

Hospice Workers Perceptions and Understanding of Spirituality and Spiritual Care

By

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DECLARATION

This research has not been previously accepted for any degree and is not being currently submitted in candidature for any degree.

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ABSTRACT

This study aimed to determine hospice workers' perceptions, understanding of and attitudes to spirituality, spiritual care and religion. In order to test the hypotheses, attitude scales and a semi-structured interview schedule was used. A sample of 73 was obtained from various hospices around KwaZulu-Natal who completed the Spiritual and Spiritual Care Rating Scale (SSCRS), the Spirituality and Religious Attitude and Practice Scale and a short questionnaire measuring biographical information, work history and issues relating to spirituality/ religion and training. The study found that study participants were aware that there were differences between spirituality and religion but had a difficulty differentiating between the two concepts. They considered themselves to be spiritual and that spirituality was relevant in their personal and professional lives. The implications of the findings are discussed.

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CHAPTER 1

Introduction

1.1 Introduction and Background to the Study

“Care of the human spirit is often a neglected and overlooked dimension of nursing since in no other area of nursing is holistic care more essential than in palliative care where nurses are faced with intense human suffering which may surpass physical and psychological care in nursing practice” (Richardson, 2002, p.1). Health care workers working in a palliative care environment provide specialised care to people who are terminally ill and to those who are dying (Lucas, 2003). This specialised palliative care includes home-care, pain control and psychological and spiritual support (Lucas, 2003). The combination of bio-psycho-social, moral and spiritual aspects of the person being cared for is viewed as holistic care (Oldnall, 1996). The primary focus of the hospice movement during its initial stages was to treat cancer patients but as time progressed HIV and AIDS became a bigger threat to countries around the world. Presently HIV and AIDS patients make up a large proportion of patients in hospices within South Africa (Hospice Association of South Africa (HASA), 2006). This poses a huge dilemma for hospices around the country and has huge implications for the health care sector, for example more nurses trained in palliative care would need to be employed within the various hospices around the country to meet the growing number of patients being admitted.

In South Africa training in spirituality is a new phenomenon. The Hospice Association of South Africa (HASA) has implemented programmes to train their caregivers in palliative care which includes a module on caring for the spiritual needs of the patient (HASA, 2006). Provincial nursing colleges also offer a spiritual component within their training programmes which is endorsed by the South African Nursing Council (SANC) (Fox, Fawcett, Kelly &

Ntlabati, 2002). However, this training is not seen to be sufficient (HASA, 2006), as spirituality is dealt with very briefly, with the spiritual needs of the patient ultimately being left to the spiritual leaders (Fox et al., 2002).

Until quite recently most of the patients cared for by hospice health care workers suffered from cancer. However with the increasing prevalence of HIV and AIDS worldwide, hospices are caring for increasing numbers of HIV and AIDS patients. Currently HIV and AIDS sufferers constitute a large proportion of patients in South African hospices (HASA, 2006). It is predicted that hospices will have to deal with more HIV and AIDS sufferers as the pandemic spreads. This has huge implications for the already understaffed and limited numbers of South African hospices. South African hospices have responded by forming partnerships with other health care agencies such as clinics, hospitals and community based organizations to provide the best possible quality of life for their patients (St. Lukes Hospice, 2002).

The acknowledgement of the spiritual nature of human beings and the recognition within nursing literature for caring for the whole person forms the background to this study. Therefore it is important to understand hospice health care workers' perception of spirituality and spiritual care.

1.2 Context of the Study

1.2.1 Health care in the South African context

Following South Africa's first democratic elections in 1994, the health care system shifted from being racially biased to one aimed at making primary health care accessible to all (Bassett, 2004). At present South Africa's health care system comprises of both public and private health care. Private health care is accessible to the privileged few while the majority of

South Africans can only afford public health care. With 2.4 million HIV-infected people in South Africa a huge burden is placed on health care facilities (UNAIDS, 2006). Due to this dilemma within the public sector health care, hospices around the country have taken it upon themselves to include HIV infected individuals into programmes previously reserved for terminal cancer patients (Bassett, 2004).

1.2.2 Hospice movement and palliative care

According to the World Health Organisation (WHO) (2002) hospice palliative care is a philosophy of care and a programme of services aimed at relieving suffering and improving quality of life for persons who are living or dying from a life limiting illness. Both hospice care and palliative care share the same meanings and are sometimes used interchangeably. At present in South Africa “palliative care” means terminal care which is in line with the World Health Organisation (2002) definition of this concept.

According to the World Health Organisation (2002), hospice palliative care:

- Does not hasten or delay death
- Offers comfort and practical, emotional and spiritual support to the person and family
- Allows people to continue receiving treatments including those aimed at slowing the progress of the disease and reducing symptoms.

The hospice movement focuses on holistic care, not on bio-medical care. According to St. Luke's Hospice (2002) a hospice is not a place but a philosophy of care and therefore can be taken to patients wherever they are, at home, residential care or frail care facilities and hospitals. Saunders (2000) states that hospices have been addressing the patients' end-of-life care issues for more than 20 years. A hospice is designed to alleviate and relieve painful symptoms and provide as much quality time with family and friends. The primary goal of a

hospice is to offer the highest quality of life as possible during a person's final days (Mayoclinic, 2006).

The hospice and palliative care movement in Sub-Saharan Africa started in 1979 with the establishment of the first hospice program, Island Hospice, in Harare. Other countries, such as South Africa, Kenya and Uganda followed suit. The focus of hospices in Sub-Saharan Africa and South Africa in particular provide interdisciplinary care to terminally ill patients and their families. In addition both families as well as community care-givers are taught to provide for the personal needs of the patient which includes support, comfort and relief of symptoms (Foley, Aulino & Sjernsward, 2003).

All hospices follow a programme that addresses the recommendation of the World Health Organisation (WHO, 2002) and these include:

- Pain and symptom management
- Supplemental nutritional and vitamins
- Psychological and **spiritual support**
- Bereavement counselling
- Orphan care planning

Palliative care forms an integral component of a hospice programme. It is based on a model that was developed for the needs of the cancer patient in the United Kingdom. Today palliative care forms an integral part of the treatment of people living with HIV as well as AIDS.

1.2.3 Cancer

Global Cancer Statistics (Parkin, Pisani, & Ferlay 2005) estimate that there were 10.9 million new cancer cases in 2005, 6.7 million deaths and 24.6 million persons living with cancer

(within three years of diagnosis). The most common cancers that have been reported have been lung (1.35 million), breast (1.15 million) and colorectal (1 million). The most common cause of cancer death is lung cancer (1.18 million) and the most prevalent cancer in the world is breast cancer with 4.4 million survivors up to 5 years following diagnosis (Parkin et al., 2005).

In Sub-Saharan Africa, the AIDS epidemic has resulted in the increased prevalence of a certain cancer, the Kaposi sarcoma. Kaposi sarcoma is an indolent cancer found mainly in northern Africa followed by eastern, southern and then western Africa (Oettle, 1982). With the HIV and AIDS epidemic growing, 57,000 new cases occur in Africa each year with many having to be cared for within a hospice setting.

1.2.4 HIV and AIDS

HIV and AIDS has become a global epidemic. Countries around the world such as Thailand, India and the Eastern Bloc countries have shown high prevalence rates. Dixon (2002) stated that over 45 million Africans were infected with HIV by 2002. According to Berry (2004) research shows that seven countries, all in southern Africa, have over 20% prevalence rates: Botswana (38.8%), Lesotho (31%), Namibia (22.5%), Southern Africa (20.1%), Swaziland (33.4%), Zambia (21.5%) and Zimbabwe (33.7%). HIV and AIDS have become one of the leading diseases facing South Africans today. By 2004, 28 % of individuals in South Africa were affected by HIV and AIDS and 13 % of all people in the world living with HIV can be found in South Africa (Berry, 2004).

1.2.5 Role of nurses and health care workers

Nursing, according to the South African Nursing council (SANC) (2004) incorporates midwifery and nursing. General nursing education and training forms the basis of education

and training. The South African government has declared nurses the backbone of the health care system (Democratic Nursing Organisation of South Africa (DENOSA), 2005). At the end of 2005, there were 99 534 professional nurses or midwives, 37 085 enrolled nurses and 54 650 enrolled nursing auxiliaries (ENAs) registered with the South African Nursing Council (SANC, 2006). According to the Health Systems Trust (2005) there has been a shift in the health care system from mainly hospital based to primary health care based services. This shift has shown a dip in the morale of the nurses as this placed an increased workload on the clinic nurse.

Statistics released by DENOSA (2005) indicate that over a ten year period (1991-2000), 2 543 applications for verification of qualifications for immigration purposes were processed. The reasons cited by Xaba and Phillips (2001) for the mass exoduses of nurses were:

- Work pressure
- Limited space for career growth
- Poorly resourced work environments
- Escalating crime and rise of HIV and AIDS (nurses felt that their safety was jeopardised through overcrowding in hospitals and the spread of HIV infection).
- Nurses being over 40 years of age.

As a result of the loss of nurses from the public health sector, there is a scarcity of nurses to work in specialised environments such as hospices. This has implications for the health care worker. If the hospice is expected to provide holistic care then the shortage of nursing staff complicates the issues. Meeting the physical needs of the patient would become a priority over meeting their spiritual needs.

1.2.6 Spirituality versus religion

Dossey, Keegan and Guzzetta (2000) ask whether spirituality and religion are the same thing. Spirituality is "the essence of our being, which permeates our living and infuses our unfolding awareness of who and what we are, our purpose in being, and our inner resources; and shapes our life journey"(Dossey, 1999, p. 3). Pargament (1999) defines religion as a "... search for significance in ways related to the sacred" (p. 11) and says that "Religion has to do with building, changing and holding on to things that people care about in ways that are related to the sacred" (p. 32). Hill, Pargament, Swyers, Gorsuch, McCullough, Hood & Baumeister (1989) see religion as reflecting *both* personal and institutional qualities and says that the personal and social domains of religion are not easily separated.

According to McSherry, Draper and Kendrick (2002), spirituality includes broader existential concepts. The focus is on a need to invest life with meaning and purpose, a belief in a God/deity, a sense of hope in life with spirituality being a unifying force where one is able to be at peace with oneself. Burkhardt (1989) defined spirituality as that which gives meaning to one's life and draws one to transcend oneself. It is a broader concept than religion and there are many others who would challenge this notion. Aldridge's (2001) notion of spirituality is characterized by the idea of transcendence but has a broader perspective than religion.

According to Garner (2002), the term spirituality emerged from Christian religion and argues that in non-religious contexts, the definition of spirituality may become so broad so as to lose its usefulness and meaning.

The study by McSherry et al. (2002) revealed that a universal concept of spirituality was identified amongst the nurses who participated in their research. The nurses' survey perceived spirituality as a "force" which enabled individuals to be at peace with oneself and the world.

A South African study conducted by Mahlangu (2001) shows that nurses' role in spiritual care is based upon compassion for human suffering, pain and acceptance of the patient as a unique being. It involves a personal concern with meaning and transcendence and a belief that 'what is seen is not all there is' (Elkins, Hedstrom, Hughes, Leaf & Saunders, 1988, p. 11). Plante and Sherman (2001) found that religion was easier to define than spirituality and that they should be seen as multifaceted, overlapping constructs whose specific definitions remain a subject of debate. Heriot (1992) summarises the debate and defines religion and spirituality as varying dimensions where, spirituality is identified as a broader notion, an umbrella under which religion and the needs of the human spirit are found.

According to the South African census statistics almost 76% of South Africa's population are of the Christian faith, followed by Hindus, Muslims, Jews and Buddhists. Apart from the various denominations, the major African indigenous churches, mainly Afrikaans and Pentecostal churches have their own governing bodies (Census, 2001). Therefore it is evident that religion is an important part of the culture in South Africa.

1.2.7 The cultural context of spirituality

O'Connell (1999) comments that one of the biggest challenges in integrating spirituality in health care is being able to understand and gain a respect for the different religious and spiritual beliefs of a diverse culture. Saudia, Kinney, Brown and Young-Ward (1991) believe that health care workers today are continually faced with issues of cultural and spiritual diversity.

Most hospices are based on Christian foundations and assumptions. Christians see Christ's suffering as evidence that God cares about their suffering because he has taken it on himself, thus dignifying suffering on behalf of others. Buddhists find support in the Buddhist dharma

where meaning in suffering is found. Atheists faced with suffering may instead take pride in their own integrity, intellectual honesty or stoicism. From a Hinduism perspective, Dasa (1998) states that spirituality is a quality that goes beyond religious affiliation. Narayanasamy (1993) supports this notion and states that spirituality embraces the needs of the believers and non-believers; therefore it is not confined within a religious context. Dom (2000) a South African ex-patriot conducting research on spirituality in South Africa reaffirms this by stating that health care professionals owe it to their patients, especially those from non-Christian and non-religious denominations, to broaden their training horizons by including multicultural philosophies and perspective. This author concludes that spiritual care can be most profound and effective when it is not attached to any one particular belief system. According to Mbiti (2001) "African religion has no set of religious literature and scriptures. It has always been based on the existential experience of people and having no scriptures has enabled African people to adopt or modify it as their situation dictated" (p. 15). According to Mekoa (1998) every aspect of an African person's life as an individual is spiritual in nature. The manner in which the individual interacts, relates to other people and the way they eat and sleep all point to the life of the African individual as being a religious event. South Africa with its multitude of cultures, values and experiences need to be studied so as to obtain a broader understanding of African spirituality. With the advent of the huge HIV/AIDS epidemic which is influencing all sectors of South African society, it is imperative that research focusing primarily on palliative health care workers working in a culturally diverse country be given greater priority and attention. There are numerous factors which need consideration when conducting such a study (Department of Health, 2001).

1.2.8 Personal importance of spirituality

Conrad (1985) and Fitzgerald (1997) make the point that an individual has to be comfortable in spiritual matters and Fitzgerald (1997) offers the motto "know thyself" to any nurse who is

faced with spiritual concerns when providing spiritual care to the patient. According to Bassett (2002) spiritual care and caring are difficult concepts to define but identifies these as forming a vital, central and unifying core of health care. Being fully present or being with the patient is one aspect of demonstrating caring for the patient with spiritual needs, and adopting a caring attitude is a requisite to nurture spiritual health (Burkhardt, 1989; Newshan, 1998; Pettigrew, 1990).

Puschalski's (1999) studies on spirituality and the dying found that it was important for health care providers to allow a moment of silence for prayer with the patient. By not respecting such a request, it can leave the patient feeling a sense of abandonment. This activity of praying can cause discomfort when firmly held beliefs are challenged and people are forced to examine what they believe and why they believe in it. Dom (2000) asserts that in order for an individual to be able to provide effective spiritual care, the nursing practitioner needs to look inwardly and examine their own spirituality.

According to Newshan (1998) some of the reluctance to engage in spiritual matters may lie with the nurses who might have little insight into their own spirituality. Newshan (1998) proposes that nurses should begin their own spiritual journey before becoming intimately involved with patients nearing their end. Furthermore, Newshan (1998) suggests that nurses should self-reflect and suggests that before nurses can readily accept responsibility of administering spiritual care to others, they must achieve awareness of an inner life. This could be promoted in an educational or clinical setting, and unless the nurse is willing to take on the responsibility of taking care of her or his own spiritual needs, the approach to the assessment will remain superficial and duty-based (Newshan, 1998). This issue has been not been addressed in South Africa.

1.2.9 Hospice health care workers role and spiritual care

Spiritual care according to McSherry et al. (2000) involves certain practices that a nurse may undertake, for example maintaining dignity and privacy, listening attentively to a patient, enabling an individual to maintain their religious practices while in hospital. Similarly, Narayanasamay (1993) provides a supporting view that spiritual care involves assisting the patient in their quest to find meaning and purpose in their illness. There were different categories of health care workers within the palliative environment to make up the sample these will be explained later on this chapter.

A review of nursing literature shows that historically nurses have not received extensive education on how to care spiritually for dying patients and their families. This lack of education has been shown to reflect the level and quality of end-of-life care that is being dispensed to patients in a palliative environment. South African nursing school's end-of-life curriculum has been lacking both in didactic education and clinical experience. A review of the curricula shows that student nurses are only trained in pain and nutrition management. The biological and social aspects are targeted but not the spiritual aspects (Health Sciences Curricula, 2005). The implementation of spirituality in the nursing curriculum is a new development in nursing colleges around the country.

It is important that health care workers are able to face the reality of their own mortality and believe that they can help another die well by realizing that human life is temporary and human beings are mere mortals (Newman, 1997). Peteet (2001) suggests that in "treating a patient who is struggling with the larger meaning of pain or loss, health care workers do well to identify the resources within themselves for dealing with suffering that are contained in his or her particular worldview" (p.187).

1.3 Types of Hospice Care Workers

This study used different categories of care givers within the palliative environment to make up the sample.

1.3.1 Nurses

In this study the term nurse was used to refer to both professional nurses as well as enrolled nursing aides who are registered with the South African Nursing Council and one who is providing direct patient care in a hospice palliative setting.

1.3.2 Caregivers

Caregivers are all those individuals who give comfort and care to the ill and dying. They are not registered with the SANC. These individuals are an integral part of the care program conducted by the hospice. They are trained hospice caregivers who provide a variety of services, such as staying with the patient, providing companionship and so on.

1.4 Aim

This study aimed to determine hospice workers' perceptions, understanding of and attitudes to spirituality, spiritual care and religion; more specifically the study sought to examine:

- Health care workers understanding of the differences between spirituality and religion.
- Health care workers attitudes toward the concept of spirituality and spiritual care.
- The role of spirituality in health care workers personal life and integration into their professional lives.

1.5 Significance of the Study

The manner in which spirituality and spiritual care are conceptualised and defined by hospice health care workers will have significant implications for professional health care practices,

nursing education and the further development of the ontology and epistemology of hospice health care workers (Olson , Paul, Douglass, Clark, Simmington & Goddard, 2003). There are few published studies on spiritual care, spirituality and religion from a South African perspective that focus on spirituality in a multi-cultural palliative environment. Thus this investigation is an initiative within the South African context that will add to the few South African studies.

Chapter two reviews all relevant literature both internationally and nationally (South African).

CHAPTER TWO

Literature Review

This chapter reviews literature relating to nursing and health care within a palliative environment. Spirituality and spiritual care literature within the international and the South African contexts are reviewed.

2.1 Theoretical Framework

Nursing theories on spirituality and spiritual care have evolved from both a humanist perspective as well as an existential-phenomenological one. ‘Rogers’ nursing theory’ (Rogers, 1970) has informed nursing theory by linking the relevance of spirituality to nursing and health. Spirituality was not specifically discussed within Rogers’ nursing theory but inputs by various theorists (Elkins, et al., 1988 & Smith, 1994) initiated a discussion of spirituality within Rogers’ (1990) nursing model. Elkins et al. described spirituality from the humanist perspective by synthesizing definitions from Frankl, Maslow, Buber and others. Elkins, et al. viewed “spirituality as a ‘human phenomenon’ that ‘exists’ at least potentially, in all persons” (p. 8). They viewed spirituality as a way of being and experiencing that comes through awareness of a transcendent dimension characterized by certain identifiable values in regard to self, others and nature, life, and whatever one considers the Ultimate (p. 10). Elkins et al. elaborated spirituality as a multidimensional construct with nine major dimensions:

Elkins et al. (1988) focused on nine dimensions of spirituality which were later collapsed into four dimensions by Smith (1994). These dimensions elicited themes that appeared frequently in definitions and descriptions of spirituality which are congruent with Rogers’ (1990) nursing model.

The nine dimensions of spirituality that Elkins et al. (1988) focused on were:

1. Transcendental Dimension: A belief in more than that which is seen, that may or may not be in the belief of God; and a belief that personal power is drawn through harmonious contact with this dimension.
2. Meaning and Purpose in Life: A deep confidence that one's life has purpose, emerging from the quest for meaning.
3. Mission in Life: A sense of responsibility to life; knowing that in "losing one's life" one "finds it" (Elkins et al., 1988, p. 12).
4. Sacredness in Life: A belief that all life is holy.
5. Material Values: A realization that ultimate satisfaction is from spiritual, not material things.
6. Altruism: A belief in social justice, and awareness that "no man is an island".
7. Idealism: A commitment to the actualization of positive potential in all aspects of one's life.
8. Awareness of the tragic: A deep awareness of human pain, suffering and death and that life has value.
9. Fruits of spirituality: Benefits of spirituality that are realized in relationships with self, others, nature and what one perceives as the Ultimate.

Smith (1994) has since reduced the number of dimensions to four.

1. The first manifestation of spirituality is feeling confident that life is meaningful.

According to Rogers (1970) "... in the process of evolution, man's search for meaning takes on new dimensions" (p. 93). Elkins et al. (1988) has described the spiritual person as "...one who has known the quest for meaning and purpose and has emerged with confidence that life is deeply meaningful and that one's own existence has purpose" (p. 11). Frankl (1984) also identified the need for the search for meaning as a basic human need where people go through

extreme sufferings to find meaning which in turn may propel them toward spiritual growth. He goes further to state that the experience of the unconditional meaningfulness of life is illustrated by the phenomenon of faith and the unshakeable belief that God exists. Frankl (1984) contended that in the realization of spiritual (godly) values, any person can experience meaning. This is irrespective of a belief in whether God exists or not (Meyer, Moore & Viljoen, 1997). Nursing theory states that spirituality is a process of bringing meaning and purpose to one's life (Stoll, 1989).

2. The second manifestation that Elkins et al. (1988) postulate is spirituality's effect upon an individual is "the actualization of positive potential in all aspects of life" (p. 11).

Rogers (1970) viewed human beings as energy fields "different from the sum of their parts" (p. 6). Frankl (1984) stated that the meaning of life transcends one's comprehension of it.

3. The third manifestation of spirituality is feeling a sense of interconnectedness with other living things.

According to Rogers (1990) humans interact within an environmental field which is continuously engaged in a mutual process of change. Reeder (1989) described it as an "integral view of human life and the cosmos" (p. 2), which is a sense of connectedness which may also manifest as a commitment to altruistic love and actions. Elkins et al. (1988) identifies altruism as an expression of spirituality. It is a sense of selflessness and empathy for others; a willingness to do more for others than for yourself (Banks, Poehler & Russell, 1984, p. 17).

4. The fourth manifestation of spirituality is a sense of beneficial connectedness with a transcendental dimension or being.

Hungelmann, Kenkel-Rossi, Klssen and Stollenwerk (1985) and Stoll (1989) found that spirituality has been described as a trusting, harmonious relationship with a transcendent dimension or ultimate other. It also includes a “deep sense of belonging, of wholeness, of connectedness and of openness to the infinite” (Shafranske & Gorsuch, 1983, p. 245).

2.2 Empirical Research

Studying spirituality within a health care environment in South Africa is a relatively new phenomenon, with most of the available literature focussing on the patient’s spirituality. Interestingly there are very few local or international studies which have investigated the spirituality of health care professionals working in a hospice care setting.

2.2.1 Importance of spirituality

Richardson (2002) observes that the care of the human spirit is often a neglected and overlooked dimension of nursing, especially in palliative care where holistic care is essential. Generally within the South African health care scenario spirituality is considered a private experience (Fox et al., 2002), with nurses taught to respect a patients’ spirituality. Lindgren and Coursey (1995) showed that (62%) of patients generally felt more comfortable discussing spirituality with their caregivers / nurses than with their doctors. The reason most frequently cited for this preference was that caregivers /nurses spend more time with the patients. Miller-Brown (2002) also acknowledges the importance of spirituality for nurses. Spirituality is necessary to find meaning and peace for the nurses, their patients as well as the family members.

In sub-Saharan Africa holistic palliative care needs to be aimed at two different levels, the nurse/caregiver level and patient level (Harding & Higginson, 2005). Despite vast evidence that pain is the primary need, psychological, spiritual and social care is crucial (Harding &

Higginson, 2005). In addition emotional and spiritual support for nurses and caregivers employed in a palliative environment is vital (Frohlich, 1998), to prevent carer exhaustion. The rising prevalence of HIV and AIDS in South Africa has motivated hospices around the country, where patients dying of AIDS are often cared for, to include spiritual education within their nursing training programmes (Madlala-Routledge, 2006).

2.2.2. Spirituality and health

Spiritual beliefs are a source of comfort and support in times of a health crisis (Greasley, Chiu & Gartland, 2001) with various empirical studies showing that aspects of spirituality and religion were highly associated with desirable health outcomes (Swinton, 2001). Terminally ill patients tend to be more spiritually inclined than non-terminal ones (Reed, 1992). There has been growing support for the hypothesis that spiritual well-being might help to bolster psychological functioning and adjustment to illness. McClain, Rosenfeld and Breitbart's (2003) study asserts that because psychological distress accompanying illness happens frequently, spirituality helps and is a crucial aspect of coping with terminal illness. Frankl (1984) suggested that with suffering/serious illness comes a need to understand issues concerning mortality, the meaning and purpose of life and the existence of a greater power.

While acknowledging the importance of spirituality and religion in health care, Sloan, Bagiella and Powell (1999) are of the opinion that spirituality and religion should not be used as a form of medical intervention as it can foster guilt in patients. In fact nursing training internationally does not include a specialisation module on spirituality. However holistic health care without a spiritual component totally contradicts the health care ethos within hospice environment where spiritual care forms an integral part of a holistic intervention (HASA, 2006). Sloan et al. (1999) argue that most studies on spirituality and healthcare are flawed by "confounding" factors such as social support. Dossey (1999) responded by stating

that Sloan et al. (1999) overlooked most of the articles and books discussing the effects of prayer on healing and failed to recognise that a lack of physician or nurse concern for the patient's spiritual was similar to the lack of concern for drinking habits, sexual practices, dietary and exercise habits in health care two decades ago. Dossey (1999) stated further that the Sloan, et al. study (1999) did not recognize that health care workers could learn to deal with spiritual and religious issues as delicately as chaplains and spiritual leaders. From a psychological perspective, spirituality is seen from an existential point of reference where individuals look to personal meaning and transcendence of the human spirit which goes beyond any particular setting or discipline (Meyer, Moore & Viljoen, 1997).

Hospice workers are a very spiritual group who feel spiritual care is too critical to be left solely to the clergy (Millinson & Dudley, 1992). Stephenson's (2002) findings support this by stating that a nurse's role should be to respect the patient's existential struggle and to provide a caring and compassionate environment. Kei, Morita and Kshiwago (2003) concluded from their study that in order to effectively alleviate existential suffering in terminally ill patients, integrated care by an interdisciplinary team is necessary. The aim is not to replace the clergy or spiritual healer but for health care workers to form part of an auxiliary team. (Rumbold, 2003).

Grant, O'Neil & Stephens (2004) used the case study of Sheila Larson, a young nurse in an article by Bellah, Madsen, Sullivan, Swidler & Tison (1996) to lay testament to the important role that spirituality plays within nursing circles. Sheila Larson's self-styled brand of spirituality commonly known as Sheilaism became a symbol of today's highly individualistic search for meaning. Sheila Larson worked in a general hospital where she implemented spirituality. Her rejection of religious authority was referred to as shallow and a threat to organized religion. The manner in which she acted out her spiritual beliefs in caring for the ill,

her daily accounts of suffering and death and her willingness to share poignant moments with others as a nurse was discounted by sociologists and many believed that the “secular” workplace was not the arena to provide holistic care (Grant et al., 2004). The idea behind inclusion of spirituality as part of nursing care has not been to replace the religious leaders or clergy but to complement and provide added support from a spiritual perspective.

Grant et al. (2004) highlighted that spirituality does have a place in an oncological and hospice nursing. A more positive assessment of nurses’ spiritual care focuses on nurses who work with the terminally ill, such as oncology and hospice nursing. These specialties have been identified as a special consideration in the provision of spiritual care (Grant et al., 2004). South African hospices have identified the need for spirituality within their organizations. On evaluation of the South African curriculum’s it was found that spirituality forms an integral component in service delivery (Gwyther, 2002).

2.2.3 Spirituality in nursing

“Nurses are increasingly being called on to engage in spiritual care with their patients. A brief historical review indicates that our current understandings of spiritual nursing care have been shaped by three eras characterized by particular approaches: the religious approach, the scientific approach, and the existential approach. We draw elements from each of these approaches to propose attributes of spiritual care in the context of nursing practice. We propose that spiritual nursing care is an intuitive, interpersonal, altruistic, and integrative expression that is contingent on the nurse’s awareness of the transcendent dimension of life but that reflects the patient’s reality”(Sawatzky & Pesut, 2005, p.19).

Nursing arose from spirituality, then turned its back on spirituality and now is turning back to see what was lost (Long, 1997). This full circle epitomises the quandary that people have been experiencing for years. Meeting the spiritual needs of patients has become a recognized,

essential part of nursing (Dennis, 1991). However nurses who work holistically with their patients must be able to care for themselves emotionally, physically, mentally and spiritually before they attempt to provide care to others (Long, 1997). The nurse needs to portray a certain character which embodies the virtues or values of patience, kindness, compassion, unselfishness, loyalty, conscientiousness and honesty (Bradshaw, 1997). While spirituality cannot be learned from a book, it permeates all aspects of life and is necessary to find meaning and peace in end-of-life decisions (Miller-Brown, 2002). Mahlangu and Uys (2004) confirmed that the nurses' role is perceived and based upon the principles of ubuntu (compassion for human suffering, pain and acceptance of the patient as a unique being).

Nurses caring for the dying are placed at the nexus between the death experience of the patient and themselves (Mair, 1989). Therefore, literature focusing on nurses' experiences with patient's spiritual issues is vital in ensuring a peaceful move over (Wesney, 1985). Highfield (1992); Mudd (1992); Millinson and Dudley (1992) stated that spirituality is integral to the dying person's achievement of the developmental task of transcendence and important for health care providers to recognize.

Personal importance of spirituality

The nurses in the McSherry et al. (2002) study perceived spirituality as a "force" which enabled them to be at peace with ones self and the world. In Missoula (Clarke, Curtis & Luce, 2003) a study was undertaken to ascertain the importance of spiritual care and it was found that respondents reported higher ratings if the quality of spiritual care embodied aspects that targeted their needs. These included being read to from a spiritual book, talking with a spiritual leader, and having their needs addressed by their physician and nurse.

The Mahlangu and Uys (2004) study on South African nurses found rich descriptions of the concept of spirituality and this concept was described as a unique individual quest for establishing or maintaining a dynamic transcendental relation with the self, others and with God. Faith, trust and religious beliefs were reported as antecedents of spirituality, while hope, peace and meaningful life were reported as a consequence of spirituality.

Olive's (1995) study into the spiritual experiences and methods of 40 self-described devout physicians found considerable spiritual involvement. Sixty seven percent of them prayed out loud with their terminally-ill patients on at least one occasion. Half the time prayer was initiated by the patients and more often physicians who are Protestant would offer prayer. It was also found that 96% of physicians felt that spiritual well-being is an important component of health care. A further study in the United States by King and Bushwick (1994) revealed that 48% of patients in the study wanted their health care provider to pray with them.

Spirituality in professional practice

Burkhardt (1998) encourages the reintegration of spirituality in health care via telling ones story through prayer. A study by Taylor (2003) identified nursing approaches to spiritual needs included kindness and respect; talking and listening; prayer, connecting with symmetry, authenticity and physical presence, quality temporal nursing care and mobilizing religious and/or spiritual resources are key resources for nurses working with patients with cancer. Narayanasamy and Owen (2001) found in their studies that adopting spiritual care interventions promoted a sense of well-being in nurses as well as formed a valuable part of total patient care. The study also showed that the patients' trust and faith in nurses produced a positive effect on patients and families and nurses themselves derived satisfaction from the experience of giving spiritual care. Parkes' (1999) study with first year students revealed that some nurses were left with feelings of guilt and frustration at their inability to handle the

illness and death and even regret as a result of their involvement with dying patients. When reviewing nurse's attitudes of the dying, Mallory's (2003) study shows that many nurses struggle with negative personal issues concerning death and dying and therefore were uncomfortable providing spiritual care at the end-of-life stage. This could be one of the many reasons why nurses shy away from spirituality. Copp (1997) in earlier studies found a relationship between unresolved personal feelings about death and dying among nurses and the constant use of defense mechanisms as a coping strategy. These defense behaviours included the avoidance of eye contact with the dying person and using bed numbers and disease when referring to the patient. Copp (1997) further stated that contact with patients was split into tasks, each of which was allocated to an individual nurse as a defense strategy against anxiety. A more recent study by Kuupelomaki's (2000) showed that the death of a patient awakens feelings of grief, anxiety, relief, anger and guilt in nurses. It has been shown that nurses find it difficult talking to dying patients, answering questions and confronting the emotions of patients. However in his studies he did find that the attitudes of nurses and doctors to death and toward the care of the dying patients were positive and humane.

A review of the various studies found that even though there is literature to support the idea that health care workers who work with the dying provide spiritual support for the dying, a 1997 Gallup survey (Norris Strohmaier & Byock, 2004), suggested that people may not always receive the level of support and spiritual care they desire. The survey revealed that if people were dying, they would want human contact (54%), especially from someone with whom they could share their fears and concerns (55%). Many just wanted to have their hands held (47%). Fifty percent indicated that prayer was very important as was having a person help them become spiritually at peace (44%). Only 36% indicated that they would want the presence of a clergy when they die. This seems to be the trend where many health care

facilities have resident spiritual care workers tending to the needs of their patients. However there are conflicting views as to who would be the first contact for spiritual support.

Reisetter and Thomas (1986) examined the quality of nursing care given to terminally ill patients, 210 nurses were studied and the results showed that there exists a positive, interactive relationship between nurses and their patients. Patients were comfortable talking to the nurses on all aspects of care. McMurray's (1997) study also revealed that caring was embodied in the nurse-patient interactions of a palliative environment. Taylor, Highfield and Amenta's (1999) study identified factors that predicted nurses spiritual care perspectives and practices and compared oncology nurses and hospice nurses. The results showed that hospice care nurses used traditional spiritual care interventions more frequently and held more positive perspectives regarding spiritual care giving than oncology nurses.

Fulcher and Dunn (2002) states that one of the experiences most feared by new oncology nurses who work closely with the dying patient is the high risk for grief and burnout. This is largely due to the nursing experience being limited in the area of spirituality because death is so feared and is associated with many personal, social and spiritual levels. They state that many new nurses have not taken the opportunity to reflect on their own history of loss. The nurses in Stephenson (2002) study reported feeling unprepared to address spiritual needs because they lacked the understanding of the meaning of spirituality in the lives of the hospice patient.

Mooney (2000) found that nurses' sound broad knowledge-base understanding of the concept of spirituality does not prepare them to handle spiritual issues. They seem to lack the confidence in their ability to address spiritual issues with their patients. Kuupelomaki (2002) concluded that nurses agreed on the importance of spiritual support, however, 58% believed

they were poorly equipped to provide support and 53% were less or not willing to provide spiritual support.

Reviewing the literature it is evident that spirituality is one of the concerns among many patients when they reach the stage of dying. Patients tend to rely on their health care worker to provide them with the strength as well as the answers to their questions. Spirituality has been shown to be underutilized in many settings. It has been shown from the literature that nurses are increasingly being called on to engage in spiritual care with their patients on a religious level, scientific level, and on an existential level.

2.3 Motivation for the Study

Reviewing literature shows that there is a paucity of local studies that address issues of spirituality and spiritual care specifically in South Africa. Two South African studies (Mahlungulu, 2001 & Bhagwan, 2002) focusing on spirituality, spiritual care and religion were conducted. Mahlungulu's (2001) study focused on spiritual care in nursing and Bhagwan's (2002) study looked at the role of religion and spirituality in social work practice. Both of these studies covered a vast area of spirituality, spiritual care and religion. What was common in these studies was that Mahlungulu (2001) and Bhagwan (2002) found that there is limited research in the field of spirituality within the South African context. Although International studies reveal that research relating to nurses' perceptions of the patients' spiritual needs dates as far back as 1957 (Ross, 1996). South Africa has recently acknowledged the importance of spirituality and spiritual care. With the influx of HIV and AIDS admissions to hospices around the country the recent introduction of holistic care has spurred talks among hospice health care workers about the value of integrating spirituality and spiritual care within their palliative care programmes (HASA, 2006). It is imperative that research focussing primarily on palliative health care workers be given greater priority and

attention. According to Madlala- Routledge's (2006) opening address at the palliative care conference it was communicated that palliative care should be implemented in the formal health care sector and that palliative care pilot programmes in the Limpopo and Northern Cape provinces should be extended to all provinces.

According to the Department of Health's HIV prevalence study it was found that the highest levels of HIV infection occurred in the KwaZulu-Natal province (Department Of Health, 2000). In March 2003, the Treatment Action Campaign reported that approximately 600 HIV+ deaths occurred in a day in South Africa. This was largely due to the fact that anti-retroviral medications (ARV's) were not made accessible to many (Treatment Action Campaign, 2005). Therefore today's health care worker is faced with not only the stress of working with HIV and AIDS and cancer but other stresses and factors as compared to those of the past. The stress of long hours, poor working conditions, high turnover of nurses due to the continuous brain drain in the country, as well as the large patient to nurse ratio (Nursing Update, 2005) influence the standard of care that health care workers are able to provide.

It is argued that a more positive assessment of nurses' spiritual care typically focusing on nurses who work with the terminally ill, such as oncology and hospice nursing needs to be considered and explored further. These specialties have been identified as a special consideration in the provision of spiritual care (Grant et al., 2004). Nurses' and health care professionals understanding of spirituality is important in understanding how nurses may provide effective spiritual care for the dying individual.

The McClain et al. (2003) study shows that spiritual well-being helps bolster psychological functioning of the patient, therefore if it does that for the patient then it would be interesting to see how this impacts on nurses who work with the terminally ill patients. Since this study

focuses on the nurse and health care professional and not on the wellbeing of the patients, it is important to be able to understand the role that spirituality plays in the nurses' personal life and how spirituality is perceived by the nurses.

Studies by O'Connell (1999) reviewed in the literature showed that one of the biggest challenges in integrating spirituality in health care is being able to understand and gain respect for the different religious and spiritual beliefs of a diverse culture necessitating an examination of their perceptions. Saudia et al. (1991) believe that practicing nurses today are continually confronted with issues of cultural and spiritual diversity and even though nurses claim to use a holistic approach, the spiritual aspect is often forgotten.

Dom (2000) asserts that in order for an individual to be able to provide effective spiritual care, the nursing practitioner needs to look inwardly and examine their own spirituality. This is an important reason as to why identifying health care workers spirituality and method of spiritual care is so vital in a context such as South Africa. It is important that when a health care worker enters an environment such as a hospice that they themselves understand their spirituality so as to be able to respond to the patients' questions and search for meaning. In identifying these issues health care workers would be more equipped and ready to handle the dying patient's wishes and requests. It is important to identify whether nurses' training is sufficient and adequate to be able to answer questions from dying patients, therefore whether nurses receive spiritual training or not is an important point to identify.

Some of the reluctance to engage in spiritual matters in the literature has come out as the nurses' lack of insight into their own spirituality. Newshan (1998) proposes that nurses should begin their own spiritual journey before becoming intimately involved with patients who are nearing their death. Furthermore, Newshan (1998) suggests that nurses should self-reflect and suggests that before nurses take on the responsibility of administering spiritual care to others,

they must achieve awareness of an inner life. This could be promoted in an educational or clinical setting, and unless the nurse is willing to take on the responsibility of taking care of her or his own spiritual needs, the approach to the assessment will remain superficial and duty-based and they would not be able to integrate spirituality into their professional lives. Newman (1997) further reiterates that if the spiritual care is inept, the patient is left on their own to struggle with their spiritual needs. Peteet (2001) suggests that in “treating a patient who is struggling with the larger meaning of pain or loss, health care workers do well to identify the resources for dealing with suffering that are contained in his or her particular worldview” (p. 187).

The present study aims to determine hospice workers’ perceptions, understanding of and attitudes to spirituality, spiritual care and religion. The chapter following gives a clear indication as to how these issues were addressed and conceptualised.

Chapter three gives a concise description of the sample, measuring instruments and procedures that were used for this study.

CHAPTER THREE

Methodology

This chapter contains a description of the sample, the measuring instruments used and the procedure followed.

3.1 Sample

A total of 73 hospice workers from a population of 107 agreed to participate in the study. The sampling ratio was 2:3. The hospice workers were drawn from four quadrants of KwaZulu-Natal: Northern KwaZulu-Natal, Central Durban, South Coast of KwaZulu-Natal and the Inner west region. For the purpose of this study, an attempt was made to include the total number of professional nurses and caregivers working in all of the hospices in KwaZulu-Natal. However two hospices declined the invitation to participate. Only professional nurses and caregivers working in a palliative, hospice care home-based, and community hospice and inpatient environment were approached to participate in the study. In the rest of the write-up the sample would be referred to as hospice workers.

The modal age of participants was 30-39 years with about a fifth over 65 years of age. Most of the participants were Black (49.3%), female (92%) and Christian (84.9%). Many participants had more than 10 years experience as a health care worker (42.5%) with 12.3% possessing more than 10 years experience working as a hospice care giver. The majority of respondents had received no training in spiritual care.

3.2 Measuring Instruments

In order to test the hypotheses, attitude scales and a semi-structured interview schedule was used. The sample participants completed the Spiritual and Spiritual Care Rating Scale (SSCRS) of McSherry et al. (2002) (Appendix 3), a Spirituality and Religious Attitude and Practice Scale originally designed by Sheridan et al (1992) and Derezotes and Talbot (1995) as mentioned in Prest and Keller (1999) (Appendix 4). A short questionnaire measuring biographical information, work history and issues relating to spirituality/ religion and training in these areas was also used (Appendix 5).

3.2.1 Spirituality and Spiritual Care Rating Scale (SSCRS)

The Spiritual and Spiritual Care Rating scale (SSCRS) developed by McSherry et al. (2002) is a 17-item scale representing four dimensions. The response format ranges from “Strongly Agree” to “Strongly Disagree”. The four dimensions are: Spirituality, Spiritual Care, Religiosity and Personalised Care (Appendix 3).

Psychometric properties

Neuman (1999) states that reliability deals with an indicator’s dependability. This is an important indicator as it means that if an instrument is reliable, it will give one the same result each time the same thing is measured. The SSCRS was tested for reliability and the 17-item SSCRS used in the study demonstrated reasonable internal consistency reliability according to McSherry et al (2002). The Cronbach’s alpha coefficient was ($n = 559$) and was 0.64. The validity of the scale was determined by the use of a Principle Component (PC) factor analysis with a Varimax Rotation to establish the construct validity of indicative structures of spirituality and spiritual care (Mc Sherry et al., 2002).

Subscales of Spirituality and Spiritual Care Rating Scale

The composition of the SSCRS is described in detail by McSherry et al. (2002).

Spirituality (existential elements).

The five items making up this dimension measure “an underlying association addressing the broader concept of spirituality incorporating existential elements”(McSherry et al., 2002, p.729) The five variables dealt with issues concerning life and existence.

For example, I believe spirituality is about finding meaning in the good and bad events of life (McSherry et al., 2002).

Spiritual Care

Five items measuring “Spiritual Care” appeared to reflect central themes of spiritual care which were identified in the literature. “The nurses must *listen*, spend *time*, respect *privacy and dignity*, maintain religious *practices*, and deliver care by displaying *qualities* such as kindness and concern.” (McSherry et al., 2002, p. 730).

For example, I believe that care givers’ can provide spiritual care by showing kindness, concern and cheerfulness when giving care.

Religiosity

Three items measure “Religiosity”. The items appeared to reflect the concepts associated with religion, systems of faith and worship. “This factor appears to underline the universal nature of spirituality by acknowledging that areas such as creativity, art, and self-expression are part of the concept, supporting the notion that spirituality is a much broader phenomenon than just assigning it to religious expressions” (McSherry et al., 2002, p. 730).

For example, I believe spirituality does not apply to Atheists or Agnostics.

Personalised Care

Three items measure “Personalised Care”. The items appeared to reflect one’s beliefs, morals, values and relationships, which are associated with the dimension of spirituality. For example, I believe spirituality involves personal friendships/relationships.

3.2.2 Spirituality and Religious Attitude and Practice Scale – (Prest and Keller, 1999)

The Spirituality and Religious Attitude and Practice Scale is the second instrument used (Appendix 4). This instrument surveyed the respondents’ spiritual and religious attitudes and practices in their personal and professional lives. The instrument contain seven sections made up of close-ended items to which participants responded using a five-point Likert scale (strongly agree to strongly disagree). The measuring instrument was devised for marriage therapists but was slightly adapted for use in this study. The wording was changed to suit the present study. For example, “It is appropriate to talk about spirituality in professional circles” was changed to “It is appropriate to talk about spirituality in nursing circles”.

Psychometric properties

Prest and Keller (1999) state that “scales were constructed from items in the survey through an item analysis of questions that appeared to be conceptually related. Cronbach’s coefficient alpha was calculated for each scale. Seven scales with alpha of .70 or higher were utilized in the analysis of the data” (p. 65). Prest and Keller (1999) concluded that the instrument had met the criteria for both face and content validity after it was verified by independent evaluators.

Subscales of the Spirituality and Religious Attitude and Practice Scale

Scale 1- The personal importance of spirituality

Six items were identified as part of Scale 1. This Scale measures the importance of spirituality in the respondent's personal life.

For example, I consider myself a spiritual person.

Scale 2 – The importance of spirituality for wellness

Three items were identified as part of Scale 2. This Scale measures the relationship of spirituality to the individual's physical and mental health and the wellbeing of the community.

For example, There is a relationship between spiritual health and mental health.

Scale 3 – The integration of spirituality and professional practice

Four items were identified as part of Scale 3. This Scale measures the desirability of integrating spirituality and spiritually derived interventions into nursing practice.

For example, It is appropriate to talk about spirituality in nursing circles.

Scale 4 – The need for education regarding spirituality.

Three items were identified as part of Scale 4. This Scale measures the desirability of further education on the interface of spirituality and therapy.

For example, A course in spirituality should be offered as part of my nursing curriculum.

Scale 5 – The relationship between spirituality and professional identity.

Three items were identified as part of Scale 5. This Scale measures the role of spirituality in the development of the respondent's professional identity.

For example, Nursing is part of my spiritual development.

Scale 6- *The personal importance of religion*

Four items were identified as part of Scale 6. This Scale measures the personal importance of religion.

For example, I find it impossible to conceive of myself as not being religious.

Scale 7- *The integration of religion and professional practice*

Nine items were identified as part of Scale 7. This Scale measures the integration of religion and professional practice.

For example, when working with patients, it is appropriate for a nurse to ask patient's about his or her religion.

3.3 Procedure

3.3.1 Ethical considerations

Permission to undertake the study was obtained from the University of KwaZulu-Natal's Ethics Committee and from the relevant Hospice management. This study adhered to the general research ethical principles, paying particular attention to the research participant's rights to privacy and confidentiality. Appropriate procedures were followed when informed consent was obtained. Research participants' names were not exposed to any individuals or groups. Similarly research participants' names were not revealed to any person during the compilation of research reports. The questions in the semi-structured interview schedule were introduced in a sensitive and non-threatening manner to the research participant. The research participants had the right to participate in the study or refuse to participate or decline participation at a later stage, without experiencing any form of victimisation. This was emphasized as an entry point to the study. In essence, participation was voluntary and there was no expectation of any direct benefits through involvement in the study. The first step in the research process was conducting a pilot study.

3.3.2 Pilot study

According to Rosnow and Rosenthal (1996) in developing and testing a questionnaire, pilot testing is absolutely necessary. The objectives of the pilot study were:

1. To determine the clarity of the questions and whether the nurses had any difficulty understanding them.
2. To assess the effectiveness of the instructions given.
3. To get a clear indication of the average time required to complete the questionnaires.
4. To identify whether any of the items were inappropriate or ambiguous.
5. To identify whether nurses felt uncomfortable with any items in the questionnaires.
6. To measure and support existing reliability and validity.

The pilot study was done on a sample of five nurses from different hospices. The nurses were selected according to their accessibility from where the researcher resides. The nurses selected had agreed to participate in the study once they had met the criteria set out by the researcher for entry to participate in the research. The interviews were conducted exactly as if it would if the actual study was to take place.

A discussion was held with the nurses in order to get their views about the questions that were included in the questionnaire. Account was taken in terms of the inputs, observations and concerns that were given by the respondents. The final draft of the questionnaire remained the same as there were no changes made to any of the items as all the nurses were positive about the items selected for inclusion. However, as the pilot study focused only on nurses it was found during the interviews that there were a large percentage of caregivers in the hospice program that expressed an interest in the study. It was decided that a broad concept of health care workers be adopted in all the questionnaires and within this caregivers as well as nurses were included in this study.

3.3.3 Conducting the study

The researcher personally approached the management of each hospice as a first step in gaining entry and by-in to conduct the research. An institutional consent form was sent via e-mail and seven out of nine Hospices responded requesting a meeting with the researcher. At the meeting the research was described to key personnel namely matrons and hospice managers. Times and dates were then allocated to the researcher pending the schedule and availability of the nurses of the various hospices.

All hospices were given the interview schedules and questionnaires together with a letter inviting nurses to participate and an informed consent form attached. There were three methods of surveys implemented, postal survey, hand delivered and electronic. The motivation behind including areas out of Durban was so that a wider geographical area would make the study more representative. Neuman (1999) states that there could be disadvantages to the postal survey and this could be non – return of questionnaires and a low response rate. This was not the case with this study as all respondents who were sent postal questionnaires completed their questionnaires. The questionnaires were picked up by the researcher so as to avoid non-return of questionnaires. The different areas identified were, Inner West Regions, South Coast Region, Durban Central and surrounding areas. The areas that were given postal surveys were the Inner West Regions (22 participants) as well as the South Coast Region (17 participants). In the North Coast area (2 participants), as arranged with the head of the hospice, the questionnaires were sent electronically, via e-mail. The number responded were in the central Durban and surrounding areas (2 participants), these questionnaires were hand delivered. The questionnaires were given to the health care workers for self completion and a deadline was agreed upon by the hospice management as well as the researcher as to when the questionnaires would be completed and ready to be fetched by the researcher. This made it easier to prevent low response rates as a deadline was set. At the Durban Central region only

eight health care workers recruited to participate. Those that refused to participate in the research stated personal reasons. According to the sister-in-charge many staff members prefer to keep their views about their spirituality private. Pinetown had initially provided a number of 30 health care workers who would be made available for the research. However, only 22 individuals completed and returned the questionnaires.

Chapter four gives a detailed analysis of each questionnaire. The findings of the analysis of the two questionnaires and the interview schedule are presented in table and description form.

CHAPTER FOUR

Results

The data collected from the 73 hospice workers was analysed using SPSS version 13.0. While the demographic data was summarized with frequencies and percentages, responses to the Spiritual and Spiritual Care Scale Rating Scale and Spirituality and Religious Attitudes and Practice Scale were analysed using descriptive (means and standard deviations) and inferential statistics (analysis of variance). The main themes emerging from the sample's understanding of the differences between spirituality and religion were listed and presented in tabular form. The frequencies of respondents endorsing the various themes were included.

4.1 Demographic data of the hospice workers

The demographic data obtained from the questionnaires are summarized in Table 1 (overleaf). Of those responding to the questionnaire, more than half the samples were between 30 and 49 years of age. It was found that very few males worked in this kind of environment and of all the respondents, only six were male. Over 80% of those completing the questionnaire were either White (n= 22) or Black (n= 36). Not surprisingly, most of the health care workers at the hospices were of the Christian faith (n= 62) since these organisations are run along predominantly Christian lines. Over forty percent of the sample had more than 10 years of experience as a health care worker (n=31) but only nine of the respondents had more than 10 years experience working as a hospice care giver. Almost seventy percent of the respondents had less than five years experience (n=51) working as a hospice care giver. The majority of respondents had not received any training in spiritual care. The rest were trained by the hospice in the form of informal in-service training, or by the church in the form of spiritual retreats. Less popular methods were by lectures and workshops. Additional background

Table 1*Demographic data of the study participants (n= 73).*

Variable	Frequency	Percentage
<u>Type of Health Care Worker</u>		
Nurse	28	38.4
Enrolled Nursing Aid	11	15.1
Care Giver	34	46.6
<u>Age</u>		
20-29	10	13.7
30-39	19	26.0
40-49	17	23.3
50-59	11	15.1
60+	14	19.2
<u>Race</u>		
White	22	30.1
Coloured	1	1.4
Indian	9	12.3
Black	36	49.3
<u>Religion</u>		
Christian	62	84.9
Hindu	3	4.1
<u>Years of Experience</u>		
<1-5	30	41.1
6-10	12	16.4
10+	31	42.5
<u>Years working as a hospice care giver</u>		
<1-5	51	69.9
6-10	13	17.8
10+	9	12.3
<u>Training Received</u>		
Lecture	1	1.4
Workshop	2	2.8
Church	4	5.6
Hospice	8	11.3
Undisclosed	6	8.5
No training	50	70.4

information collected on the respondents are presented in Tables 2 to 5. These include descriptions of the sample's work history, a typical work day and their perceptions of the influence of religion (both positive and negative) on effective care.

4.1.1 Work history of Hospice Workers

The employment background of the respondents is summarised in Table 2.

Table 2*Work history of participants*

Previous Employment	Frequency
Hospital nurse	15
Care giver (volunteer)	14
Old age home (volunteer)	6
Home care	4
Community nurse	4
Palliative care (volunteer)	3
Hospice nurse	3
Terminal care (volunteer)	3
Social worker	3
Other	25

From Table 2, it can be seen that the work history of the hospice workers interviewed was quite varied with some people being employed within the health care sector and others giving their time voluntarily. Most of the hospice workers were involved in some type of nursing care. Very few of the respondents had prior experience in palliative care with only three respondents having served as hospice nurses and three people having volunteered to provide terminal care. Of these who had never previously worked in a health care setting before there were educators, domestic workers, a pharmacist and a minister.

4.1.2 Typical Day

Participants in the study were requested to list their daily activities and a summary of these activities is presented in Table 3.

Table 3*Typical daily activity of participants*

Activity	Frequency
Administration	27
Home visits	23
Physical care	19
Activities with patients	10
Inpatient care	5
Counselling Patients	5
Other	4

Most of the respondents spent a large part of their time involved with administration (such as filing) whilst the other main activities were home visits and the physical care of the patients (Table 3). Home visits involved following up patients who were no longer housed at the hospice to ensure that they were taking their medications properly and eating proper meals. Other activities involved activities with patients such as praying and these workers were also involved in counselling both patients and their families. Some of the respondents were involved in more than one activity, for example those involved in Administration were also involved in activities with patients. There were two who were involved in a combination of inpatient care and counselling.

4.1.3 The following tables (4 and 5) contain the sample's responses to the question

"Have you found religion to be a barrier to effective care?"

Table 4*Reasons why religion enhances effective care*

Main Reasons	Frequency
Provides a structure within which one can operate	5
Adds meaning and importance to life	4
Gives hope that there is a god	4
Helps patients accept death	3
People need religious contact when terminally ill	3
Understanding patients religion helps in the care given	3
Care is enhanced if patient has faith	3
If one can get beyond religion and look at spirituality	3
Other	5

Thirty three respondents felt that religion enhances effective care (Table 4). Religion was seen as providing a construct within which health care workers could operate whilst providing care to their patients. Hospice workers felt that religion helped patients accept their illness and death. It was also proposed that understanding the patients' religion helps in understanding the patient and assists in providing the necessary care.

A condensed analysis of the main reasons why religion presents as a barrier to effective care is presented in Table 5 (overleaf). Forty one of the respondents saw religion as a barrier to effective care (Table 5). Respondents felt that health care workers could discriminate against patients that were not of the same religion as them. It was also mentioned that health care workers may find it difficult to respect the rights of patients from different religious backgrounds and that it posed a challenge to provide the same level of care to all persons,

especially if they were of a different religion. The remaining 28 agreed that spirituality is a barrier to effective care without elaborating on their answer.

Table 5
Reasons why religion is a barrier to effective care.

Main Reason	Frequency
Discriminate against patient on religious grounds	4
Different religion to care giver	3
Challenge to remain unbiased	3
Need to respect patients rights	2
Barrier if patient has guilt	1
Agree with no reasons provided	28

4.2 *Hospices workers’ understanding of the differences between spirituality and religion*

While many of the respondents felt there was no clear differentiation between spirituality and religion, a large number gave distinct definitions of religion (Table 6) which were different to their definition of spirituality (Table 7-overleaf). The discussion on religion showed that people had a difficult time differentiating between spirituality and religion. Some of the respondents thought that religion and spirituality were synonymous. The respondents were asked to provide a definition of religion and the analysis of their responses is presented in Table 6.

About a third saw religion as a structured system of beliefs that prescribed specific customs and values. Others saw it as an organised system that demands certain rituals and rites or a

belief in god (or a supernatural power) and having faith in a merciful creator. Several believed that religion dictated worship in a formal structure such as a designated church or by belonging to a specific denomination while a few believed that religion was a learnt way of life directed by your upbringing. Less clear suggestions as to what religion encompasses was a belief that you were able to meet god and that religion had to do with praying and thanking God for what he has given. Others saw religion as being reality and one saw it as a man made construct. An analysis of the definitions of spirituality given by the participants, according to their understanding of spirituality, is given in Table 7-(overleaf).

Table 6

Participants' definition of Religion

Main Theme	Frequency
Structured system of beliefs and customs	24
Rituals and rites	13
Ones beliefs	13
Belonging to a church/denomination	13
Belief in god/supernatural	7
Learnt way of life directed by upbringing	4
Religion and Spirituality are synonymous	4
Praying	4
Other	5

About half of the definitions of spirituality engendered a feeling of closeness to and worship of God/a supernatural power/a creator (Table 7). Some of the respondents defined it as the essence of what makes us human and is concerned with issues of the spirit or the soul. Other respondents saw spirituality as the ability to have inner peace, as part of our life experiences

and something that gives meaning and purpose to life. Spirituality was also differentiated from religion in that spirituality was seen as not having rules. Spirituality was seen as more personal and less structured than religion.

Table 7

Participants' definition of Spirituality

Main Theme	Frequency
Worship god	12
Relationship between creator and creation	8
Derivation of inner peace	6
Closeness to god	5
Belief in spirits	5
Life experiences	4
Belief in greater being	3
Gives meaning and purpose to life	3
Individual belief	3
Dedication to Christianity	3
Other	15

4.3 Hospice Workers attitudes towards the concept of spirituality and spiritual care

Spirituality, spiritual care, religiosity and personalised care are measured by the subscales of the Spirituality and Spiritual Care Rating Scale by McSherry et al (2002). The means and standard deviations are presented in Table 8 (overleaf).

The first two subscales, *Spirituality* and *Spiritual Care* contain 5 items each resulting in the lowest possible score of 5 and the highest possible score of 25. On both these subscales the means for the entire sample are relatively high. For *Spirituality*, the respondents appear to endorse the idea that the concept spirituality contains a strong existential element.

Table 8

Means and standard deviations of the hospice workers on the four subscales

Subscales	Mean	Standard Deviation
Spirituality	19.49	3.80
Spiritual Care	21.73	3.68
Religiosity	7.11	2.45
Personalised Care	11.94	2.39

They tend to agree that life should be filled with meaning, purpose and a sense of hope. With regard to *Spiritual Care*, they appear to strongly support the values of listening, spending time, respecting dignity and privacy, religious practices, and kindness and concern (McSherry et al., 2002) in their interactions with patients. The last two subscales contain three items each, resulting in the lowest possible score of 3 and the highest of 15. The low scores on the *Religiosity* subscale indicate that the respondents do not think of spirituality as a universal concept but as something strongly linked with religion, faith and forms of worship. With *Personalised Care*, however, the high mean indicates that the sample sees morals, supportive and personal relationships as unique aspects of spirituality.

Although subscale differences on the demographic variables ‘Age’, ‘Race’, ‘Years of Experience’ and ‘Type of Hospice Worker’ were not included as hypotheses of the study, the

appropriate analyses were conducted and revealed some interesting results. These results need to be treated with caution since the cell sizes are small and the variances in several instances are high.

4.3.1 Spirituality and Spiritual Care by select demographic variables

There were differences in the responses of the different health care workers to the Spiritual Care, Personalised Care and Religiosity subscales (Table 9- Overleaf). Although there were differences in the mean responses of the health workers to the *spirituality*, the differences were not significant. The Post hoc analysis showed that there were significant differences between the ENAs and Care Giver categories of health and that these differences were only significant on the sub-scales *spiritual care* and *religiosity* and *personalised Care*.

The analysis of the 'Age' variable in Table 9 showed that there were only significantly different responses to the items in the *spiritual care* and *religiosity* subscales. However, the post hoc analysis did not reveal any significant differences between the different age categories. This is probably due to the large variance in the different age categories. There were no significant differences in the responses from participants who fell into different categories based on their years of experience (Table 9). The results of the t-test performed on the 'Race' variable showed that there were significantly different viewpoints with regards to the *spirituality* subscale (Table 9). The mean scores show that Whites attached greater importance to the items listed in this sub-scale than Blacks and that there were widely differing responses as indicated by the SD in Table 9.

Table 9

Tests of difference (One way anova and t-test) on the Spiritual and Spiritual Care Rating Scale subscales by select demographic variables

	Sub-scales							
	Spirituality		Spiritual Care		Personalised Care		Religiosity	
	Mean (SD)	F(df)	Mean (SD)	F(df)	Mean (SD)	F(df)	Mean (SD)	F(df)
DEMOGRAPHICS								
Category		2.34 (2,70)		3.22* (2,70)		3.29*(2,70)		3.98*(2,70)
Nurse (n=28)	17.54 (7.82)		19.92 (7.16)		5.39 (2.86)		11.54 (4.73)	
ENA (n=11)	21.18 (3.51)		24.45 (.82)		8.00 (2.45)		14.64 (.92)	
Caregiver (n=34)	15.97 (7.02)		18.5 (7.41)		6.76 (3.34)		10.50 (4.41)	
Age group		2.26 (4,66)		2.71*(4,66)		1.83 (4,66)		2.83*(4,66)
20-29 (n=10)	16.30 (8.21)		21.30 (4.57)		8.50 (2.88)		12.20 (3.33)	
30-39 (n=19)	18.89 (5.62)		21.52 (5.69)		6.37 (2.27)		12.58 (3.49)	
40-49 (n=17)	13.76 (8.56)		15.53 (8.84)		5.18 (3.45)		8.76 (5.60)	
50-59 (n=11)	21.18 (3.54)		22.82 (1.94)		6.64 (2.46)		13.55 (1.81)	
60+ (n=14)	17.21 (7.44)		19.57 (8.42)		6.43 (4.05)		11.36 (4.94)	
Years of experience		2.02 (2,70)		1.96 (2,70)		1.49 (2,70)		1.63 (2,70)
<5years (n=30)	16.57 (7.06)		19.77 (6.56)		7.17 (3.22)		6.42 (3.14)	
6-10years (n=12)	14.75 (9.13)		16.75 (10.23)		5.67 (3.85)		11.53 (4.17)	
>10 years (n=31)	19.13 (5.97)		21.35 (5.50)		6.00(2.70)		9.58 (5.88)	
Race §		2.30*(56)		1.17 (56)		-1.54 (56)		1.10 (56)
Black (n=22)	14.94 (7.71)		18.33 (7.94)		6.89 (3.61)		10.64 (5.04)	
White (n=36)	19.55 (6.84)		20.73 (6.91)		5.50 (2.82)		12.05 (4.17)	

* p < .05

** p < .01

§ Results of t Test

4.4 *The role of spirituality in hospice workers' personal life and integration into their professional lives*

The 'role of spirituality in health care workers personal life' and 'integration into their professional lives' are sub-scales that define the Spirituality and Religious Attitudes and Practice Scale of Prest and Keller (1999). Table 10 looks at health care workers' understanding of the seven sub-scales based on the mean and standard deviations of these subscales.

Table 10

Means and standard deviations of the hospice workers on the seven subscales

SUBSCALES	Mean	Standard Deviation
PIS	21.48	5.98
SFW	12.37	2.52
SPP	15.18	4.09
NERS	11.56	3.37
SPI	11.73	3.25
PIR	14.38	4.47
IRPP	25.12	10.17

The *personal importance of spirituality* (PIS) (Table 10) show that respondents considered themselves to be spiritual. However, the standard deviation shows that there was quite a variable response to the items making up this scale. There was a high level of agreement that spirituality is relevant in the personal lives of the study participants (Mean = 21.48).

The importance of spirituality for wellness (SFW) (Table 10) was defined by three items. These mean scores indicate that all the items in the subscale were considered to be of importance in determining the importance of spirituality for wellness. *The integration of spirituality and professional practice* (SPP). The majority of health care workers felt strongly that spirituality was important in health care circles, as indicated by the mean score in Table 10. From the items making up this subscale, it is evident that it is necessary to work with a patient's spirituality if you expect to help them find and develop a spiritual path. There was a small variance in the responses for this subscale. The *need for education regarding spirituality* (NERS) was defined by three items. The highest possible mean value in Table 10 shows that there was a high respondent agreement that there was a need to integrate spirituality with assessments and interventions. Hospice care workers felt that it was desirable for nurses to receive supervision and training in spiritual issues as part of the nursing curriculum. The relationship between *spirituality and professional identity* (SPI) was defined by three items. The highest mean value in Table 10 indicates that there is a strong link between spirituality and professional identity. Thus, spiritual development and talking about spirituality in health care circles is important in developing the link between spirituality and professional identity. The four items measuring the *importance of religion in the respondents' personal life* (PIR) indicates that (Table 10) there was some consensus among the respondents with regards to the importance they attached to religion in their personal lives. The nine items measuring the *desirability of integrating religion and religiosity* derived interventions into health care yielded a low mean score indicating that the respondents did not favour the *integration of religion and professional practice* (IRPP). Subscale differences on the demographic variables 'Age', 'Race', 'Years of Experience' and 'Type of Hospice Worker' were investigated and gave further insight into the responses given by study participants for the Spiritual and Religious Attitude Practice Scale subscales.

Table 11

Tests of difference (One way anova and t-test) on the Spiritual and Religious Attitude Practice Scale subscales by select demographic variables

	Sub-scales						
	PIS	SFW	SPP	NERS	SPI	PIR	IRPP
DEMOGRAPHICS	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Category [F(df)]	1.54 (2,70)	2.28 (2,70)	5.93** (2,70)	2.39 (2,70)	6.21** (2,70)	4.26* (2,70)	12.74** (2,70)
Nurse (n=28)	22.64 (5.20)	2.28 (.43)	3.64 (.69)	3.01 (.57)	2.81 (.53)	4.79 (.90)	9.26 (1.75)
ENA (n=11)	22.55 (3.72)	2.02 (.61)	2.11 (.64)	2.17 (.65)	1.26 (.38)	2.75 (.83)	6.47 (1.95)
Caregiver (n=34)	20.18 (6.94)	2.75 (.47)	4.37 (.75)	3.79 (.65)	3.54 (.61)	4.22 (.72)	9.08 (1.56)
Age group [F (df)]	2.67*(4,66)	1.11 (4,66)	3.82** (4,66)	2.74* (4,66)	4.56** (4,66)	2.65* (4,66)	3.17* (4,66)
20-29 (n=10)	20.50 (5.93)	13.10 (2.38)	16.80 (4.05)	12.60 (2.46)	12.90 (2.13)	15.50 (3.17)	32.00 (9.03)
30-39 (n=19)	21.42 (5.07)	12.26 (2.16)	16.68 (3.11)	12.47 (2.65)	12.68 (2.36)	16.47 (3.81)	29.11 (8.60)
40-49 (n=17)	18.59 (8.19)	11.41 (3.81)	12.18 (5.48)	9.47 (4.87)	9.06 (4.70)	12.06 (5.49)	22.65 (11.46)
50-59 (n=11)	23.64 (3.04)	13.18 (1.47)	15.27 (3.50)	12.36 (2.58)	12.73 (2.80)	13.64 (4.50)	20.73 (5.48)
60+ (n=14)	24.71 (3.99)	12.57 (1.79)	15.64 (1.98)	12.00 (1.61)	12.00 (1.30)	14.50 (3.57)	22.93 (10.82)
Years of experience [F (df)]	2.61 (2,70)	1.90 (2,70)	4.78* (2,70)	5.41** (2,70)	4.60* (2,70)	4.29* (2,70)	5.61** (2,70)
<5years (n=30)	20.73 (6.24)	12.90 (2.20)	15.83 (3.31)	12.30 (2.60)	12.17 (2.31)	15.13 (3.36)	29.20 (8.68)
6-10years (n=12)	19.00 (6.09)	11.25 (3.52)	12.00 (5.44)	8.83 (4.76)	9.25 (4.71)	11.08 (5.84)	25.58 (6.60)
>10 years (n=31)	23.16 (5.34)	12.29 (2.30)	15.77 (3.73)	11.90 (2.95)	12.26 (3.01)	14.94 (4.40)	21.00 (11.17)
Race [t (df)]	3.38 ** (56)	1.34 (56)	.99 (56)	1.17 (56)	1.62 (56)	-.86 (56)	-3.39** (56)
Black (n=22)	6.43 (1.07)	1.6 (.34)	4.82 (.80)	3.99 (.66)	3.95 (.66)	4.81 (.80)	9.29 (1.54)
White (n=36)	4.42 (.94)	3.01 (.50)	3.05 (.65)	2.34 (.50)	2.19 (.47)	4.29 (.91)	8.29 (1.77)

KEY FOR TABLE

PIS = Personal Importance of Spirituality SFW = Spirituality for wellness SPP = Spirituality and Professional Practice
 NERS = Need for education regarding spirituality SPI = Spirituality and Professional Identity PIR = Personal Importance of Religion
 IRPP = Integration of Religion into Professional Practice * p < .05 ** p < .01

4.4.1 *Spiritual and Religious Attitude Practice by select demographic variables*

In the category of health worker, significant differences were found for all subscales except for *personal importance of spirituality*, *spirituality for wellness* and *need for education regarding spirituality* (Table 11). Significant differences on the Post hoc analysis were found in the responses given by ENAs and Care Givers for the *spirituality and professional practice*, *spirituality and professional identity* and *personal importance of religion*. For the sub-scale *integration of religion into professional practice*, there were two categories within the type of hospice worker that gave significantly different responses, namely, ENA and Nurse and ENA and Care Giver.

The responses of the different age groups were found to be significant for all sub-scales except for *spirituality for wellness* (Table 11). The Post hoc analysis showed that the “Age” variable produced significantly different responses only in the *spirituality and professional practice and spirituality and professional identity* subscales. For the Spirituality and Professional Practice, there were differences in responses in the 30-39 year group and the 40-49 year group. For *spirituality and professional identity*, differing responses were given by the 20-29 year group and 40-49 year group as well as the 30-39 year group and the 40-49 year group.

The “Years of Experience” variable failed to show any significant differences in responses to the items in the subscales *personal importance of spirituality* and *spirituality for wellness* (Table 11). Post hoc tests conducted on the remaining nine subscales showed that for each subscale there were differences between the 1-5 year group and the 6-10 year group as well as between the 6-10 year group and the >10 year group. Only the *integration of religion into*

professional practice subscale had differences between the 1-5 year group and the >10 year group.

The t-Test conducted on the 'Race' variable showed that there were differences in the responses given by Blacks and Whites for the subscales *personal importance of spirituality* and *integration of religion and professional practice*.

4.5 Summary

This study was conducted in various hospices in KwaZulu-Natal and these hospices were all faith based along the lines of Christianity. Although not a focus of this study, the demographic variables yielded some interesting results that demonstrated that there were differences in the responses of the participants in terms of category of health care worker, age, years of experience and age. Furthermore, study participants were aware that there were differences between spirituality and religion. However, the majority of respondents had difficulty differentiating between the two concepts. Religion was viewed as a structured system of beliefs that prescribed specific customs and values. In general, spirituality was seen as the worship of a supernatural being which gives inner peace and meaning to life. The respondents appear to endorse the idea that spirituality contains a strong existential component. Spiritual care on the other hand deals with their interactions with the patient where the patient is treated with dignity and respect. Study participants considered themselves to be spiritual and that spirituality was relevant in their personal lives. The respondents felt strongly that spirituality was important in health care circles. In considering health care workers perceptions of spirituality and spiritual care, religion could not be ignored because study participants interpreted religion and spirituality as closely tied concepts.

CHAPTER FIVE

Discussion

5.1 Introduction

In this chapter the results obtained from the semi-structured questionnaire, the Spirituality and Spiritual Care Rating Scale and the Spirituality and Religious Attitude Practice Scale are discussed. The aims of the study were to identify hospice workers understanding of the differences between spirituality and religion; their understanding of and attitudes towards the concepts of spirituality and spiritual care; the role spirituality plays in the health care workers' personal life and the importance of integrating it into their professional lives.

5.2 The Differences between Religion and Spirituality

In view of the fact that spirituality and religion are such interrelated concepts, a further exploration of these concepts was conducted using a questionnaire to test the respondents understanding of spirituality and religion. Although religion did not form the focus of this study, it was found to be an important component embedded within the understanding and perceptions of study participants since they used religion and spirituality interchangeably. The first aim of the study looked at the differences between spirituality and religion.

From the semi-structured questionnaire it was apparent that respondents realised that there is a fundamental difference between spirituality and religion but the concept of spirituality could not be clearly differentiated. The questions that probed the understanding of religion and spirituality revealed that many people regarded both of these concepts as synonymous. Although the vast majority of the answers in this study revealed that people recognised that there were some differences between spirituality and religion, most of the respondents could

not provide a coherent distinction between these concepts. A study conducted by McSherry et al. (2002) also found that spirituality is often mistaken for religion and a major problem in the investigation of spirituality and religion is that these two terms are elusive and often used interchangeably and this makes it hard to delineate. Plante and Sherman (2001) found that since religion was easier to define than spirituality, spirituality should be seen as a multifaceted, overlapping construct whose specific definition remains a subject of debate. This study showed that religion was seen as a construct within which health workers could operate whilst providing care for their patient.

Participants in this study viewed religion as a belief in a supernatural power/being and as very structured with rites and rituals. This is in line with literature reviewed by Plante and Sherman (2001) where researchers saw religion as involving a social institutional dimension which may include theological beliefs, practices, commitments and congregational activities of an organizational institution (Plante & Sherman, 2001). Pargament (1999) takes this one step further by stating that religion is a "process" (p.12). It has to do with building, changing and holding onto things that people care about in ways that are related to the sacred. What was viewed as sacred to the respondents in this study was a sense of belonging to a particular church or denomination. The majority of the interviewees were of the Christian faith and they saw religion as belonging to a particular church or denomination. At its inception over 20 years ago, the Hospice Movement was based on Christian philosophy (Saunders, 2000). Therefore it is not surprising that Christianity is the dominant faith among those that participated in the research. In the palliative setting it is easy to identify the important role that religion has on the execution of all professional duties (Saunders, 2000). The respondents also viewed religion as a structure within which one could operate and as such played a vital role in enhancing effective care.

From the definitions of spirituality, it appears that people were less confident of their understanding of spirituality than of religion. Participants were able to clearly define religion but found spirituality to be much more difficult to define. About half of the respondents defined spirituality as a feeling of closeness to God/power/creator. Therefore there is confusion from the respondents in the study in that there isn't any clear indication as to whether individuals linked their spirituality to their religious faith or whether spirituality was adapted as a broad concept. It may be premature to assume that spirituality has no meaning outside religious contexts, it follows a deeper path, incorporating a broader definition. However, some respondents in the study found spirituality to be linked to inner peace, as part of life experiences and something that gives meaning and purpose to life. Aldridge's (2001) notion of spirituality was characterized by the idea of transcendence but has a broader perspective than religion. Narayanasamy (1993) postulated that spirituality embraces the needs of the believers and the non-believers, therefore it is not confined within a religious context and Elkins et al. (1988) highlights the importance of spirituality as a "human phenomenon" (p. 8) that exists in all persons. From an African perspective, religion involves an existential experience of people, having no set religious scriptures or literature (Mbiti, 2001). Therefore all the above is in agreement with the hypothesis of Elkins et al. (1988) that "spirituality is a way of being and experiencing that comes through an awareness of a transcendental dimension characterised by identifiable values in regard to self, others nature, life and whatever others would consider as being the Ultimate" (p. 10). In this study individuals viewed spirituality as a relationship between the individual and a creator. Mahlangu and Uys (2004) saw spirituality as being important and as a unique quest for establishing or maintaining a dynamic transcendental relation with self, others and with God. Therefore within the South African context nurses need to be educated with regard to African

religions and spirituality so that they may be more professional in administering and incorporating it into their everyday practice.

5.3 Spirituality and Spiritual Care Rating Scale

5.3.1 The importance of spirituality

Spirituality as measured by McSherry et al. (2002) was found to be of importance in the personal life of the respondents and it was seen as a way of finding meaning in life as well as in obtaining inner peace. Spirituality seemed to be attached to a strong existential element. McSherry et al. (2002) found that nurses do perceive spirituality as a “force” which enables them to be at peace with themselves and the world. Mahlangu and Uys (2004) highlighted the importance of inner peace, hope, finding meaning and purpose in life, illness and death in the lives of nurses. The health workers in this study agreed that life should be filled with purpose and a sense of hope. The study further showed that the ‘White’ respondents attached greater importance to spirituality than the ‘Black’ respondents. This was interesting as Mbiti (2001) postulated that religion in Black (African) culture involves an existential spiritual experience, therefore ‘Black health workers’ may have incorporated spirituality through their daily practices as part of their daily routine. Whereas, the White respondents who were made up of mostly caregivers and senior staff members may have reached the stage where their own mortality has come to question and saw the value in spiritual care for themselves as well as for their patients (Foley, 2000). From the nursing theory perspective (Elkins et al., 1988) spirituality has been shown to have a positive effect in the personal lives of individuals by creating a “deep sense of belonging, of wholeness, of connectedness and of openness to the infinite” (p. 245).

5.3.2 Spiritual care

The findings with regards to attitude and perception of spiritual care showed that hospice workers attached a great deal of importance to spiritual care. They understood that it was important to develop a relationship with the patient by spending time with the patients whilst, at the same time, respecting the privacy and dignity of the patient. Norris et al. (2004) found that patients have spiritual needs but the practice of spiritual care by hospice workers is often infrequent and an underutilized facet of care. What was found to corroborate these findings was that respondent's typical daily activities included administration, home visits and physical care with counselling being given less of a priority. Nurses therefore may have limited time to attend to the spiritual needs of their patients. This identified a huge gap in the way that hospices operate since all the hospices that agreed to participate in this study were faith based and the staff and volunteers were expected to provide some form of spiritual care to the patients. Even though the hospice workers in this study supported the values of listening, spending time and respecting dignity and privacy, spiritual care was inevitably left to the religious leaders. Sloan et al. (1999) concluded that health care workers should not deal with the spiritual and religious aspects and that these issues should be left to chaplains and spiritual leaders. Dossey (1999) disagrees and states that health care workers can learn to deal with the spiritual and religious issues as delicately as chaplains and spiritual leaders. In earlier studies Millinson and Dudley (1992) found that spiritual care is too critical to be left to the clergy. More recently, Kei et al. (2003) highlighted the same sentiments in their study which stated that in order for existential suffering to be alleviated, an integrated system of care by an interdisciplinary team is necessary. Rumbold (2003) found that the aim was not to replace the clergy but for health care workers to form part of an auxiliary team. Perhaps the issue that this has highlighted is that the management of the hospices themselves are unaware of what spiritual care involves. South Africa at present is losing many of its nurses through

emigration for better job prospects and therefore there is a shortage of nursing staff (DENOSA, 2005). Time to spend with the patient is limited and it may seem an easier choice to leave spiritual care to the religious leaders. Furthermore, Narayansamy and Owen (2001) found that adopting spiritual care interventions promotes a sense of well being within health care workers as it plays a valuable part in total patient care. This study shows that nurses recognised the significance of their roles in providing 'spiritual care' to their patients but found that they are short staffed and consumed with secondary roles such as administration, home visits and physical care. What was problematic was a lack of time and resources. This was evident from the findings as there were differences between the roles of the ENAs and the caregivers. ENAs provided mainly for the physical needs of the patient whereas caregivers were able to be present for the patient and provide human contact.

5.3.3 Religiosity

Respondents in this study did not think of spirituality as a universal concept but as something strongly linked with religion, faith and forms of worship. Eventhough Plante and Sherman (2001) postulate that religion is easier to define than spirituality and that the latter should be seen as a multifaceted construct. The semi-structured interview schedule revealed similar findings; individuals looked at spirituality as a form of worship to God as well as a relationship between creator and creation. The findings for this scale did not support the theoretical reasoning that spirituality is universal in the sense that it can be applied to all, even atheists and agnostics (Burnard, 1988).

5.3.4 Personalised Care

The subscale *personalised care* attempted to investigate study participant's personal beliefs with regards to the provision of spiritual care to the patients. Once again respecting a

patient's privacy and dignity was seen as an important component of this subscale. Friendship and taking cognisance of patients' morals were seen as important components of personalised care. These findings have positive implications for the quality of health care provided in a hospice setting.

Narayanasamy and Owen (2001) found that patients' trust and faith in nurses produced a positive effect on everyone concerned. The health workers themselves derived satisfaction from the experience of giving spiritual care. A small number of respondents in this study found that if one could get beyond religion and look to spirituality they would be able to provide the same level of care to all persons. Taylor (2003) also identified that nursing approaches for spiritual care included kindness and respect, talking and listening, prayer, connecting with authenticity and mobilising religious and spiritual resources was important to working with terminally ill patients. What was found in the study was that there was a difference between ENAs and caregivers: ENAs were more experienced in giving care to the patient whereas caregivers were less experienced. It was further found that understanding the patients religion helps in the care given and it was shown that patients needed religious contact when terminally ill. However, Dom (2000) found that health care workers needed to avoid an ethnocentric view of care and step out of their frame of reference. Bash (2004) emphasised the importance of respecting a person's religious, spiritual and cultural needs. Respecting a patient's privacy and dignity was seen as important among the health workers in this study. Acknowledging and debating the challenge of spiritual care is arguably the first step towards optimally meeting the needs of patients, however, a dilemma arises as to how nurses who operate within a particular belief (example, Christianity) offer ideal spiritual care to patients who hold different beliefs. This study has shown that most of the respondents were of a Christian faith. This is an area of concern in that nurses may shy away from personalised

care for fear of their faith and beliefs being challenged, but Dom (2000) states that health care professionals owe it to their patients, especially those from non-Christian backgrounds to broaden their training by including multi-cultural/multi-religions philosophies and perspectives. Conner and Eller (2004) found that health care workers need to develop culturally appropriate spiritual nursing interventions. This would be imperative in a multi-cultural country such as South Africa.

5.4 Spirituality and Religious Attitude and Practice Scale

5.4.1 Spirituality in professional health work

From the analysis of the Spirituality and Religious Attitude and Practice Scale, it was evident that respondents felt that the spiritual aspects were more important than the religious aspects. The overall results for the subscale investigating the personal importance of spirituality showed that the respondents in general felt that spirituality was essential in their daily lives. However, the highly variable responses given may be attributed to the inability of some to differentiate spirituality from religion. Furthermore, the study participants recognised that their spiritual well-being was contingent upon their physical and mental health as well as their environment (community).

The integration of spirituality and professional practice, the need for education regarding spirituality, and the relationship between spirituality and professional identity were not seen as separate issues by the respondents in this investigation. Responses obtained showed that health care workers felt that integrating spirituality and professional practice was important, but felt they lacked the skills to do so. Miller-Brown's (2002) view is that spirituality is not learned from a book and acknowledges that spirituality permeates all aspects of life and is necessary to find meaning and peace. This goes against what the respondents in this study

claim as a debilitating factor. Mahlangu and Uys (2004) similarly state that African nurse's role is perceived and based upon the principles of "*ubuntu*". Yet many of the respondents' in this study felt ill-equipped to handle spiritual issues. However, the Post hoc test revealed that there is a difference between the nurse and caregiver. Mooney (2000) identified junior nurses as being ill-equipped and lack the confidence in their ability to address spiritual issues with their patients whereas Foley (2000) found that senior health workers have reached the stage where their own mortality has come to question and they are more equipped to handle issues of spirituality. The caregiver in this study were senior individuals therefore were more likely to be more equipped. This was also the case in this study where more experienced nurses saw the value of spiritual care. Foley's (2000) study found that women who described their health as good or excellent and had at least a college education had higher spirituality scores and made them more spiritually inclined.

While respondents in this study recognised the role of spirituality in the development of their professional identity, they were not comfortable in integrating the two as they lacked the training to help them achieve this. As such, the majority of respondents strongly supported the need for further training in integrating spirituality with their work in the hospice. The nurses interviewed expressed the need for formal education regarding spiritual issues. The implementation of spirituality within the nursing curriculum is a new development in colleges around the country (Health Sciences Curricula, 2005).

The vast majority of the participants had received little or no training in spirituality and spiritual care and it is obvious that there is a great need for educating hospice care workers in the interface of spirituality and therapy. Wasner, Longaker, Fegg and Borasio (2005) found in their study that the effects of spiritual care training had a positive influence on the spiritual

wellbeing and the attitudes of the participating palliative care professionals. Narayanasamy (2006) found the impact of empirical studies of spirituality and culture on nurse education positive. Upon evaluating the South African hospices' training curriculum's it was found that spirituality now forms an integral component in service delivery (Gwyther, 2002). Nursing colleges around the country are offering a spiritual component within their training programmes which has been endorsed by the South African Nursing Council (Fox et al, 2002)

The study participants felt that spirituality played a role in the development of their professional identity. To them it appeared that everything they did at the hospice was shaped by their spirituality when in fact their roles were shaped by their religious practices. Byrne (2002) found that the holistic approach to nursing care has recently shifted to the spiritual dimension of care. Byrne (2002) goes further to state that nurses require guidance and support as to whom they should provide spiritual care. Bassett (2002) found that health care workers need to ensure they provide their patients with what they want and not what the health care workers believe they want.

Research by Mallory (2003) showed that health care workers tend to struggle with negative personal issues and are therefore uncomfortable in providing spiritual care. The various reasons stated may be unresolved personal feelings of death and dying (Copp, 1997). Death according to Kuupelomaki (2000) awakens feelings of grief and anxiety, anger and guilt.

With the over 50's in this sample having the highest mean scores on personal importance of spirituality, Fulcher and Dunn's (2002) explanation that many new nurses may not have had the opportunity to reflect on their own history of loss and spirituality, rendering them vulnerable. Older hospice care workers are able to come to terms with their own spirituality

due to their life experiences. Elkins et al (1988) refers to this as an altruistic relationship; a sense of selflessness and empathy for others and Banks et al (1984) refers to this as a willingness to do more for others than for one's self. In support of the health care workers hesitation to render spiritual care and support, Long (1997) postulated that if nurses want to work holistically with their patients they need to have the ability to care for themselves emotionally, physically, mentally and spiritually before they attempt to care for others. Frohlich (1998) emphasised the importance of emotional and spiritual support for health care workers. Inadequate care for the carer can lead to the carer becoming exhausted and the burden of the carer can become too great. Therefore Harding and Higginson (2005) emphasised the importance of level of care and identified two levels, at the health care worker level and at the patient level.

5.4.2 Personal and professional importance of religion

Most of the interviewees recognised the importance of religion in their personal lives. Since all interviewees were from faith based organisations, it stands to reason that most people from these organisations would rate religion as highly important in their personal lives. The people interviewed recognised the importance of integrating religion and professional practice. Since all the hospices included in this study were faith based, the participants were aware of the desirability of integrating religion and religiously derived interventions into clinical practice. However, from their responses it appears as if they recognised the practical implications of integrating religion into their care of patients but were not quite sure how to go about doing so. Taylor (2003) highlighted the importance of quality temporal nursing care and mobilizing religious and/or spiritual resources for nurses working with terminally ill patients. However, there is a danger that nurses may become too ethnocentric in their dispensing of care to the patient. Fawcett and Noble's (2004) study on the perspective of the

Christian nurse and the potential tension between the nature of spiritual care and professionalism was explored and what was found was that nurses are challenged when confronted with patients with different religious beliefs. In this study it was shown that respondents saw religion as a barrier to effective care. Hospice workers found that they could discriminate against patients who were not of the same religion as them. It was also found that it may be difficult to respect the rights of a patient who comes from a different religious background and this can pose a challenge to them. Joseph (1986) found that integrating religion and religiously derived interventions into practice can cause discomfort when firmly held beliefs are challenged and people are forced to examine what they believe in and why they believe. There is likelihood that this can occur in South Africa.

5.5 Summary

The findings of this study show that hospice workers understood there is a fundamental difference between spirituality and religion but the concept of spirituality could not be clearly differentiated. Spirituality was seen as a universal concept but as something strongly linked with religion, faith and forms of worship. Religion was viewed as a belief in a supernatural power/being and it was very structured with rites and rituals. Therefore there is confusion from the respondents in the study in that there isn't any clear indication as to whether individuals linked their spirituality to their religious faith or whether spirituality was adapted as a broad concept. Spirituality was found to be of importance in the personal life of the respondents and the spiritual aspects were more important than the religious aspects. Hospice workers seemed to attach a great deal of importance to spiritual care and once again respecting a patient's privacy and dignity was seen as an important component in health care. Hospice workers felt that integrating spirituality and professional practice was important and spirituality played a vital role in the development of their professional identity. Those

interviewed recognised the importance of integrating religion and professional practice and since most of the interviewees were from faith based organisations, it stands to reason that most people from these organisations would rate religion as highly important in their personal lives.

CHAPTER SIX

Recommendations, Limitations and Conclusions

6.1 Recommendations

While researchers in the field of palliative care have studied spiritual/religious variables more than in other areas of medicine, studies in South Africa are lacking. Therefore, one of the recommendations for individuals working within the palliative care and hospice settings is that appropriate guidelines for spiritual care should be developed. It is critical that good research focusing on South African populations need to be conducted. Spirituality was seen as important for the hospice workers but they felt ill-equipped to handle spiritual issues therefore it is important they be trained appropriately to address spiritual concerns.

Effective training is central to good health care in any palliative care programme. Continuous training and education, especially in spirituality and spiritual care, is vital for successful implementation of a holistic care programme. What has been found within this study is the need for more effective training on issues of spirituality. The training that is provided is inadequate. Spirituality needs to become an important subject within the nursing curricula for nurses to use it openly and frequently.

A country such as South Africa needs to integrate cultural competency training and practices where health care workers' are able to care for their patients in a culturally sensitive and appropriate manner. Cultivating respect for their patients across cultural and racial lines is important in a palliative environment.

A model developed by Bennett (1986) that could be used for creating an awareness of the broad diversity of cultures within the South African context is Bennett's Intercultural Sensitivity Model. It is a six stage continuum of cultural development, the first stage *Denial of cultural differences* aims to promote recognition of the presence of diverse cultural differences within the individual's environment. The second stage, *Defence of one's own culture* aims to promote similarities between the different cultures and to recognise and appreciate differences. The third stage, *Minimisation of other cultures in order to protect one's own cultural identity* is for the individual to learn more about their own culture, in order to place it into the context of society. The fourth stage, *Cultural Acceptance* suggests that the individual should accept cultural issues and differences. The fifth stage, *Adaptation to Cultural Differences* the individual should be able to operate successfully within another culture. This is where the individual is armed with sufficient knowledge of their own and another culture. They are able to assess and evaluate behaviour. The final stage, *Integration of Full Cultural Awareness into everyday interactions*, the individual is able to move between the different cultures competently. They are able to draw on their cultural knowledge.

6.2 Limitations of the Study

The limitations of this study were:

- The size of the sample was too small to make any generalisations.
- The sample of each hospice was not representative of the hospices as not all individuals were willing to participate in the study.
- The majority of those that participated in this study were of the Christian faith which made it difficult to generalise how all health care workers (irrespective of what faith they were) incorporated spirituality and spiritual care into their professional and personal lives.

Notwithstanding the above limitations the present study offers useful insights into how health care workers view spirituality and spiritual care and the role that these factors play in both their personal and professional lives.

6.3 Conclusion

In conclusion, this study has revealed that nurses as well as care-givers understand there is a difference between spirituality and religiosity, however, the limitation they face on a daily basis is the lack of understanding as to what these concepts mean. This can only be rectified by ongoing training and guidance on spiritual teachings that go beyond the realm of religious affiliations. In the various hospices that participated in the study, there were professional nurses not willing to participate and upon further investigation it was found that of those that refused to participate were not of the dominant religion (Christianity). This lends speculation to the fact that some individuals are afraid to speak out on their personal spirituality which goes against the foundations upon which the hospice movement was primarily based. Therefore, limitation of this study is that it did not take into consideration those individuals who may have felt threatened if they spoke out on their personal beliefs. Training programmes will therefore need to consider the multicultural and multifaith communities that our nurses and patients embrace.

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APPENDIX 1a

To the Manager

Re: Hospice Workers Perception and Understanding of Spirituality and Spiritual Care

I am a Masters student at the University of KwaZulu-Natal specialising in Counselling Psychology. As part of our course work, we are required to submit a mini-dissertation that represents original research. As such I have decided to look at how spirituality influences the care given by hospice nurses. I have decided to target the nurses as much research has been carried out on the terminally ill patient. Nurses represent an understudied sector of the population yet they are called on to work in very stressful situations.

I am therefore requesting your permission to interview your nurses for the purposes of my study. I realise that after obtaining your institutional support for my study, I need to get the consent of the nurses to participate in the study. My study has been approved by the ethics committee at the University of KwaZulu-Natal. I could either interview the nurses directly or alternatively make available the questionnaires for self completion, as per your preference. Although there are three questionnaires 1(10 minutes), 2 (5 minutes) and 3 (15 minutes), the total time required from the nurses is 30 minutes.

I have attached my research proposal and an institutional consent form for your perusal and acceptance. I would be happy to answer any further questions that you may have. You could contact me on 0824328030, 031-4030339 after office hours or alternately via email at 205511488@ukzn.ac.za.

I would like to thank you for your time and look forward to hearing from you.

Kind regards,
Akashni Maharaj
School of Psychology
University of KwaZulu-Natal
Durban

APPENDIX 1b

University of Kwa-Zulu Natal
Howard College Campus
Private Bag X54001
Durban
4000

MINI DISSERTATION: Hospice Nurses Perceptions and Understanding of Spirituality and Spiritual Care.

TO WHOM IT MAY CONCERN

CONSENT TO PARTICIPATE IN RESEARCH

This is to request your permission to take part in this research so that we can evaluate hospice nurses perceptions of spirituality and spiritual care. This research is in partial fulfillment of a masters thesis in counselling psychology being currently completed by Akashni Maharaj at the University of Kwa-Zulu Natal. This research would be conducted by Akashni Maharaj and supervised by Mrs Cynthia Patel.

If you agree to participate in this study you will be allowing me access to your nursing staff both part and full time. They would be asked to fill in a questionnaire as well as a spirituality and spiritual care rating scale. The participation of your nurses is completely confidential and voluntary. Your nurses have the right to withdraw at any stage of the process. The results will be reported to you once they have been collated and this would give insight as to what role spirituality plays in the nurses everyday care of the sick and dying. Further information regarding the study can be obtained from Akashni Maharaj on 0824328030.

Signing your name means that you agree to participate in this study.

I,.....on behalf of the organization,
..... agree to participate in this study. I
understand that my nurses' participation is entirely voluntary and that he/she can withdraw at
any time.

Signature

Date



RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031-2603587
EMAIL: ximbap@ukzn.ac.za

27 JULY 2005

MRS. A MAHARAJ (205511488)
PSYCHOLOGY

Dear Mrs. Maharaj

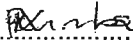
APPLICATION FOR ETHICAL CLEARANCE: "HOSPICE NURSES PERCEPTION OF SPIRITUALITY AND SPIRITUAL CARE"

Your application in connection with the above was recently considered by the Humanities and Social Sciences Ethics Committee and it has been decided to refer it back in view of the following:

1. Informed consent to be submitted in line with ethics guidelines (format attached)
2. Questionnaire to be provided
3. Indication on how confidentiality will be ensured

Kindly forward your response to the undersigned as soon as possible

Thank you


MS. PHUMELELE XIMBA
RESEARCH OFFICE

cc. Faculty Officer
→ cc. Supervisor (Cynthia Patel)

*I believe that this
research should now
be approved*



13/12/06

APPENDIX 3

SPIRITUALITY AND SPIRITUAL CARE RATING SCALE

SA = strongly agree
D = disagree

A = agree
SD = strongly disagree

N = neutral

	S A	A	N	D	SD
I believe nurses' can provide spiritual care by arranging a visit by the hospital chaplain or the patients' own religious leader if requested.					
I believe that nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care.					
I believe spirituality is concerned with the need to forgive and a need to be forgiven					
I believe spirituality involves only going to church/place of worship					
I believe spirituality is not concerned with a belief and faith in a God or supreme being.					
I believe spirituality Is about finding meaning in the good and bad events of life.					
I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need.					
I believe nurses can provide spiritual care by enabling a person to find meaning and a purpose in their illness.					
I believe spirituality Is about giving a sense of hope in life.					
I believe spirituality is to do with the way one conducts ones life here and now.					
I believe nurses can provide spiritual care by listening to and allowing patients' time to discuss and explore their fears, anxieties and troubles.					
I believe spirituality is a unifying force which enables one to be at peace with oneself and the world.					
I believe spirituality does not include areas such as art, creativity and self expression.					
I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient.					
I believe spirituality involves personal friendships/relationships.					
I believe spirituality does not apply to atheists or agnostics.					
I believe spirituality includes peoples morals.					

APPENDIX 4

SPIRITUALITY AND RELIGIOUS ATTITUDE PRACTICE SCALE

SA = strongly agree

A = agree

N = neutral

D = disagree

SD = strongly disagree

SECTION 1	S A	A	N	D	SD
I consider myself to be a spiritual person					
I regularly spend time getting in touch with my spirituality					
I find it impossible to conceive of myself as not being spiritual					
Spirituality is relevant in my personal life					
I meditate regularly					
I have had a spiritual crisis in my life					
SECTION 2					
There is a relationship between spiritual health and mental health					
There is a relationship between spiritual health and physical health					
There is a relationship between spiritual health and the health of the community					
SECTION 3					
It is appropriate to talk about spirituality in nursing circles					
It is necessary to work with a patients' spirituality if you expect to help them					
Every person has a spiritual dimension that should be considered in nursing practice					
Nurses should help each patient to find and develop his/her own spiritual "path"					
SECTION 4					
I want to learn more about integrating spirituality with assessment and interventions					
It is desirable for nurses to receive supervision and training in spiritual issues					
A course in spirituality should be offered as part of my nursing curriculum					
SECTION 5					
It is appropriate to talk about spirituality in nursing circles					
Nursing care is part of my spiritual development					
Spirituality is relevant in my professional life					
SECTION 6					
I find it impossible to conceive of myself as not being religious					

I consider myself to be a religious person					
Participation in an organised religion is the primary source of my spirituality					
I pray regularly					
SECTION 7	SA	A	N	D	SD
<p>When working with patients, it is appropriate for a nurse to:</p> <ul style="list-style-type: none"> • Ask patients about his or her religion • Recommend patients join a religion • Recommend patients leave a religion • Recommend participation in a religious programmes • Discuss my own religious beliefs • Talk with a patient about GOD • Help patients see that God can be viewed as being female as well as male • Use or recommend religious books • Use religious language or concepts 					

APPENDIX 5

QUESTIONNAIRE

Name:

Age:

Gender:

Race:

Religion:

Specialisation

Years of Experience:

Please answer all questions if possible.

1. How long have you been working as a hospice care nurse.?

2. Can you describe for me your work history?

3. Describe for me your typical day at the hospice?

4. What is the difference between religion and spirituality?

5. Have you found religion to enhance or to be a barrier to effective care?

6. Have you had any training in spiritual care?

