

## **Student nurses' perspectives of spirituality and spiritual care**

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## **Student nurses' perspectives of spirituality**

### **Introduction**

Health is a holistic concept that incorporates physical, social, cultural, emotional and spiritual dimensions (Chan, 2009). Of these dimensions, spirituality is least understood and most contested. Spirituality is a vague, poorly defined term, but Swinton and Pattison (2010) argue that this lack of clarity is a strength that can have powerful clinical implications. Spiritual care in all its diverse forms can highlight the importance of meaning, purpose, hope and relatedness for individuals experiencing illness. Over the past thirty years, there has been growing recognition of the importance of spirituality in nursing but little examination of how spirituality is taught, understood and applied in practice by student nurses about to embark on their professional careers.

### **Background**

Literature related to spirituality in nursing education is sparse. The lack of attention to spirituality in the undergraduate curriculum may be similar to barriers often cited by nurses in practice. These barriers include a lack of knowledge, a lack of time, failure by staff to be in touch with their own spirituality, confusion about the nurse's role in providing spiritual care, and fear of imposing their own philosophy on others (Satterly, 2001; Milligan, 2004). In other studies, nurses reported a lack of competence to deliver spiritual care (Stranahan, 2001; Hubbell et al., 2006). Some authors suggest that inadequate preparation may contribute to nurses' perceptions of incompetence and avoidance of spiritual matters in practice (Taylor, 2008; Baldacchino, 2008; McSherry, 2007).

Previous studies have predominantly investigated the challenges faced by registered nurses in spiritual care-giving, but there is a lack of research about pre-registration nursing students' understanding and experiences (Chism and Magnam, 2009; McSherry et al., 2008). Available studies with pre-registration students have focussed predominantly on educational issues. One study described teaching strategies to enhance students' spiritual sensitivity (Cantanzaro and McMullen, 2001), while a review of the literature identified that reflection in clinical practice was an important process to enhance spiritual practice (Greenstreet, 1999). Another study surveyed baccalaureate nursing programs (n = 132) to identify how the concept of spirituality was addressed in curricula (Lemmer, 2002).

Few studies have surveyed students about their understanding of spirituality and spiritual practice. Of the few available studies, it was reported that nursing students are inclined to rely on their own experiential understanding and intuition about spirituality and how it may be applied in practice (Pesut, 2002; Hoffert et al., 2007). McSherry et al. (2008) reported that students hold diverse views about what constitutes spirituality with the majority adopting an existential, holistic and integrated concept of spirituality. Some students had defined views about spirituality; felt that spirituality was a personal matter and that nursing lecturers should not attempt to influence their beliefs (McSherry et al., 2008).

Most of these studies with students were conducted in either North America or the United Kingdom with homogenous samples and reflect a Judeo-Christian perspective (Tiew & Creedy, 2011). To fully understand and describe the meaning of spirituality and spiritual care/needs, further research should include culturally and religiously diverse samples and perspectives

(Conner and Ellen, 2004; Creel, 2007). Studies conducted in Hong Kong and Taiwan, for example, indicated differences between Western and Chinese cultures on spirituality, spiritual needs, and desired spiritual care (Mok et al., 2009; Chung et al., 2007).

It is also possible that the new generation of students may have different worldviews, cultural beliefs and values about spirituality and spiritual care from those of current nurses. There is a need to understand students' views and how their spiritual development is shaped in order to inform content and learning experiences offered in pre-registration education (Hart and Ailoae, 2007).

Of specific interest to this present study are students' perspectives of spiritual practice in Singapore healthcare, the extent of patients' spiritual needs, and support received from healthcare professionals in students' development of their practice. Singapore is a multicultural society. The majority of its population is Chinese, followed by Malay and Indian with an even broader multicultural workforce. In 1990, nursing education in Singapore evolved from a hospital-based apprenticeship system to a diploma programme and then to a degree in nursing in 2006. Therefore, the educational preparation of nurses in the workforce is varied and little is known generally about spiritual education and practice in Singapore.

## **The study**

### *Aim*

This study aims to explore final-year undergraduate student nurses' perspectives of spirituality and spiritual care-giving.

### *Objectives*

1. Describe student nurses' understanding of spirituality and spiritual care.
2. Examine relationships between students' demographic characteristics, and spirituality and spiritual care.

### *Design*

A descriptive, cross sectional design was used.

### *Participants*

Convenience sampling was used to recruit from the three educational institutions (two polytechnics and a university) in Singapore. Inclusion criteria were final-year nursing students undertaking a diploma or degree leading to nursing registration.

### *Instrument*

The survey consisted of a demographic information form and the Spiritual Care-Giving Scale (SCGS). The SCGS was developed because of limitations of existing scales. There is no one composite tool that measures all spiritual dimensions; and existing instruments were predominantly developed and used with homogenous samples and from cultures with dominant Judeo-Christian beliefs (Tiew & Creedy, 2011). Through a critical review of the literature (Tiew & Creedy, 2011), themes drawn from a qualitative study (Tiew & Drury, 2011), and testing with a large cohort of student nurses contributes to the ability of SCGS to assess perceptions of spirituality in a culturally relevant way. This paper presents results drawn from a larger program of work to develop a culturally relevant spiritual assessment scale (Tiew and Creedy, 2011).

The SCGS is a 35-item instrument with 5 factors: Attributes for Spiritual Care (Factor 1); Spiritual Perspectives (Factor 2); Defining Spiritual Care (Factor 3); Spiritual Care Attitudes (Factor 4); and Spiritual Care Values (Factor 5). The SCGS uses a 6-point Likert scale with responses ranging from one (strongly disagree) to six (strongly agree). See Appendix 1. The SCGS has a Cronbach alpha of 0.96 and significant reliability ( $r=0.811$ ;  $p < 0.01$ ) (Tiew and Creedy, 2011).

#### *Data collection procedure*

Data collection occurred between April and August 2010. The researcher addressed each student cohort at the end of a class. The purpose of the study and procedures were explained and questions taken. Participants were informed of their right not to participate and withdraw at any time without prejudice. Participants submitted the completed survey form into a locked box located in their school administration office.

#### *Ethics approval*

Approval for the study was granted by the National University of Singapore Institutional Review Board (IRB) and the three participating educational institutions.

#### *Approach to analysis*

Descriptive statistics were used to explore the sample profile and scores they obtained for each item. Pearson's product-moment correlation, t-test, and ANOVA were used to test any significant association/difference on the samples' average total SCGS scores to demographic

characteristics. Data were analyzed using the Statistical Package for the Social Sciences (SPSS) 17.0 (2009) personal computer version and significance was set at  $p < 0.05$ .

## **Results**

### *Profile of the study sample*

The survey response rate was 61.9% (745/1204). The majority of respondents were female (86.4%), single (95.2%), median age 21 years, who nominated a religious affiliation (75.2%) and were from diverse ethno-cultural backgrounds (69.3% Singaporeans, 8.1% Malaysians, 15.6% People's Republic of China and 7.1% from other nationalities). Most respondents (66%) were Chinese, the rest were Malays (19%), Indians (8%) and Others (7%) (see Table 1).

### *Student responses on the Spiritual Care-Giving Scale*

The average item mean value on the SCGS was 4.54 (SD=0.98) reflecting a high level of agreement. The item with the lowest mean was item 9 "Without spirituality, a person is not considered whole" (mean= 3.95, SD=1.36), and the highest mean was item 2, "Spirituality is an important aspect of human being" (mean = 4.82, SD=0.95). Mean values were also computed for each factor. Mean value for Factor 1 was 4.63 (SD=0.93); 4.7 (SD=0.96) for Factor 2; 4.66 (SD=0.93) for Factor 3; 4.35 (SD=1.01) for Factor 4, and 4.23 (SD=1.16) for Factor 5. Factor 2 (Spirituality Perspectives) had the highest mean value indicating consistent agreement about the nature of spirituality.

The highest mean score in Factor 1 "Attributes for Spiritual Care" reflected participants' agreement that establishing a trusting nurse-patient relationship was important for spiritual care.

In Factor 2, “Spirituality Perspectives,” the item with the highest mean score revealed participants’ view of spirituality as an important aspect of being human. In Factor 3 “Defining Spiritual Care”, the item describing spiritual care as a process and not a one-time event or activity achieved the highest mean score. The highest mean score in Factor 4 - “Spiritual Care Attitudes” was participants’ belief that spiritual care was important because it gave patients hope. Responses on Factor 5 “Spiritual Care Values” identified that students believed spiritual care was an important part of holistic nursing care (see Table 2).

#### *Associations between demographic characteristics and perceptions of spirituality*

There was a positive but weak relationship between age and the average total SCGS score ( $r = 0.088$ ,  $p=0.017$ ). There were no significant differences on the average total SCGS score and gender ( $t=0.077$ ,  $p=.368$ ), religious beliefs ( $t=-.334$ ,  $p=0.487$ ), race ( $F=0.682$ ,  $p=0.564$ ), and nationality ( $F=1.019$ ,  $p=0.384$ ). However, there was a significant difference on SCGS score and different type of programme. The mean SCGS score for diploma students was 168.45 ( $SD=22.22$ ), which was lower than the score indicated by degree students (mean=176.68,  $SD=18.72$ ;  $t= -2.93$ ,  $p=0.004$ ). The effect size between degree and diploma programme was 0.375. Additionally, there was a significant difference in item mean scores for different sites (Site A: mean=4.54,  $SD=0.61$ ; Site B: mean= 4.44,  $SD=0.66$ ; Site C: mean=4.7,  $SD=0.53$ ;  $F=5.557$ ,  $p=0.004$ ). Post-hoc analysis showed a significant difference between Site C vs. Site B ( $p=0.001$ ) and Site A vs. Site B ( $p=0.04$ ). The effect size between the three sites was 0.0137.

## **Discussion**



This work represents the only study conducted in Singapore that investigated nursing students' perspectives about spirituality and spiritual care. Studies conducted with nursing students in other countries, have predominantly focussed on the effects of spiritual education on attitudes. Moreover these studies were usually conducted in western countries with homogenous samples of students attending religious-affiliated institutions. Findings of the present study with an ethnoculturally diverse sample contribute to our understanding of the universality of spirituality.

#### *Students' perceptions of spirituality*

Overall, participating students scored high on the SCGS. In Factor 1, Attributes for Spiritual Care, participants generally expressed agreement with the concept that spirituality is innate and universal, but fewer agreed that a person is not considered whole if they do not have spirituality (item 9). It could be that this statement did not adequately reflect the ideological perspective of participants. Spiritual perspectives appeared to be humanistic in nature (item 2). The views of respondents closely reflected that of Sanders (2002) who proposed that individuals' spiritual values imbue virtues such as caring, compassion, love of humanity, and engagement with people. Similarly, in Attributes for Spiritual Care (Factor 1), participants indicated agreement about the humanistic attributes such as spiritual awareness, empathy, and establishing trust required for spiritual care. Students considered these attributes important precursors for spiritual care. This finding was consistent with other studies of registered nurses and affirmed the importance of spiritual awareness before nurses can address the spiritual needs of patients (e.g. Pesut and Reimer-Kirkham, 2010; McSherry et al., 2004).

For Factor 2 (Spirituality Perspectives), responses revealed a high level of agreement with conceptualisations of spirituality and spiritual care. For example, participants consistently agreed with the notion of spirituality as (1) characteristic of being human; (2) developmental; (3) a unifying force to find meaning and purpose in life, and (4) a peaceful state of well-being attained through transcending and connecting with the external environment. These findings reveal a heightened sense of spiritual awareness from this cohort of young (median age was 21 years) nursing students from diverse ethno-cultural backgrounds. This result highlights the need to dispel a commonly held belief that spirituality develops with age (MacKinlay, 2008; Ahmadi, 2000; McFadden, 1999). Participating student nurses reported a high level of spiritual awareness that was not constrained by age. The results suggest that perhaps student nurses do not become “more” spiritual with age but rather deeper insights are gained.

Although students valued spirituality and acknowledged the significance of spiritual care, survey results indicated difficulties in its application in practice. Controversy about the definition of spirituality has contributed to a lack of understanding and poor application in practice (McSherry, 2007). Historically, the roots of spirituality can be traced from religion. Medical and nursing services were traditionally offered by members of religious orders of various denominations (Modjarrad, 2004). Previous studies reported that nurses expressed discomfort with the spiritual aspects of care and maintained that religious clerics and counsellors with expertise in spirituality should take responsibility (McClung et al., 2006). Participants identified the importance of supporting and nurturing their own spiritual well-being as reported in item 4 (Spirituality is an expression of one’s inner feelings that affect behaviour). Students considered that certain attributes, such as empathy and critical reflection need to be nurtured to enhance

spiritual development and care-giving. This nurtured development is important because when one is content and whole, the “self” is able to better understand and focus on the concerns of others when offering spiritual care (Burkhart and Hogan, 2008; Carr, 2008; Kendrick and Robinson, 2000).

Factor 3 (Defining Spiritual Care) revealed that students perceived spiritual care as relational and that this relationship developed over time with the patient. Although the assessment of spiritual needs is an aspect of spiritual care, student nurses did not perceive this. Item 17 (being with the patient) scored the lowest mean value and may be attributed to students’ observations of nursing practice in the clinical setting. In the Singaporean health care system, nurses are encouraged to be “busy” to a point where they may become task-oriented and may neglect the emotional and spiritual dimensions of care. It could be that students had an inadequate understanding of what spiritual care entails and did not equate meaningful conversation with spiritual care.

In Factor 4 (Spiritual Care Attitudes) respondents valued the importance of a team effort in the provision of spiritual care (item 40). Students learnt about teamwork in their nursing programme and may have considered this approach to be applicable in spiritual care too. There is also a possibility that participants recognised their limitations and comfort level to provide spiritual care and viewed the multidisciplinary approach as a means of support for their practice. This result is encouraging given that previous studies suggest that the poor integration of spirituality in practice may be due to misinterpretations of a multidisciplinary approach to spiritual care from an “ownership” instead of a “collaborative” perspective (Hubbell et al., 2006; Koenig et al., 2004), further abrogating nurses’ role in spiritual care.

Students agreed about the importance of spiritual care in providing hope to patients, but fewer respondents agreed that spiritual care should be addressed throughout their nursing education programme. It is often assumed that spiritual education is essential for the development of spiritual care giving abilities (Hoffert et al., 2007, Meyer, 2003). Although some Nursing boards responsible for program accreditation do encourage the inclusion of spiritual care as a core competency for nurses, this is not the case in all countries, and currently does not occur in Singapore. The results of the present study suggest that rather than formal class-based activities, individual reflection, spiritual guidance, experiential activities and in-depth discussion in small groups in the clinical setting may be more effective learning strategies. These pedagogical approaches can be documented in curriculum documents and reviewed according to feedback and learning outcomes. Importantly, other authors have proposed that spiritual care and role-modelling need to be positively reinforced in the educational institution in order to promote the development of spiritual care abilities (Burkhart and Hogan, 2008; Ross, 2006; Vance, 2001).

Responses to items related to Spiritual Care Values (Factor 5) scored the lowest overall mean score on the SCGS. Participants did value the importance of spiritual care (item 11) and this finding is consistent with other studies (McSherry et al., 2008; Wallace et al., 2008; Pesut, 2002). But there was less consistency in responses across other items. For example, respondents' lowest score was on item 9 which stated that "without spirituality, a person is not considered whole". Although students readily agreed with items related to the nature of spiritual care, their views on the values inherent within spirituality are more individualised.

### *Factors associated with perceptions of spirituality*

There was a positive and significant relationship between SCGS scores and the programme being undertaken by participants. Although, the three educational institutions reported not offering spirituality as a “stand-alone” module, two institutions commented that spirituality “runs through the teaching program.” As only one institution gave permission to assess the curriculum, a comparison of program content could not be conducted. It could be that spiritual care and role-modelling were not positively reinforced in one participating polytechnic institution where the students were studying. The influence of the learning environment on the development of spirituality has been postulated in other studies (e.g., Baldacchino, 2008; Meyer, 2003).

The degree programme offers a more broad-based curriculum that encourages students to select electives from other disciplines to deepen their personal and professional development. Delaney (2010) affirmed that individual’s spiritual awareness is enhanced and facilitated by self-knowledge, self-reflection, and journaling. It is through these activities that individuals are able to transcend and connect with their external environment, thereby fostering and enhancing their spiritual perspectives.

### **Limitations**

The findings of this study need to be considered in light of several limitations. Firstly, participants were recruited from one cohort of final-year nursing students across three educational institutions in Singapore and may not be generalised to other countries. Comparative research with students from other Asian countries may reveal the extent to which the perceptions identified in the current study are shared across settings. Further, as this was a convenience

sample, participants who volunteered in this study may have a vested interest in this topic. Their views may differ from other students who did not volunteer; however, the good response rate may minimize this effect. There is also the possibility that participants wanted to receive the approval of their lecturers. Responses may therefore be biased even though confidentiality of participation and anonymity were ensured. Finally, as the nature of spirituality is complex and multidimensional, exploring students' understanding and perceptions of spirituality and spiritual care via a questionnaire might limit the range of possible issues and views. Although steps have been taken to produce a valid and reliable scale more work is required to refine the scale and look at its applicability in clinical practice.

### **Implications for Nursing**

In this study, the characteristics of spirituality and spiritual care were conceptualised from a student perspective and may provide guidance for educational content and learning strategies in preregistration programmes.

In clinical practice, nursing leaders may consider using the SCGS to determine the views of staff, address areas for development, and incorporate spirituality concepts in their organisational policies and guidelines. However, there must also be visible leadership commitment from senior hospital administrators to foster a culture of spiritual care not only in the care provided to patients but also towards colleagues.

Lastly, a concerted tripartite approach, involving nursing leaders, educators and regulators, could be taken to improve spiritual care standards in practice and education. Nursing boards responsible for program accreditation could encourage the inclusion of spiritual care (1) as a core

competency for nurses and (2) require explicit integration of spirituality in the nursing care delivery model. Educational institutions need to introduce concepts of spirituality and spiritual care in a meaningful and integrated way. Faculty need to receive professional development and support to embrace these concepts as a central part of their educational mission and demonstrate integration of these concepts in curriculum documents and their chosen pedagogical methods.

### **Conclusion**

Findings from this ethno-culturally diverse Asian sample are similar to those reported by studies conducted in the UK and North America. There was some congruence between the views of this group of 3<sup>rd</sup> year undergraduate students and results of other studies with students and practising nurses. A novel finding is that participants considered spirituality as an inherent part of being human; developmental in nature; and vital for well-being. Personal attributes were viewed as important for spiritual care. Participants undertaking the degree programme reported a different personal and professional understanding and awareness of spirituality than students in the diploma programs. This could be related to student qualities (such as level of academic achievement) and academic environment such as experience of faculty, and pedagogy that encourages critical reflection and engagement. However, understanding spirituality and spiritual care does not equate with translation into practice and further attention needs to be given to minimise barriers to spiritual care in practice.

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