Student nurses perceptions of spirituality and competence in delivering spiritual care: A European pilot study

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Keywords: Spiritual care competence
Nurse education
Spirituality

Accepted 17 September 2013

Introduction

The spiritual aspect of life is recognised as having an important part to play in health, wellbeing and quality of life. This can be seen in: work globally (e.g. WHO, 2002a); the increasing body of scientific evidence indicating that spirituality has significant mental and physical health benefits (e.g. Koenig et al., 2012) and that spiritual care is integral to patients’ wellbeing (Ross, 2006; Nixon et al., 2013); the attention given to spiritual care within health services e.g. employment of hospital chaplains. A plethora of spiritual/religious care guidance, policy and education documentation is also available internationally (e.g. WHO, 2002b; NICE, 2004; Department of Health, 2009; www.palliatief.nl).

Spiritual care is expected of nurses as can be seen internationally in nursing codes of ethics (e.g. Malta Code of Ethics, 1997; International...
Council of Nurses, 2000; Nursing and Midwifery Council, 2008) and nurse education guidelines (e.g. Quality Assurance Agency for Higher Education, 2001; Kunnskapsdepartementet, 2008; NMC, 2010; V and VN, 2012). For example, in the UK, The NMC expects:

“All nurses must carry out comprehensive, systematic nursing assessments that take account of relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors, in partnership with service users and others through interaction, observation and measurement.”

[NMC, 2010; p18]

Despite the inclusion of spiritual care within nurse education guidelines, there is still uncertainty as to how the subject should be formally taught and integrated within pre-registration/undergraduate nurse education programmes. Research is starting to address this question.

Defining Spirituality/Spiritual Care

Within nursing, whilst spiritual care is expected, there is no single shared definition of ‘spirituality’ and ‘spiritual care’ (McSherry and Ross, 2010). Indeed there is the view that constructing an authoritative definition of spirituality may not be possible and indeed may be unhelpful (Swinton and Pattison, 2010). Some critique spirituality and argue that it is all about psychosocial needs (Paley, 2008), however, studies done by the World Health Organization Quality of Life Spiritualit...
Perceptions of Spirituality/Spiritual Care

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care practice.

literature as follows.

returned blank forms.

by the authors during class time. Those not wishing to participate
in the following three questionnaires were selected to capture personal

 Origins of the sample.

<table>
<thead>
<tr>
<th>Country</th>
<th>Type of university included (religious or secular)</th>
<th>Year of course</th>
<th>Total students present on day of data collection</th>
<th>No. of students completing full set of measures</th>
<th>% of sample completing full set of measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wales, UK</td>
<td>1 × secular</td>
<td>1</td>
<td>188</td>
<td>147</td>
<td>27.7</td>
</tr>
<tr>
<td>Malta</td>
<td>1 × secular</td>
<td></td>
<td>182</td>
<td>181</td>
<td>31.4</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2 × religious</td>
<td>3, 4</td>
<td>136</td>
<td>136</td>
<td>25.6</td>
</tr>
<tr>
<td>Norway</td>
<td>1 × religious</td>
<td>1</td>
<td>82</td>
<td>67</td>
<td>12.6</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>618</td>
<td>531</td>
<td>100.00</td>
</tr>
</tbody>
</table>

and students was voluntary and anonymity and confidentiality were

The sample was given verbal and written information about the study 1–2 weeks in advance of the questionnaires being administered by the authors during class time. Those not wishing to participate returned blank forms.

Data Collection

Five questionnaires addressing the study aims were selected on the basis of fitness for purpose, validity and reliability from a review of the literature as follows.

The following three questionnaires were selected to capture personal characteristics of the sample as there was indication from the literature that students’ personal spirituality, values and beliefs may impact upon their spiritual care practice.

- Purpose designed demographic questionnaire asking questions about gender, age, educational background, religious affiliation/life view etc.

- JAREL Spiritual well-being Scale (Hungelmann et al., 1996). JAREL measures spiritual well-being and contains 21 items scored 1–6 with high scores (maximum 126) indicating high spiritual well-being and low scores (lowest 21) indicating low spiritual well-being. The scale incorporates 3 subscales: faith/belief; life/self responsibility; life satisfaction/self actualization. All 21 items loaded at 0.50 or above for all 3 factors (Hungelmann et al., 1996). Treated as a categorical variable, JAREL measures three levels of spiritual well-being: low (0–50); medium (51–84) and high (85–126). JAREL was selected because of its inclusion of both existential and religious domains of spirituality ensuring relevance to religious and secular universities. It was specifically developed for nursing.

- Spiritual Attitude and Involvement List (SAIL, Meemeenbroek et al., 2008). SAIL consists of 26 items arranged in 3 dimensions with 7 subscales: Connectedness to oneself (meaningfulness, trust, acceptance); to the environment/others (caring for others, connectedness with nature); to the transcendent (transcendent experiences, spiritual activities). Psychometric properties were tested in five samples differing in age, spiritual and religious background, and physical health. Factorial, convergent and discriminant validity were demonstrated, and each subscale showed adequate internal consistency and test-retest reliability (Meemeenbroek et al., 2008). SAIL can be employed as a continuous measure ranging from 1 to 6 with higher scores indicating higher levels of spiritual attitude/involvement or it can be employed as a binary variable whereby high spiritual attitude/involvement is indicated by a SAIL score >4.

Perceptions of Spirituality/Spiritual Care

The Spirituality & Spiritual Care Rating Scale was selected to measure students’ perceptions of spirituality and spiritual care (SSCRS, McSherry et al., 2002) is a valid and reliable measure of spirituality/spiritual care with the intended sample. It has been used in over 42 studies in 11 countries demonstrating consistent levels of reliability & validity with Cronbach’s alpha scores ranging from 0.64 (McSherry, 1997) to 0.84 (Khoshknab et al., 2010). There are 17 statements scored on a 5 point scale from ‘strongly agree’ to ‘strongly disagree’. A high overall score indicates a broader view of spirituality (i.e. inclusive of both religious and existential elements) and spiritual care (i.e. facilitating religious rites/rituals as well as addressing patients’ need for meaning, value, purpose, peace and creativity). In previous studies the SSSCRS has produced a 4 factor model including: existential spirituality (view that spirituality is concerned with peoples’ sense of meaning, purpose, value, peace and creativity i.e. items f,h,i,j,l); religiosity (view that spirituality is only about religious beliefs/practises i.e. items d,m,p); spiritual care (view of spiritual care in its broadest sense including religious and existential elements e.g. facilitating religious rituals and showing kindness i.e. items a,b,g,k,n) and personal care (taking account of peoples’ beliefs and values and dignity i.e. items n,o,q) (McSherry et al., 2002). The Scale, however, has not yet been used to intentionally explore these factors within samples.

Spiritual Care Competence

The Spiritual Care Competency Scale (SCCS, van Leeuwen et al., 2009) was chosen to measure students’ perceptions of their competence in delivering spiritual care. It is a valid and reliable measure of spiritual care competency with the intended sample. Cronbach’s alpha domains range from 0.56 to 0.82. It has good homogeneity, average inter-item correlations >0.25 and good test-retest reliability (van Leeuwen et al., 2009). It contains 27 items scored on a 5 point scale from ‘completely disagree’ to ‘completely agree’, therefore the highest possible competency score is 135 and the lowest is 27. There are 6 subscales measuring: assessment and implementation of spiritual care; professionalization and improving the quality of spiritual care; personal support and patient counselling; referral to professionals; attitude towards patients’ spirituality; communication. The SCCS can be employed as a continuous measure of competency ranging from 1 to 5 with higher scores indicating higher levels of perceived competency or it can be employed as a binary variable whereby competency is indicated by a mean SCCS score across all questions >3.5.

The questionnaires were translated from English into Norwegian and Dutch using a forward–backward translation protocol by two translators who were fluent in English. The two translations were compared by the researcher in charge. Adjustments were made with the consent of both translators resulting in a single version. This version was back translated into English by two bilingual translators who did not have access to the original English version of the questionnaire. The backward translation was compared and considered equivalent to the original version.

The construct validity of the translated questionnaires was tested by comparing them with the original versions and was demonstrated for almost all items.

The computed Cronbach’s alpha, which is a reliability coefficient based on internal consistency, was 0.61 for the Dutch version and 0.80 for the Norwegian version indicating satisfactory to high reliability.
graphic responses were categorised and the mean, median and standard deviation scores were calculated for the 4 standardised measures (SSCRS, SCCS, JAREL, SAIL).

Results

The Sample

Tables 1 and 2 show that the majority of the 86% responding (n = 531) were female nursing students in year 1, aged up to 20 years studying at secular universities. Interestingly, although most were studying at secular universities (62%), the majority were religious (87%), predominantly Christian (80%) and regularly prayed (60% daily/weekly) and attended religious meetings (51% daily/weekly). Just over a third sought rest in nature and practised art daily or weekly. Over half had experienced life events (55%) which were mostly negative, such as loss of a loved one/illness. Most (60%) had no previous healthcare experience and were educated to secondary level (66%).

Respondents rated highly on spiritual wellbeing (JAREL); 71.9% of the sample rated high, just over a quarter (28.1%) rated medium and no-one rated in the low category. This means that the majority rated high in faith/belief, life/self responsibility and life satisfaction/self actualisation.

The mean overall Spiritual Attitude and Involvement (SAIL) score for respondents (n = 529) was 4.05 (median = 4.04; SD = 0.56). Using the binary cut-off point of >4, just over half (53.9%) the sample was categorised as having high and just under half (46.1%) was categorised as having low spiritual attitude/involvement. Using the cut-off point of >4 for the 3 dimensions of the scale, 77.7% demonstrated a high sense of connectedness to self (mean 4.38, SD 0.56), 87.3% demonstrated a high sense of connectedness to the environment/others (mean 4.68, SD 0.65), and 21.4% demonstrated a high sense of connectedness to the transcendent (mean 3.22, SD 0.93).

Perceptions of Spirituality/Spiritual Care

The mean SSCRS score for respondents (n = 530) was 3.99 (per question) (median = 4.0; SD = 0.37) indicating a broad rather than specific view of spirituality/spiritual care. Table 3 shows that the sample tended towards an existential view of spirituality (mean = 3.81) but that they also viewed it as concerning only religious views/practices (mean = 3.94). This finding seems contradictory and may indicate that more work needs to be done on the SSCRS before the 4 factors can be used in this way; such work is in progress. Students considered both spiritual (mean = 4.29) and personal (mean = 4.01) care as important.

Perceived Competence in Delivering Spiritual Care

The mean SCCS score for respondents (n = 528) was 3.74 (Median = 3.74; SD = 0.42). Using the cut off point of >3.5, three quarters of respondents (75.4%) perceived themselves to be competent in delivering spiritual care while a quarter (24.6%) did not.

Table 3

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Spirituality &amp; Spiritual Care Rating Scale (SSCRS) mean subscale scores (n = 530).</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSCR subscale</td>
<td>Mean score (SD)</td>
</tr>
<tr>
<td>Existential spirituality (view that spirituality is concerned with peoples’ sense of meaning, purpose, value, peace and creativity)</td>
<td>3.81 (0.47)</td>
</tr>
<tr>
<td>Religiosity (view that spirituality is only about religious beliefs/practices)</td>
<td>3.94 (0.60)</td>
</tr>
<tr>
<td>Spiritual care (view of spiritual care in its broadest sense including religious and existential elements)</td>
<td>4.29 (0.45)</td>
</tr>
<tr>
<td>Personal care (taking account of peoples’ beliefs and values and dignity)</td>
<td>4.01 (0.51)</td>
</tr>
</tbody>
</table>
Table 4
Spiritual Care Competency Scale (SCCS) mean subscale scores (n = 528).

<table>
<thead>
<tr>
<th>SCCS subscale</th>
<th>Mean score (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionalisation and improving the quality of</td>
<td></td>
</tr>
<tr>
<td>spiritual care</td>
<td>3.38 (0.67)</td>
</tr>
<tr>
<td>Assessment and implementation of spiritual care</td>
<td>3.45 (0.64)</td>
</tr>
<tr>
<td>Referral</td>
<td>3.63 (0.62)</td>
</tr>
<tr>
<td>Personal support and patient counselling</td>
<td>3.78 (0.58)</td>
</tr>
<tr>
<td>Attitude towards patients’ spirituality</td>
<td>4.38 (0.60)</td>
</tr>
<tr>
<td>Communication</td>
<td>4.48 (0.34)</td>
</tr>
</tbody>
</table>

The mean score for each of the 6 subscales is reported in Table 4 and shows that students perceived themselves to have greatest competence in the areas of ‘Communication’ (mean = 4.48) and ‘Attitude towards patients’ spirituality’ (mean = 4.38). This was also found when the cut-off point of > 3.5 was used to indicate competency, with 98.1% and 93.6% of students perceiving themselves to be competent in these areas respectively (Table 5). Almost 80% perceived themselves to be competent in ‘Personal support and patient counselling’ (mean = 3.78). The areas in which higher proportions of students rated themselves as ‘not competent’ were related to ‘Assessment and implementation of spiritual care’ (mean = 3.45) and ‘Professionalisation and improving the quality of spiritual care’ (mean = 3.38).

Discussion
Conducting any large international study presents numerous challenges. This pilot study indicates that such a study is feasible in terms of execution, delivery of outcomes and that the measures are suitable for an international student sample.

Our study sample was largely female and Christian which is unsurprising given the countries and universities included. The findings may, therefore, not be representative of the countries included or of other European and non-European countries. Given this religious profile it is not surprising that the majority of students held a broad view of spirituality/spiritual wellbeing (JAREL) and just over half rated highly on spiritual attitude and involvement (SAIL), however it is not clear why only a minority demonstrated a high sense of connectedness to the transcendent. This finding may be explained by the wider spirituality literature’s suggestion, that how an individual’s faith is worked out and integrated or not within their lives is deeply personal and individual. Alternatively it may be because of the way the questions are asked in the two scales; religious respondents may not recognise themselves in the ‘transcendent’ questions in SAIL and JAREL is more explicit in its religious questions. Given that nursing and midwifery are caring professions with high levels of responsibility, it is encouraging that the majority of students were religious and regularly prayed/attended religious meetings i.e. their personal spirituality may have predicted their perceived ability to give spiritual care, as identified by van Leeuwen et al. (2008) and Taylor et al. (2008). They felt highly competent in the more humanistic and interpersonal aspects of spiritual care such as ‘communication’ and ‘attitude towards patients’ spirituality’, which suggests that we are selecting the right type of student onto our courses; an encouraging finding at a time when the UK Government is looking at selection criteria for new nurse recruits (Calkin, 2013) because of national scandals highlighting poor care standards (Francis, 2013). Areas in which students felt least competent were the more specialist areas of spiritual care involving ‘Assessment and implementation of spiritual care’ and ‘Professionalisation and improving the quality of spiritual care’, aspects which, if addressed within their education programmes, may enhance competency prior to registration. This would answer Bradshaw’s (1997) question of whether spiritual care can be taught. We have only addressed perceived competency in this pilot study. It would be interesting to capture actual spiritual care competency when such measures become available; such work is underway.

Limitations
Our study is limited by its sample size and homogeneity. The inclusion of four countries did not produce diversity of life view (the majority of the sample was Christian). Although we obtained a high response rate (86%) it is possible that the exclusion of non-respondents introduced some bias. We captured students’ perceptions at one point in time only.

Conclusion
We have described how a sample of undergraduate nurses/midwives held a broad view of spirituality/spiritual care and that they perceived themselves to be competent in spiritual care delivery, particularly in the humanistic aspects. Whilst these findings are noteworthy, our sample was predominantly Christian and data were only collected at one point in time. It would be useful to explore if these findings hold in student samples in countries with more diverse cultural backgrounds, as called for by Tiew and Creedy (2011) and to examine any changes over time as students progress through their courses. The next step would be to identify the factors contributing to the acquisition of spiritual caring skills and competency so that education programmes could be tailored to help students deliver truly holistic care as per regulatory body requirements. Such a study is in progress involving universities from 13 countries using the method and measures that this pilot study identified as appropriate.

Funding Statement
The study was funded by the University of Glamorgan Research Investment Scheme.

Conflict of Interest
No conflict of interest has been declared by the authors.

Acknowledgements
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Table 5
Proportion of students categorised as competent/incompetent using 3.5 cut-off point (n = 528).

<table>
<thead>
<tr>
<th>SCCS subscale</th>
<th>% incompetent</th>
<th>% competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>1.9</td>
<td>98.1</td>
</tr>
<tr>
<td>Attitude towards patient spirituality</td>
<td>6.3</td>
<td>93.6</td>
</tr>
<tr>
<td>Personal support and patient counselling</td>
<td>21.3</td>
<td>78.7</td>
</tr>
<tr>
<td>Referral</td>
<td>38.0</td>
<td>62.0</td>
</tr>
<tr>
<td>Assessment and Implementation of spiritual care</td>
<td>42.9</td>
<td>57.1</td>
</tr>
<tr>
<td>Professionalisation and improving the quality of</td>
<td>49.6</td>
<td>50.4</td>
</tr>
<tr>
<td>spiritual care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

if they develop an awareness of and sensitivity to the full range of spiritual needs with which their patients may present as outlined by the WHOQOL SRBP Group (2006) and the RCN (2011). It is encouraging that students considered both spiritual and personal care as important.

It is reassuring that respondents perceived themselves to be marginally more competent than not in spiritual care, especially as the majority had just started their courses. This finding may be accounted for by the fact that the majority were religious and regularly prayed/attended religious meetings i.e. their personal spirituality may have predicted their perceived ability to give spiritual care, as identified by van Leeuwen et al. (2008) and Taylor et al. (2008). They felt highly competent in the more humanistic and interpersonal aspects of spiritual care such as ‘communication’ and ‘attitude towards patients’ spirituality’, which suggests that we are selecting the right type of student onto our courses; an encouraging finding at a time when the UK Government is looking at selection criteria for new nurse recruits (Calkin, 2013) because of national scandals highlighting poor care standards (Francis, 2013). Areas in which students felt least competent were the more specialist areas of spiritual care involving ‘Assessment and implementation of spiritual care’ and ‘Professionalisation and improving the quality of spiritual care’, aspects which, if addressed within their education programmes, may enhance competency prior to registration. This would answer Bradshaw’s (1997) question of whether spiritual care can be taught. We have only addressed perceived competency in this pilot study. It would be interesting to capture actual spiritual care competency when such measures become available; such work is underway.

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