Religions **2015**, *6*, 1346–1357; doi:10.3390/rel6041346

OPEN ACCESS

religions

ISSN 2077-1444

www.mdpi.com/journal/religions

Article

Nurses' Perceptions of Spirituality and Spiritual Care in Different Health Care Settings in the Netherlands

René van Leeuwen † and Annemiek Schep-Akkerman *,†

Knowledge Center Spirituality and Health Care, Christian University of Applied Sciences Viaa, PO Box 10030, 8000 GA Zwolle, The Netherlands; E-Mail: r.vanleeuwen@viaa.nl

† These authors contributed equally to this work.

* Author to whom correspondence should be addressed; E-Mail: a.schep@viaa.nl; Tel.: +31-384-255-542.

Academic Editors: Fiona Timmins and Wilf McSherry

Received: 13 October 2015 / Accepted: 2 November 2015 / Published: 27 November 2015

Abstract: This paper shows similarities and differences in perceptions and competences regarding spirituality and spiritual care of nurses in different health care settings. Research on this specific topic is limited and can contribute towards a nuanced implementation of spiritual care in different nursing care settings. Four hundred forty nine nurses in different health care settings completed a questionnaire concerning spirituality and spiritual care, spiritual care competence, and personal spirituality. Respondents reported a generic (instead of more specific) view of spirituality and spiritual care, and they perceived themselves to be competent in providing spiritual care. Compared to nurses in hospital settings, nurses in mental health care and home care have a more generic view of spirituality and spiritual care and report a higher level of competence. Next to this, they perceive themselves more as spiritual persons. Future research is needed to develop further understanding in setting specific factors and their influence on nurses' views and competence regarding spiritual care. Nursing education and management should consider an emphasis on spiritual competence development related to working settings of nurses.

Keywords: spirituality; spiritual care; nursing; hospital care; mental health care; home care

1. Background

The import of spirituality and spiritual care in nursing is highly influenced by the nurses' perceptions and competence [1]. Studies show that nurses hold widely varying perceptions of the concept of spirituality, and they show at least some competence for spiritual care [2–5]. These studies show results from specific health care contexts and reported results in general without taking in account the working context of nurses. The study reported in this paper explores whether the work and organizational context of nurses influences their perception of spirituality and competence in spiritual care.

McSherry and Ross state that according to research, spiritual care is regarded by the nursing profession as a legitimate and a fundamental aspect of nursing practice [1]. The spiritual dimension of the patient's condition is deeply subjective [6], which means that the patient's interpretation of spirituality depends upon his or her personal view of life and existence. In this way, spirituality can be interpreted as a functional concept [2,7]. Defining spirituality this way, it is an umbrella concept that covers a family of underlying concepts. Despite the absence of a paradigmatic definition in nursing [8], attempts are being made toward consensus about the definition of spirituality. Recently, an agreement was reached about the following definition of spirituality within the context of palliative care: spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationships to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices [9].

Studies provide a growing insight in what spirituality means within the context of health care in general and more specifically, in nursing. Other than the "definition issue", the relevance of spirituality and spiritual care for nursing becomes clearer in practice related research. Reviews showed that quality of spiritual care is related to specific patients' needs and to the development of nurses' competency, and the role of education [10–12].

Literature shows a positive correlation between the nurses' perception of the relevance of spirituality and spiritual care [3,4,13]. Dutch nurses (n = 372) say that spiritual care is relevant in nursing, but are also aware that it is still far from commonplace in today's nursing practice. Nurses state they need more competence and practical guidelines to put spiritual care into practice [3]. A great majority of the respondents in this survey (90%) agreed with a functional description of the concept of spirituality, associated with the concept's meaning and purpose, view of life, and questions of life. The survey showed that age and spiritual/religious affiliation seem to be predictors for the way and degree to which nurses provide spiritual care. This was also recognized in the survey by McSherry and Jamieson [13], who stated that the increasing secularization of society and health care appears to cause anxiety among some nurses and uncertainty concerning personal beliefs and professional practice.

A survey among 4054 British nurses showed respondents had a broad, inclusive understanding of spirituality, accepting that there is a broad spectrum of spiritual beliefs [4]. A vast majority of the respondents found that spirituality and spiritual care can be classified as core nursing values or principles of care. The nurses regarded this aspect of care as an essential part of their role. The respondents also expressed a certain lack of competence, because they called for further guidance and educational preparation. The authors stated that there seems to be an acceptance that, irrespective of one's personal belief, there is a fundamental need to support patients' spiritual needs. The results of the above mentioned surveys imply a consensus among nurses regarding their perception of spirituality (broad

functional concept) and spiritual care (part of nursing) and the need for guidance and education. Differences in outcomes seemed to be related to personal factors (age, gender, working experience, personal spirituality).

Timmins and McSherry emphasize that organizational factors are also of importance when addressing spirituality and spiritual care in healthcare [8]. They state that spirituality and spiritual care have the potential to transform organizational cultures, values, and attitudes. Literature emphasizes the importance of the role of leadership and management concerning the implementation of spiritual care [14,15]. The above mentioned surveys also asked respondents for job title and specialty (sector of health care in which one is working). The studies show no in-depth analyses regarding these variables. It is not clear whether these variables are predictors for nurses' attitudes towards spirituality and spiritual care. A survey among staff nurses in Turkey showed that nurses in pediatric and psychiatric departments reported higher sensitivity to spirituality and spiritual care compared to other departments [16]. Ruder, who investigated the nurses' perceptions of spiritual care [17], emphasizes explicitly that her study did not address the relationship between the sector of healthcare where the nurse worked and the spirituality. By stating this, she suggests that this relationship might be significant. The question arises whether similarities and differences in perceptions of nurses regarding spirituality and spiritual care exist between different health care settings. An answer to this question would be a contribution toward a nuanced implementation of spiritual care in holistic professional nursing care and the role of nursing leadership in such processes.

The aim of the present study was to gain insight into the different perceptions and competences regarding spirituality and spiritual care between hospital nurses, mental health nurses, and nurses in home care settings in the Netherlands. Furthermore, to consider the consequences of the findings for nursing practice, nursing education, and nursing management.

2. Method

A cross-sectional study was designed. Three groups of nurses were recruited to participate in the study: nurses employed in hospitals, nurses working in mental health care, and nurses working in home care. The researchers approached nurses in six hospitals (participating units: neurology, surgery, oncology, heart surgery, children, and internal medicine) and three organizations in mental health care (participating units: crisis, long stay, gerontology, addiction, outpatient). The researchers visited the units for one or two days, and nurses present were asked to participate. The total sample size of the nurses in the twenty units of the six hospitals came to 340, and the total sample size of the nurses in the three institutions in mental health care was 260. In addition, a random sample of 600 nurses in home care was sent an email with the request to participate in the study.

Inclusion criteria: nurses had to be qualified *(i.e.*, excluding students), and staff nurses had to be active as nurses for the last five years. For each sector a minimum of 61 nurses was required, calculated by: number of nurses (n) = (reliability^2 × standard deviation of measurement^2)/precision^2 = (1.96^2 × 0.6^2)/0.15^2 = 61 (standard deviations: [18]) The participating hospitals and organizations, as well as nurses in home care, were recruited from different parts of the Netherlands (north, east, central).

2.1. Ethical Considerations

To recruit the sample, approval was obtained from the board of the faculty of the university, and from the board of the participating hospital units, mental health organizations, and home care settings. These institutions did not have standing ethical review committees. After approval from all care managers, the aim and content of the study was explained to the nurses in hospitals and mental health care around a shift or during a coffee or lunch break, and to the nurses in home care by email. All participants also received written information about the study and the rights of the participants: participation was voluntary and anonymous, and respondents retained the right to withdraw from the survey without any restrictions. As a result, data analyzed were anonymous.

2.2. Data Collection

Data were collected by questionnaire. Nurses were asked face-to-face (hospital and mental health care) or by email (home care) to complete a self-administered questionnaire. When nurses agreed to participate, nurses in hospitals and mental health care received the questionnaire as hardcopy. Before completing the questionnaires, nurses received information about the study's aim. During the coffee or lunch break nurses could fill out and hand in the questionnaire. Nurses in home care were addressed by email and could fill out the questionnaire online over a period of four weeks. After two weeks, a reminder was send. Questionnaires required about 15 minutes to complete. The questionnaire consisted of four parts: (1) demographic characteristics, (2) perceptions of spirituality and spiritual care, (3) self-assessment of spiritual care competence, and (4) evaluation of one's personal spirituality. Data were collected and analyzed between late 2012 and early 2014.

2.3. Content, Validity and Reliability of Questionnaire

(1) Demographic characteristics asked for: gender, age, worldview, educational background, and experienced life events in last three years. Next to this, the participants were asked to assess their personal spirituality with a numeral figure between one and ten.

(2) Perceptions of spirituality and spiritual care: measured with the Spirituality and Spiritual Care Rating Scale (SSCRS) [19]. The SSCRS has 17 statements scored on a 5-point scale ranging from "strongly disagree" (1) to "strongly agree" (5). This scale has four subscales: existential spirituality, religiosity, spiritual care and personal care). A high overall score indicates a more generic 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). The SSCRS has been used in more than 42 studies in 11 countries demonstrating consistent levels of reliability and validity with Cronbach's Alpha scores ranging from 0.64 to 0.84 [19,20].

(3) Self-assessment of spiritual care competence: measured with the Spiritual Care Competence Scale (SCCS) [21]. The SCCS contains 27 items scored on a 5-point scale ranging from "completely disagree" (1) to "completely agree" (5). This scale has six subscales: assessment and implementation of spiritual care, professional development and improving the quality of spiritual

care, personal support and patient counseling, referral to professionals, attitude towards patients' spirituality, and communication. A high overall score indicates higher levels of perceived competency. The SCCS is a valid and reliable measure of spiritual care competence. It has good homogeneity, average inter-item correlations (> 0.25) and good test-retest reliability. Cronbach's Alpha scores range from 0.56 to 0.82 [21].

(4) Evaluation one's personal spirituality: measured with the Spiritual Attitude and Involvement List (SAIL) [22]. The SAIL consists of 26 items scored on a 6-point scale ranging from "totally not" or "never" (1) to "highly" or "often" (6). This list is arranged in three dimensions: connectedness to oneself (meaningfulness, trust, acceptance), connectedness to others and nature, and connectedness to the transcendent (transcendent experiences, spiritual activities). A high overall score indicates higher levels of spiritual attitude/involvement. 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. Cronbach's Alpha scores of the subscales range from 0.74 to 0.88 [22].

Parts 1, 3, and 4 were already available in Dutch. Part 2 was translated from English to Dutch. Translation was executed using a forward-backward translation protocol by two translators fluent in English and Dutch. The two translations were compared by the principal investigator. Adjustments were made with the consent of both translators resulting in a single version. This version was back-translated into English by a bilingual translator who did not have access to the original English version. The backward translation was compared and considered equivalent to the original version.

2.4. Data Analysis

The answers to the questionnaire were entered into IBM SPSS Statistics version 20 for descriptive analysis. Frequency and percentage of demographic characteristics, and summary scores (mean and standard deviation (sd)) were calculated for the 3 standardized measures (SSCRS, SCCS and SAIL). This included the subscales of these parts of the questionnaire. Summary scores will be compared between sectors and demographic characteristics. All comparisons were made assuming a p-value of 0.05. In addition, correlations between the summary scores were calculated.

3. Results

3.1. Participant Demographics

In total, 202 nurses in hospital care, 160 nurses in mental health care, and 87 nurses in home care completed the questionnaire. Response rate in hospital care is 59%, mental health care is 62% and 15% in home care. Characteristics of nurses per sector are shown in Table 1. Most nurses in this study were female. Almost half of all participating nurses in hospital care were younger than 31 years of age, while in home care only 15% of the participating nurses belong to this age group. Around half of all nurses state they are Christian, and in hospital and mental health care, one third state they are atheistic, agnostic, or have "no faith". One third of the participating nurses have a higher (meaning bachelor degree)

education level. More than half of all nurses reported having experienced important life events (as marriage or divorce, personal achievement in education, and illness or loss of loved ones). Nurses in home care and mental health care score higher for personal spirituality than nurses in hospital care (resp. 6.3 and 5.9 *vs*. 4.9).

Table 1. Characteristics of nurses.

	Hospital care	Mental health care	Home care
Number of nurses	202	160	87
% female	90	71	99
% younger than 31 years of age	46	32	15
% Christian	56	46	58
% atheistic/ agnostic/ 'no faith'	29	38	16
% with secondary vocational education	45	35	26
% with higher education	27	35	32
% with experienced life events	58	61	54
Mean numeral figure for one's personal spirituality	4.9	5.9	6.3

3.2. Characteristics of Perceptions and Competences of Spirituality and Spiritual Care

Figure 1 shows the summary scores of the standardized measures (SSCRS, SCCS and SAIL) with subscales on how nurses in different sectors in health care (hospital care, mental health care, and home care) in the Netherlands perceive spirituality and spiritual care, what their view is in this, and how competent they think they are in providing spiritual care (see Appendix for numeric scores and SD).

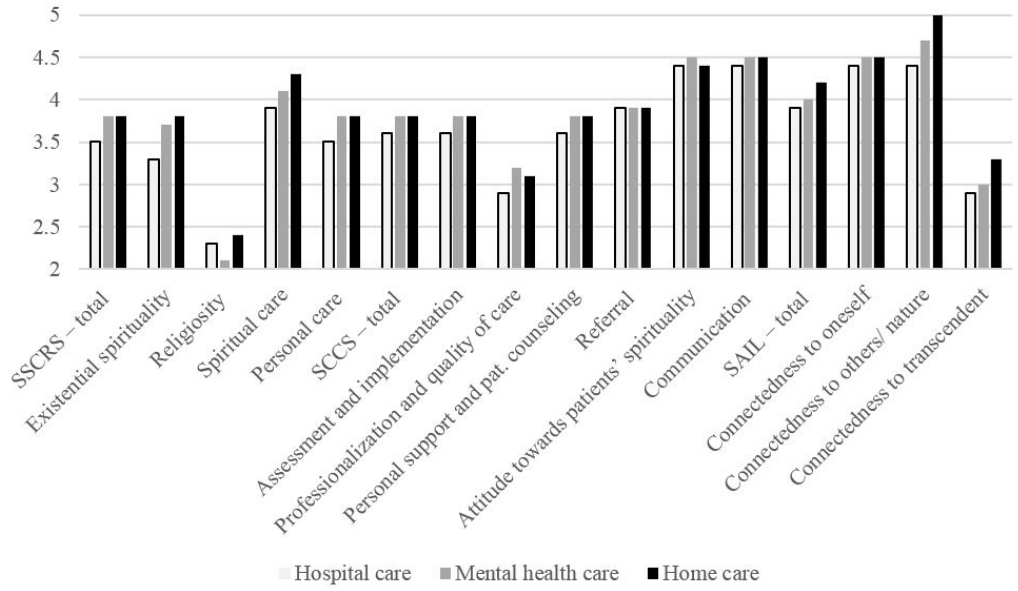

Figure 1. Summary scores of standardized measures: Spirituality and Spiritual Care Rating Scale (SSCRS), Spiritual Care Competence Scale (SCCS) and Spiritual Attitude and Involvement List (SAIL) with subscales per health care setting.

Overall, nurses in mental health care and home care reported a more generic (instead of more specific) view of spirituality and spiritual care (mean score SSCRS both 3.8), a higher score on self-assessed competence (mean score SCCS both 3.8), and a higher level of spiritual attitude/involvement (mean score SAIL resp.: 4.0 and 4.2) compared to nurses in hospital care (SSCRS: 3.5, SCCS: 3.6, SAIL: 3.9). This means that nurses in mental health and home care include both religious and existential elements in spirituality. Next to this, they do think they are competent in providing spiritual care, and spirituality does play a role in their lives, more than nurses in hospital care.

Looking closer at subscales: SSCRS—respondents show a low score on subscale 'religiosity' (2.1–2.4). This indicates that nurses do not state that spirituality is only about religious beliefs and practices, and, supplementary. A high score for subscale 'spiritual care' (3.9–4.3) indicating these nurses include religious and existential elements.

SCCS—respondents feel more competent in communication about spirituality (4.4–4.5) and about their attitude towards patients' spirituality (4.4–4.5) than about professionalization and improving the quality of spiritual care (2.9–3.1). There is no difference between sectors with regard to feeling competent in assessment and implementation, referral to professionals, and communication about spirituality.

SAIL—participating nurses show a low connectedness to the transcendent (2.9–3.3) and high connectedness to others and nature (4.4–5.0). For nurses in hospital care, the connectedness with oneself is just as high as the connectedness to others and nature.

3.3. Factors and Spirituality within Health Care Sectors

Table 2 shows the summary scores of the standardized measures per age group and health care sector. For the SSCRS: with exception of the older nurses in mental health care, there is no difference in view of spirituality and spiritual care between the age groups within each health care sector. For spiritual competences (SCCS): again apart from the older nurses in mental health care, the nurses from 31–50 years of age show somewhat higher scores on self-assessed spiritual care competences than the nurses in the other age groups. Nurse's personal spirituality (SAIL): the nurses in the higher age groups report a higher level of connectedness to oneself, others, nature, and the transcendent than the younger ones within each health care sector. The numerical figure for one's personal spirituality is the lowest for the youngest nurses within each health care sector.

Table 2. Summary scores of standardized measures (with SD): SSCRS, SCCS and SAIL per age group and health care setting.

	Hospital Care			**Mental health Care**			**Home Care**		
	< 31 y	31–50 y	> 50 y	< 31 y	31–50 y	> 50 y	< 31 y	31–50 y	> 50 y
SSCRS	3.5 (0.5)	3.5 (0.5)	3.5 (0.6)	3.7 (0.5)	3.7 (0.5)	3.9 (0.6)	3.8 (0.4)	3.8 (0.4)	3.8 (0.5)
SCCS	3.6 (0.5)	3.7 (0.6)	3.6 (0.4)	3.7 (0.5)	3.9 (0.5)	4.0 (0.5)	3.7 (0.4)	3.9 (0.5)	3.7 (0.6)
SAIL	3.8 (0.6)	3.9 (0.9)	3.9 (0.6)	3.9 (0.7)	4.0 (0.6)	4.2 (0.7)	4.1 (0.7)	4.2 (0.7)	4.3 (0.6)
Personal spirituality	4.1 (2.7)	5.6 (2.6)	5.0 (2.8)	5.3 (2.7)	5.9 (2.5)	6.5 (2.0)	4.9 (2.9)	6.6 (1.9)	6.5 (1.9)

Table 3 shows that the nurses who say they are atheistic, agnostic, or have 'no faith' score lower on spiritual attitude/involvement (*i.e.*, a lower level of connectedness to oneself, others and nature, and the transcendent) than Christian, Islam/Hinduism/Buddhism, and humanistic nurses, in addition to a lower score for their personal spirituality. Apart from this, there are no significant differences between nurses with a different life view within health care sectors.

Table 3. Summary scores of standardized measures (with SD): SSCRS, SCCS and SAIL per life view and health care setting (Chri = Christian, Isl = Islam/Hinduism/Buddhism, Hum = Humanistic, Ath = Atheistic/agnostic/no faith).

	Hospital Care				**Mental Health Care**				**Home Care**			
	Chri	Isl	Hum	Ath	Chri	Isl	Hum	Ath	Chri	Isl	Hum	Ath
SSCRS	3.6 (0.5)	3.6 (0.3)	3.8 (0.5)	3.2 (0.5)	3.8 (0.5)	4.0 (0.4)	3.8 (0.4)	3.7 (0.6)	3.8 (0.4)	3.7 (0.3)	3.8 (0.5)	3.7 (0.5)
SCCS	3.7 (0.6)	3.8 (0.3)	3.8 (0.4)	3.5 (0.6)	3.9 (0.5)	3.7 (0.5)	3.8 (0.5)	3.8 (0.6)	3.8 (0.4)	4.2 (0.5)	3.8 (0.8)	3.7 (0.6)
SAIL	4.0 (0.7)	4.0 (1.2)	3.9 (0.7)	3.6 (0.6)	4.2 (0.6)	4.5 (0.8)	3.9 (0.4)	3.9 (0.6)	4.3 (0.7)	4.7 (0.4)	4.4 (0.7)	3.6 (0.5)
Personal Spirituality	5.7 (2.5)	4.0 (3.8)	6.3 (2.0)	3.1 (2.6)	6.0 (2.4)	7.0 (1.4)	6.6 (1.4)	5.3 (2.8)	6.6 (2.0)	7.3 (0.6)	6.7 (1.6)	4.4 (2.5)

Correlation between the three summary scores (total) is high (with p-value < 0.001) (see Table 4). Regression analysis shows that the strongest predictor of the summary scores is the numerical figure of one's personal spirituality.

Table 4. Correlations summary scores of standardized measures.

	SCCRS	**SCCS**	**SAIL**
SCCS	0.57	-	-
SAIL	0.53	0.46	-
Personal spirituality	0.57	0.46	0.63

4. Discussion

As we said in the background section, little is known about sector specific differences among nurses in perception regarding spirituality and spiritual care. Therefore, a comparison of the results of this study to other research is hard to make.

Compared to results from research that is not sector specific, the average summary scores correspond with the scores of nursing students with regard to the SSCRS [18,23]. In addition, are slightly higher than scores of the SSCRS of graduated nurses in other countries [16,24]. With regard to the SCCS and SAIL, the scores are slightly higher than those in nursing students in the Netherlands [2,25], but in general, differences in the scores are small. Nurses in general seem to have a generic perception of spirituality and spiritual care competency level. Age and life view seems to be associated with differences in perceptions of, and attitude towards, spirituality and spiritual care competence, which confirms other research [3,25–27].

It can be asked why nurses in hospital care show significantly lower scores in perceptions of spirituality and competence in spiritual care compared to nurses in other sectors of health care. Is it because of characteristics of the sector or because of personal characteristics of the nurses (e.g., age, their personal spirituality)? Do older and more experienced nurses choose to work in home care or mental health care because of more person-centered care? Or do home care nurses and mental health care nurses more often face spiritual issues because of the setting's characteristics? It is known from literature that older and experienced nurses perceive themselves to be more competent in providing spiritual care [2]. It is an interesting aim for future research to gain more insight in these sector specific factors and their influence on nurses' view and competence regarding spiritual care.

In a recent study among hospital nurses, Rushton mentions the following main barriers to providing spiritual care and to defining spirituality within the hospital setting: lack of guidelines, lack of time, and lack of training [28]. These factors are mentioned in the literature on spirituality and nursing in general [10,29]. In recent years, much attention has been given to the development of guidelines and educational training programs regarding spiritual care in nursing and the investigation of its effects [1,12]. Research regarding working place related factors is, as far as we know, still limited. Biro, for example, states that nurse managers can advocate for organizational change to make spiritual care a part of standard practice [30]. Other than the educational aspect of spiritual care, more research is needed with regard to these organizational aspects. Reimer-Kirkham *et al.* emphasize the importance of leadership for integration of spirituality and spiritual care in the workplace [15]. They state that this leadership should be developed and that nurse managers are positioned to facilitate this process in their organization. Our study shows that in this process, workplace characteristics should be considered. Therefore, nursing practice, nursing education, and nursing management should consider an emphasis on spiritual competence development related to working settings of nurses.

This study was limited in the sense that, first, it was a cross-sectional study and warrants no conclusions about the causality of findings. Second, although we obtained a normal response rate in hospital care and mental health care (resp. 59% and 62%), the response rate in home care was low (15%). This could have introduced some bias. Our sample of nurses was not a random selection. Non-response may be explained by lack of interest in the subject of spirituality. If so, the respondents from home care may be more interested in spirituality than the "average home care nurse". This could explain the high scores for this group of nurses.

5. Conclusions

Compared to nurses in hospital care, overall, nurses in mental health care and home care have a more generic (instead of more specific) view of spirituality and spiritual care, have a higher level of perceived competence, and see themselves more as spiritual persons. The most important factor that contribute to perceptions of spirituality and competence in spiritual care is the nurse's personal spirituality.

Setting specific factors that influence perception on spirituality and competence in spiritual care that are related to working settings of nurses deserve further in depth research.

Acknowledgments

We want to thank all nurses who participated in the study and filled out the questionnaire. Moreover, we like to thank the nursing students who carried out the data collection for this study: Geerjanneke Beltman, Eline Dalsum, John Foppen, Ingrid Haan, Alie Oost-ten Napel, Mineke Plaggenmarsch, Suzanne Platenkamp, Dieneke Pul, Clarie Veldkamp, and Annie Wolfs. We also thank Steven Fouch and Bart Cusveller for their kind and critical reflection on the draft manuscript.

Author Contributions

René van Leeuwen was responsible for the study design. Annemiek Schep-Akkerman executed the data analysis. René van Leeuwen and Annemiek Schep-Akkerman were responsible for the drafting of the manuscript.

Conflicts of Interest

The authors declare no conflict of interest.

Appendix. Summary Scores of Standardized Measures (with SD): SSCRS, SCCS and SAIL with Subscales per Setting and Indication of Significance Difference between Health Care Settings

	Hospital care	Mental health care	Home care	Sign. difference
SSCRS—total	3.5 (0.5)	3.8 (0.5)	3.8 (0.4)	Yes
Existential spirituality	3.3 (0.8)	3.7 (0.7)	3.8 (0.6)	Yes
Religiosity	2.3 (0.7)	2.1 (0.7)	2.4 (0.7)	Yes
Spiritual care	3.9 (0.8)	4.1 (0.7)	4.3 (0.7)	Yes
Personal care	3.5 (0.8)	3.8 (0.8)	3.8 (0.7)	Yes
SCCS—total	3.6 (0.6)	3.8 (0.5)	3.8 (0.6)	Yes
Assessment and implementation	3.6 (0.7)	3.8 (0.7)	3.8 (0.7)	No
Professionalization and quality of care	2.9 (0.8)	3.2 (0.9)	3.1 (0.8)	Yes
Personal support and pat. counseling	3.6 (0.7)	3.8 (0.6)	3.8 (0.6)	Yes
Referral	3.9 (0.8)	3.9 (0.8)	3.9 (0.7)	No
Attitude towards patients' spirituality	4.4 (0.7)	4.5 (0.6)	4.4 (0.6)	Yes
Communication	4.4 (0.6)	4.5 (0.6)	4.5 (0.6)	No
SAIL—total	3.9 (0.7)	4.0 (0.6)	4.2 (0.7)	Yes
Connectedness to oneself	4.4 (0.7)	4.5 (0.6)	4.5 (0.6)	No
Connectedness to others/nature	4.4 (0.7)	4.7 (0.6)	5.0 (0.6)	Yes
Connectedness to transcendent	2.9 (1.2)	3.0 (1.2)	3.3 (1.2)	No

References

1. Wilfred McSherry, and Linda Ross. "Nursing." In *Oxford Textbook of Spirituality in Health Care*. Edited by Mark Cobb, Christina M. Puchalski and Bruce Rumbold. New York: Oxford University Press, 2012, pp. 70–83.
2. René van Leeuwen, Lucas Tiesinga, Berrie Middel, Doeke Post, and Henk Jochemsen. "The effectiveness of an educational programme for nursing students on developing competence in the provision of spiritual care." *Journal of Clinical Nursing* 17 (2008): 2768–81.
3. Annemiek Schep-Akkerman, and René van Leeuwen. "Spirituele zorg: vanzelfsprekend, maar niet vanzelf (Spiritual care: obvious, but not natural)." *Tijdschrift voor Verpleegkundigen* 119 (2009): 34–39.
4. Wilfred McSherry, and Steve Jamieson. "An online survey of nurses' perceptions of spirituality and spiritual care." *Journal of Clinical Nursing* 20 (2011): 1757–67.
5. Josephine Attar, Donia Baldacchino, and Liberato Camilleri. "Nurses' and midwives acquisition of competency in spiritual care: A focus on education." *Nurse Education Today* 34 (2014): 1460–66.
6. Aru Narayanasamy, and Jan Owens. "A critical incident study of nurses' responses to the spiritual needs of their patients." *Journal of Advanced Nursing* 33 (2001): 446–55.
7. John Swinton, and Pattison Stephan. "Moving beyond clarity: Towards a thin, vague, and useful understanding of spirituality in nursing care." *Nursing Philosophy* 11 (2010): 226–37.
8. Fiona Timmins, and Wilfred McSherry. "Spirituality: The Holy Grail of contemporary nursing practice." *Journal of Nursing Management* 20 (2012): 951–57.
9. Christina Puchalski, Robert Vitillio, Sharon K. Hull, and Nancy Reller. "Improving the spiritual dimension of whole person care: Reaching national and international consensus." *Journal of Palliative Medicine* 7 (2014): 642–56.
10. Linda Ross. "Spiritual care in nursing: An overview of the research to date." *Journal of Clinical Nursing* 15 (2006): 852–62.
11. Harold Koenig, Dana King, and Verna Carson. *Handbook of Religion and Health*, 2nd ed. New York: Oxford University Press, 2012.
12. Nell Cockell, and Wilfred McSherry. "Spiritual care in nursing: An overview of published international research." *Journal of Nursing Management* 20 (2012): 958–69.
13. Wilfred McSherry, and Steve Jamieson. "The qualitative findings from an online survey investigating nurses' perceptions of spirituality and spiritual care." *Journal of Clinical Nursing* 22 (2013): 3170–82.
14. Bonnie Weaver Battey. "Perspectives of spiritual care for managers." *Journal of Nursing Management* 20 (2012):1012–20.
15. Sheryl Reimer-Kirkham, Barbara Pesut, Richard Sawatzky, Marie Cochrane, and Anne Redmond. "Discourses of spirituality and leadership in nursing: A mixed methods analysis." *Journal of Nursing Management* 20 (2012): 1029–38.
16. Ferda Ozbasaran, Safak Ergul, Ayla Bayik Temel, Gulsah Gurol Aslan, and Ayden Coban. "Turkish nurses' perceptions of spirituality and spiritual care." *Journal of Clinical Nursing* 20 (2011): 3102–10.
17. Shirley Ruder. "Spirituality in nursing: Nurses' perceptions about providing spiritual care." *Home Healthcare Nurse* 31 (2013): 356–67.

18. Linda Ross, René van Leeuwen, Donia Baldacchino, Tove Giske, Wilfred McSherry, Aru Narayanasamy, Carmel Downes, Paul Jarvis, and Annemiek Schep-Akkerman. "Student nurses perceptions of spirituality and competence in delivering spiritual care: A European pilot study." *Nurse Education Today* 34 (2014): 697–702.
19. Wilfred McSherry, Peter Draper, and Don Kendrick. "Construct validity of a rating scale designed to assess spirituality and spiritual care." *International Journal of Nursing Studies* 39 (2002): 723–34.
20. Masoud Fallahi Khoshknab, Monir Mazaheri, Sadat Maddah, and Mehdi Rahgazor. "Validation and reliability test of Persion version of the Spirituality and Spiritual Care Rating Scale (SSCRS)." *Journal of Clinical Nursing* 19 (2010): 2939–41.
21. René van Leeuwen, Lucas Tiesinga, Berrie Middel, Doeke Post, and Henk Jochemsen. "The validity and reliability of an instrument to assess nursing competencies in spiritual care." *Journal of Clinical Nursing* 18 (2009): 2857–69.
22. Eltica de Jager Meezenbroek, Machteld van den Berg, Gerwi Tuytel, Adriaan Visser, and Bert Garssen. "Het meten van spiritualiteit als universeel fenomeen: De ontwikkeling van de Spirituele attitude en interesse lijst (SAIL) (Measuring spirituality as a universel phenomenon: Development of the Spiritual attitude and involvement list (SAIL))." *Psychosociale Oncologie* 14 (2006): 14–15.
23. Kathleen Lovanio, and Meredith Wallace. "Promoting spiritual knowledge and attitudes: A student nurse education project." *Holistic Nursing Practice* 21 (2007): 42–47.
24. Ka Fai Wong, Linda Y. K. Lee, and Joseph K. L. Lee. "Hong Kong enrolled nurses' perceptions of spirituality and spiritual care." *International Nursing Review* 55 (2008): 333–40.
25. Eltica de Jager Meezenbroek, Bert Garssen, Machteld van den Berg, Gerwi Tuytel, Dirk van Dierendonck, Adriaan Visser, and Wilmar Bernardus Schaufeli. "Measuring spirituality as a universal human experience: Development of the Spiritual Attitude and Involvement List (SAIL)." *Journal of Psychosocial Oncology* 30,(2012): 141–67.
26. Moon Fai Chan. "Factors affecting nursing staff in practicing spiritual care." *Journal of Clinical Nursing* 19 (2010): 2128–36.
27. Lay Hwa Tiew, and Vicki Drury. "Singapore nursing students' perceptions and attitude about spirituality and spiritual care in practice: A qualitative study." *Journal of Holistic Nursing* 30 (2012): 160–69.
28. Lucy Rushton. "What are barriers to spiritual care in a hospital setting?" *British Journal of Nursing* 23 (2014): 370–74.
29. Wilfred McSherry. *Making Sense of Spirituality in Nursing and Health Care Practice: An Interactive Approach*, 2nd ed. London: Jessica Kingsley Publishers, 2008.
30. Anne L. Biro. "Creating conditions for good nursing by attending to the spiritual." *Journal of Nursing Management* 20 (2012): 1002–11.