The Relationship of Nursing Students' Spiritual Care Perspectives to Their Expressions of Spiritual Empathy

Lisa Astalos Chism, DNP, APRN, BC; and Morris A. Magnan, PhD, RN

ABSTRACT

Guided by Chism's Middle-Range Theory of Spiritual Empathy, the overarching purpose of this study was to determine the extent to which nursing students' spiritual care perspectives account for their expressions of spiritual empathy. In this descriptive correlational study, spiritual care perspectives accounted for 8.6% of the variance in nursing students' (N = 223) expressions of spiritual empathy after controlling for relevant demographic and spirituality variables. Findings of the study suggest that the provision of spiritual care in nursing practice depends, in part, on nurses clarifying their own spiritual care perspectives.

Nurses have been interested in providing spiritual care to patients since the time of Nightingale (Macrae, 1995). In the past 2 decades, the attention given to spiritual care in the nursing literature has increased dramatically (Gray, 2006; Milligan, 2004). Current research supports that nurses have a high regard for spiritual care (Milligan, 2004; Taylor, Highfield, & Amenta, 1994). In addition, a small body of research suggests that having a positive attitude about spiritual care in nursing practice correlates highly with nurses' provision of spiritual care (Chan et al., 2006; Hall & Lanig, 1993; Stranahan, 2001). However, little attention has been given to understanding the extent to which nursing students' attitudes toward spiritual care influence their provision of specific forms of spiritual care.

In the context of the Middle-Range Theory of Spiritual Empathy (MTSE) (Chism, 2007), it has been asserted that nurses' expressions of *spiritual empathy*—verbally expressing one's understanding of a patient's spiritual concerns—is itself a form of spiritual care and an essential feature of nurse-patient interactions that facilitates the patient's movement toward experiences of spiritual well-being. According to the MTSE, the extent to which nurses express spiritual empathy depends, in part, on their own spiritual care perspectives (i.e., attitudes and beliefs). These spiritual care perspectives are believed to be influenced by the demographic and spirituality characteristics of nurses. Assertions made in the MTSE are speculative in nature and require empirical validation. Therefore, the twofold purpose of this exploratory, theory-driven inquiry was to determine to what extent nursing students' spiritual care perspectives account for their expressions of spiritual empathy, and to examine the relationship of demographic and spirituality characteristics to expressions of spiritual empathy. Having knowledge about the effect of nursing students' spiritual care perspectives on their expressions of spiritual empathy may help to determine the most effective pedagogical approaches for preparing nursing students to provide spiritual care to their patients.

Received: March 17, 2008
Accepted: August 29, 2008
Posted: July 30, 2009

Dr. Chism is Nurse Practitioner, Woodhaven, and Dr. Magnan is RN Care Manager, St. Joseph Mercy Oakland, Pontiac, Michigan. At the time this article was written, Dr. Magnan was Assistant Professor of Nursing at Oakland University, Rochester, Michigan.

The authors thank Dianne Norris, PhD, RN, Associate Dean of Academic Affairs, Oakland University, and Elizabeth Johnston Taylor, PhD, RN, Associate Professor, Loma Linda University, for the careful review and thoughtful contributions made to an earlier version of this manuscript. They also thank Andrea Rogers, MILS, Beaumont Hospitals, for her invaluable assistance in retrieving important literature.

Address correspondence to Lisa Astalos Chism, DNP, APRN, BC, Nurse Practitioner, Department of Internal Medicine, Beaumont Hospitals, Woodhaven, MI 48183; e-mail: lisachism@comcast.net.

doi:10.3928/01484834-20090716-05

LITERATURE REVIEW

Research supports that nurses consider the provision of spiritual care to be within the purview of nursing and a pertinent part of nursing care (Lundmark, 2006; Milligan, 2004; Stranahan, 2001; Taylor & Amenta, 1994; Taylor et al., 1994). Still, there is no uniform agreement about the meaning of spiritual care in the nursing literature. Although most nurse authors agree that the term *spiritual care* refers to behavior, there is neither agreement in the literature regarding what behaviors encompass spiritual care nor about the antecedents or consequences of spiritual care. Taylor, Amenta, and Highfield (1995) described spiritual care in nursing rather broadly as encompassing behaviors that attend to the promotion of health in response to stressors that may affect the spiritual perspectives of individuals. Thus, it seems reasonable to think that spiritual care in nursing encompasses a variety of diverse behaviors such as active listening, facilitating a trusting relationship, communicating acceptance, and connecting with patients (McEwen, 2005; Narayanasamy & Owens, 2001; Taylor et al., 1995; Treloar, 1999), as well as concrete religious practices such as prayer (Stiles, 1990). Taylor (2002) suggested that "symmetry" (p. 69) between nurses and patients is essential to the provision of spiritual care, whereas Stiles (1990) suggested that spiritual care cannot occur unless the nurse-patient relationship is "mutual and dialogic" (p. 235). Thus, although some authors have suggested that active listening, creating trust, connecting, and being present (Greenstreet, 1999; Stiles, 1990) are components of spiritual care, others believe these activities are antecedent features of nurse-patient relationships that are prerequisite to the provision of spiritual care (Milligan, 2004).

The provision of spiritual care occurs within the context of the nurse-patient relationship.

Despite a growing body of evidence that suggests spiritual care is important to nursing, nurses often fail to regularly provide spiritual care to their patients (Lundmark, 2006; Narayanasamy, 1993; Taylor et al., 1995). The reasons for this have not been fully elucidated. Confusion about the nurse's role versus the chaplain's role in providing spiritual care has been cited as one reason nurses fail to assess patients' spiritual needs (Narayanasamy, 1993; Treloar, 1999). Also, a small body of research has shown consistently that feeling unprepared to meet patients' spiritual needs acts as a barrier to the provision of spiritual care (Narayanasamy, 1993). In addition, lower levels of nursing education and nurses' feeling uncomfortable about providing spiritual care have been associated with the provision of less spiritual care (Taylor et al., 1995; Treloar, 1999).

Nurses' attitudes about spiritual care greatly influence their provision of spiritual care (Chan et al., 2006). Research suggests that nurses with more positive attitudes about spiritual care are more likely to provide spiritual care to their patients (Chan et al., 2006; Hall & Lanig, 1993; Stranahan, 2001). For example, Stranahan (2001) reported a moderately strong positive correlation ($r = 0.389$ to 0.595) between nurses' perceptions of spiritual care and their use of spiritual care practices such as encouraging prayer, praying with patients, and discussing spiritual topics with patients.

Research regarding nurses' attitudes about spiritual care in nursing has shown that nurses with higher levels of nursing education (Taylor & Amenta, 1994) as well as nurses with a higher personal sense of spiritual well-being (Hall & Lanig, 1993; Musgrave & McFarlane, 2004; Soeken & Carson, 1986; Stranahan, 2001; Taylor & Amenta, 1994; Taylor, Highfield, & Amenta, 1994) have more positive attitudes toward spiritual care. Consequently, enhancing nurses' personal sense of spiritual well-being often is cited as one way to promote more positive attitudes about spiritual care among nurses (Musgrave & McFarlane, 2004; Stranahan, 2001; Taylor & Amenta, 1994; Taylor, Highfield, & Amenta, 1999).

The provision of spiritual care occurs within the context of the nurse-patient relationship. Relationships in which there is a sense of connection between the nurse and the patient seem to be more conducive to the provision of spiritual care (Greenstreet, 1999; Stiles, 1990). It has been suggested that empathy (i.e., verbally expressing an understanding of the patient's concerns) helps promote a sense of connection between the nurse and the patient (Olson, 1995). Some authors suggested that empathy is the foundational element of the nurse-patient relationship (Bennett, 1995) that is necessary for caring, understanding interactions. Chism (2007) proposed that spiritual empathy is itself a form of spiritual care and the essential feature of nurse-patient interactions that facilitates the patient's movement toward experiences of spiritual well-being. According to Chism (2007), the extent to which nurses' express spiritual empathy depends, in part, on their own spiritual care perspectives; that is, the attitudes they have about spiritual care in nursing, which in turn, are affected by certain demographic (e.g., age, gender, education) and spirituality (e.g., religiosity, church attendance) characteristics. However, the data needed to support these assertions have yet to be produced. Therefore, the specific aims of this exploratory, theory-testing study were to:

- Explore the relationships among demographic variables, spiritual care perspectives, and expressions of spiritual empathy among nursing students (specific aim #1).
- Determine to what extent nursing students' spiritual care perspectives account for their expressions of spiritual empathy after controlling for relevant demographic characteristics (e.g., age, educational level, gender) (specific aim #2).

CONCEPTUAL FRAMEWORK

Chism's (2007) MTSE (**Figure**) provided the conceptual framework for this study. The MTSE consists of five concepts interrelated by four propositional statements (Chism, 2007). Concepts of the theory include nurses' perspectives of spiritual care, nurse-expressed spiritual empathy, patient-perceived empathy, patient distress, and spiritual well-being. Within the theory, nurse-expressed empathy is conceptualized as the core or foundational concept that stimulates movement toward the patient's experience of spiritual well-being. The nurse's spiritual care perspective influences activation of nurse-expressed spiritual empathy. Concepts of the MTSE are interrelated by four relational statements. The relational statements are:

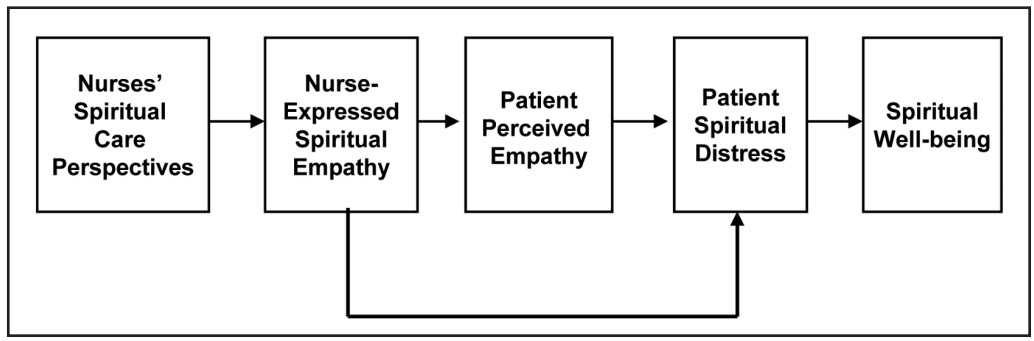


Figure. Chism's Middle-Range Theory of Spiritual Empathy.

- A patient's level of spiritual distress has a direct but inverse effect on his or her level of spiritual well-being.
- Nurse-expressed spiritual empathy as well as patient-perceived empathy are joint determinants of the level of patient spiritual distress experienced.
- Nurse-expressed spiritual empathy directly and positively affects patient-perceived empathy.
- The nurse's own spiritual care perspectives directly affect the quality and quantity of nurse-expressed spiritual empathy.

The MTSE is speculative in nature and in need of empirical validation through theory-testing research. Theory-testing research involves testing propositions derived from the relational statements of the theory. This study examined the validity of the relational statement that nurses' perspectives of spiritual care influence nurses' expressions of spiritual empathy. Chism (2007) defined nurses' perspective of spiritual care as the attitudes and beliefs nurses have regarding spiritual care in nursing, whereas nurses' expressions of spiritual empathy was defined as the nurses' verbal expression of understanding of the patient's spiritual concerns. Having a positive attitude about spiritual care in nursing is presumed to be a necessary, but not a sufficient, condition for expressing spiritual empathy.

METHOD

Design

A descriptive correlational design was used to explore the relationships among demographic variables, spiritual care perspectives, and expressions of spiritual empathy. The correlational aspect of the design was a good choice because the central area of concern for this study was to determine whether the empirical data support the theoretical proposition that relates nurses' spiritual care perspectives to expressions of spiritual empathy.

Sample and Setting

The target population for this study was undergraduate-level and graduate-level nursing students. The accessible population included undergraduate and graduate level nursing students at a midwestern university. Inclusion criteria were age 18 or older and enrollment in the university's school of nursing.

Sample Size and Power

Correlation and hierarchical linear regression were the critical analyses used to evaluate the relationship of nursing students' spiritual care perspective to their expressions of spiritual empathy. With alpha set at 0.05 and power at 0.80, a sample of 129 participants was needed to detect a significant small to moderate correlation ($r = 0.25$). Similarly, with alpha set at 0.05 and power set at 0.80, a minimum sample size of 223 participants was needed to detect a small to medium effect ($f^2 = 0.05$) using a hierarchical regression model with six predictors.

Sampling Plan

A nonprobability convenience sample of university-level nursing students ($N = 223$) was used for this study. Students were recruited and data were collected during regularly scheduled class sessions. Nursing faculty were contacted in advance to obtain permission to visit classes in session and to coordinate dates for data collection. All nursing students attending class on the targeted data collection days were given an opportunity to participate in the study. A recruitment script, read by the principal investigator (L.A.C.), was used to introduce the study to potential respondents and invite participation.

Instrumentation

Data for this study were collected using three paper-and-pencil tools: the Spiritual Care Perspectives Scale (SCPS) (Taylor, 2006), the Expression of Spiritual Empathy Scales (ESES 1 and ESES 2), and a demographic worksheet. The concept, nurses' perspectives of spiritual care (NPSC), was theoretically defined as the attitudes and beliefs nurses have regarding spiritual care in nursing.

TABLE 1

Characteristics of the Sample (*N* = 223)

Characteristic	*n* (%)
Gender	
Female	192 (86%)
Male	31 (14%)
Ethnicity[a]	
White	183 (82%)
African American	13 (6%)
Hispanic/Latino	1 (0.4%)
Asian American	13 (6%)
Native American	1 (0.4%)
Hawaiian/Pacific Islanders	3 (1.3%)
Other	7 (3%)
Education prior to nursing program[a]	
Associate	18 (8%)
Bachelor	36 (16%)
Master	26 (12%)
Doctorate	1 (0.4%)
Current degree program	
Traditional bachelor	166 (74%)
Second degree	37 (17%)
Doctor of Nursing Practice	20 (9%)

[a] *Not all participants provided ethnicity or college education level.*

Empirically, NPSC was the score obtained on the Spiritual Care Perspectives Scale (SCPS). The SCPS elicits self-reports about nurses' attitudes, beliefs, comfort, and confidence related to the provision of spiritual care in nursing practice. The SCPS is a 12-item Likert-type questionnaire that uses a 5-point response format. Respondents provide self-reports of their level of agreement (1 = *strongly agree*; 5 = *strongly disagree*) with each of the stated items. Some of the items are reverse coded. A total score is obtained by summing scores across all items. The theoretical range of possible scores is 12 to 60. Written permission to use the SCPS was obtained from its author, Dr. Elizabeth Johnston Taylor. In past studies involving RNs, internal consistency reliability was good (Cronbach's alpha = 0.82). In the current study, internal consistency reliability was equally good, with a Cronbach's alpha of 0.80.

The concept, nurses' expressions of spiritual empathy (NESE) was theoretically defined as the nurse's verbal expression of understanding the patient's spiritual concerns. Empirically, NESE was the score obtained on the Expression of Spiritual Empathy Scale 3 (ESES 3). The ESES 3 is comprised of two components Expression of Spiritual Empathy 1 (ESES 1) and Expression of Spiritual Empathy 2 (ESES 2). ESES 1 and ESES 2 are author-developed single-item scales designed to elicit self-reports regarding the frequency (0% to 100%) of enacting spiritual empathy in clinical practice when an opportunity presents itself. The ESES 1 provides a self-reported measure regarding what percentage of time (0% to 100%) nurses have expressed empathy when given the opportunity during the past 6 months. ESES 2 elicits self-reported estimates of the projected percentage of time (0% to 100%) nurses anticipate expressing spiritual empathy during the next 1-month period. The scores on ESES 1 and ESES 2 were summed to obtain an expression of spiritual empathy total score (ESES 3). Internal consistency reliability of the ESES 3 was modest (Cronbach's alpha = 0.66) but acceptable for a two-item instrument.

Finally, a demographic sheet was used to elicit demographic information such as age, gender, and educational level. In addition, respondents were asked to provide information about prior spiritual training, having a religious affiliation, church attendance, and considering oneself spiritual.

Data Collection Procedure

This study was approved by the internal review board of the university. Data for the study were collected at the time of recruitment during regularly scheduled nursing class sessions. The date and time of data collection were determined in collaboration with the faculty of record for each course. To ensure a timely return of survey questionnaires and to minimize interference with day-to-day operations, recruitment of participants and data collection occurred sequentially at the end-of-class sessions. The principal investigator provided potential participants with a research packet containing an information sheet, two consent forms (one for the investigator and one for potential participants to keep), a demographic sheet, the SCPS survey, the ESES 1 and ESES 2, and a blank envelope. Participants were instructed to complete the questionnaires onsite and then seal them, whether completed or not, in the envelope provided before returning them to the principal investigator. Because all students returned questionnaires, anonymity was preserved and neither the investigator nor the instructor knew which students actually completed questionnaires. Confidentiality was maintained by separating signed consents from the data collection sheets.

Data Analysis

Data were analyzed using SPSS version 15.0 software. Planned analyses were organized according the specific aims of the study. The focus for specific aim #1 was on exploring the relationships among demographic variables, spiritual care perspectives, and expression of spiritual empathy. Zero order Pearson product-moment correlations were used to examine these relationships. In addition, analysis of variance (ANOVA) was used to compare mean scores on the spiritual care perspectives scale and

expressions of spiritual empathy scales across degree groups (traditional, second degree, Doctor of Nursing Practice [DNP]). With regard to specific aim #2, hierarchical regression analyses were conducted to determine the extent to which nursing students' spiritual care perspectives accounted for their expressions of spiritual empathy after controlling for relevant demographic and spiritual background variables.

To ensure that assumptions underlying inferential statistics were met the following procedures were used. First, data were cleaned. Then, initial screening of variables was undertaken to ensure normality of the distribution of interval level variables. Next, specific assumptions underlying inferential statistics were evaluated. Bivariate scatter plots were used to evaluate the assumption of linearity underlying correlation analyses. Nonsignificance of Levene's statistic as well as knowledge of the normality of the distribution of relevant variables provided assurance that the assumption of homogeneity of variance was met before proceeding with ANOVA. Standardized residuals scatter plots were examined to ensure that assumptions related to normality, linearity, homoscedasticity, and independence of residuals were met before conducting hierarchical regression analyses. Power for all statistical tests was set at alpha = 0.05.

TABLE 2

Spiritual Characteristics of the Sample

Characteristic	Total (N = 223)	Traditional Degree (n = 166)	Second Degree (n = 37)	DNP Degree[a] (n = 20)
Consider oneself spiritual				
No	16 (7%)	12 (7%)	4 (11%)	0 (0%)
Somewhat	110 (49%)	88 (53%)	14 (38%)	8 (40%)
Yes	96 (43%)	66 (40%)	19 (51%)	11 (55%)
Spiritual training				
No	195 (87%)	148 (89%)	31 (84%)	16 (80%)
Yes	28 (13%)	18 (11%)	6 (16%)	4 (20%)
Religious affiliation				
No	33 (15%)	23 (14%)	8 (22%)	2 (10%)
Yes	190 (85%)	143 (86%)	29 (78%)	16 (80%)

[a] *Not all DNP students provided information for "Consider oneself spiritual" or "Religious affiliation."*

RESULTS

Characteristics of the sample can be found in **Table 1**. The sample (N = 223) was comprised of both female (n = 192; 86%) and male (n = 31; 14%) nursing students. The educational background of the participants included students with associate (8%), bachelor (16%), and master's (12%) degrees. Most participants (74%) were enrolled in the traditional baccalaureate nursing program. Others were enrolled in the accelerated second-degree program (17%) or the DNP program (9%). Age range for the entire sample was 19 to 57 years (mean age = 27, SD = 9). ANOVA showed statistically significant between group differences in age (F[2,221] = 162, $p < 0.001$). Post hoc analyses using a Bonferroni correction (alpha = 0.01) showed that traditional degree students were significantly ($p < 0.001$) younger (range = 19 to 45 years, mean age = 23 years, SD = 5.0) than both the second degree (range = 24 to 57 years, mean age = 35 years, SD = 8) and DNP students (range = 30 to 54 years, mean age = 46 years, SD = 8), and second-degree students were significantly ($p < 0.001$) younger than DNP students.

Regarding spirituality, the majority (87%) of the participants denied receiving any spiritual training. Most participants indicated that they had a religious affiliation (85%). Approximately 90% of the sample indicated that they felt they were either *somewhat* or *very* spiritual individuals. **Table 2** presents spiritual characteristics of the sample organized by degree groups.

Specific Aim #1

The focus of specific aim #1 was on exploring relationships among demographic variables, spiritual care perspectives, and levels of spiritual empathy reported by nursing students. As shown in **Table 3**, "considering oneself spiritual" correlated most highly with SCPS scores (r = 0.457, $p \leqslant 0.001$). Also, "church attendance," "gender" (being female), and "religious affiliation" correlated significantly with SCPS scores, but the magnitudes of these correlations were small (r = 0.24, 0.26, and –0.19, respectively; $p < .001$ for all). The variables of "age," "spiritual training," and "level of education" did not correlate significantly with SCPS scores.

An examination of the correlations (**Table 3**) of demographic variables to the expression of spiritual empathy scores (ESES 1, 2, and 3) showed that "considering oneself spiritual" and "spiritual training" had small but significant correlations (r = –0.22 to 0.22, $p < 0.001$) with ESES scores. The correlations of "age," "gender," and "degree group" (r = 0.16, 0.15, and 0.13, respectively; $p < 0.05$ for all) to ESES 3 scores were small but significant. "Religious affiliation" and "church attendance" did not correlate significantly with ESES 3 scores.

TABLE 3

Pearson Product-Moment Correlations among Study Variables

Study Variables	1	2	3	4	5	6	7	8	9	10	11
Total score for SCPS		0.016	0.258**	0.457**	–0.040	–0.199**	0.247**	–0.031	0.328**	0.350**	0.371**
Age			–0.110	–0.146*	–0.115	0.140*	–0.014	0.772*	0.134*	0.147*	0.162*
Gender				0.216**	0.122	–0.198**	0.068	0.055	0 .101	0.184**	0.154*
Consider oneself spiritual					–0.109	–0.308**	0.483**	0.117	0.190**	0.219**	0.222**
Spiritual training						0.005	–0.217**	–0.092	–0.231**	0.159*	0.217**
Religious affiliation							–0.288**	0.012	–0.063	–0.002	–0.040
Yearly church attendance								0.034	0.068	0.137*	0.109
Degree group									0.128	0.103	0.138*
ESES 1										0.660**	0.927**
ESES 2											0.894**
ESES 3											

Note. SCPS = Spiritual Care Perspectives Scale; ESES = Expression of Spiritual Empathy Scale.
*p < *0.05.*
**p < *0.01.*

Specific Aim #2

The focus for specific aim #2 was on determining the extent to which nursing students' spiritual care perspectives influenced their expression of spiritual empathy after controlling for relevant demographic variables. To address this question, hierarchical regression analysis was performed (**Table 4**). The order of entry for the six predictors was based on the logic of entering nonmodifiable demographic characteristics first, spirituality background variables second, and spiritual care perspective scores last. Thus, the background variables of "age," "gender," and "degree group" entered the regression model first and accounted for 6.4% of the variance in expression of spiritual empathy, although degree group did not contribute significantly to variance in expression of spiritual empathy. At step two, spirituality variables of "consider oneself spiritual" and "spiritual training" entered the regression model and accounted for another 6% of the variance in expression of spiritual empathy. Spiritual care perspective entered the regression model at the final step and accounted for an additional 8.6% of the variance in expression of spiritual empathy above and beyond what was already accounted for by the background variables and the spirituality variables. Overall, the total variance in expression of spiritual empathy accounted for was 21%. Of note, spiritual care perspective uniquely accounted for 8.6% of the variance in expression of spiritual empathy which represents 41% of the total variance accounted for in expression of spiritual empathy. In addition, an evaluation of the standardized betas suggests that spiritual care perspective ($\beta = 0.337$) was the best predictor of expressions of spiritual empathy.

STUDY LIMITATIONS

Findings of this study need to be interpreted with caution due to several important limitations. Of importance, the reader needs to be aware that using a nonprobability convenience sample of university-level nursing students limits generalizability of the findings to other samples and settings. Although this threat to external validity is recognized as an important limitation of the study, it is likely to be of lesser importance in a theory-test study than threats related to construct validity. For example, using only one instrument to measure each construct may have underrepresented dimensions of constructs, thereby lowering construct validity. In addition, the concept *expression of spiritual empathy* was measured by combining scores obtained on the ESES 1 and ESES 2 scales to obtain an ESES 3 score. The ESES 1 and ESES 2 are single-item scales that cannot be tested for reliability. Therefore, it is not clearly established that these scales accurately measured the outcome, expression of spiritual empathy. Although it is noted that these validity threats are present, it is also recognized that in the early phase of theory-testing research, lesser degrees of precision in measurement might be tolerated to determine whether empirical findings support the purported theoretical relationships. Clearly, further inquiry using more robust measures of concepts is warranted.

DISCUSSION

Three factors ("church attendance," "gender," and "religious affiliation") showed small but significant cor-

TABLE 4

Hierarchical Regression Analysis for Variables Predicting Expression of Spiritual Empathy

Variable	Beta	β	*t*	R^2	R^2 Delta	*F*	*p*
Step 1							
Age	1.43	0.240	2.30				0.022
Gender	29.19	0.186	2.74				0.007
Degree group	–4.72	–0.053	–0.511				Not significant
				0.064	0.064	4.91	0.003
Step 2							
Consider oneself spiritual	13.00	0.146	2.16				0.032
Spiritual training	–30.94	–0.186	–2.84				0.005
				0.124	0.060	6.03	<0.001
Step 3							
Spiritual care perspective total score	2.70	0.337	4.81	0.210	0.086	9.49	<0.001

relations with nursing students' attitudes about spiritual care. A fourth factor, "considering oneself spiritual" showed a moderately strong positive relationship with nursing students' attitudes about spiritual care. Other researchers have identified "considering oneself spiritual" as a strong predicator of positive attitudes about spiritual care (Musgrave & McFarlane, 2004; Taylor & Amenta, 1994; Taylor et al., 1994, 1999). Although it is somewhat reassuring to see that findings of this study concur with findings of other studies, it seems prudent to consider that none of the four factors (church attendance, gender, religious affiliation, and considering oneself spiritual) is modifiable. Therefore, further work is needed to identify and describe a set of modifiable predictors that, if manipulated through education or training, might lead to more positive attitudes about spiritual care with subsequent increases in the provision of spiritual empathy. Others have reported that spiritual care education is a moderate predictor of positive attitudes about spiritual care (Musgrave & McFarlane, 2004; Taylor & Amenta, 1994; Taylor et al., 1994). Although spiritual care education often is identified as influencing attitudes about spiritual care, the explicit focus of spiritual care educational programs is rarely specified. In addition, without knowing what variables actually predict positive changes in spiritual care attitudes, it seems that the effect of spiritual care educational program on nurses' spiritual care attitudes could be uncertain.

It is also important to note that the effect of spiritual care attitudes on the expression of spiritual empathy was modest (8.6% of the variance accounted for). This suggests that other, as yet unidentified, factors influence nursing students' expressions of spiritual empathy. Identifying additional factors, besides spiritual care perspectives, that predict expressions of spiritual empathy might help nurse educators understand more fully how to activate this important caring process.

As predicted by the MTSE, spiritual care perspectives accounted for a significant amount of variance in expressions of spiritual empathy. No other studies have examined the effect of spiritual care perspectives on nursing students' expressions of spiritual empathy. However, others have reported significant relationships between nurse's attitudes about spiritual care and their spiritual care practices (Chan et al., 2006). Chan et al. reported a strong positive association between nurses' perceptions of spiritual care and spiritual care practices. These investigators identified "explore spiritual needs with patients" (Chan et al., 2006, p. 144) as a spiritual care practice which is somewhat more global than previously identified practices which included active listening and prayer (Hall & Lanig, 1993). Similarly, Stranahan (2001) reported significant positive relationships between attitudes about spirituality and spiritual care practices (such as praying with patients). Interestingly, Stranahan found the strongest relationship to be between attitudes about spirituality and the spiritual care behavior "talked with my patient about a spiritual or religious topic" (p. 98). Collectively, these findings suggest that positive attitudes about spiritual care influence nurses' provision of various kinds of spiritual care.

IMPLICATIONS FOR NURSING EDUCATION

The findings from this study have implications for nursing education, nursing practice, and nursing science. The literature regarding nurses' provision of spiritual care repeatedly calls for increased education about spiritual care (Narayanasamy, 1993; Taylor et al., 1995; Taylor et al., 1994), but the focus for these educational programs is rarely made explicit. Findings from this study suggest that educational programs that help nursing students examine their own attitudes and beliefs about spiritual care are warranted. In addition,

pedagogical approaches to promoting positive spiritual care perspectives among nursing students need to be explored. Unless nursing students can be taught how to get in touch with and clarify their own spiritual care perspectives and adopt positive attitudes about spiritual care, it seems unlikely that they will provide empathetic spiritual care to their patients.

From a nursing practice viewpoint, knowledge gained from this study makes it clear that nurses' spiritual care perspectives—attitudes and beliefs about spiritual care—influence their expressions of spiritual empathy. Nurses can use this information to reflect on their own attitudes toward spiritual care and determine how their attitudes about spiritual care affect their daily practice and the quality of spiritual care delivered (or not delivered). In addition, nurses might benefit from knowing that, in theory (MTSE), spiritual empathy—the simple verbal expression of understanding a patient's spiritual concerns—is itself a form of spiritual care and a necessary step in promoting the spiritual well-being of their patients.

Finally, the study of spiritual care in nursing has been predominantly atheoretical with greater attention given to process and less attention given to outcome. Developing knowledge that focuses on nursing-sensitive outcomes, such as spiritual well-being, will help advance nursing as a unique discipline and science. The MTSE links process (i.e., expression of spiritual empathy) to outcome (i.e., spiritual well-being of the patient). Further research testing this discipline-specific theory is needed to help bridge the gap between theory and practice.

It should be noted that the MTSE is still in its early stages of development and testing. Although concepts of the theory have been defined, robust empirical measures for MTSE theoretical concepts have yet to be developed. Thus, garnering additional support for the empirical adequacy of the MTSE will depend, in part, on the quality of the instruments developed to measure MTSE concepts. In addition, the small amount of variance accounted for in the expression of spiritual empathy suggests that other important predictors of the expression of spiritual empathy need to be identified. Others have noted the importance of using qualitative research to discover rich, new information regarding a phenomenon of interest (Vishnevsky & Beanlands, 2004). Tripp-Reimer and Doebbeling (2004) suggested that qualitative approaches are particularly important because they:

> highlight the human dimension in health care by foregrounding the perceptions, experiences, and behaviors of both consumers and providers of care. (p. S65)

Additional research using qualitative methodologies might further our theory development efforts by providing information needed to develop more robust measures of concepts (and dimensions of concepts) and by revealing other important predictors of the expression spiritual empathy.

CONCLUSION

The purpose of this theory-driven study was to test the validity of the relational statement that nurses' spiritual care perspectives influence their expressions of spiritual empathy. An important finding of this study is that as predicted by theory (MTSE), nursing students' attitudes about spiritual care (i.e., their spiritual care perspectives) accounted for a modest but significant amount of variance in their expression of spiritual empathy. This finding provides limited, but early support for the empirical adequacy of one segment of the MTSE. Further empirical work is needed to determine whether the theoretical proposition that nurses' own spiritual care perspectives directly affect the quality and quantity of nurse-expressed spiritual empathy is upheld when tested under different circumstances with diverse samples in different settings (e.g., RNs working in acute care, chronic care, and hospice), as well as using more robust measures of theoretical concepts.

REFERENCES

Bennett, J.A. (1995). "Methodological notes on empathy": Further considerations. *Advances in Nursing Science, 18*(1), 36-50.

Chan, M.F., Chung, L.Y., Lee, A.S., Wong, W.K., Lee, G.S., Lau, C.Y., et al. (2006). Investigating spiritual care perceptions and practice patterns in Hong Kong nurses: Results of a cluster analysis. *Nurse Education Today, 26,* 139-150.

Chism, L. (2007). *Spiritual empathy: A model for spiritual well-being*. Unpublished doctoral dissertation, Oakland University, Rochester, MI.

Gray, J. (2006). Measuring spirituality: Conceptual and methodological considerations. *The Journal of Theory Construction & Testing, 10*(2), 58-64.

Greenstreet, W.M. (1999). Teaching spirituality in nursing: A literature review. *Nurse Education Today, 19,* 649-658.

Hall, C., & Lanig, H. (1993). Spiritual care behaviors as reported by Christian nurses. *Western Journal of Nursing Research, 15,* 730-741.

Lundmark, M. (2006). Attitudes to spiritual care among nursing staff in a Swedish oncology clinic. *Journal of Clinical Nursing, 15,* 863-874.

Macrae, J. (1995). Nightingale's spiritual philosophy and its significance for modern nursing. *Image: the Journal of Nursing Scholarship, 27,* 8-10.

McEwen, M. (2005). Spiritual nursing care: State of the art. *Holistic Nursing Practice, 19,* 161-167.

Milligan, S. (2004). Perceptions of spiritual care among nurses undertaking postregistration education. *International Journal of Palliative Nursing, 10,* 162-171.

Musgrave, C.F., & McFarlane, E.A. (2004). Israeli oncology nurses' religiosity, spiritual well-being, and attitudes toward spiritual care: A path analysis. *Oncology Nursing Forum, 31,* 321-327.

Narayanasamy, A. (1993). Nurses' awareness and educational preparation in meeting their patients' spiritual needs. *Nurse Education Today, 13,* 196-201.

Narayanasamy, A., & Owens, J. (2001). A critical incident study of nurses' responses to the spiritual needs of their patients. *Journal of Advanced Nursing, 33,* 446-455.

Olson, J.K. (1995). Relationship between nurse-expressed empathy, patient-perceived empathy, and patient distress. *Image: Journal of Nursing Scholarship, 27,* 317-322.

Soeken, K.L., & Carson, V.J. (1986). Study measures nurses' attitudes about providing spiritual care. *Health Progress, 67*(3), 52-55.

Stiles, M. (1990). The shining stranger. Nurse-family spiritual relationship. *Cancer Nursing, 13,* 235-245.

Stranahan, S. (2001). Spiritual perception, attitudes about spiritual care, and spiritual care practices among nurse practitioners. *Western Journal of Nursing Research, 23,* 90-104.

Taylor, E. (2002). *Spiritual care: Nursing theory, research, and practice.* Upper Saddle River, NJ: Prentice-Hall.

Taylor, E. (2006). *Spiritual care perspectives scale (SCPS)—Revised (Description and development of SCPS).* Unpublished manuscript, Loma Linda University, Loma Linda, CA.

Taylor, E., Amenta, M., & Highfield, M. (1995). Spiritual care practices of oncology nurses. *Oncology Nursing Forum, 22,* 31-39.

Taylor, E.J., & Amenta, M. (1994). Midwifery to the soul while the body dies: Spiritual care among hospice nurses. *The American Journal of Hospice and Palliative Care, 11,* 28-35.

Taylor, E.J., Highfield, M., & Amenta, M. (1994). Attitudes and beliefs regarding spiritual care. A survey of cancer nurses. *Cancer Nursing, 17,* 479-487.

Taylor, E.J., Highfield, M.F., & Amenta, M. (1999). Predictors of oncology and hospice nurses' spiritual care perspectives and practices. *Applied Nursing Research, 12,* 30-37.

Treloar, L. (1999). Spiritual care. Assessment & intervention. *Journal of Christian Nursing, 16,* 15-18.

Tripp-Reimer, T., & Doebbeling, B. (2004). Qualitative perspectives in translational research. *Worldviews on Evidenced Based Nursing, 1*(Suppl. 1), S65-S72.

Vishnevsky, T., & Beanlands, H. (2004). Qualitative research. *Nephrology Nursing Journal, 31,* 234-238.

Stay up to date

The *Journal of Gerontological Nursing,* the only monthly publication in the field, provides a forum for all aspects of gerontological nursing with clinically relevant original articles. The Continuing Nursing Education Quiz and special sections on geropharmacology, dementia, clinical concepts, legal issues, public policy, and technology innovations provide a total guide to the field in a full-color magazine format.

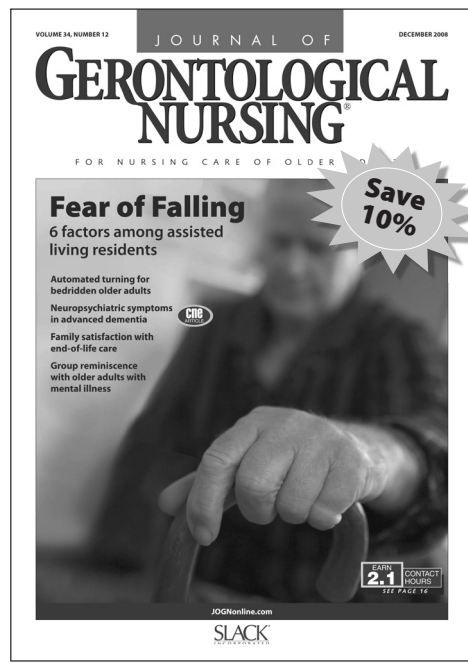
Subscribe today and Save 10% off your print subscription

For Individuals – Only $80*
For Institutions – Only $265!*

Institutions: upgrade to electronic access – contact us directly at customerservice@slackinc.com or contact your preferred subscription agent.
*Pricing reflects discount

Visit: www.jognonline.com

SLACK Incorporated
Health Care Books and Journals
6900 Grove Road
Thorofare, NJ 08086
Call: 800-257-8290 or 856-848-1000, Fax: 856-848-6091
Email: customerservice@slackinc.com



Editor: Kathleen C. Buckwalter, RN, PhD, FAAN
ISSN #0098-9134

CODE: 2J245

Copyright of Journal of Nursing Education is the property of SLACK Incorporated and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.