and interaction with the patient in ways that support spiritual expression and exploration. Much more research needs to be conducted to validate and further investigate the spiritual needs of the terminally ill and serious ill patient.
Chapter III

Methodology and Procedures

Introduction

Terminally ill and seriously ill patients face many adjustments when approaching the end of life. Spiritual needs tend to be a prominent defense in facing illness through transcending the meaning of life and beyond (Reed, 1987). Spirituality becomes a means of gaining control, finding meaning in life and disease, transcendence, and well-being. It is important for nurses to assess the patient’s spiritual perspective and implement nursing strategies that help the patient to achieve spiritual well-being. The purpose of this study is to identify the spiritual needs perspectives of the hospitalized patient, to determine the difference in spiritual perspectives between the seriously ill and the terminally ill hospitalized adult, and to determine the relationship between spiritual perspectives and well-being in the terminally ill patient.

Research Questions

1. What are the spiritual needs perspectives of the hospitalized patient?
2. Is there a difference in spiritual perspectives between seriously ill hospitalized adults and terminally ill adults?
3. Is there a relationship between spiritual perspectives and well-being?

Population/Sample/Setting

The study will take place in Lafayette, Indiana, in two hospitals. The population will be all terminally ill patients hospitalized on the oncology or hospice units. The
seriously ill patients will be patients admitted to the intensive care units and step-down units during a 6 month period. The anticipated number of participants is 50 terminally ill patients and 50 seriously ill patients selected from an anticipated 100 terminally ill patients and 100 seriously ill patient populations.

The criteria for inclusion in the study for the terminally ill patient group will be: (a) patients diagnosed with a terminal illness, such as cancer or end-stage renal disease, with a prognosis of less than 6 months to live, (b) awareness of the prognosis of the illness, (c) 21 years or older, (d) able to respond to questions appropriately, and (e) willingness to participate in the study. The criteria for inclusion in the study for the seriously ill patient group will be: (a) patients diagnosed with a serious illness that has a potential for death without appropriate treatment and/or complications from treatment and have a potential for recovery with treatment, (b) awareness of the prognosis of the illness, (c) 21 years or older, (d) able to respond to questions appropriately, and (e) willingness to participate in the study.

Protection of Human Subjects

Permission to conduct the study will be obtained from Ball State University and the Institutional Review Board. Permission will also be sought from the two hospitals in Lafayette, Indiana. Subjects’ rights and welfare will be protected by not identifying any personal information gained from the surveys. There are no risks to the welfare of the participant. Participation is voluntary. Benefits to the participants will be a chance to reflect on spirituality and coping with a terminal or serious illness, which could potentially be therapeutic to the participants. A documentation of review form, HIPPA, summary of safeguard statement, informed consent statement, protocol, and other
supporting documents may be required. Each patient will receive a cover letter or verbal explanation of the study. Care will not be affected if the patient does not want to participate.

*Procedures*

After approval is received from the Institutional Review Board of the hospital and Ball State University, the researcher will contact the hospital’s vice president of nursing to discuss the study. Arrangements will then be made to talk with the division directors, unit managers, and unit staff. The researcher will set up unit meetings to explain the purpose of the study. A copy of the abstract and the Spiritual Perspective Scale (SPS) and the Index of Well-Being (IWB) scale will be provided. After explanation of the purpose of the study and method of data collection, the unit managers and unit staff will be consulted to identify appropriate patients for the study. Each selected patient will be given an information sheet and an explanation of the study. The researcher will administer the SPS and IWB to the participants and provide an envelop for return of the information. The researcher will visit the hospital units twice weekly on Mondays and Thursdays.

*Methods of Measurements (Instrumentation)*

The Spiritual Perspective Scale (SPS) and Index of Well-Being (IWB) will be used to measure the spirituality and well-being of the participants. The Spiritual Perspective Scale (SPS) is a 10-item questionnaire addressing perceptions of spirituality, and how spirituality influences life and how individuals engage in spiritual based activities. The questions are rated on a 1 to 6-point Likert scale with 6 indicating greater spiritual perspective and 1 no spiritual perspective (Reed, 1987, p. 338). The scores are
calculated to obtain the arithmetic mean across all items. The reliability and validity has been demonstrated in terminally ill patient and healthy adults from previous studies (Reed, 1987). The reliability of the SPS, using Cronbach’s alpha coefficient, ranged from .93 in the non-terminally ill hospitalized group to .95 in the terminally ill hospitalized and the healthy adult groups. Inter-item correlations ranged from .57 to .68 across all groups. Validity was evidenced by the women who reported having a religious background scored higher on the SPS (1987, p. 337).

The Index of Well-Being (IBW) will be utilized to measure the patient’s satisfaction with life. The tool is a nine-item questionnaire that is scored using a 6-point Likert scale, with 6 indicating the greatest satisfaction and 1 indicating dissatisfaction. The scoring of the IBW is based on a sum of two weighed scores: an overall score of a life satisfaction item weighed by 1.1 and then the mean score of the remaining eight items weighed by 1.0. The potential scores range from 2.1 to 12.6, with the higher score indicating satisfaction with life. The participants will be asked how health is experienced on a scale of 1 to 5, with 1 indicating poor and 5 indicating excellent health. The reliability and validity has been demonstrated in terminally ill patient and healthy adults from previous studies (Reed, 1987). For the IBW, the reliability was measured by the Cronbach’s alpha coefficient of .90. Inter-item correlations were ranged from .51 to .61. Validity was estimated to be moderate with a Pearson’s correlation of .35 between well-being and self-esteem and self-confidence (1987, p. 338).

Research Design

This study is a modified replication study. The design is a comparative descriptive research design. According to Burns and Grove (2005) a comparative
Descriptive design is used “to examine and describe differences in variables in two or more groups” (p. 234). For this study, the two groups will be the terminally ill patient group and the seriously ill patient group. The variables to be measured are perceptions of spirituality, and how spirituality influences life, how individuals engage in spiritual based activities, life satisfaction, and change in spiritual views since diagnosis.

**Intended Method of Data Analysis**

Descriptive statistics will be used to analyze the data. For the correlation of the relationship between spiritual perspectives and well being, the Pearson’s correlation will be used to find the $r$ value. The $r$ value will determine if spiritual perspectives and spirituality have no relationship, a positive relationship, or a negative relationship to each other. A $t$-test will be used to compare means of spirituality and well-being in the terminally and seriously ill groups. Burns and Grove (2005) defined the $t$-test as a measure of the significant differences between statistical measures of two samples. For this study, the two samples are the seriously ill and the terminally ill patient groups and the difference in spirituality and well-being variables among these two samples will be analyzed.

**Summary**

Holistic nursing care is important to all patients; however, for the terminally ill and seriously ill patients holistic care is essential for promoting well-being. Spirituality is an important dimension of all patients, and is part of the holistic being of body, mind, and spirit. The anticipated sample is 50 terminally ill patients and 50 seriously ill patients. Two questionnaires will be given to each patient by the researcher. The design is comparative descriptive research design. $T$-test will be used to analyze spirituality and
well-being in the terminally ill and seriously ill groups. Findings will provide information about the perspectives on spiritual care.
References


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