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Self-reported frequency of nurse-provided spiritual care

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ABSTRACT

Aim: To describe how frequently RNs provide 17 spiritual care therapeutics (or interventions) during a 72–80 h timeframe.
Background: Plagued by conceptual muddiness as well as weak methods, research quantifying the frequency of spiritual care is not only methodologically limited, but also sparse.
Methods: Secondary analysis of data from four studies that used the Nurse Spiritual Care Therapeutics Scale (NSCTS). Data from US American RNs who responded to online surveys about spiritual care were analyzed. The four studies included intensive care unit nurses in Ohio ($n = 93$), hospice and palliative care nurses across the US ($n = 104$), nurses employed in a Christian health care system ($n = 554$), and nurses responding to an invitation to participate found on a journal website ($n = 279$).
Results: The NSCTS mean of 38 (with a range from 17 to 79 [of 85 possible]) suggested respondents include spiritual care therapeutics infrequently in their nursing care. Particularly concerning is the finding that 17–33% (depending on NSCTS item) never completed a spiritual screening during the timeframe. "Remaining present just to show caring" was the most frequent therapeutic (3.4 on a 5-point scale); those who practiced presence at least 12 times during the timeframe provided other spiritual care therapeutics more frequently than those who offered presence less frequently.
Conclusion: Findings affirm previous research that suggests nurses provide spiritual care infrequently. These findings likely provide the strongest evidence yet for the need to improve spiritual care education and support for nurses.

Nurses assert that they provide holistic care that addresses the spiritual as well as other dimensions of personhood. Nursing diagnoses recognize that the health-related challenges care recipients experience often create spiritual distress and opportunities for spiritual transformation (Carpenito-Moyet, 2013). Nursing curricula and textbooks include instruction on assessing and addressing patient spiritual needs (Taylor, Testerman, & Hart, 2014; Timmins, Murphy, Begley, Neill, & Sheaf, 2016). This nurse assessment and support of patient spirituality is typically labeled spiritual care.

Spiritual care, or spiritual nursing care, was defined by Pesut and Sawatzky (2006) as essentially an "expression of self.... Spiritual nursing care begins from a perspective of being with the client in love and dialogue but may emerge into therapeutically oriented interventions that take direction from the client's religious or spiritual reality" (p. 23). The interventions, or therapeutics, that nurses offer as spiritual care are diverse. Sometimes interventions that are essentially elements of basic caring (e.g., showing respect, non-procedural touch) are considered spiritual care; likewise, care that is psychosocial care (e.g., listening) is also equated with spiritual care. This confusion, along with the concern about what is spirituality versus religion, muddies the research that investigates what spiritual care nurses provide. Plagued by this conceptual muddiness as well as weak methods, research quantifying the frequency of spiritual care is not only methodologically limited, but also sparse (Kalish, 2012; Taylor, 2008). Thus, this paper will present evidence about the frequency of nurse-provided spiritual care that is driven by more conceptual clarity and based on a large sample from multiple sites.

1. Background

Some patients desire a nurse or other health care clinician to inquire about and/or address their spiritual concerns (e.g., Phelps et al., 2012; Williams, Meltzer, Arora, Chung, & Curlin, 2011). Indeed, findings from a study of persons with advanced cancer ($N = 343$) documented

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that when spiritual needs are addressed, medical costs can be reduced, quality of life can be improved, and patients become more receptive to hospice (Balboni et al., 2010; Balboni et al., 2011). When patient spirituality is addressed by a health care provider patients report greater satisfaction with their health care experience (Astrow, Wexler, Texeira, He, & Sulmasy, 2007; Williams et al., 2011). Using Press Ganey data obtained from Asian Americans ($N = 805$) recently discharged from a hospital, one study found that this relationship between spiritual needs being met and patient satisfaction was best explained by whether nurses provided spiritual care (Hodge, Sun, & Wolosin, 2014).

While this somewhat limited body of evidence suggests spiritual care is often desired and contributes to positive outcomes, there is meager evidence documenting how frequently it is provided. Existing evidence, however, suggests variation in the frequency of nurse-provided spiritual care with nurse self-reports generally being between infrequently and occasionally (Gallison, Xu, Jurgens, & Boyle, 2013; Musa, 2016; Ramondetta et al., 2013; Rodin et al., 2015; Ronaldson, Hayes, Aggar, Green, & Carey, 2012; Taylor, Highfield, & Amenta, 1999). This variation may be explained by how and what type of spiritual care therapeutic is being measured (Epstein-Peterson et al., 2015; Hubbell, Woodard, Barksdale-Brown, & Parker, 2006; Taylor et al.), by subspecialty (e.g., hospice nurses provide spiritual care more frequently than do oncology or acute care nurses [Taylor, et al.; Ronaldson et al.]), by social mores dictated by the country in which the nurse practices (Ramondetta et al.), and by personal spirituality or religiosity that interfaces with perspectives about spiritual care in nursing practice. Indeed, findings from several studies from around the world indicate that nurses' personal spirituality or religiosity is directly correlated with their attitudes about providing spiritual care (e.g., Chew, Tiew, & Creedy, 2016; Musa, 2016; Ross et al., 2016).

The infrequency of spiritual care exists even though nurses simultaneously report believing it is an important part of nursing care (Chew et al., 2016; Epstein-Peterson et al., 2015; Turan & Yavuz Karamanoglu, 2013). This disconnect between perceptions about how spiritual care is important to provide and the infrequency may be explained by the research that describes what nurses identify as barriers preventing spiritual care; these barriers include lack of time, lack of privacy, inadequate training, uncertainty about what are spiritual and religion and the nurse's role in addressing them, and fear about proselytizing religion (Gallison et al., 2013; Kalish, 2012; McSherry & Jamieson, 2011).

Whereas many studies measure nurse beliefs or attitudes about spiritual care, there is a paucity of trustworthy evidence about the frequency of spiritual care. Studies that do examine frequency are plagued by: small, local, and convenient samples; measurement tools with unknown validity; failure to report frequencies of specific spiritual care practices; and vague response options (e.g., what does *occasionally* mean?). Given cultural mores presumably play a significant role in determining frequency of spiritual care, it is important to note that only six published studies with only US American samples were found to date, only two of which was conducted within the past decade (Epstein-Peterson et al., 2015; Rodin et al., 2015; Gallison et al., 2013). Evidence about how frequently nurses provide spiritual care and what spiritual care therapeutics are provided can inform nurses as to what is standard practice. This can guide nurses to reflect on how it ought to be (or ought not to be), and whether more education and managerial support is necessary.

2. Purpose

The purpose of this study was to describe how frequently nurses in the United States of America provide various spiritual care therapeutics using a pooled sample from four different studies. The following research questions were posed: How frequently do nurses report providing each of the 17 interventions included in the Nurse Spiritual Care Therapeutics Scale (NSCTS)? What interventions are most frequent? Least frequent? What are the correlations between providing any therapeutic and providing spiritual care in general? Does frequency of spiritual care vary among the samples?

3. Methods

This study involved secondary analysis of survey data from four cross-sectional, descriptive studies that used survey methods. Each study received ethical review and approval from an institutional review board. Inclusion criteria for these studies was that the study used the Nurse Spiritual Care Therapeutics Scale (Mamier & Taylor, 2014) and that U. S. American nurses were in the sample. The Mamier (2009) study sought to identify frequency and type of nurse-provided spiritual care practices, as well as potential correlates (i.e., demographic and work-related factors, nurse religiosity). The Taylor and colleagues study (unpublished) investigated how facets of nurse religiosity were associated with provision of spiritual care. Ricci-Allegra (2015) examined whether spiritual perspectives, mindfulness, and provision of spiritual care were related. Foith (2016) assessed not only frequency of spiritual care, but also what were perceived barriers to providing spiritual care.

3.1. Sample

Samples were of convenience although Foith's sampling procedure initially involved randomization. Whereas two studies targeted recruitment of nurse participants from populations highly likely to be Christian (i.e., Mamier et al., and Taylor, et al.), the other two studies recruited participants from professional organizations (i.e., Ricci-Allegra, Foith). Whereas three studies recruited participants via email, one study recruited via websites for the *Journal of Christian Nursing*, *American Journal of Nursing*, and *Home Healthcare Now*. All nurses (except for 6% of Taylor et al.'s sample) were RNs; 51% of Ricci-Allegra's sample were APNs. (Table 1 provides further detail.)

3.2. Data collection

3.2.1. Procedure

All studies utilized online survey methods to obtain nurse responses to the NSCTS. These online surveys began with an anonymous consent procedure that informed potential participants about the study and invited their participation.

3.2.2. Instrument

The Nurse Spiritual Care Therapeutics Scale (NSCTS) measures the frequency of 17 therapeutics determined by an expert panel to represent spiritual care appropriate for a nurse to provide (Taylor, 2008). Except for Item 17 (about being present for a patient) that received partial support, these therapeutics likewise were considered practices that uniquely address patient spirituality rather than the psychosocial dimension; they were also identified as practices that are not uniquely religious. For example, prayer is a common spiritual practice that can be experienced with or without a religious affiliation. The evaluative process provided by this 9-member expert panel generated a content validity index of 0.88 for the NSCTS (Taylor).

Further psychometric evaluation of the NSCTS was completed by Mamier and Taylor (2014). Construct validity was studied with exploratory factor analysis. A one-dimensional solution yielded individual factor loadings between 0.407 and 0.836 and accounted for 49.5% of the variance. Further support for the validity of the NSCTS is provided by studies that document significant associations between nurse religiosity and NSCTS (Mamier, 2009; Taylor, et al., unpublished), and Mamier's finding that those who received spiritual care training reported more frequent spiritual care provision. In this pooled dataset, the NSCTS internal reliability was supported by a Cronbach's alpha of 0.94.

The NSCTS items can be summed to provide a total score. The 17 items are introduced by a stem that reads, “During the past 72 (or 80)

Table 1
Description of samples and recruitment methods.

Investigators	Sample size/response rate	Sample characteristics	Recruitment methods
Foith	93/unknown	Mostly female (85%) with at least a BS degree (62%) and self-reporting a religious affiliation (76%), working full-time (73%) day shift (59%) in an ICU (86%).	All active RNs in northeastern Ohio were emailed an invitation with a hyperlink to the survey; emails were obtained from list generated by state nursing board (every 100th nurse was contacted); ICU RNs were invited to self-select, yet 13 others responded.
Mamier	505/21%	Those completing the NSCTS in a sample of 554 were described as ethnically diverse (47%); most were Christian (92%), working full-time (75%) on a day shift (58%); 36% worked in a children's hospital.	All RNs employed within a Christian health system were emailed an invitation that included a hyperlink to the survey
Ricci-Allegra	104/unknown	Hospice and Palliative Care Nurses Association members, 34% of whom were staff RNs, and 51% APNs, most working full time (85%) during the daytime (97%) with at least a BS degree (84%). All but one was White; 67% reported a religious affiliation. Respondents worked in a variety of inpatient and outpatient hospice and palliative care settings across the U.S. (21–32% of the sample from the Northeast, Midwest, South, and West).	Study participants were recruited through the Hospice and Palliative Nurses Association via advertisements in two HPNA eNewsletters and email invitations sent to members of the Research and Advanced Practice Nurse Special Interest Groups. Interested participants accessed the survey via the link provided.
Taylor et al.	279/unknown	Only US American nurses providing direct patient care were included in this secondary analysis. These nurses were mostly White, religious RNs; most had at least a baccalaureate and roughly 2/3rds did not work in a religiously-affiliated organization.	Advertising in Journal of Christian Nursing (JCN) and Nurses' Christian Fellowship newsletter; invitations to participate posted on website home pages of JCN, Home Healthcare Now, and on Facebook page of American Journal of Nursing

hours of providing patient care, how often have you:"; responses options include *never (0)*, *1–2 times*, *3–6 times*, *7–11 times*, and *at least 12 times*. (The Mamier and Ricci-Allegra studies included word descriptions along with these numeric response options [i.e., *never*, *rarely*, *occasionally*, *often*, *very often*].)

3.3. Analysis

Data were managed and analyzed using SPSS version 23. After compiling the four datasets, it was observed that there were <1% of the data missing for each of the 17 items; thus, missing values were replaced by imputing the series mean. Frequencies and measures of central tendency were computed for all NSCTS items as well as the sum of these items. Correlations among all NSCTS items were computed using Spearman correlational analyses (2-tailed) given the ordinal nature of the NSCTS items; correlations between each of the items and the NSCTS total were also computed with corrected item-total correlations. An independent samples *t*-test was used to compare respondents who frequently versus less frequently practiced presence (NSCTS item 17) by how frequently they provided spiritual care in general (NSCTS items 1–16 summed). One-way analysis of variance (ANOVA) with Scheffe post hoc analysis was used to compute whether differences in the total NSCTS score existed between the four samples. Whereas the dataset with imputed series means for missing data was used for ANOVA, frequencies, measures of central tendency, t-testing, and correlations were computed with the raw data. The minimum level of significance accepted was $p < 0.05$.

4. Results

4.1. How frequently do nurses provide spiritual care?

Table 2 presents the measures of central tendency for the 17 NSCTS items individually and collectively. All items received responses reflecting the full range possible. By examining these measures of central tendency, the frequency with which this collective sample of nurses perceived they provided each of 17 therapeutics during the past 72–80 h of work is known. Only four therapeutics were observed to have a median of 3 (the half-way point on the 5-point response scale). The remaining 14 therapeutics were less frequently used in these nurses' practice. Indeed, except for therapeutic of "remaining present just to show caring" with a mean of 3.4, the means for all the therapeutics fell under 3.0 (the indicator for *about 3–6 times*). Of course, these trends are likewise reflected in the NSCTS total mean, median, and range.

4.2. What spiritual care therapeutics are provided most frequently? Least frequently?

The most frequent spiritual care therapeutics provided included (listed in descending order from most frequent to less): remaining present (Item 17); listening to spiritual themes or concerns (Items 3 and 5); and assessing health-related S/R beliefs and practices (Item 4). Although means for these items ranged between 2.7 and 3.4, 7–17% of the sample reported never providing these therapeutics. The therapeutics provided least included (in ascending order): offering to read a spiritually nurturing passage such as the patient's holy scripture, arranging for patient's clergy to visit, documenting spiritual care provided, offering to pray, and encouraging a patient to talk about the spiritual challenges of living with illness. The percentages of nurses who never provided any of these therapeutics ranged from 45 to 69%. Except for remaining present, assessing for patient S/R, and listening for spiritual themes, <7% of the sample reported providing any therapeutic *at least 12 times*.

Corrected item-total correlations showed strong positive correlations between each of the 17 therapeutics and the NSCTS total score indicating that nurses who did provide any one of the therapeutics, also provided spiritual care by implementing other NSCTS therapeutics. Correlations ranged from 0.45 (for Item 17) to 0.79 (for Item 7); except for Item 17, all correlated >0.57.

Not only because Item 17 (remaining present for a patient after a procedure) was least correlated with other therapeutics, but also because presence is considered fundamental to spiritual care (Sullivan, 2014), and because during the initial development of the NSCTS (Taylor, 2008) there was concern that this item reflected psychosocial care or simply good nursing, we examined whether differences existed in spiritual care frequency between those who practiced presence frequently (at least 12 times or more during the past 72–80 h of work, $n = 215$) and those who did so less frequently ($n = 815$). Frequency of spiritual care among those who practiced presence frequently ($M = 41.3$, $SD = 14.2$) was significantly higher than among those who were less often present for patients ($M = 32.5$, $SD = 11.5$), $t(292) = -4.18$, $p < 0.0001$. (Levene's test indicated unequal variances ($F = 24.87$, $p < 0.0001$), so degrees of freedom were adjusted from 1028 to 292.)

4.3. Did frequencies for these 17 interventions vary among the samples?

ANOVA showed a significant difference existed between the four samples ($F[3,1026] = 80.55$, $p < 0.0001$). Post hoc analysis revealed

Table 2
NSCTS frequencies and measures of central tendency.

Item	*N*	Mean	*SD*	Median	Skew-ness	Frequency of *0 times* responses	Frequency of *at least 12 times* responses
1. Asked a patient about how you could support his or her spiritual or religious practices	1029	2.15	1.05	2	0.76	31.4%	3.3%
2. Helped a patient to have quiet time or space for spiritual reflection or practices	1030	2.12	1.03	2	0.63	33.2%	1.7%
3. Listened actively for spiritual themes in a patient's story of illness	1030	2.96	1.23	3	0.89	13.3	13.9
4. Assessed a patient's spiritual or religious beliefs or practices that are pertinent to health	1028	2.75	1.20	3	0.26	16.7	10.3
5. Listened to a patient talk about spiritual concerns	1030	2.71	1.11	3	0.29	13.9	6.9
6. Encouraged a patient to talk about how illness affects relating to God—or whatever is his or her Ultimate Other or transcendent reality	1029	2.23	1.13	2	0.64	32.9	4.3
7. Encouraged a patient to talk about his or her spiritual coping	1030	2.23	1.15	2	0.67	32.6	3.7
8. Documented spiritual care you provided in a patient chart	1026	1.81	1.09	1	1.38	53.3	4.1
9. Discussed a patient's spiritual care needs with colleague/s (e.g., shift report, rounds)	1029	2.02	1.06	2	0.86	39.3	2.3
10. Arranged for a chaplain to visit a patient	1029	2.07	1.12	2	0.89	38.9	3.8
11. Arranged for a patient's clergy or spiritual mentor to visit	1028	1.65	0.91	1	1.36	58.3	0.8
12. Encouraged a patient to talk about what gives his or her life meaning amidst illness	1025	2.15	1.18	2	0.84	37.2	5.3
13. Encouraged a patient to talk about the spiritual challenges of living with illness	1028	1.98	1.11	2	0.95	44.6	3.0
14. Offered to pray *with* a patient	1027	1.96	1.10	2	1.05	45.2	3.7
15. Offered to read a spiritually nurturing passage (e.g., patient's holy scripture)	1029	1.46	0.79	1	1.87	68.8	0.7
16. Told a patient about spiritual resources	1028	2.13	1.09	2	0.78	34.9	3.1
17. After completing a task, remained present just to show caring	1030	3.37	1.20	3	−0.26	6.9	20.9
NSCTS total	1011	37.61[a]	13.18	36	0.63		

[a] Item mean = 2.2.

Ricci-Allegra's sample with hospice and palliative care RNs (half of whom were APNs) to be significantly different from the other three samples of nurses. Foith's sample of mostly ICU nurses also differed from Mamier's sample of nurses working in a Christian health care system. The means of these samples were as follows: 54.4 for hospice/palliative nurses, 37.0 for nurses employed in a Christian healthcare system, 34.8 for nurses recruited primarily via nursing journal websites, and 32.5 for mostly ICU RNs in Ohio.

5. Discussion

These findings offer the strongest evidence yet about how frequently nurses in the United States provide spiritual care. These findings corroborate what a handful of studies with smaller samples and weaker instrumentation have observed: Nurses do provide spiritual care, but it is easy to describe it as infrequent. Furthermore, correlational analyses suggest that nurses who do provide one spiritual care therapeutic are more likely to provide other therapeutics. In particular, nurses who remain present to a patient after a procedure provide significantly more spiritual care, suggesting that this "simple" feature of caring, viewed by many as the most fundamental aspect of spiritual care, may be indicative of how frequently a nurse provides spiritual care in general.

Whether nurse-provided spiritual care is frequent or infrequent is open for interpretation. NSCTS item means indicated that these nurses during the previous 72–80 h (akin to 2 weeks of full-time work) provided each of the 17 therapeutics, between roughly 1–6 times. Based on the NSCTS total score, the overall average for each item (i.e., 2.2) indicates that, on average, each therapeutic was provided 1–2 times during the previous 72–80 h that the RN worked. If we make a conservative estimate based on each therapeutic being offered 1–2 times, that means that each nurse provided spiritual care 17–34 times during the stated time period. Does this suggest a frequent provision of spiritual care? Again, if conservatively estimating that a nurse cares for four patients each 12-hour shift, and the nurse works six shifts during this timeframe, then the nurse will have provided nursing care for 24 patients during 72 h. If the nurse reported providing 17–34 therapeutics during this time, then it is possible that the nurse may have provided one therapeutic to each patient. Of course, one patient may receive two therapeutics and another none (and so forth), as patient needs manifests. Conversely, if a nurse cared for six patients on each of ten 8-hour shifts worked (i.e., 60 patients), then it is much less likely that a patient would receive such spiritually supportive care. This exercise underscores how simply asking frequency during a specified time period still is inadequate to determine how frequent is nurse-provided spiritual care.

Even with the conservative estimate of spiritual care frequency, it is easy to interpret these data as showing infrequent spiritual care. If holistic care and cultural sensitivity are signature elements of nursing care as nursing ethics codes state, then assessing for spiritual distress, documenting this assessment, listening for spiritual themes, and some of the other NSCTS therapeutics arguably ought to be part of nursing care for every patient. Thus, these findings add to those of other nurse scholars who observe barriers to and infrequency of spiritual care in nursing practice (e.g., Gallison et al., 2013; Kalish, 2012; McSherry & Jamieson, 2011).

It is instructive to examine what therapeutics nurses provide most and least frequently, as these may indicate what is comfortable or not for a nurse to provide. Respondents may have viewed the offer of a prayer or reading of spiritually nurturing text as proselytization. Likewise, encouraging patients to talk about spiritual "challenges" (as opposed to the higher scoring "what gives life meaning" item) possibly was perceived to be prompting patients to dwell on the negative. Nurses may also be admonished to not initiate contact with patient clergy, given that it can be considered the role of staff chaplains to make such a referral. The infrequent documentation of spiritual care reported by these nurses may reflect their infrequent provision of spiritual care or a perception that patient spirituality is extremely private and not to be

disclosed in a healthcare record. It is also possible that documentation may not occur by nurses who fear managerial retribution for inappropriate spiritual care. Whatever the reason, these findings indicate there is room for discussion and education within nursing about how to ethically and effectively provide care.

Likewise, it is informative to examine what therapeutics were provided most frequently. Spiritual assessment, listening for spiritual themes or concerns, and remaining present to show caring are either typically required by nurse admission assessments or non-invasive. That is, perhaps spiritual care that is prompted and required happens, as does spiritual care that has little chance of creating offense or embarrassment. Given the essential nature of these therapeutics, however, is it still concerning that they happen so infrequently. Indeed, two items measured frequency of spiritual assessment or screening (Items 1 and 4). Although Item 4 was one of the most frequent therapeutics, 74% did not do it >3–6 times during the previous 72–80 h of caring. More worrisome, 89% responded to a similar item (*Asked a patient about how you could support his or her spiritual or religious practices*) with *about 3–6 times* or less; 31% did so *0 times*.

The finding that hospice and palliative nurses provide more spiritual care than nurses in other specialty areas is unsurprising, as this was observed in two previous studies (Ronaldson et al., 2012; Taylor et al., 1999). This higher frequency presumably reflects the nature of caring for persons who face their mortality and often experience spiritual and existential issues; it also reflects the palliative care philosophy and hospice professional imperatives that all patients ought to be screened for spiritual distress, that hospice teams must include a chaplain, and so forth (Dahlin, 2013).

6. Limitations

The limitations of these findings are due not only to the nature of secondary analysis, but also due to the design and methods of the primary studies included. Although the NSCTS may be the most systematically developed and psychometrically established tool existing to measure spiritual care frequency, it still has limitations. For example, this study identified how failure to measure number of patients to whom care was provided limits interpretation of findings. Likewise, the NSCTS measures nurse perceptions rather than patient or an objective observer's perceptions. These studies utilized convenience samples; thus, it is unknown how generalizable are these findings. It is also unknown how work or personal factors (e.g., work milieu, personal religiosity) are associated with frequency in this amassed dataset. It is particularly limiting that we do not know how much the hospice/palliative care nurses' more frequent spiritual care was because of the care context or because half of these respondents were APNs.

7. Conclusion

These findings provide the strongest evidence yet for the need to improve spiritual care education and support for nurses. These findings indicate that even the basics of spiritual screening, deep listening for spiritual themes, and presence—arguably essential to holistic and healing nursing care, are infrequent among most nurses. If nurses had the ability, resources, and encouragement to provide ethical spiritual care, it is likely patient experiences would be more satisfying. Indeed, it is also possible that nurses' experiences of caring would also be more satisfying.

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