

# Nurses' and carers' spiritual wellbeing in the workplace

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## KEY WORDS

Assessing spiritual well-being; SHALOM; spiritual dissonance

## ABSTRACT

### Objective

The aim of the study was to investigate nurses' and pastoral carers' spiritual wellbeing (SWB) and how it relates to their workplace.

### Design

The study design was a survey of total populations in selected health care services.

### Setting

The setting was a public and a private hospital in a regional setting, and three hospices in major cities which had a religious affiliation.

### Subjects

Responses were obtained from 154 (11%) nurses and 8 (6%) carers in the public hospital, 40 (7%) nurses in the private hospital and 16 nurses and 7 carers (17%) in the three hospices.

### Main outcome measure

The Spiritual Health and Life Orientation Measure (SHALOM) was used to provide insights into staff ideals for spiritual wellbeing, as well as their lived experiences in relating with self, others, the environment and/or God. The nurses' and carers' perceptions about how well clients are supported in these four domains of spiritual wellbeing in their workplace were also explored.

### Results

The beliefs and worldview of health care staff influence their ideals for spiritual wellbeing (SWB) to a greater extent than age, gender, or workplace setting. These ideals markedly impact on their lived experiences which reflect their SWB. Ten percent of these staff showed spiritual dissonance in more than one of the four domains of SWB.

The major finding of this study is the influence that nurses' and carers' personal experience has on the level of help they thought clients received from the services offered in their workplace. Those who are more fulfilled in relationships, with themselves, others, the environment and/or God, believe that clients receive greater help in these areas from the services provided in their workplace.

### Conclusion

SHALOM is a useful indicator of four domains of SWB of health care staff who project their own lived experience onto the way they see clients having their spiritual wellbeing nurtured. This has implications for health care staff in the workplace.

## INTRODUCTION

There are many claims in the literature that 'spirituality' and 'wellbeing' are both multifaceted constructs that are elusive in nature (Sessanna et al 2007; Buck 2006; Swinton 2006; de Chavez 2005; McSherry et al 2004). An extensive review of the literature reveals common themes mentioned when discussing a combination of these two concepts in the form of spiritual wellbeing (SWB) (Como 2007; Sinclair et al 2006; Ross 2006; Delgado 2005; Chiu et al 2004; Moberg 2002; Govier 2000; Martsolf and Mickley 1998; Dyson et al 1997; Burkhardt 1989; Ellison 1983). Four main themes appeared in the framework definition proposed by the National Interfaith Coalition on Ageing, in Washington DC, USA, that SWB is 'the affirmation of life in a relationship with God, self, community and environment that nurtures and celebrates wholeness' (NICA 1975).

These themes and their components are included in the model of spiritual health (SH) developed by Fisher, where he describes spiritual health as a, if not *the*, fundamental dimension of people's overall health (ie physical, mental, emotional, social and vocational). Spiritual health is a dynamic state of being, shown by the extent to which people live in harmony within relationships in the following domains of spiritual well-being:

*Personal* domain - wherein one intra-relates with oneself with regards to meaning, purpose and values in life. The human spirit employs self awareness in its search for self worth and identity.

*Communal* domain - as expressed in the quality and depth of interpersonal relationships between self and others relating to morality, culture and religion. These are expressed in love, forgiveness, trust, hope and faith in humanity.

*Environmental* domain - moving beyond care and nurture for the physical and biological to a sense of awe and wonder; for some people it is the notion of unity with the environment.

*Transcendental* domain - the relationship of self with something or some-One beyond the human level (ie ultimate concern, cosmic force, transcendent reality

or God). This involves faith toward, adoration and worship of, the source of mystery of the universe (Fisher 1998).

In this model, spiritual wellbeing is reflected in the quality of relationships that people have in one or more of the four domains of spiritual health.

### Measuring spiritual well-being

Many available religiosity/spirituality measures ask people for a single response about 'lived experience' on a series of questions (Ross 2006). In the best instruments, these questions are built on theoretical frameworks of relationships between spirituality and health that are considered important by the developers of the scales. The 'scores' thus obtained are arbitrary indicators of spiritual health or wellbeing, especially if they have only a small number items (Boero et al 2005). A questionnaire can never reveal the true nature of spirituality or wellbeing; it can only provide indicators that reflect or are 'consequences of spiritual health, not the phenomenon itself' (Moberg 2002).

The power of a questionnaire depends on its theoretical base and the rigour with which it is developed and tested (Gray 2006). Fisher developed SHALOM (1999) in the belief that an instrument based on input from 850 secondary school students with diverse cultural and religious backgrounds should have appropriate language and conceptual clarity for studies of SWB within general populations and individuals across all age groups. An initial selection of 60 items from Fisher's model of SH was reduced to the 20 item SHALOM using exploratory factor analysis - 5 items in each of the 4 domains.

Confirmatory factor analyses on SHALOM using data from 4462 people, including nurses and carers, showed good reliability as well as validity (Gomez and Fisher 2003). The acronym SHALOM reveals its two components - **S**piritual **H**ealth measure **A**nd **L**ife-**O**rientation **M**easure. The 'life orientation measure' elicits the 'ideals' people have for 'spiritual health' in the four domains of relationships with self, others, environment and/or God. The spiritual health measure asks people to reflect on 'lived

experience; how they feel each item reflects their personal experience most of the time.'

With only 20 items, SHALOM cannot be considered an exhaustive measure of SWB. If the researcher/carer and respondents/clients had time, it would be possible to use suitable qualitative procedures to mine the depths of people's SWB. However rather than taking hours, in 5-10 minutes, plus 5 minutes scoring time, SHALOM provides an effective means of indicating key aspects of four domains of SWB.

Fisher (1998) proposed that each person's beliefs and world-view impact on their understanding and commitment to the importance of each of these four domains. Therefore it is important to gain some idea of a person's world-view before attempting to 'measure' their SWB. In SHALOM, each person is compared with themselves as their standard. No arbitrary group norms are employed to compare or rank people. The difference between their 'ideals' and how they feel ('lived experience') gives an indication of their SWB in each of the four domains. For example, if people do not think relating with the environment, or God, is important for SWB, when they score 'low' on the 'lived experience' category, it is in harmony with their 'ideals' in these domains of SWB.

Some people believe all that is necessary for SWB is a wholesome relationship with oneself (MacLaren 2004). Other people believe that you can only truly be yourself in relation with others (Thatcher 1993). With an impending global warming crises; people are beginning to see the importance of relating with the environment for sustenance and the wellbeing of humanity. Relating with a transcendent other/God is not restricted to religious practice. Some studies have

introduced terms such as 'higher power' to replace 'God' in attempts to be more 'politically correct' and/or less offensive to non-theists (Hungelmann et al 1985). In the development of SHALOM, terms such as 'godlike force' and 'supernatural power' were trialled but found wanting as they were not meaningful to young people and therefore possibly a range of adults also. Whether theistic, or not, people have a concept of 'God.' As they compare their ideal of whatever, with their lived experience, it is up to each person to define their own meaning for each notion. For example, there are many different religions and denominations or branches of religions because of people's different views. A brief question about religion is asked in the demographic section of this survey, along with gender and age, but religion *per se* is not included in SHALOM.

The aim of this study was to investigate nurses' and pastoral carers' spiritual wellbeing and how it relates to their workplace.

## METHOD

Following approval from ethics committees, staff in selected health services were invited to complete SHALOM. A Plain Language Statement and the survey in an envelope were attached to pay-slips of all staff in a public hospital (1365 nurses, 132 carers) and a private hospital (570 nurses) in a regional centre, as well as in three hospices (95 nurses, 40 carers) in separate states of Australia. The survey comprised demographic data and SHALOM.

SHALOM has 20 items, five for each of four domains of spiritual wellbeing, reflecting quality of relationships with self, others, the environment, and/or with God.

**Table 1: Items in the four domains of SWB in SHALOM**

Personal	Communal	Environmental	Transcendental
sense of identity	love of other people	connection with nature	personal relationship with the Divine/God
self-awareness	forgiveness toward others	awe at a breathtaking view	worship of the Creator
joy in life	trust between individuals	oneness with nature	oneness with God
inner peace	respect for others	harmony with the environment	peace with God
meaning in life	kindness toward other people	sense of 'magic' in the environment	prayer life

The respondents were asked to rate each of the 20 items using a 5-point Likert scale:

1 = very low      2 = low              3 = moderate  
4 = high            5 = very high

to show:

- how important each area is for an *ideal* state of spiritual wellbeing, and
- how they felt each item reflects their personal *experience* most of the time, and
- how much *help* they think clients gain from their health care service to develop these aspects of life.

All statistical analyses (ie correlations (power=0.95), cross-tabulations (power=0.95), t-tests (power=0.94), ANOVA (power=0.89), multiple regression analyses (power=0.99)) were performed using SPSS for Windows Version 15.0. G\*Power3 was used to compute the statistical power for tests (Faul et al 2007).

## RESULTS

### Participants

Responses were obtained from 154 nurses (11% response rate) and 8 carers (6% response rate) in the public hospital, 40 nurses (7% response rate) in the private hospital, and 16 nurses and 7 carers (17%) in the three hospices. The rate of responses reported here is commensurate with other recent surveys in the public hospital (personal communication, HR Department, February 2008). The results are therefore not necessarily representative of the institutions surveyed.

There were more female nurses (87%) than males and all but one of the carers was female. Nurses in the hospices were older (average 49.4 years) than nurses in the hospitals (39.1 years) ( $t(199)=4.48$ ,  $p<0.001$ ). Pastoral carers were even older: public hospital (51.3 years) and hospices (55.7 years).

The religious beliefs of staff responding to this study was similar in each of the health care settings, even though the private hospital and the hospices had

a religious affiliation,  $X^2(8, n=225=14.3, p=0.075, \phi=0.252)$ .

### Spiritual wellbeing

Statistical tests showed very good results for the twelve factors relating to SHALOM (Personal, Communal, Environmental, Transcendental measures of 'ideal,' 'lived experience,' and 'help'). They had alpha values ranging from 0.81 to 0.91, accounting for between 60 and 88% of the variance in each factor. The correlation values for all five items in each factor were greater than 0.68, well above the minimum acceptable value of 0.4.

ANOVA showed that setting was not significant for any of the SWB factors studied here (t-values ranged from 1.17 to 0.19, with  $p$  ranging from 0.24 to 0.85).

To check the relative impact on SWB, age, gender, position and religion were entered as predictor variables in linear regression analyses. The  $R^2$ -values (which give approximate percentages) and  $\beta$ -values (which indicate the size of effect of each predictor variable) are recorded in table 2.

### Ideals for SWB

There are obviously factors other than gender, age and religion which contribute to the ideals or world view that nurses and carers hold and that impact on their relationships with self, others, the environment and God. However these are outside the scope of this study. Females often score higher than males on the ideals for Personal and Communal SWB (Gomez and Fisher 2005) but the Environmental impact here could relate to the older females working in the hospices who are also more religious. Staff who identified as 'Christian' scored higher than the other religions on the Transcendental (God) factor, with religions being higher than no religion.

### Lived experiences of SWB

These results read (with apologies to Descartes), 'What I think, I am,' in keeping with the idea expressed in Proverbs 23:7, 'As a man thinks in his heart, so is he.' It is clear that people's 'ideals' are the greatest single factor contributing to 'lived experience' in each of the four domains of SWB studied here. In other

words, what people are in their heads and their hearts is worked out in their lives. There is a small influence of gender, with 40 year olds scoring lower than others

on how well they relate to other people. Religious beliefs discriminated in staff's lived experience of relating with God, as they did for ideals.

**Table 2:  $\beta$ -values and  $R^2$  values for regression analyses of influences on SWB**

Categories of SWB	Predictor variables	Domains of SWB			
		Personal	Communal	Environmental	Transcendental
	R2	0.04	0.06	0.07	0.26
Ideal	gender	*0.19	**0.20	*0.16	
	religion		*0.14		***0.42
	age			**0.22	***0.22
	R2	0.28	0.39	0.59	0.69
Lived experience	ideal	***0.50	***0.56	***0.75	***0.59
	gender		*0.12		
	age		*-0.12		
	religion				***0.36
	R2	0.29	0.30	0.33	0.30
Help	lived experience	***0.51	***0.62	***0.55	***0.45
	age				*0.15
	position			*0.12	

\* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$

### Perceived help for SWB

The carers were slightly more concerned with their clients' environmental wellbeing than were the nurses. Older staff have a slighter higher perception of how well they nurture clients' relations with God. However the greatest impact is shown by these nurses' and carers' own lived experiences influencing the perceptions they have of the help provided in their workplace for nurturing the four domains of clients' SWB. These results support the theoretical views expressed by MacLaren (2004) that nurses' spirituality 'can become the unspoken element which underpins and may improve the quality of their care' and Pesut and Thorne (2007) that 'the identities which nurses bring to spiritual care encounters have far-reaching implications for patient experiences.' An exploratory study with 60 graduate nurses found a 'relationship of nurse's involvement and beliefs in spirituality and their attitudes toward providing spiritual care' (Willis 2000).

## DISCUSSION

### Spiritual dissonance

Numerical values of 'scores' on each scale of a SWB measure do not mean much unless they relate to something substantial. A key outcome of health service provision is holistic care for clients (McBrien 2006). In this study we were concerned with the health staff's perceptions of their own SWB as well as their perceptions of the help provided to clients in this area in their workplace.

Lived experience impacts markedly on perceived help for clients, but how? As most people admit they are not perfect, so it is not surprising to note some decline from 'ideals' to 'lived experiences.' Some variation is expected, but how much is unhealthy?

It has previously been proposed by Fisher (2006) that spiritual dissonance is indicated by a difference in mean value of greater than 1.0 between the 'ideal' and 'lived experience' in any domain of SWB,

measured using SHALOM. For example, if a person's ideal rated as 'high' (mean value = 4.0 across the 5 items), a 'lived experience' score below 3.0 (less than 'moderate') would indicate spiritual dissonance. Table 3 shows correlation values between the differences (d values) and help categories (c values) in the four domains of SWB (Personal, Communal, Environmental and Transcendental).

The differences (d-scores) correlate moderately with each other indicating a pattern across domains. These d-scores would be expected to show a relation to ideals and lived experiences (because they are the difference between these two factors), and they do.

**Table 3: Pearson Correlation values of 'differences' with 'help' in domains of SWB**

	d-COM	d-ENV	d-TRA	PER-c	COM-c	ENV-c	TRA-c
d-personal	***0.587	***0.550	***0.310	***-0.322	***-0.351	***-0.241	**-.0201
d-communal		***0.497	***0.300	***-0.316	***-0.364	**-.0193	ns -0.058
d-environmental			***0.406	***-0.266	**-.0211	*-.0133	ns -0.114
d-transcendental				*-.0162	*-.0161	ns -0.123	ns -0.089

\*p<0.05; \*\*p<0.01; \*\*\*p<0.001; ns=not significant

Personal = PER; Communal = COM; Environmental = ENV; Transcendental = TRA

The interesting finding is the extent to which differences relate to perceived help (c values), especially in the Personal and Communal domains, to a lesser extent in the Environmental and almost non-existent in the Transcendental domains.

Using Fisher's definition above, spiritual dissonance was shown in the Personal domain (n=26, 11.6%), Communal domain (n=17, 7.6%), Environmental domain (n=15, 6.7%) and Transcendental domain (n=38, 16.9%). Greater dissonance was shown in the Transcendental domain by people who identified as non-religious,  $\chi^2(1, n=225=12.0, p=.001, \phi=-.23)$ . This could perhaps indicate a remnant of religious influence lingering in the minds of non-religious people, positing a requirement of a god as an ideal for their own spiritual wellbeing (M=2.74, SD 1.25), which they are rejecting in practice (M=2.06, SD=.91), in contrast to the religious (M<sub>ideal</sub>=3.85, SD=1.15; M<sub>expc</sub>=3.60, SD=1.09).

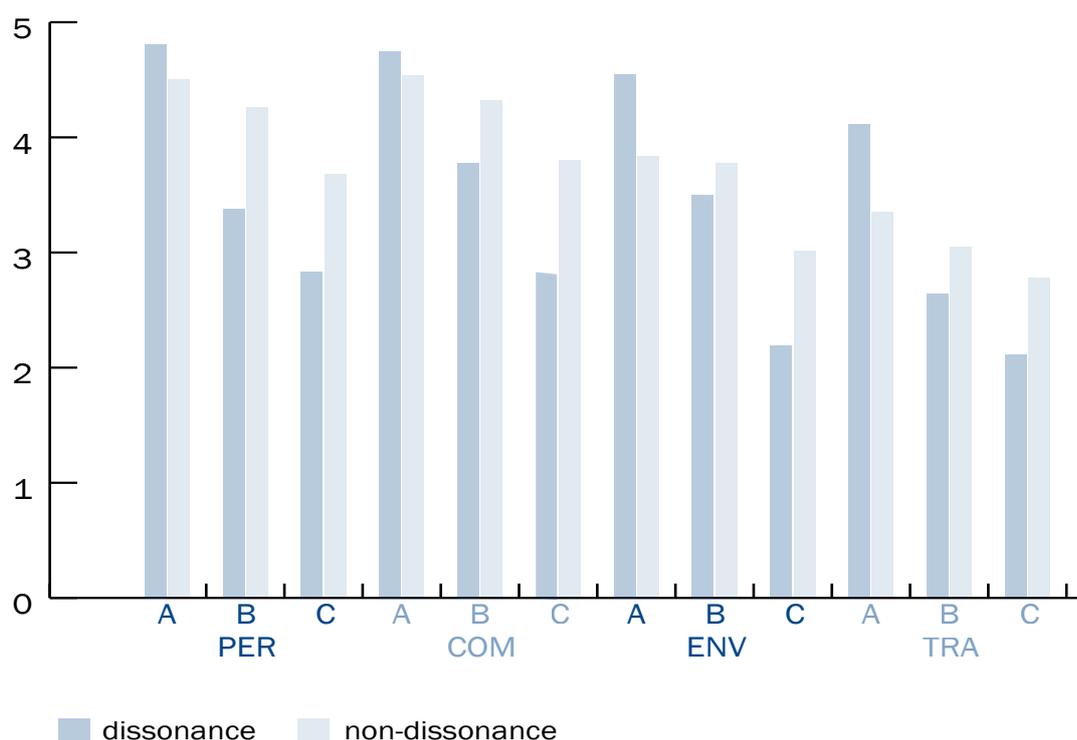
Only two staff (0.9%) showed dissonance in all four domains, another 6 (2.7%) in three domains, a further 15 (6.7%) in two domains, with 40 (17.8%) showing dissonance in only one domain of SWB.

The health care staff who showed dissonance in more than one domain (ie in 4, 3 or 2 = 10.3%) (hereafter called dissonants), were significantly different from the rest of the staff when it came to investigating the impact of dissonance on perceived help for clients' SWB. However these spiritual dissonants were not easily identifiable, being spread over a variety of work areas, with no distinct pattern by age, gender, setting, position or religion (See table 4 for cross-tabulation results).

**Table 4: Cross-tabulations between spiritual dissonants and non-dissonants**

Variable	df	N	X <sup>2</sup> value	p <sup>sig</sup>	Phi
Age	4	216	3.070	ns0.546	0.12
Gender	1	219	0.012	ns0.912	-0.01
Setting	2	225	0.589	ns0.745	0.05
Position	2	225	1.050	ns0.591	0.07
Religion	4	225	3.580	ns0.466	0.13

The following graph shows mean values for each of the three factors: (A) ideal, (B) lived experience and (C) help, for each of the four domains of SWB (Personal, Communal), Environmental and Transcendental) compared by dissonance.



A=ideals B= lived experience C=help  
 Personal = PER; Communal = COM; Environmental = ENV; Transcendental = TRA

The spiritual dissonants were more idealistic (higher As) however their lived experiences did not match their idealism (much lower Bs). As a consequence, in keeping with the above finding of the influence of lived experience on perceptions of help, dissonants thought less help was provided by the workplace for clients in nurturing these aspects of their care (low Cs).

It would be valuable to follow up this study with one on personality to see how strong a relationship personality has on ideals compared with lived experiences of SWB. A study on burnout would also reveal whether dissonance in the domains of SWB, measured by SHALOM, related to emotional exhaustion and/or depersonalisation (Maslach et al 1996) in comparison with a study using another SWB scale (Marsh 1998).

It would also be desirable to observe people who tested high on dissonance in these SWB domains to see if they actually provided lower quality of care to clients, in line with their perceptions of the workplace.

If it was found that the dissonants did provide lower care for the SWB of clients, the questions would need to be raised as to whether these people refer clients to others, or if professional support would be warranted to improve their skills in this area. Issues of competence and cost would need to be weighed against quality of client care in line with the stated mission and vision statements of the health care services. Recent research concluded that 'prevailing health care systems ... do not always lend themselves to holistic (including spiritual) approaches to care. This study identifies a need for nurse education to redress the clearly inadequate preparation nurses are given for this aspect of their role' (Lea 2005).

There is not space here to discuss the issue of whose responsibility it is to provide spiritual care for clients (Pesut 2006; Narayanasamy 2004; Kellehear 2002; Govier 2000). However this study has shown that SHALOM can be used to identify the potential of staff to provide such care. Identifying these people may go some way to helping overcome barriers to spiritual care (as expressed in Vance 2001).

## CONCLUSION

SWB is a complex construct however this study has shown that SHALOM is a useful indicator for four domains of spiritual health and wellbeing of health care staff, reflected in the quality of relationships they have with self, others, the environment and/or God. The beliefs and worldview of health care staff influence their ideals for SWB to a greater extent than age, gender, or workplace setting. These ideals markedly impact their lived experiences which reflect their SWB. In turn, their lived experiences have a major influence on their perceptions of help provided to clients in these areas in their workplaces.

Spiritual dissonance, resulting from distinct differences between ideals and lived experiences in four domains of SH, was identified in a particular group (comprising ten percent) of these health care staff. They held high ideals they were not able to realise, resulting in lower perceptions of the workplace.

Using SHALOM to indicate levels of SWB of health care staff has implications for care of clients in the workplace.

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