12-1993

Spirituality Among Terminally Ill Hospitalized Adults and Healthy Non-Hospitalized Adults in a Military Environment

Richard M. Holt
Incarnate Word College

SPIRITUALITY AMONG TERMINALLY ILL HOSPITALIZED ADULTS AND HEALTHY NON-HOSPITALIZED ADULTS IN A MILITARY ENVIRONMENT

A Thesis

by

RICHARD M. HOLT, R.N., B.S.N.

Presented to the Graduate Faculty of
Incarnate Word College
in Partial Fulfillment
of the Requirements
for the Degree of

MASTER OF SCIENCE
IN NURSING

December 1993

SPIRITUALITY AMONG TERMINALLY ILL

HOSPITALIZED ADULTS AND HEALTHY

NON-HOSPITALIZED ADULTS

IN A MILITARY ENVIRONMENT

A Thesis

by

RICHARD M. HOLT

APPROVED:

Brenda S. Jackson

Brenda S. Jackson, Ph.D., R.N.
Chairman of Committee

Regina C Aune

Regina Aune, Ph.D., R.N., Member

Barbara Herlihy

Barbara Herlihy, Ph.D., R.N., Member

Dedication

This thesis is dedicated to God, my father. To my loving wife and son, Yolonde and Richard. Their support, encouragement, patience, and sacrifice were my source of strength during this program. Thank you.

ACKNOWLEDGMENTS

I wish to express my sincere thanks the following individuals who have made this moment possible: Linda Steele, Ph.D., RN., Colonel (Ret) Margaret P. Nelson, USAF, NC, Colonel (Ret) Patricia Nelms, USAF, NC, and the professors of Department of Nursing Science of Incarnate Word College. If it were not for their encouragement and support this day would not be possible. I would like to give a special thanks to Lieutenant Colonel Patricia C. Ravella, Ph.D., R.N. for her editing assistance and behind the scenes support.

RMH

December 1993

ABSTRACT

Spirituality Among Terminally Ill
Hospitalized Adults and Healthy
Non-Hospitalized Adults
in a Military Environment

Richard Martin Holt, R.N., B.S.N. Incarnate Word College

The purpose of this study was to identify whether or not terminally ill hospitalized adults indicated greater spirituality and well-being than healthy non-hospitalized adults. Reed's (1986b & 1987) studies are the bases for this treaty although this is not a replicate study. The conceptual framework of this research is founded on the developmental life-span, and energy field patterns (Rogers, 1980) impacting spirituality and well-being. It was hypothesized that terminally ill hospitalized adults indicate greater spirituality than healthy non-hospitalized adults in a military environment. A terminally ill and healthy adult group of N=30, (n=15 each) were selected for a convenience sample. Four key variables: age, gender, education, and religious preference were investigated. All 30 participants completed two questionnaires: the Spiritual Perspective Scale and the Index of Well Being. A t-test of differences between the group means did not support the hypothesis $t = .13$, $p < .90$. The Pearson r coefficient product determined the relationship between spirituality and well-being. The SPS on the IWB was moderately positive between the two groups, but did not reach a statistically significant difference $(r = .33, p < .08)$. Spirituality, although salient, is not as "transcendent" as it is perceived in this and other studies. There are areas that can be expressed and measured despite the dimensions of spirituality that are inexpressible. Spirituality and well-being are two inseparable entities in the healing process, and their impact on individuals' experiencing a terminal event can create energy field and environmental changes.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ILLUSTRATIONS

Figure Page

CHAPTER 1

INTRODUCTION

Human beings in their effort to understand the interaction between "self" and the universe, must face many unwanted challenges. In the developmental life-span the ultimate challenge to one's self, which cannot be eluded, is death. Death is a natural process and is something that is inevitable. However, the actual dying process or terminal event does not come easy. This is especially true in a society which idealizes health and beauty; aging and illness are appalling and repugnant.

In an era of rapidly advancing technology there is greater propensity to focus on regeneration and restoration of human life to its youthfulness rather than understanding the nature and process of death and dying. Often, much of our effort centers on transforming the old to the new, yet failing to understand the transformation that takes place as one grows older. Growing older is a growth process; more importantly it is a developmental process of the adult life-span.

In a study on developmental life-span, Reed (1986a), stipulated that "facing a limited life-span often is a difficult human experience. This fact is well documented

in Feifel, 1974; Peteet, 1979; Plumb & Holland, 1981 in research on anxiety, fear, and depression related to life threatening illness and dying". More significantly, dying can also be regarded as the most complex and differentiated phase of life by transcending human phenomenon associated with the end of life. Individuals faced with a devastating illness, such as terminal cancer, are transformed. This transformation is a process unique to that individual which requires more than meeting the biological needs but the spiritual needs as well.

Spirituality is positing a valued place as a potential resource for nurse clinicians who seek to gain a better understanding of the importance of incorporating the spiritual needs of the patient in their daily care. When assessing the patient's overall health status, it becomes extremely crucial that the spiritual dimension be included in the health care assessment. The spiritual dimension is a vital force which penetrates the very fabric and core of human spirituality, thus becoming an intricate part of humanness. Stiles (1990) found that "the spiritual dimension of nursing is 'being with' rather than 'doing to' patients and families. The spiritual relationship is being fully present to patients

and families as well as providing knowledgeable and skilled nursing care." Miller (1985) made clear the importance of meeting the spiritual needs of patients by citing research by Banks, 1980 & Moberg, 1979 into the health and spiritual dimension; and spiritual well-being:

> The spiritual core transcends man's humanness, provides meaning in living, and enables persons to have faith and perceptions that move beyond the natural and rational (Banks, 1980). Because the spiritual is interwoven with all aspects of life, the totality of human needs cannot be met without attention to spiritual well-being (Moberg, 1979).

PURPOSE

This research study focuses on spirituality among terminally ill hospitalized adults and healthy non-hospitalized adults in a military environment. The primary purpose is to examine the spirituality and well being of terminally ill hospitalized adults to determine whether or not they show more spirituality than healthy non-hospitalized adults. This research examines and compares terminally ill and healthy adults as they explore their differences in religiousness (Reed, 1986b).

The potential significance of spirituality including the clinical assessment of incorporating the spiritual needs of terminally ill adults into nursing practice is yet to be determined. Assessing the need for spirituality of the terminally ill adult implies healing (whether biological and/or spiritual), a methodology essential in the therapeutic process and general well being of the patient.

STATEMENT OF THE PROBLEM

This research addresses the following question: what differences exist in spirituality among terminally ill hospitalized adults compared with healthy non-hospitalized adults? Inquiry into the previous studies done by Reed (1986b, 1987) on the significance of spirituality among terminally ill adults implies that spirituality is salient and transcendent of all human experiences; nevertheless, more research is required in this area.

In order to gain insight into spirituality, nursing must become cognizant of the effects spirituality has on enhancing human wholeness during illness (Reed, 1991). Therefore, this research seeks to understand the spiritual needs of terminally ill persons residing in a

different geographical region of the country and in a different culture.

The importance of this study is further supported by the result of a comprehensive literature review. Reed (1987) states that more studies support the evidence of spirituality as significant to humans, especially, to those that are terminally ill or dying, because it serves as a resource for them. Consistent with Reed's (1991) study there is insufficient research conducted on spirituality from an applied perspective of patient needs for nursing intervention. Results of studies suggest that nurses' methods of intervening vary in their effectiveness. Miller (1985) believes that further research is required on spiritual well-being as a tool for patient coping strategies. Before nurses can incorporate dimensions of spirituality into nursing education programs, they must attain a better understanding about how to enhance this construct through research.

HYPOTHESIS

The hypothesis presented is terminally ill hospitalized adults indicate greater spiritual perspective than healthy non-hospitalized adults in a

military environment. The null-hypothesis will state there is no difference in spirituality between terminally ill hospitalized adults and healthy non-hospitalized adults in a military environment.

Reed's (1987) study included a third group of non-terminally hospitalized adults in order to measure a broader segment of the adult population. The Index of Well-Being (IWB) and other information were incorporated to test participants' satisfaction with life as it was currently experienced. The Index of Well-Being is used in this study; however, this study will not look at the non-terminally ill hospitalized group.

ASSUMPTIONS

There are many assumptions that could be directed toward terminally ill patients and healthy adults, some of which are:

1. Terminally ill patients are in the acceptance phase of dying.

2. Dying, like other developmental phases of life, is accompanied by increased spirituality.

3. Terminally ill patients will ask for assistance in dealing with spirituality and coping with their fate.

4. The terminal patient will fear isolation or avoidance by others.

5. The healthy group has no chronic or serious illness.

LIMITATIONS

The limitations of this study are listed below:

1. Significant number of subjects who are unable to complete the study because of their disease state.

2. Death occurring before the study is complete.

3. Insufficient number of subjects that meet criteria of study.

4. Subjects withdraw from study prior to completion.

DEFINITIONS

For the purpose of this study, the following terms are traditionally defined according to the ambiance of the community:

Spirituality:

" . . . the quality of those forces which activate us, or are the essential principle influencing us. Spiritual, although it might, does not necessarily mean

religious; it also includes the psychological. The spiritual is opposed to the biological and mechanical, whose laws it may modify" (Vaillot, 1970, p. 30).

Webster's Third New International Dictionary (Grove, 1986), defines spirituality as ". . . something that in ecclesiastical law belongs to the church or to a person as an ecclesiastic or to religion."

Emblen's (1992) concept or definition of spirituality is " . . . referred to a dynamic, principle, or an aspect of the person that related to God or god, other person, or aspects of personal being or material nature" (p. 43).

Burkhardt (1989) addresses the many definitions of "spirituality" as an integrated force or dynamic principle that combines all human manifestations, however, knowledge and understanding of the concept as a basis for research and its essence for discipline has yet to emanate.

Spiritual dimension: Murray & Zentner's (1985) description is quite vivid:

". . . a quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning, and purpose, even in those who do not believe in any god. The spiritual dimension tries to be

in harmony with the universe, strives for answers about the infinite..." (p. 474).

Transcendence: Lane (1987) defines ". . . as the ability of the human spirit to step beyond who and what we are" (p. 333).

OPERATIONAL DEFINITIONS

Terminally ill - patients diagnosed with a terminal disease (presumed incurable) with a life expectancy of six months to one year.

Healthy non-hospitalized adults - individuals not currently hospitalized, have not been hospitalized within the past year, who perceive themselves without chronic or serious illness, and are not under the supervision of a physician. In a state of general good health both physically and mentally.

Spirituality - the ability to transcend self in search of a higher plane, supreme being or God.

Transcendence - beyond who and what we are in this physical state. Touching on thoughts unexplainable.

CHAPTER 2

LITERATURE REVIEW

The philosophy of nursing characteristically emphasizes the whole person concept as a holism which seeks to understand the physical, emotional, psychosocial, and spiritual needs of the patient. However, Rogers' (1970) definition of the whole person concept describes "man as a unified whole possessing his own integrity and manifesting characteristics that are more than the sum of his parts." This would be more relevant as a basis for this philosophical treaty because it takes us further into the reality of true human spirituality.

Reed (1991) perceives "there is a growing body of basic nursing research into the underlying processes and correlates of spirituality." She continues, "the scant amount of empirical work into spirituality related to nursing interventions is rivaled by substantial clinical knowledge on the topic" (p. 123). Looking retrospectively over the last fifteen years, nursing has become more attuned to incorporating the spiritual needs of the patient into the theoretical framework of nursing practice. Recognizing the need for a nursing diagnosis, "Spiritual Distress," Kim, McFarland, & McLane (1987)

based the assumption that humans introspectively possess a bonding to a higher level of experience or spiritual orientation, which can be sifted through and unsettled during times of crisis. This process reprioritizes the basic needs of the individual.

In nursing practice, meeting the spiritual needs of the patient is nothing new. However, pioneers (Dickerson, 1975; & Stoll, 1979) researching spirituality early in their writings attempted to establish ways to assess the spiritual meaning and the spiritual needs of the patient. Each looked for ways to define spirituality and how it related to patient care outcome. Reed (1991) commented that the framework for spiritual care of patients involves integrating religious and psychosocial behaviors. Lane (1987) identified the needs of the human spirit as introspective of the patient, always laboring to find meaning, surrendering to change, desiring and executing commitments. According to Stoll (1979) "crisis situations, whether they be loss, illness or hospitalization, bring one face-to-face with the ultimate issues of life--the limitations of one's humanness, the loss of personal and environmental control, and the meaning of pain and suffering in the overall purpose of life" (p. 1575).

The findings of initial research into the significance of spirituality among terminally ill hospitalized adults are becoming a more actively committed issue in the clinical arena as well as in the developmental life-span theory. In recent studies, researchers have observed spirituality among certain groups to be more intense during certain critical events in life. Nelson (1989) alluded to variations in ethnic differences, both intrinsic/extrinsic according to religious orientation, that could intensify critical events in ones life. Again, these findings require more research data to substantiate what has been identified.

CHAPTER 3

THEORETICAL/CONCEPTUAL FRAMEWORK

Defining the concept of spirituality is not easy. For years nurses have defined spirituality on the basis of religious needs (including worship and practice perspectives). Emblen (1992) believed that in doing so "nurses may omit care for patients' transcendent and relational needs--needs that emerge from the struggle with survival issues of meaning and hope; thus, omission of spiritual care may occur not because a nurse lacks interest, but rather because the nurse defines spiritual care narrowly" (p. 41). Taking a model view of development and late-life potential, Chinen (1984) defines "transcendence phenomenologically (transcendence awareness) as experiences which exhibit two features - a sense of mystery and 'beyondness'" (p. 50). This transcendent state can be summed up in one clear statement described by O'Malley (1989), "deeper than those nature-hungers is a far subtler call like the one Augustine heard, to reach beyond the limits of time and space: 'Our hearts are restless till they rest in Thee'" (p. 343).

Lane's (1987) article "the care of the human spirit" boldly recaptures the essence and the goals of nursing by looking at three distinct ways of providing spiritual care:

- look at the nature and activities of the human spirit
- understand ways to support the human spirit
- for those (nurses) who have a sense of vocation, how that sense of vocation can deepen and broaden the patient's spiritual care

The founding of a new journal, Christian Nursing, demonstrates a renewed interest in those areas. What was once a part of the heritage of nursing (spiritual dimension) somehow was lost in the age of advancing technology. Nursing's goal is to recapture the vocational aspects of spirituality. Lane (1987) distinguishes nursing's goal as a domain, "health" oriented, with care of the human spirit or spiritual care once again becoming a major emphasis or focal point in nursing practice. The same thought is presented by Rogers (1970) but in a more conjectural fashion where the goals of nursing are defined as:

> "Professional practice in which nursing seeks to promote symphonic interaction between man and environment, to strengthen the conference and integrity of the human field, and to direct and redirect patterning of the human and environment fields for realization of maximum health potential" (p. 122).

This is evident in the nurse/patient relationship which seeks understanding into what spirituality is and its place in nursing practice. As we gain insight into Rogers' concept of "accelerated change" we may better comprehend what is taking place. Wilson & Fitzpatrick (1984) take the Rogerian theory of "accelerated change" and look at several key points in how the human-environment correlates with energy fields:

> As an open system, humans and environment are in continuous interaction, mutually changing each other. In open systems, there are certain elements that are uniquely human including feelings, reason, decision making or choice, and goal setting. These changes are manifestations of the whole and emerge from the human-environment with creative and innovative, continuous, nonlinear, and rhythmical interactions (p.25).

Humans are social creatures by nature. Few can transcend the need for social interaction, therefore, many are bound by this state. In times of need we tend to gravitate toward others to achieve spiritual and religious goals (Hubert, 1963). Often, this human experience is not expressed openly because of labels attached, especially in a contemporary society. This places the nurse in an excellent, but often precarious position of using that "sixth sense" or hunch to explore the nature of the individual present. Exploring the spiritual needs of the patient often comes during the later part of the assessment process. This is due to the relationship that must develop in order to gain trust. The development of a bond between the nurse and patient may take hours, days, or perhaps it may never occur.

In Rogers' conceptual system, energy fields play a key role in understanding man and the universe. An energy field is interpreted as a fundamental unit of the universe, an open system, ever changing, and can therefore be identified as an evolutionary unit. The energy field of man is what makes him different from his environment. Therefore, nursing care of the terminally ill is an energy field, revealing patterns that may implicate the process of energy exchange between persons

and the environment. For example, care givers and receivers tend to expend a great deal of energy between environments. This is observed on many nursing care units where patients, because of their illness, absorb quantities of energy from the nursing staff (entropy). As a result of the energy deficit, nurses leave their work place exhausted and drained.

It is true that other environmental fields can cause energy field deficits with both patient and nurse. On the other hand, patients' energy fields can be absorbed by nurses in order to repattern themselves (negentropy). There is a continuous exchange of energy flowing between the patient and nurse. The spirit of the patient continues to reach out or "pray" for healing even though the body is too ill to consciously seek that healing. This becomes evident in the nurse/patient relationship as it seeks understanding into what spirituality is and its place in nursing practice.

During time of illness, unitary human beings have a greater tendency for healing because they are an open system to environment. Rogers theorizes that man's interaction with the environment is continuous and mutually changing with each other. These changes take place as a result of human-environment interaction which

are creative and innovative, continuous, nonlinear, and rhythmical (Rogers, 1980).

Assessing the spiritual needs of the terminally ill patients and understanding one's own spirituality lays the foundation for environmental growth and change, a change towards healing. In selecting Rogers' theory of "unitary human beings" it provides an openness in which to build and interact with other theorist on aging and developmental process. Human beings, as open systems during times of extreme illness, are likened to fertile ground waiting to be seeded.

Continued research into spirituality in terminally ill adults is warranted as described. Whereas, nursing from an historical perspective has always acknowledged the importance of spiritual dimension of patient care, the need remains for further solid empirical support so that the spiritual needs of the patient are incorporated into nursing practice.

Rogers' and health and life-span development models formed the theoretical bases for this research. In the life-span development process terminally ill persons, in their capacity to transcend human phenomenon associated with the end of life, particularly during the last phase of life, acquire perceptions that may be spiritual or

transcendent. Reed (1987) asserts that "as a developmental phase, dying can be distinguished from other life phases by certain characteristics. Spirituality is postulated as one characteristic particularly salient during the dying phase" (p. 335).

Reed (1986b) cites Piaget's 1972 findings which asserts that "during development, movement from concrete to abstract thinking occurs; individuals become less bound by their immediate context and use conceptual symbols rather than physical objects to perceive life" (p. 35). Adults have the ability to transcend beyond the physical, and thus are able to extract meaning from experiences whether stressful or conversed experiences (Chinen, 1984). This transcendent state occurs with maturation which may develop to help the individual cope with the physical and perceptual losses of dying (Reed, 1986b).

"Conceptualization of spirituality is relevant in later developmental phases of life and other times of increased awareness of mortality" (Reed, 1991). The concept is congruent with the desired definition because it looks at the developmental phases that accompany certain characteristic changes associated with increased spirituality and dying. The theoretical perspective of

"life-span theories of adult social-cognitive and personality development" (Reed, 1991) indicates a tendency in later life for a spiritual or transcendent perspective of reality. Compatibility of previous research methods is evident in a combined cross-sectional study with longitudinal strategies. There is valid evidence of significant changes theorized as a person moves across the health-life and death-dying continuum. This phenomenon measured by the author is dynamic as described in the developmental changes that take place as one's perception about distance of self from death, and how important spirituality is in the advancing age of life. As an individual grows older one becomes more aware of the finality of life and how limited one is in controlling that life. Based on the work by Neugarten (1979) "mid-life crisis" and the shift in time perspective from that of "time-lived-since-birth" to "time-left-until-death" is a significant experience of middle adulthood (Reed, 1986b). In the course of daily living, from middle to older adulthood, one's perception about one's health in relationship to events can affect the perception of one's life span. Thus, as a person grows older, there are indicators of potential developmental changes in adulthood (Reed, 1991).

Theorists are redefining the concept of religiousness and spirituality within the context of patient care. With the elderly population rapidly becoming a majority in the United States, meeting the spiritual needs of the patient and family is becoming a vital issue in nursing practice. Therefore much is to be gained by studying the aging process, and the phenomenon of human experience in relationship to spirituality and dying. The phenomenon of human experience is considered to be observable, verifiable, objective, and significant by others. Although nursing has for many years acknowledged the importance of the spiritual dimensions of patient care, nursing is now applying spirituality to its practice.

The conceptual dimensions of Reed's (1987) study are addressed which could not be ruled out as "transcendent," but may at least in part, be expressed and measured. The results of this study have given a better understanding of the human response toward spirituality of the terminally ill. This could be a key factor associated with the dimensions of human experience in the last years of life-that religion be relevant, and an available self-care strategy during the close of life.

CHAPTER 4

METHODOLOGY

DATA COLLECTION:

This study added to the findings by other researchers supporting their views that spirituality is a potential variable in the dying process. A cross-sectional, descriptive design was implemented for this quantitative investigation. There are no significant confounding variables identified within the study. Each patient was interviewed by the researcher and permission was obtained prior to carrying out the study. Records were reviewed with confidentiality and patients' rights were maintained at all times. The questionnaires were given to subjects in Group I by the investigator. Subjects were instructed to either hand them back upon completion or forward them by mail. The questionnaires were presented to Group II for completion and picked up on the next day.

SAMPLING

Reed (1987) studied three adult groups of 100 each matched on age, gender, education, and religious

background from the same geographical location in the Southeastern United States. This study examined a convenience sample of two groups of 15 adults looking at key variables: gender, age, ethnicity, religious background, and education. They were categorized according to the following criteria: Group I, healthy non-hospitalized persons, and Group II, terminally ill hospitalized adults who are aware of their terminal illness. To gain more insight into terminally ill individuals, the terminally ill group was restricted to the inpatient units as opposed to ambulatory outpatient unit. To define hospitalization, all hospitalized individuals must have been admitted one full day and night prior to the study.

A nonprobalility sample of N=30 subjects was approached for inclusion in this study. Group II (n=15) participants were hospitalized for the occurrence or recurrence of incurable cancer. Family members assisted the patient in completing the questionnaires as required. This may produce an error in sampling, but if the patient was too ill or incapable of writing, a family member was able to provide information regarding the patient's routine activities. If a patient was to die during the interview or study, selections would be considered a

factor in sampling error. Nonprobalility sampling elements were selected by non-random methods. Group I participants were relatively healthy and free of any serious illness, and were selected from the base shopping mall and work settings of the military environment. All participants were mentally alert and literate in English.

Protection of human subjects was insured. Permission to conduct the study was obtained by the Institutional Review Board of Incarnate Word College and Wilford Hall USAF Medical Center, San Antonio, TX. In addition, permission to use the Spiritual Perspective Scale (SPS) and Index of Well Being (IWB) were obtained from the authors.

INSTRUMENTS

The Spiritual Perspective Scale (SPS) was designed to measure the behavioral and belief response of individuals regarding their perceptions of spirituality. The instrument was found to be congruent with studies by Reed and others. Sodestrom and Martinson (1987) found that "patients use spiritual beliefs and practices as coping mechanisms to obtain peace, strength, or direction in the stressful situations their illness creates" (p 41).

in the stressful situations their illness creates" (p 41).

The Spiritual perspective scale (SPS), previously known as the Religious Perspective Scale (RPS) (Reed, 1986b), was developed to provide measurement of the saliency of spiritual views in a participant's life. In the initial study it was designed to scale the religious beliefs and behaviors that existed in each group. Participants were directed to respond to the items as they related to their perception of what religion meant to them personally.

The instrument was adapted from King and Hunt's (1975) Dimension of Religiosity Scale (DRS) (pp. 13-23). King and Hunt's scale was revised to develop the RPS which was a 13-item instrument to measure belief and behavior associated with the personal and organizational form of religiousness. The instrument was shortened from a 13-item scale to a 10-item scale. The 10-item SPS measurement looked closely at perceptions held by the participants who had certain spiritual views and engaged in related spiritual interactions. "The instrument is based on a conceptualization of spirituality as a human experience particularly relevant in later developmental

phases of life and other times of increased awareness of mortality (Reed, 1991)."

The author administered the SPS using the questionnaire format. Response to each question is quite easy (10-item) using a Likert type scale of 1 to 6. Descriptive words parallel each number presented. Examples of the items are:

A. How often do you share with others the problems and joys of living according to your spiritual beliefs?

1. Not at all
2. Less than once a year
3. About once a year
4. About once a month
5. About once a week
6. About once a day

B. How often do you read spiritually-related material?

1. Not at all
2. Less than once a year
3. About once a year
4. About once a month
5. About once a week
6. About once a day

The SPS is scored by calculating the arithmetic mean across all items. Possible scores range from 1 to 6,

with 6 indicating greater spiritual perspective (Reed, 1986b).

PSYCHOMETRIC PROPERTIES

The reliability and validity of the SPS instrument was addressed in previous research studies on terminally ill and healthy adults (Reed, 1986b, 1987). Throughout each study, the instrument showed consistency with each variable. It was initially tested on over 400 adults of various age groups, including healthy, seriously ill, and hospitalized terminally ill individuals. Reliability, estimated by Cronbach alpha, was consistently above *.90* in both initial studies. In inter-item correlation, no item fell below *.41;* the average inter-correlation ranged from *.54-.60.* However, all item scale correlation were above *.60.*

The SPS demonstrates two types of validity, criterion-related and discriminate validity (Reed, 1986b, 1987). Criterion-related validity is defined by Polit & Hungler (1991) as "the degree to which scores on an instrument are correlated with some external criterion, and discriminate validity is an approach to construct validation that involves assessing the degree to which a single method of measuring two constructs yielding different results" (pp. 642 & 644). Within the context

of research methodology, Reed's study maintains its construct validity found in the sample of women and lower socioeconomic groups who tend to score higher on the SPS, as they have on similar instruments; and participants who identify no religious background score significantly lower than those who did identify a religious background (Reed, 1991).

The psychometric properties of the Spiritual Perspective Scale were acceptable according to the literature review. Information regarding other researchers' usage of the instruments could not be obtained at this time; however, Reed does allude to the fact that confirmation of the instrument's usage is reliable and valid. The SPS continues to be used on large samples successfully in a variety of adult populations by Reed. No test-retest of the instrument was documented. Participants from the same geographical location (Southeastern United States) were divided into three groups; each were matched on four variables that may influence spiritual perspective: age, gender, years of education, and religious background.

Each study presented by the author demonstrated there is consistency. The scores across the board were homogeneous (Cochran C $(3,99)=.35$, $p = .88$).

Distributions of scores were similar and nearly normal across all groups, but were slightly positively skewed. As stated earlier, the reliability estimated by Cronback's alpha was rated consistently at *.90* and above with little redundancy. The average inter-item correlation ranged from *.54-.60* across the adult group. There were no subscales defined within the tool itself.

Reed's adoption of the SPS has proven to be quite a readable tool for the population intended. Answering the questionnaire took some time for participants who were terminally ill. However, the author supported those who were unable to write because of their disease process and condition of health at the time and conducted an interview. There was little likelihood that the instrument could be misinterpreted; it is clear and concise.

The Index of Well Being (IWB) was used to measure patient satisfaction with life as it is experienced. The IWB was constructed by Campbell, Converse, and Rodgers (1976) who claimed that the index taps both cognitive and affective dimensions of general well-being. The instrument consists of nine items; the first eight are in the form of semantic differentials and the last is a rating of overall life satisfaction.

Reliability and validity of the IWB have been examined in previous research on samples of 2160 (Campbell et al, 1976) and 114 (Reed, 1986b). Alpha coefficients were above *.89* and item-scale correlation were *.67* and above; no item fell below. Concurrent validity has also been estimated to be moderate by a Pearson correlation of *.35* found between well-being and two variables, self-esteem and self-competence (Campbell et al, 1976).

Responses to the nine items are on a 6-point Likert-type scale with 6 indicating the greatest life satisfaction.

Example of the items are:

1. My present life is:

Rewarding _ _ _ _ _ _ Disappointing
1 2 3 4 5 6

2. My present life is:

Discouraging _ _ _ _ _ _ Hopeful
1 2 3 4 5 6

The IWB is scored as a weighted sum of two scores: a) the score on the overall life satisfaction item weighted 1.1, and b) the mean score of the eight semantic differentials, weighted *1.0*. Potential score range from *2.1 to 12.6*.

In addendum to these instruments, Reed added two additional items to elicit other data. A perceived health rating from 1 for poor health to 5 for excellent health was used to validate the participants' understanding of their health status. The second, open-ended question about changes, if any, that had occurred in spiritual views during recent months or years was attached to the SPS.

DATA ANALYSIS

Data analysis of this research focused on convenience sampling, because subjects selected for this study were readily available. The research design for this proposal looked at the correlation or comparison of spirituality among terminally ill hospitalized with non-hospitalized healthy adults. A T-test was used to study the differences between the two independent groups, the SPS and IWB scores. The proposed sample size provides a power of *.80* to statistically detect a difference between groups of 1 Standard Deviation (SD) or more. The level of significance used in the research to avoid a Type II error is $r = .40$, $p < .05$. $N = 30$, $n = 15$ terminally ill hospitalized adult, and $n = 15$ healthy non-hospitalized adults.

CHAPTER 5

ANALYSIS OF DATA

This chapter will report the results of the study on spirituality among terminally ill hospitalized adults vs healthy non-hospitalized adults in a military environment. This convenience sample consisted of *N=30, n=15* terminally ill adult patients and *n=15* healthy adults.

DEMOGRAPHICS

The mean age for Group I (healthy adults) was *46.53(SD = 16.38,* range *18* to *78* years), and for Group II (terminally ill adults) the mean age was *51.20(SD = 16.99,* range from *19* to *75* years). Seven men *(46.7%)* and 8 *(53.3%)* women comprised the healthy adult group. The terminally ill adult group had *12* men *(80.0%)* and *3* women *(20.0%)* see Table 1.

Table 1. STATUS

t-test for independent samples: STATUS

GROUP 1 - Status EQ Healthy
GROUP 2 - Status EQ Terminal

Variable		# of Cases	Mean	Standard Deviation	p-value
Age	Group 1	15	46.53	16.38	.45
	Group 2	15	51.20	16.99	
Ed	Group 1	15	15.77	3.23	.02*
	Group 2	15	13.50	1.66	
SPS	Group 1	15	48.47	9.96	.90
	Group 2	15	48.00	10.45	
IWB	Group 1	15	4.63	.39	.17
	Group 2	15	4.95	.80	

* $p < .05$

Fifty-three percent of the participants in the healthy group reported a Protestant background, whereas *46.7%* were Catholic. In the terminally ill group *73.3%* were Protestants, *20.0%* Catholic, and *6.7%* identified themselves as other see Table 2. The ethnicity of the participants in both groups included white *(73.3%)*, blacks *(16.7%)*, Hispanic *(3.3%)* and other *(6.7%)*. None of the reported demographic differences were statistically significant.

Table 2. ETHNICITY

Status by Ethnic

	Ethnic				
Count / Row Pct	White 1.00	Black 2.00	Hispan 3.00	Other 4.00	Row Total
Healthy 1	10	4	1		15
	66.7	26.7	6.7		50.0
Terminal 2	12	1		2	15
	80.0	6.7		13.3	50.0
Column Total	22	5	1	2	30.0
	73.3	16.7	3.3	6.7	100.0

Table 3. RELIGION

Status by Relig Count Row Pct	Prot	Cath	Other	Row Total
Status Healthy 1	8 53.3	7 46.7		15 50.0
Terminal 2	11 73.3	3 20.0	1 6.7	15 50.0
Column Total	19 63.3	10 33.3	1 3.3	30 100.0

Educationally the two groups showed a statistically significant difference with a $t = 2.42$, $p < .02$. In the sample study Group I, healthy adults had a higher education level than those in Group II. Group I ranged from *12* to *21.5* years, mean score *15.77(SD = 3.234)*. For Group II, the years ranged from *11* to *18*, mean score *13.5(SD = 1.658)* see Table 1. One subject in the terminally ill adult group did not finish formal high school but did complete a graduate equivalent course. The data collected did not show any degree of significance between the educational levels of the two groups.

DATA COLLECTION

Data collection occurred from May through July of 1993 with the two sample groups. This study had *N=30* participants; *n=15* comprised in Group I (healthy non-hospitalized adults) and *n=15* comprised Group II (terminally ill hospitalized adults). The process of data collection ensured the protection of human rights of each individual participating in the study (i.e., informed consent, anonymity, and confidentiality). The investigator explained to the participants that this study focused on: spirituality and wellness of healthy adults, (Group I) of a military population; and spirituality of terminally ill hospitalized adults experiencing a critical event in their lives (Group II). (Note, the investigator was not allowed to use the word terminally ill when speaking to patients regarding their diagnosis and disease state, a limitation set by the medical staff and chaplain). The researcher reviewed hospital charts and interviewed the primary nurses to insure that criteria were met for the terminally ill hospitalized sample.

Participants in Group I were selected to match the particpants in Group II through a random process.

Questionnaires were mailed or returned promptly within two to three days post receipt. Group II took 30 to 45 minutes to complete their questionnaires while in the hospital. This included introduction, explanation of informed consent, and time spent discussing issues surrounding some of the questions presented in the questionnaires. Comparisons between groups, t-tests were used to study independent variables. For comparisons between measures, the Pearson r correlation coefficient was used.

Each participant provided feedback, general information, and completed the SPS and IWB independently, with the exception of a few in Group II who required some assistance because of their illness. In these circumstances, special consideration was given to maintain consistency across participants; items were read by the data collector without interpretation or emphasis on content. In response to the health status rating participants from the terminally ill group only identified that they had cancer but did not give an estimated time to live.

DATA ANALYSIS

RESULTS

The hypothesis that terminally ill hospitalized adults would indicate greater spiritual perspective than healthy non-hospitalized adults was not supported in this study. Terminally ill hospitalized adults did not show any significantly greater spirituality over the healthy non-hospitalized group with a $t = .13$, $p = .90$ using the SPS. The mean score for the terminally ill group was $48.47 (SD = 9.96)$, and the mean score for the healthy group was $48.00 (SD = 10.45)$ see Table 1.

Further analysis of the IWB scores on both groups was done. The IWB scores were not significantly different between the two groups as a whole $t = 1.41$, $p = .17$ see Table 1. The IWB scores were low to moderate in similarity; ranging from 3.34 to 6.30, (possible range of 2.10 to 12.60) indicating a low to moderate degree of well being among the two groups.

Women in this study did not show any significant variations in scores on the SPS from both groups, healthy $(n=8)$ mean 49.37 $(SD = 10.8)$ and terminally ill $(n=3)$ mean 50.66 $(SD = 11.01)$, $t = -.18$, $p = .86$. The IWB showed that terminally ill women had a greater sense of well-being than the healthy group, a significantly

different score. The healthy group's mean *4.56 (SD = .44)*, and the terminally ill group mean *5.78 (SD = .60)*, showing a $t = -3.77$, $p < .004$ see Table 4.

Table 4. FEMALES

t-test for independent samples: FEMALES

GROUP 1 - Status EQ Healthy
GROUP 2 - Status EQ Terminal

Variable	# of Cases	Mean	Standard Deviation	p-value
SPS				
GROUP 1	8	49.37	10.82	.86
GROUP 2	3	50.67	11.01	
IWB				
GROUP 1	8	4.56	.44	.004*
GROUP 2	3	5.78	.60	

* $p < .05$

When healthy men *(n=7)* and women *(n=8)* were compared on the SPS $t = -.37$, $p = .72$ and IWB $t = .71$, $p = .49$ there were no differences in scores see Table 5. Yet, when terminally ill men *(n=12)* were compared to terminally ill women *(n=3)*, on IWB scale, the scores were significantly different $t = -2.28$, $p < .04$ see Table 6. There were no changes in SPS scores. This is consistent with Reed's 1986 study which reported differences between the two groups. Gender (female) and the Religious Perspective Scale scores were significant in the healthy group, being both female and terminally ill contributed significantly to greater spirituality (religiousness). Comparing healthy men and terminally ill men there were no significant difference shown see Table 7.

Table 5. HEALTHY

t-test for independent samples: HEALTHY

GROUP 1 - SEX EQ MALES
GROUP 2 - SEX EQ FEMALES

Variable	# of Cases	Mean	Standard Deviation	p-value
SPS				
GROUP 1	7	47.43	9.60	.72
GROUP 2	8	49.37	10.82	
IWB				
GROUP 1	7	4.71	.35	.49
GROUP 2	8	4.56	.44	

Table 6. TERMINAL

t-test for independent samples: TERMINAL

GROUP 1 - SEX EQ MALES
GROUP 2 - SEX EQ FEMALES

Variable	# of Cases	Mean	Standard Deviation	p-values
SPS				
GROUP 1	12	47.33	10.70	.64
GROUP 2	3	50.67	11.01	
IWB				
GROUP 1	12	4.75	.72	.04*
GROUP 2	3	5.78	.60	

* $p < .05$

Table 7. MALES

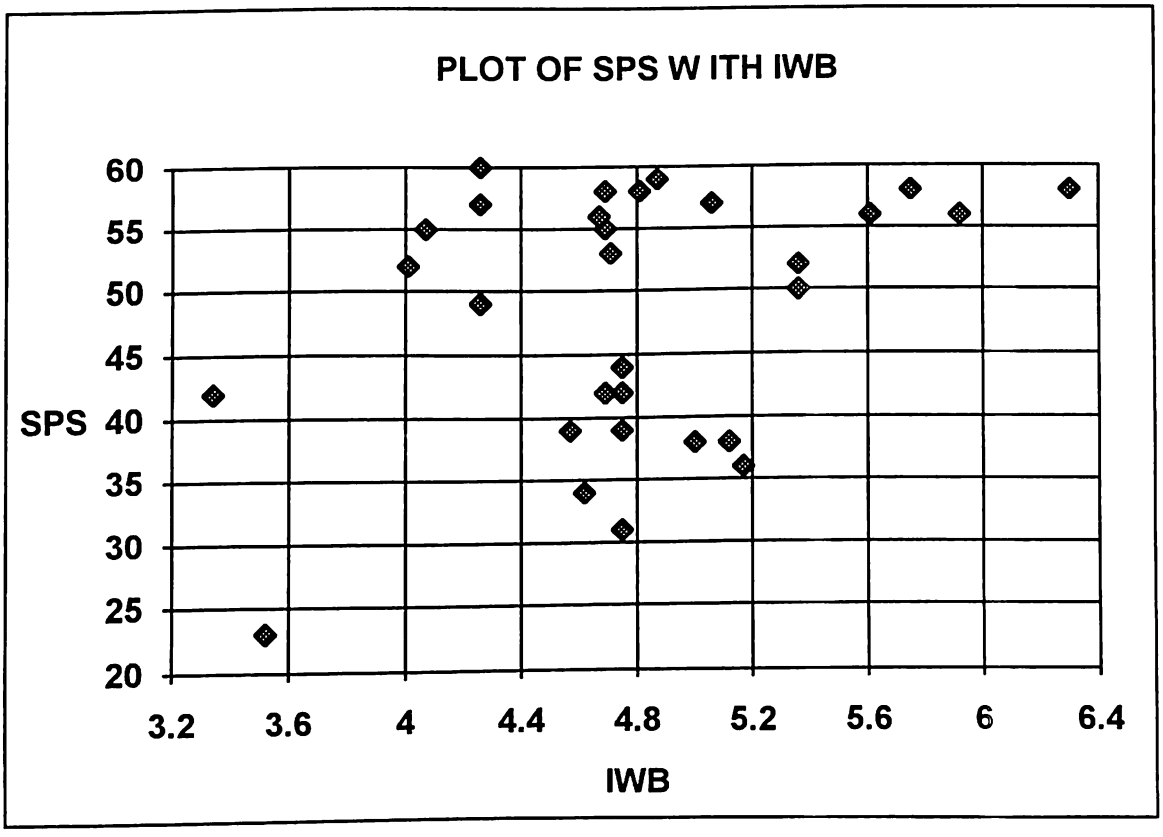
t-test for independent samples: MALES

GROUP 1 - Status EQ Healthy
GROUP 2 - Status EQ Terminal

Variable	# of Cases	Mean	Standard Deviation	p-value
SPS				
GROUP 1	7	47.43	9.60	.98
GROUP 2	12	47.33	10.70	
IWB				
GROUP 1	7	4.71	.35	.89
GROUP 2	12	4.75	.72	

The Pearson r coefficient product determined the relationship between well-being and spirituality. Of the *N=30* cases plotted, regression statistics of SPS on IWB were moderately positive in relationship between the two, but did not reach a statistically significant difference *($r = .33$, $p < .08$)*. On the plotted graph of the SPS with IWB there was one subject who scored low on both scales, the SPS 23 and the IWB 3.52 see Figure 1. During the interview the subject did display periods of emotion (crying) and stated crying was something he did on a daily basis. Another subject who placed modest on SPS and low on the IWB scores, did not have a religious preference. Reed's (1986b) study showed a significant relationship between well-being and religiousness scores among two variables in the healthy groups. However, among the terminally ill there was no significant relationship found.

Figure 1. PLOT OF SPS WITH IWB



Age was not a significant variable in this study. Correlation of the SPS with age did not show any statistically significant difference $t = .28$, $p < .13$ see Figure 2. The IWB and age showed no difference, however, the plotted graph indicates as one grows older one sense of well-being becomes less acute $t = .22$, $p < .24$ see Figure 3. Participants from the ages of 18 to 55, on the plotted graph, appeared to show a moderate sense of well-being. Further research using a larger sample would present more data.

Figure 2. PLOT OF SPS WITH AGE

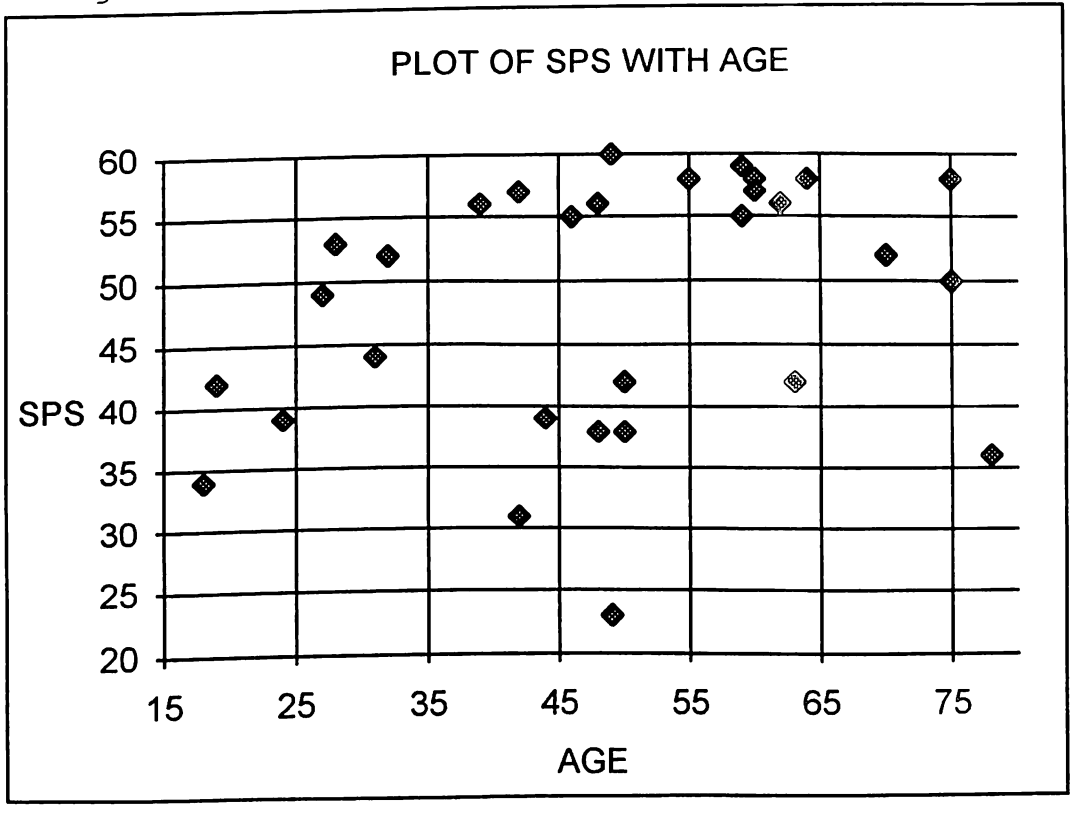
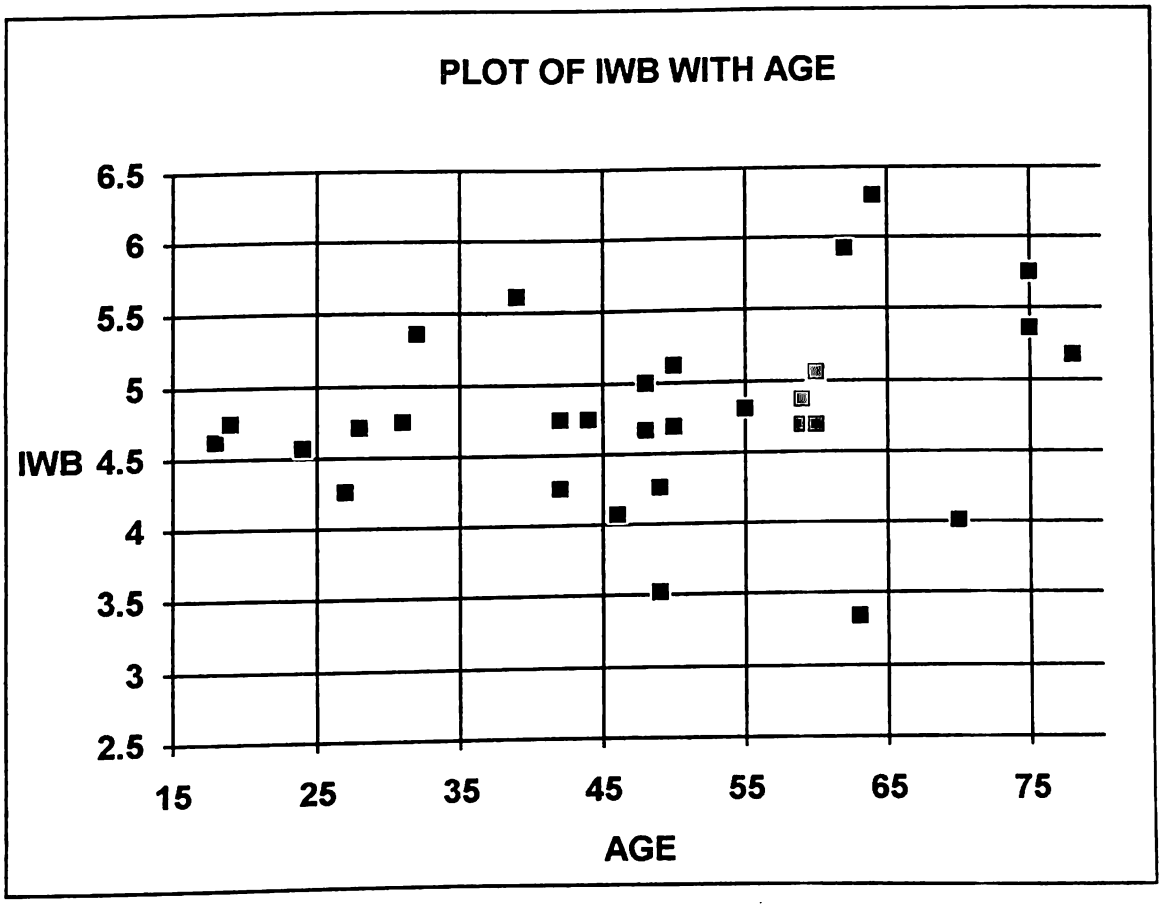


Figure 3. PLOT OF IWB WITH AGE



Reed's (1986b & 1987) studies showed a significant correlation between age and well-being among the healthy group, but the correlation of the IWB was weak among the terminally ill group.

CHAPTER 6

DISCUSSION/CONCLUSION

The purpose of this study was to examine spirituality among terminally ill hospitalized adults vs non-hospitalized healthy adults in a military environment. The SPS and IWB were instruments used to measure the relationship between the two groups. Even though the hypothesis was not supported in this study, the study revealed that terminally ill patients did not show any greater spiritual perspective than healthy adults, confirming the null hypothesis. It is not clear whether or not spirituality among both groups was indicative of a military environment. This would require further investigation.

The results of this study have validated findings of the SPS and IWB scores in other studies (Reed, 1986b & 1987). It also raises questions created by these findings. Is there a correlation between other groups (military culture) in relationship to SPS and IWB scores? Did education have an influence on the groups well-being? Military members (healthy males and females) scored high on the SPS and low to moderate on the IWB in comparison to pervious studies, and, terminally ill females scored the same on the SPS, but higher on IWB against all groups

in this study. The educational levels were generally higher in the military sample, especially among the healthy group over the terminally ill group. In the terminally ill group, higher SPS scores combined with their disease state created an environment of increased well-being. It may be assumed that individuals with higher educational skills would tend to rationalize or intellectualize their state of being, rather than rely on external factors.

The convenience sample, may have been too small to show significant data in sex, age, religion, ethnicity, and education. There is need for further research to compare women to men in both terminally ill and healthy groups. Some limitations were presented prior to the study that may have had an impact on the outcome of the study. The investigator was instructed not to use the word terminally ill to any of the hospitalized individuals or to intervene with any of the subject's spiritual or emotional needs.

Previous research (Reed, 1987; Devine, 1980; Kivett, 1979) documented that females (gender) and females of low socioeconomic groups tend to score higher than males in areas of religion and spirituality. There may be a tendency for women to show more sensitivity in

interpreting and translating their "energy-field and environment" (Rogers, 1970) than men. However, society can and does have an effect on (male) behavior, and social norms impacting that behavior.

When comparing the overall relationships between spirituality and well-being among the two sample groups none were found. Any significant relationship between the two (spirituality and well-being), however small, is consistent with previous findings (Reed, 1986b & 1987). Individuals who identify themselves as healthy were inclined to have other distractions (interests) in their lives that would tend to give them a more or less positive sense of well-being. Since terminally ill hospitalized adults are making daily adjustments to changes in their lifestyle and illness, creating a balance is somewhat difficult at times. There appear to be a correlation between spirituality and well-being no matter how insignificant (Reed, 1987; Carey, 1974; Hadaway, 1978; Spreitzer & Snyder, 1979). Statistically the numbers show that despite their illness, terminally ill adults have as much potential for well-being as their healthy adults cohorts.

Comparing Reed's (1987) study, the influence of illness and hospitalization did not have any significant

impact on SPS scores, given the similarity in SPS scores between Group I and II. Age did not show any less significant relationship to well-being in the terminally ill group. The older terminally ill individuals' state of well-being was significantly higher than the younger terminally ill group. Previous findings supported the "timing-of-events" theory; dying is more timely among older persons and, thus, may be more easily integrated among the older terminally ill individuals (Neugarten, 1979).

Findings of the open-ended question with regard to recent change in spiritual views showed no variance between the two groups. Of the sample size, approximately one-third took the time to complete the open-ended question. Those individuals in the terminally ill group did express changes toward spirituality, whereas, those in the healthy group responded that spirituality played an important part in their daily lives.

The conceptual framework of this study seeks to identify correlation between dying and spirituality among military members. Findings in this study only provided relative support that increased spirituality accompanies dying. Other studies have inferred that crises and life-threatening

experiences have influenced spiritual changes (Hall, 1986; McLaughlin & Malony, 1984; O'Brien, 1982). Efficacy about change may be generated by cross-sectional design, although indirect evidence of these interpretations is questionable (Achenbach, 1978; Hultsch & Deutsch, 1982; Reed, 1987)). This phenomenon looks at the life-span developmental process and theorizes the significant changes that are associated with the end of life particularly during the last phase of life. Additional studies into different cultures and various populations would aid in developing a design for studying spirituality as it relates to the developmental life-span and the dying process.

Spirituality, although salient, is not as "transcendent" as it is perceived in this and other studies. There are areas that can be expressed and measured despite the dimensions of spirituality that are inexpressible. That is why this study and others are important for future research. Spirituality and well-being are two inseparable entities in the healing process, and their impact on individuals' experiencing a terminal event can create energy field and environmental changes. These energy field changes in turn could have an impact on others exposed to that environment integrating spiritual dimensions of care to terminally ill individuals.

RECOMMENDATIONS

1. Conduct future research studies on military members for further understanding of developmental life-span critical events, and their impact on increased spirituality.
2. Examine the effect spirituality and well-being have on the lives of different socioeconomic groups.
3. Replicate this study using a larger sample.
4. Replicate Reed's (1987) study in a military environment.
5. Recommend a qualitative study be done for to gather more information.

REFERENCES

Achenbach, T. M. (1978). Research in developmental psychology: Concepts, strategies, methods. New York: The Free Press.

Burkhardt, M. A. (1989). Spirituality: An analysis of the concept. Holistic Nursing Practice. 3(3), 69-71.

Banks, R. (1980). Health and the spiritual dimension: Relationships and implications for professional preparation programs. Journal of School Health. 50, 195.

Campbell, A., Converse, P. E., & Rodgers, W. L. (1976). The quality of American Life: Perceptions, evaluations and satisfaction. New York: Russel Sage Foundation.

Chinen, A. B. (1984). Modal logic: A new paradigm of development and late-life potential. Human Development. 27, 42-56.

Dickerson, C. (1975). The Search for spiritual meaning. American Journal of Nursing. 75(10), 1789-1793.

Emblen, J. D. (1992). Religion and spirituality defined according to current use in nursing literature. Journal of Professional Nursing. 8(1), 41-47.

Feifel, H. (1974). Religious conviction and the fear of death among healthy and the terminally ill. Journal of the Scientific Study of Religion. 13, 353-360.

Grove, P. (Ed.). (1986). Webster's third new international dictionary, unabridged.Springfield, MA: Merriam-Webster.

Hall, C. M. (1986). Crisis as opportunity for spiritual growth. Journal of Religion and Health. 25, 8-17.

Hubert, M. (1963). Spiritual care for every patient. Journal of Nursing Education. 2, 9-11; 29-31.

Hultsich, D. F. & Deutsch, F. (1981). Adult development and aging: A life-span perspective. New York: McGraw-Hill.

Kim, M. J., McFarland, G. K., & McLane, A. M. (1987). Pocket guide to nursing diagnosis (2nd ed.). St. Louis, MO.

King, M. B. & Hunt, R. A. (1975). Measuring the religious variable: National replication. Journal for the Scientific Study of Religion. 14, 13-22.

Lane, J. A. (1987). The care of the human spirit. Journal Professional Nursing. 3, 332-337.

McLaughlin, S. A. & Malony, N. (1984). Near-death experience and religion: A further investigation, Journal of Religion and Health. 23, 149-159.

Miller, J. F. (1985). Assessment of loneliness and spiritual well-being in chronically ill and healthy adults. Journal of Professional Nursing. 1, 79-85.

Moberg, D. (1979). Spiritual well-being: Sociological perspectives. Washington, DC. University Press of America.

Murray, R. B. & Zentner, J. P. (1985). Nursing concepts for health promotion. Engle wood Cliffs, NJ: Prentice Hall.

Nelson, P. B. (1989). Ethnic differences in intrinsic/extrinsic religious orientation and depression in the elderly. Archives of Psychiatric Nursing. 3(4), 199-204.

Neugarten, B. L. (1979). Time, age, and the life cycle. The American Journal of Psychiatry. 136, 887-889.

O'Brein, M. E. (1982). Religious faith and adjustment to long-term hemodialysis. Journal of Religion and Health. 21, 68-80.

O'Malley, W. J. (1989). Toward an adult spirituality. America. 161(15), 341-344.

Peteet, J. R. (1979). Depression in cancer patients. Journal of the American Medical Association. 224, 1487-1489.

Plumb, M. & Holland, J. (1981). comparative studies of psychological functions in patients with advanced cancer. II: Interviewer-rated current and past psychological symptoms. Psychosomatic Medicine. 43, 243-253.

Polit, D. F. & Hungler, B. P. (1991). Nursing research: Principles and methods (4th ed.) Philadelphia: J. B. Lippincott.

Reed, P. G. (1983). Implications of the life-span development framework for well-being in adulthood and aging. Advances in Nursing Science. 6, 18-25.

Reed, P. G. (1986a). Death perspectives and temporal variables in terminally ill and healthy adults. Death Studies. 10, 443-454.

Reed, P. G. (1986b). Religiousness among terminally ill and healthy adults. Research in Nursing & Health. 9, 35-41.

Reed, P. G. (1987). Spirituality and well-being in terminally ill hospitalized adults. Research in Nursing & Health. 10, 335-344.

Reed, P. G. (1991). Spirituality and mental health in older adults: Extant knowledge for nursing. Family and Community Health. 14(2), 14-25.

Rogers, M. E. (1970). An Introduction to the Theoretical Basis of Nursing. Philadelphia: F. A. Davis.

Sodestrom, K. E. & Martinson, I. M. (1987). Patient's spiritual coping strategies: A study of nurse and patient perspectives. Oncology Nursing Forum. 14(2), 41-46.

Stiles, M. K. (1990). The shinning stranger: nurse--family spiritual relationship. Cancer Nursing. 13(4), 235-245.

Stoll, R. I. (1979). Guideline for spiritual assessment. American Journal of Nursing. 79, 1574-1577.

Vaillot, M. C. (1970). The spiritual factors in nursing. Journal of Practical Nursing. 20, 30-31.

Wilson, L. M. & Fitzpatrick, J. J. (1984). Dialectic thinking as a means of understanding systems-in-development: Relevance to Rogers' principles. Advances in Nursing Science. January. 24-41.

APPENDIX A

LETTER OF APPROVAL FOR USE

OF COPYRIGHTED MATERIAL

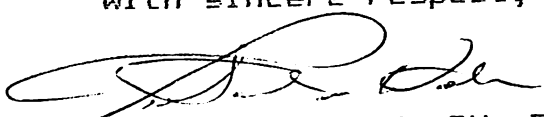
5762 Cedar Cove
San Antonio TX 78249-3128
18 February 1992

Dr Pamela G. Reed
University of Arizona
College of Nursing
Tucson AZ 85721

Dear Dr Reed,

I am a graduate student in Adult Nursing at Incarnate Word College. This letter is a request for your permission to use the Religious Perspective Scale instrument and a copy of the instrument for review. As a graduate student, I am currently participating in an instrument search for my reseach program this semester, and must receive the material and your approval as quickly as possible. If you have any questions, please contact me at work (512) 536-3894 or at home, (512) 561-7700. If there is any cost involved, please forward the bill to me. Thank you for your prompt reply.

With sincere respect,



RICHARD M. HOLT, RN, BSN
Graduate Student

College of Nursing

THE UNIVERSITY OF
ARIZONA
HEALTH SCIENCES CENTER

Tucson, Arizona 85721
(602) 626-6154

February 27, 1992

Richard M. Holt, RN, BSN
Graduate Student
Incarnate Word College
5762 Cedar Cove
San Antonio, TX 78249-3128

Dear Mr. Holt:

Thank you for your interest in my instrument, now called the Spiritual Perspective Scale. I have enclosed a copy of the instrument, with information on it, and a Request Form, for your review. Please complete and return the Request Form as indicated. I would be happy to address any questions or comments that you may have once you have read the material. I look forward to hearing from you.

Sincerely,

Pamela G. Reed

Pamela G. Reed, PhD, RN
Associate Professor
Mental Health Division

Request Form

I request permission to copy the Spiritual Perspective Scale (SPS) for use in my research entitled, Spirituality Among Terminally Ill Hospitalized Adults and Healthy Adults in a Military Population

In exchange for this permission, I agree to submit to Dr. Reed a copy of the following:

1. An abstract of my study purpose and findings, especially which includes the correlations between the SPS scale scores and any other measures used in my study. (This will be used by Dr. Reed to assess construct validity).
2. The reliability coefficient as computed on the scale from my sample (Cronbach's alpha).
3. A copy of the one-page scoring sheet for each subject tested.
4. My data coding dictionary (if data are sent on disk).

Any other information or findings that could be helpful in assessing the reliability or validity of the instrument would be greatly appreciated (e.g. problems with items, comments from subjects, other findings).

This data will be used to establish a normative data base for clinical populations. No other use will be made of the data submitted. Credit will be given to me in reports of normative statistics that make use of the data I submitted for pooled analyses.

(Signature)

16 December 1992

(Date)

Position and Full Address

Graduate Student Incarnate Word College

Master in Nursing Science Program

5762 Cedar Cove

San Antonio TX 78249-3128

Permission is hereby granted to copy the SPS for use in the research described above.

Pamela G. Reed

Pamela G. Reed

December 18, 1992

(Date)

Please send <u>two signed</u> copies of this form to:

Pamela G. Reed, Ph.D., R.N.
College of Nursing
University of Arizona
Tucson, Arizona 85721

APPENDIX B

LETTERS TO

WILFORD HALL USAF MEDICAL CENTER

Richard M. Holt, RN, BSN
5762 Cedar Cove
San Antonio TX 78249-3128

Linda J. Stierle, Col, USAF, NC
Director of Nursing Services
Wilford Hall USAF Medical Center

SGN

1. My name is Richard M. Holt, Major, USAF, NC, and I am currently attending graduate school at Incarnate Word College, School of Nursing, San Antonio TX, through tuition assistance. I am currently assigned at the USAF School of Aerospace Medicine, Department of Aerospace Nursing as an instructor.

2. I am requesting permission to utilize a group of patients treated at your medical center as the study population for my thesis. My advisors for this study are: Brenda Jackson, RN, PhD, Regina Aune, RN, PhD, and Barbara Herlihy, RN, PhD.

3. The purpose of this research proposal is to replicate the study conducted by Dr. Pamela Reed of the University of Arizona, Tucson AZ, "Spirituality Among Terminally Ill and Healthy Adults." The research was based on a comparative study of terminally ill and healthy adults exploring their differences in religiousness. The primary focus of this research is to examine the potential significance of spirituality among terminally

ill patients and assess the clinical significance of incorporating the spiritual needs of terminally ill adults into nursing practice. It is expected that this study will not inconvenience the nursing staff. No special facilities will be needed for the purpose of this study. The anonymity and confidentiality of all participants will be protected throughout the gathering of personal data.

4. I will be glad to discuss the study with you at your convenience and will be awaiting your decision. If you have any questions, I may be reached at the above address or by telephone 561-7700 or at extension 4-3894 at USAFSAM/AN.

RICHARD M. HOLT, RN, BSN
Graduate Student

FROM: RDA/7143 18 Mar 93

SUBJ: Clinical Investigation Proposal #93EX135 (AFR 169-5 EXEMPT), "Spirituality Among Terminally Ill Hospitalized Adults and Healthy Non-Hospitalized Adults in a Military Environment"

TO: NS/Capt Paul F. Langlois

1. Your proposal was reviewed by the WHMC Institutional Review Committee on 17 Mar 93 and approved as written. Please refer to the above number in future correspondence regarding the study.

2. Please forward a copy of the final report to RDA when the study is completed.

3. Investigators are encouraged to obtain and use a laboratory notebook for recording their data. Notebooks may be obtained from non-medical supply, stock #7530-00-2223524. If you are unable to obtain a notebook from non-medical supply and desire to use one, contact our Admin section at ext. 7141.

Ramesh Persaud

RAMESH PERSAUD, Sgt, USAF
Asst Protocol Coordinator
Clinical Investigations

From: Capt Paul F. Langlois Capt P. Langlois

To: Major Holt

Subj: Clinical Investigations Proposal #93-EX-135

Date: 06 April 1993

Your study, "Spirituality Among Terminally Ill Hospitalized Adults and Healthy Non-Hospitalized Adults in a Military Environment," has been approved by the Nursing and Institutional Review Board at WHMC. I am listed as the P.I. of this study because you are not stationed at WHMC.

If you have any questions, please contact me at 670-7263.

APPENDIX C

CONSENT FORMS

Dear Patient,

My name is Major Richard Holt, a student at Incarnate Word College, currently pursuing a masters in adult nursing science. I am conducting a study on the spiritual needs of patients experiencing a critical event in their lives. This study will give nursing as a whole an in-depth look at your spiritual experiences. It will also provide nursing and other health care professionals the insight needed to plan and enhance the quality of spiritual care provided.

Your participation in this study is completely voluntary. If you choose to participate, I assure you that all of your responses will be strictly confidential.

RICHARD M. HOLT, Major, USAF, NC

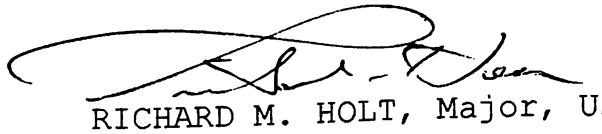
Graduate Student, Incarnate Word College

Dear Subject

My name is Major Richard Holt a student at Incarnate Word College. I am currently pursuing a masters in adult nursing science. As part of the masters program I've selected to conduct a research study focused on assessing the spiritual needs of patients experiencing a critical event in their lives. This study will provide data for possible curriculum development for nursing programs in the area of spirituality. It will also provide nursing and other health care professionals the insight needed to plan and enhance the quality of spiritual care provided to patients diagnosed with terminal illness.

Your participation in this study, as a control group, will provide input on spirituality from a healthy population and is strictly on a voluntary. If you choose to participate, I assure you that all of your responses will be strictly confidential.

Thanks you for your time and support.



RICHARD M. HOLT, Major, USAF, NC

Graduate Student, Incarnate Word College

APPENDIX D

SPIRITUAL PERSPECTIVE SCALE

INDEX OF WELL-BEING

QUESTIONNAIRES

Spiritual Perspective Scale Scoring Sheet

Subject No. _____

Age _____

Sex _____

Education (yrs.) _____

Religious Affiliation (if any) _____

Ethnic Group _____

Health Status/or Diagnosis of Adult _____

Item 1 _____

Item 2 _____

Item 3 _____

Item 4 _____

Item 5 _____

Item 6 _____

Item 7 _____

Item 8 _____

Item 9 _____

Item 10 _____

Overall Scale Score _____

Code No. _____

SPIRITUAL PERSPECTIVE SCALE

Introduction and Directions: A person's spiritual views may be an important part of their life. In general, spirituality refers to an awareness of one's inner self and a sense of connection to a higher being, nature, others, or to some purpose greater than oneself. I am interested in your response to the questions below. There are no right or wrong answers, of course. Answer each question to the best of your ability by marking an "X" in the space above that group of words which best describes you.

1. In talking with your family or friends, how often do you mention spiritual matters?

/ Not at all	/ Less than once a year	/ About once a year	/ About once a month	/ About once a week	/ About once a day

2. How often do you share with others the problems and joys of living according to your spiritual beliefs?

/ Not at all	/ Less than once a year	/ About once a year	/ About once a month	/ About once a week	/ About once a day

3. How often do you read spiritually-related material?

/ Not at all	/ Less than once a year	/ About once a year	/ About once a month	/ About once a week	/ About once a day

4. How often do you engage in private prayer or meditation?

/ Not at all	/ Less than once a year	/ About once a year	/ About once a month	/ About once a week	/ About once a day

Directions: Please indicate the degree to which you agree or disagree with the following statements by marking an "X" in the space above the words which best describe you.

5. Forgiveness is an important part of my spirituality.

/ Strongly Disagree	/ Disagree	/ Disagree more than agree	/ Agree more than disagree	/ Agree	/ Strongly Agree

6. **I seek spiritual guidance in making decisions in my everyday life.**

Strongly Disagree	Disagree	Disagree more than agree	Agree more than disagree	Agree	Strongly Agree

7. **My spirituality is a significant part of my life.**

Strongly Disagree	Disagree	Disagree more than agree	Agree more than disagree	Agree	Strongly Agree

8. **I frequently feel very close to God or a "higher power" in prayer, during public worship, or at important moments in my daily life.**

Strongly Disagree	Disagree	Disagree more than agree	Agree more than disagree	Agree	Strongly Agree

9. **My spiritual views have had an influence upon my life.**

Strongly Disagree	Disagree	Disagree more than agree	Agree more than disagree	Agree	Strongly Agree

10. **My spirituality is especially important to me because it answers many questions about the meaning of life.**

Strongly Disagree	Disagree	Disagree more than agree	Agree more than disagree	Agree	Strongly Agree

Do you have any views about the importance or meaning of spirituality in your life that have not been addressed by the previous questions?

_____

_____

Thank you very much for answering the questions

IWB

rections: Here are some words and phrases which I would like you to use to describe how you feel about your present life. Put an "X" over the number that you think best describes how you feel about your present life.

___ 1. My present life is:

	1	2	3	4	5	6	
BORING	___	___	___	___	___	___	INTERESTING

___ 2. My present life is:

	1	2	3	4	5	6	
ENJOYABLE	___	___	___	___	___	___	MISERABLE

___ 3. My present life is:

	1	2	3	4	5	6	
USELESS	___	___	___	___	___	___	WORTHWHILE

___ 4. My present life is:

	1	2	3	4	5	6	
LONELY	___	___	___	___	___	___	FRIENDLY

___ 5. My present life is:

	1	2	3	4	5	6	
FULL	___	___	___	___	___	___	EMPTY

___ 6. My present life is:

	1	2	3	4	5	6	
DISCOURAGING	___	___	___	___	___	___	HOPEFUL

___ 7. My present life is:

	1	2	3	4	5	6	
REWARDING	___	___	___	___	___	___	DISAPPOINTING

___ 8. My present life:

	1	2	3	4	5	6	
DOESN'T GIVE ME MUCH CHANCE	___	___	___	___	___	___	BRINGS OUT THE BEST IN ME

___ 9. In thinking about my life as a whole, I am:

	1	2	3	4	5	6	
COMPLETELY DISSATISFIED	___	___	___	___	___	___	COMPLETELY SATISFIED

- THANK YOU ! -

VITAE

Major Richard Martin Holt was born in El Dorado, Arkansas, on 21 August 1950, the son of Jimmie Mae Holt and Richard M. Holt, II. After completing High School in 1968, he entered Southern Arkansas University at Magnolia, Arkansas for an Associate of Science in Nursing. Several years later he moved to New Orleans, LA where he met his future bride. In June 1980 Major Holt was married to Ms Yolonde Juliet Parsons and entered the United States Air Force in the fall of 1980 to current. He has a son, Richard V. Holt born 20 November 1982. During the Spring of 1987, he completed his Bachelor of Science in Nursing from McKendree College, Lebanon, Illinois. He is also a member of the Phi Kappa Phi National Honor Society. In the Summer of 1991, Major Holt entered graduate school at Incarnate Word College School of Nursing Science in San Antonio, Texas. Major Holt's numerous accomplishments over the past twenty-three years of nursing are: Head Nurse Critical Care, Critical Care Coordinator, Clinical Supervisor, Flight Clinical Coordinator, Cardiac Catheterization Nurse, and Faculty at Brooks AFB USAF School of Aerospace Medicine, Department of Aerospace Nursing. Major Holt is presently a candidate for the Master of Science degree in Nursing in December, 1993.

Permanent address: 6815 Appaloosa
San Antonio, Taxas

This thesis was typed by Richard M. Holt.