

**The Spiritual Dimension in Nursing:
A Mixed Method Study
on Patients and Health Professionals**

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PhD Thesis

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List of Papers

Paper I

Berg Torskenæs, K. & Kalfoss, M. H. (2013) Translation and focus group testing of WHOQOL Spirituality, Religiousness, and Personal Beliefs module in Norway. *Journal of Holistic Nursing*, 31(1), 25–34.

Paper II

Torskenæs, K. B., Kalfoss, M., & Sæteren, B. (2015) Meanings given to spirituality, religiosity, and personal beliefs: Explored by a sample of a Norwegian population. *Journal of Clinical Nursing*, 24(23–24), 3355–3364. doi:10.1111/jocn.12962

Paper III

Torskenæs, K. B., Baldacchino, D. R., Kalfoss, M., Baldacchino, T., Falzon, M., & Grima, K. (2013) Nurses' and caregivers' definition of spirituality from the Christian perspective: A comparative study between Malta and Norway. *Journal of Nursing Management*, 23(1), 39–53. doi:10.1111/jonm.12080

Paper IV

Baldacchino, D., Torskenæs, K., Kalfoss, M., Borg, J., Tonna, A., Debattista, C., Decells, N., & Mifsud, R. (2013a) Spiritual coping in rehabilitation—a comparative study: Part 1. *British Journal of Nursing*, 22(4), 228–232.

Baldacchino, D., Torskenæs, K., Kalfoss, M., Borg, J., Tonna, A., Debattista, C., Decells, N., & Mifsud, R. (2013b) Spiritual coping in rehabilitation—a comparative study: Part 2. *British Journal of Nursing*, 22(7), 402–408.

Abstract

Introduction: The main aim of this mixed method research was to investigate how patients and health professionals in Norway and Malta understand the spiritual dimension in relation to holistic nursing and coping with illness. The international WHOQOL-SRPB field-test instrument, which measures spirituality, religiousness, and personal beliefs, developed by the World Health Organization (WHO), was applied to help focus on this important subject. It was translated by following the WHOQOL SRPB Group's (WHO, 2004) fixed translation process, and it was subsequently validated. This involved conducting focus group interviews with healthy and sick adults for the cognitive testing of the instrument. The focus group setting provided the opportunity to expand the interviews and explore participants' understanding of the spiritual dimension and the value they ascribe to it in their own lives and when coping with illness. A comparative study with Malta provided an intercultural understanding, which enriched and enhanced the overall understanding of the spiritual dimension.

Method: This thesis is a report of a mixed method study with a convergent comparative design. With this design, it was possible to draw on the strengths of each method to answer the research question. For both the quantitative and qualitative approaches, data was collected from an identical sample, but the analysis was performed using separate methods. For the quantitative approach, data was analyzed using SPSS Version 17.0 statistical software; the qualitative data were analyzed using thematic content analysis and the systematic text condensation approach. The main integration of the quantitative and qualitative strands of this thesis occurred in the overarching interpretation and discussion section. Completing this thesis involved three major steps, which also represent the papers included:

The first was the translation of the WHOQOL-SRPB field-test instrument, which entailed using a quantitative approach, survey, and a qualitative aspect, namely the cognitive testing in focus groups (Paper I).

The second was exploring patients' and health professionals' understanding of the spiritual dimension in Norway by expanding the focus group interviews, which was a qualitative approach (Paper II).

The third was the comparative study between Norway and Malta, specifically investigating (1) health professionals' understanding of spirituality, commonalities, and differences (Paper

III) and (2) spiritual coping experienced by patients with chronic illness in Norway and Malta (Paper IV). Both involved qualitative approaches.

Findings: This thesis yielded a translated international instrument, tested for validity, and culturally relevant among patients and health professionals in the present study. It showed satisfactory validity within the present sample despite some limitations of the liability in one of the instrument's eight facets. Taking these limitations into consideration it can be recommended for use both in research and in the education of health professionals in the context of the spiritual dimension. Further research is needed with a diverse sample to strengthen the validity of the instrument.

The participants involved considered the spiritual dimension important, and ascribing importance to the spiritual dimension seemed to be independent of their backgrounds. The high mean score on the survey answers and the qualitative analysis through derived themes support this conclusion. The spiritual dimension was understood as something multidimensional, transcendent, and sacred. The analysis of both the survey and the themes derived corroborate this view, and the finding is independent of whether participants had secular or religious backgrounds.

Furthermore, it was found that both patients and health professionals seldom discussed the spiritual dimension for various reasons, including its multidimensionality, a lack of knowledge, and a lack of the vocabulary required to discuss spiritual issues. Thus, many patients reported that their spiritual needs were neither identified nor met. In addition, the findings showed several differences between Norway and Malta. In Malta, more terms that are religious were used to explain spirituality, while in Norway more existential phenomenological terms were used. The spiritual dimension was shown to be an important aid for patients coping with chronic illness.

Conclusion: In light of the findings, the spiritual dimension is important for wholeness and for daily living, both for patients and health professionals. The spiritual dimension appears to lend cohesion to holistic nursing, joining the physical, psychological, and social aspects. The spiritual dimension is important when coping with illness; spiritual coping strategies were shown to be most effective, whether religious or existential. Moreover, the spiritual dimension seemed to be a resource in nursing. Therefore, increased understanding of the spiritual

dimension would possibly enhance holistic nursing, which may bring more wholeness into the nursing profession. Patients will feel that professionals have seen them as whole persons when their spiritual needs are met.

1. Introduction

1.1 A Personal Approach

With this thesis, I hoped to contribute to the growing interest in the spiritual dimension of nursing. The *spiritual dimension* is defined in the context of nursing as having to do with meaning, purpose, fulfillment in life, hope, and the wish to live, and it includes belief and faith (Ross, 1997; Sheldrake, 2007). My background in nursing as an intensive care nurse in Sweden, the United States, and Norway influenced my choice of topic. Having worked in intensive care *high tech*, or high technology, for several years without being aware of its dichotomy *high touch*, the human element of caring, I found *high touch* to be scarce.

Naisbitt and Cracknell (1982) described this dichotomy, *high touch*, as focused on using interpersonal skills. After I became familiar with the practice of total patient care in the United States in 1973, where the human elements of care was an important part of caring for the whole patient, I came to understand the importance of holistic care. Nurses had their “own” individual patients, and they had to tend to all those patients’ different needs, whether physical, psychological, or spiritual. This made me realize how much *high touch* was missing in the *high-tech* environment of the intensive care units in 1970s Sweden. The most valued qualifications for nurses at that time were technical skills. The rapid introduction of new technology in the 1970s, which influenced nursing, especially in intensive care units, greatly contributed to this situation (Burkhardt & Nagai-Jacobson, 2002). According to Barnum (1994), “only when technology is second nature will the nurse be secure enough to focus on high-touch aspects” (p. 63). Thus, only once nurses are familiar with all the technology in the intensive care ward it will be possible for them also to be aware of the human elements of care.

Understanding the dichotomy between *high tech* and *high touch* was an awakening for me that enabled me to see the importance of the interpersonal elements of nursing. It highlighted patients’ need for more than high-tech skills. As an intensive care nurse with expertise in nursing technology, I could now concentrate on the human elements of nursing and shift my focus to holistic nursing. According to Eriksson (2007), holistic nursing addresses the patient’s physical, social, psychological, and spiritual needs. Spirituality in this context

includes both secular and religious existential needs. The word “spiritual” derives from the Latin noun *spiritus*, which means breath, air, or wind and refers to images of life (Delgado, 2005).

A study on job satisfaction among intensive care nurses in Norway showed that for nurses to gain job satisfaction, their work had to be meaningful. The nurses with high competence experienced less stress and better job satisfaction. Their work became more meaningful due to their expertise in *high tech*, which made it possible to also become aware of *high touch*, the human elements of care. This seems to work both ways: when nurses are aware of the human element of caring, patients receive holistic care and provide positive feedback to the nurses, which increases the nurses’ job satisfaction (Berg, 2002).

This has also been my own experience. For example, while working in the intensive care ward, I was assigned a patient, a drug addict from Oslo, who was at risk of being HIV positive. The patient, who had been in the ward for over a week, needed breathing assistance with a respirator as well as other medical treatment. The nurses’ report indicated that she was restless and sometimes pulled out the IV tube and urine catheter, but that she was calm when a nurse was at her bedside. Because of the HIV risk, the nurses developed the habit of sitting in the doorway at a distance from the patient.

When I took over the responsibility of her care, I asked myself how I could be at her bedside, which reportedly would give her peace, while at the same time using my eight hours effectively. The technical aspects of nursing care consumed a great deal of the nurses’ time; in addition, they also had to administer and register medication. Being comfortable with the high-tech tasks, I observed the patient and wondered what I could do for her. The patient could whisper despite the tube in her throat, and we could communicate a little. She was aware of the voluntary work of the Marita Foundation in Oslo and had been there. I saw that her hands were filthy and needed to be cleaned and that her nails needed to be cut. I asked if she wanted me to do that for her. She looked startled, doubting if I really wanted to do that for her, but agreed to let me. While I was busy with the manicure, she asked why I was doing this. I explained that we were two people meeting, interacting, and giving to each other; she stroked my cheek and looked happy. I went home that day knowing that the patient had received holistic care, including spiritual care, and for me it meant increased job satisfaction.

For everyone working in a care situation, it is important to take personal beliefs and values seriously. Research has shown that nurses who do assess patients' spiritual needs have reflected on their own view of life (Rykkje, Eriksson, & Rahlm, 2013; Ross, 1997). Leenderts (2014) also emphasized the importance of a person's own values when she determined that we have moved from a paradigm where our own values were kept private and health professionals were neutral about their own values to a paradigm where acknowledging personal beliefs and values are part of being professional. In this new paradigm, health professionals should use their own values with discriminatory awareness; thus, one should clarify one's own values only if the patient seems to benefit from it (Leenderts, 2014).

1.2 Background of the Spiritual Dimension in Nursing

To understand the spiritual dimension of health care, one needs to examine the roots of health care. The principles of charity described in the biblical story of the Good Samaritan inspired nuns and monks at convents and monasteries to help the sick and needy. Nursing as a profession has its roots in the work of Florence Nightingale, who wrote *Notes on Nursing* and established the nursing school at St. Thomas Hospital in 1860. Her work was based on two principles: her Christian faith and on science. Furthermore, she believed in care that focused on unity, wellness, and the interrelationship of human beings (Huxley, 1975; Calabria, 1997). Cathinka Guldberg, a nurse, established the first diaconal hospital in Norway in 1868. Her view was that the spiritual dimension of nursing was a natural part of caring for the sick. To attend to patients' spiritual needs was for a long time included in nursing and deemed an important task. For example, it was said about Ingeborg Skjervheim, a nurse working at the first diaconal hospital in 1945, that she not only attended to her patients' physical needs but also cared about their soul and spiritual well-being. Thus, she had a holistic view in her nursing practice (Bergh, 2009).

In the wake of the Second World War, a mechanistic and reductionist view of human beings developed, which also influenced nursing. During the subsequent technological and scientific developments, it was difficult to retain a holistic view of nursing where patients' spiritual needs were part of nursing care (Stifoss-Hanssen & Kallenberg, 1998). The medical model—based on scientific theory, quantification, and physicalism—dominated the delivery of health care (Wood, 1998). Moreover, medical technological development influenced nursing as a

profession, and nurses' technological skills became more important than their interpersonal skills. Physical care with all its technical elements, or *high-tech* care, was time consuming and challenging for nurses, who needed special education that emphasized technology. The interpersonal human elements of nursing, *high touch*, where nurses interact with patients and use the communication skills of nursing was more or less neglected. However, *high touch* is needed to balance *high tech* nursing to prevent dehumanization of care.

Numerous nursing theorists, such as Neuman in the 1920s, Roy in the late 1930s, Watson in the 1940s, Eriksson in the 1980s, and many others, began searching for the roots of nursing. They wanted to find a way back to a holistic view of nursing that included the spiritual dimension. They theorized, rewrote nursing, and conceptualized what nursing is and is not (Kirkevold, 1998). By doing that in different ways, many of them reestablished and emphasized the human elements in care and, with that, the holistic view of care.

The Neuman Systems Model from 1979, for example, is a theory based on individuals' relationship with stress, their reaction to stress, and reconstitution factors. Its focus is on the person as a complete system, with interrelated physical, psychological, sociocultural, spiritual, and developmental factors. This holistic and system-based approach to nursing supports the spiritual dimension. Roy's adaptation model from 1976 focused on flexibility and change as it relates to holistic nursing. Adaptation occurs when people respond positively to environmental changes (Roy & Andrew, 1999). Watson's theory from 1979 addressed human love and charity. She declared that the spiritual dimension is the most important dimension in nursing and that it provides life to all other aspects of the profession (Watson & Woodward, 2010). Eriksson (1987), who developed the caritative caring theory, viewed the patient as an entity made up of the body, soul, and spirit. She divided the spiritual dimensions into existential spirituality, religious spirituality, and Christian spirituality. She focused on the meaning of the spiritual dimension and health, and she emphasized respect for the absolute dignity of the human being (Kirkevold, 1998). Some of these nursing theories are examined in the theory chapter.

For the last 30 years, spirituality in nursing has been a theme for discussion and speculation. Despite this, nursing education in Norway did not include a great deal of information on spirituality as late as 1992. For example, *Klinisk sykepleie* [Clinical Nursing] by Hallbjørg Almås (1992) failed to mention spirituality although the book was widely used in nursing

education. Spirituality was at that time often connected with a person's religiousness and prayer practices. Later, Gjengedal and Jakobsen's (2001) *Sykepleie praksis og utvikling* [Nursing Practice and Development] included a chapter about spirituality and culture. Gjengedal and Jakobsen (2001) noted that in Scandinavia, nurses have difficulty assessing and identifying spiritual needs among their patients, while in other parts of the world, nurses are more familiar with spirituality and the role religion plays in people's lives. Consequently, the authors broadened the concept to include religious and existential needs. In the last 20 years, nursing research has uncovered the inadequacy of spirituality in nursing care. For example, caring for the dying and hospice care, medical nursing, dementia nursing, and psychiatric nursing have received a great deal of research attention (Baldacchino, 2003; Tornøe, Danbolt, Kvigne, & Sorlie, 2014; Ødbehr, Kvigne, Hauge, & Danbolt, 2014; Haug, Danbolt, Kvigne, & Demarinis, 2015; Koslander, da Silva, & Roxberg, 2008). Many nurses still feel that their spirituality is private; therefore, they do not discuss spirituality among themselves. In addition, a lack of knowledge about the spiritual dimension leads to a lack of discussion of this topic (Ødbehr et al., 2014).

A study from a palliative care center in Norway involving serious cancer diagnoses showed that few health professionals prioritized and responded to patients' spiritual and existential needs (Sæteren, Lindstrom, & Naden, 2011). In this study, the nurses helped the patients with everything relating to physical needs, but few dared to take the initiative to talk about existential and spiritual concerns. The patients assumed this was due to nurses' unfamiliarity with talking about subjects concerning suffering and death. Nevertheless, the existential or the serious things in life should concern all nurses working with people, especially in palliative nursing (Sæteren et al., 2011). The existential questions are included in the spiritual dimension when using a wide definition, which this thesis does. Carr (2008) found that only occasionally were spiritual assessment and spiritual care prioritized due to the conceptual confusion of the meaning of the spiritual dimension in nursing care. Her findings further identified special qualities nurses need to develop caring relationships, such as receptivity, humanity, competency, and positivity (Carr, 2008).

1.3 A Brief Presentation of This Thesis

This thesis contributes to the emerging field of spiritual care in nursing, and the research is situated in nursing science, drawing on insights from the psychology of religion and spirituality. Research has shown that the majority of health professionals do not recognize spiritual needs (Ross, 2006; McSherry & Jamieson, 2011). Consequently, many patients experience spiritual distress (Burkhardt & Nagai-Jacobsen, 2002; McSherry & Jamieson, 2013). The spiritual dimension in nursing should be a natural part of holistic care and of the human elements of caring, the high-touch care.

The purpose of this thesis was to explore the spiritual dimension in nursing in Norway and Malta and to understand how patients and health professionals view the spiritual dimension in their own lives and when coping with illness. The thesis addresses the research question, How do patients and health professionals understand the spiritual dimension in relation to illness coping and holistic nursing?

To focus on the spiritual dimension, a measuring instrument was required. The options available for measuring spirituality in a population included the Spiritual Well-Being Scale (Paloutzian & Ellison, 1991), the Functional Assessment of Chronic Illness Therapy (FACIT)–Spiritual Well-Being measure (Brady, Peterman, Fitchett, Mo, & Cella, 1999), and many others. However, most of those instruments are designed for patients suffering from cancer and receiving palliative care, and for this thesis, the researcher required an instrument that was applicable for both patients and health professionals and not focused on a specific disease. A field-test instrument developed by the WHO related to quality of life and designed to measure spirituality, religiousness, and personal beliefs (WHOQOL-SRPB), seemed suitable and was chosen. This instrument is designed to include all kinds of spirituality in any culture, and it contains eight different facets or dimensions of spirituality, which are explained in a subsequent section.

One round of data collection was conducted in Norway and one in Malta. First, the chosen instrument had to be translated into Norwegian by following the translation methodology set out in the WHOQOL-SRPB Group's standardized translation protocol (WHO, 2004). It includes forward translation, consensus from an expert panel, back translation, pretesting and cognitive interviews, and the construction of a final version. Cognitive interviewing in focus

groups produced the final version of the instrument. The translation process is described in Paper I. The focus group interviews were expanded to generate knowledge about the participants' understanding of the spiritual dimension as referred to by the WHOQOL-SRPB concepts of spirituality, religiousness, and personal beliefs. The expanded interviews are described in Papers II, III, and IV.

To obtain a broader understanding of the spiritual dimension, a comparative study involving participants in Malta was initiated and included. The study, which compared spirituality and illness coping in different contexts, is described in Papers III and IV. Thus, the context of this thesis includes both Norway and Malta. The main context was the Norwegian setting, detailed in Papers I and II. Norway covers 323,810 square kilometers and has a population of 5.1 million; 15.6% of the population is immigrants or descendants of recent immigrants from neighboring countries and the rest of the world (Statistics Norway, 2015a,b). Norway has a Lutheran Christian heritage, and until January 1, 2017, the country had a state church. Nevertheless, due to the low rate of attendance of weekly church services, Norway is considered a secularized country. However, this is questionable because 74.3% of the population remains members of the Lutheran Church (Statistics Norway, 2013). Norway supports religious freedom and is multicultural, with most world religions represented (Rykkje et al., 2013; Haug et al., 2015; Sørensen, 2012).

Malta, with a population of 446,547, occupies 316 square kilometers. This island country is approximately 1,200 times smaller than Norway, with about 100 times more people per square kilometer. The non-Maltese population accounted for 4.8% of the total in 2011, and many people of British, French, and Lebanese origin have assimilated into the Maltese nation. In Malta, 95% of the population is registered as Roman Catholics (Gouder, 1996). The cultural influence from the British colonial era can be defined as Latin European. Malta is a family-centered country, and many of its older inhabitants receive care from family members, who are classified as informal caregivers (Baldacchino, 2003).

According to the WHO (2004), the sample for the study needed to include both healthy and sick adult people. In Norway, this was achieved by including patients from one nursing home and two rehabilitation centers and health professionals from a surgical ward at one hospital, from one rehabilitation center, and from one nursing home. Patients and health professionals recruited from one general hospital and one psychiatric hospital, as well as informal

caregivers from the community, represented the sample in Malta. The purpose of comparing the views of the spiritual dimension in nursing of participants from these two relatively different countries was to examine and attempt to understand whether differences in cultural and religious background affect the study outcome. In addition, it was intended to compare the understanding of and importance ascribed to the spiritual dimension in a multicultural and a less religious and secularized country to that in a country with a heavy religious background. These issues are further discussed in the discussion chapter of this thesis.

1.4 Concept Clarification

In this section, concepts frequently used in this thesis, such as holistic nursing, health, spiritual/religious coping, and quality of life, are clarified. Also the concepts related to the WHOQOL-SRPB field-test instrument, namely spirituality, religiousness, and personal beliefs, and, finally, the understanding of the spiritual dimension used in this thesis are explained.

1.4.1 Holistic Nursing/Care

The terms “holism” and “holistic” come from the Greek root *holos*, which means “all,” “whole,” “entire,” and “total.” Holistic medicine deals with the human being as a whole and involves a multifaceted approach to the health–disease issue. It considers the physical, psychological, sociological, and spiritual dimensions of the human being. Similarly, holistic medicine emphasizes the importance of the interaction between the different dimensions (Papathanasiou, Sklavou, & Kourkouta, 2013). Bradshaw (1994) said about holism that the whole is greater than the individual parts.

In nursing, holistic care is synonymous with total patient care, where one addresses patients’ physical, psychological, emotional, social, and spiritual needs. It is care involving the entire person, where all parts of an individual share equal importance in a balanced way (McSherry, 2007). According to McSherry (2007), holistic care should not be viewed as forming different parts of a pie chart, which often is how holistic care is symbolized. He emphasized wholeness and that each part is integrated into the others’ dimensions. Moreover, McSherry described spirituality as “being the thread, the force that penetrates, integrates and harmonizes all the different dimensions of a person in an equal, unique, hidden and mysterious manner” (2007,

p. 62). Ross (1997) agreed with this view when she noted that the spiritual dimension is what pervades all other dimensions of human beings. Baldacchino (2010, p. 24) held a similar view, although she pictured the different dimensions as circles that overlap each other in a bigger circle, which emphasizes the integration of the various dimensions with one another.

1.4.2 Health

In 1948, the WHO defined *health* as a state of complete physical, mental, and social *well-being*, and not merely the absence of disease or infirmity. This well-known definition has been widely criticized for being utopic due to the absolutism of the word “complete”—no one can possess complete well-being. Another problem with the definition is that the demography of the population and the nature of disease have changed dramatically since 1948 (Larsen, 1996). One of the critics of this definition is a Norwegian scholar Professor Hjort (2010), who views the WHO’s definition of health as the definition for a happy life. He formulated his own definition of health, “the surplus of energy in relation to daily demands” (Hjort, 2010, p. 181), which relates health to coping in everyday life. Good health was for him equal to having the ability and capacity to cope with and adapt to life’s difficulties and everyday demands (Hjort, 2010).

Fugelli and Ingstad (2001) concluded that there are three important qualities of health, namely wholeness, pragmatism, and individualism. Wholeness, which applies to all aspects of life and society, is a quality also found in the WHO definition. Pragmatism, in this context, means health is a relative phenomenon, experienced and evaluated according to what people find reasonable to expect given their age, medical condition, and social situation. Individualism refers to health being a personal phenomenon, as every human being is unique (Fugelli & Ingstad, 2001). The latter two qualities are missing from the WHO definition.

1.4.3 Spiritual/Religious Coping

In their cognitive-phenomenological-transactional (CPT) model, psychologists Lazarus and Folkman (1984) defined coping as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p. 141). They further defined stress as a phenomenon arising from a dynamic interaction between events in a person’s environment and the person himself, including thoughts and feelings. This encounter raised questions, conscious or unconscious:

Am I in trouble or am I benefitting now, or in the future, and in what way? According to Lazarus and Folkman, a person's own interpretation of the stressor influences one's well-being, and not the stressor alone. A person who encounters a threatening stimulus might react first with a *primary appraisal*, during which the individual assesses the challenges or demands made by the situation and determines if it is irrelevant, benign-positive, or stressful. The next reaction might be a *secondary appraisal*, which is the individual's estimation of his or her ability to cope and determination of what might and can be done in the situation. *Reappraisal* follows, which involves a check on the relative effectiveness of any coping behavior carried out to reduce the demand or to adapt to the stressor. Primary appraisals, secondary appraisals, and reappraisals interact with each other in determining the degree of stress experienced.

According to Lazarus and Folkman (1984), one can cope using either *emotional-focused strategies* and/or *problem-focused strategies*. Emotional-focused strategies lessen emotional distress and maintain hope and optimism, for example, through avoidance, minimizing, distancing, and many other actions that can be used to change the meaning of a situation. Problem-focused strategies define the problem and search for alternative solutions for actions. The results of coping depend on a person's coping resources, social skills, social support, and material resources (Lazarus & Folkman, 1984).

From a psychological religious point of view, coping has been defined as "a search for significance in times of stress" (Pargament, 1997, p. 90). Significance involves both feelings and beliefs associated with importance and value, but it can also be object oriented. For example, significant factors can be possessing good health, developing or maintaining close relations, psychological and spiritual well-being, freedom, and equality. The more our significance is threatened, challenged or harmed, the greater the stress. In addition, coping is both a process of the individual preserving what is significant in life and the process of transformation. Whether the coping process will be *preservative* or *transformative* depends on the individual's personal history. To achieve a positive coping effect, the various elements of coping have to work together. Pargament (1997) presented three styles of religious coping: self-directing, where control is sought by the self; deferring, where control is passively turned over to God; and collaborative, where control occurs in collaboration with God. His findings showed that even when coping was self-directing, the participants maintained an affiliation

with their churches (Pargament, 1997).

1.4.4 Quality of life

The WHO (1995) defined *quality of life* as “an individual’s perception of their position in life in the context and culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (p. 1405). Quality of life concerns six areas of life: the physical, the psychological, level of independence, social relations, surroundings, and spirituality/religiousness and personal beliefs. Quality of life is linked to every part of being human. In the WHO definition, the authors recognized a person’s value system by seeing both the individual and the whole person, which supports the holistic view of nursing care proposed in this thesis. In a similar vein, Næss, Eriksen, and Tambs (2007) examined definitions of quality of life. They claimed that a person has high quality of life if the person often views experiences as good or valuable, and low quality of life if the person views most experiences as bad or negative. The researchers considered positive and negative aspects of life and regarded psychological well-being as equal to quality of life (Næss et al., 2007). The present study leans toward the WHO definition while including all areas of life and maintaining a holistic view.

1.4.5 Spirituality

Several researchers have attempted to understand the meaning of spirituality (Ross, 1997; Delgado, 2005; Sheldrake, 2007). However, although many have attempted to define spirituality (Ross, 2006; Delgado, 2005; Sivonen, 2000; Rykkje, 2013), in nursing there is no single universal definition. Therefore, in this section, different approaches to spirituality from nursing, psychology of religion, and sociocultural studies are presented.

According to De Marinis (2008), each individual has an existential dimension and spiritual nature through which a variety of expressions appears that represents different kinds of meaning-making systems, whereas for Narayanasamy (2006), spirituality is the very essence of our being and what gives meaning and purpose to our existence. Sivonen (2000) carried out a semantic analysis of spirituality. She claimed that there are different aspects that cannot be neglected in caring such as “the human’s search for strength, meaning and goals, shared relationships, spiritual uplifts, quality of life and relationships with God (a relationship with an abstract other), and goodness”(p. 334). Other scholars mentioned meaning, purpose, and fulfillment, connectedness, and self-transcendence as values occurring in various definitions

of spirituality (Burkhardt & Nagai-Jacobsen, 2002; Barnum, 1994; Reed, 1992). This highlighted the diversity of understandings of the spiritual dimension among researchers.

Delgado (2005) conducted a multicultural investigation with the aim of conceptualizing spirituality in nursing by examining people's views of life in Western and Eastern countries. In addition, she explored existentialism and theistic and atheistic views of life. She described four characteristics important for understanding spirituality and argued that none of them can stand by themselves. According to Delgado (2005), spirituality (1) requires faith or acceptance of a belief system, (2) is a personal search for meaning and purpose, (3) is connection and relatedness to others, and (4) is self-transcendence. Her findings showed that the consequence of spiritual connections is inner peace, which entails optimism and hope and may indicate successful coping with stress. She hoped to motivate nurses to see spirituality as a powerful force for holistic nursing (Delgado, 2005).

Stifoss-Hanssen and Kallenberg (1998) formulated a definition of the spiritual dimension that covers the existential questions of both a religious and secular nature. They contended that the spiritual dimension is like an umbrella, covering both the existential questions and the work involving them. Working with those questions would create value awareness and a person's view of life or faith (Stifoss-Hanssen & Kallenberg, 1998).

McSherry (2007) emphasized that spirituality is universal for everyone and that it is something that goes beyond everything. It is not up to the individual to do something or work to reach a state of spirituality:

Spirituality is universal, deeply personal and individual; it goes beyond formal notions of ritual or religious practice to encompass the unique capacity of each individual. It is at the core and essence of who we are, that spark which permeates the entire fabric of the person and demands that we are all worthy of dignity and respect. It transcends intellectual capability, elevating the status of all humanity. (McSherry, 2007, p. 35)

Baldacchino (2010) studied definitions of spirituality and found that the spiritual dimension is what builds the person and integrates the bio-psychosocial components. Furthermore, la Cour and Hvidt (2010) conducted research in Denmark investigating how the word "spirituality" is understood in a secular country. Their study supports the view that there is no common understanding of spirituality, as it seems to mean different things to different people. They found three domains expressing spirituality—the secular existential domain, the spiritual

existential domain, and the religious existential domain. This emphasizes the importance of both clarifying the context in which spirituality is used and connecting it with an expanding understanding. In another study, la Cour, Ausker, and Hvidt (2012) identified six understandings of spirituality: positive dimensions in human life and well-being, new age ideology, an integrated part of established religious life, a vague striving opposed to religion, selfishness, and ordinary inspiration in human activities. La Cour et al. (2012) meant that the word “spirituality” is too broad to produce meaningful conversation unless it is defined. They emphasized that when researchers use the word “spirituality,” it should always comprise the possibility of another reality than that already known; a context, specific situations, activities, or acts; and individual longing and experiences of a special relatedness. The authors of the Danish study agreed with most of McSherry’s definitions discussed above.

Zinnbauer, from a psychological point of view, defined spirituality as “a personal or group search for the sacred” (Pargament, Zinnbauer, Paloutzian, & Park, 2005. p. 35). He emphasized first that it is a search conducted by a person or group(s) in an attempt to identify, articulate, maintain, or transform something. Second, it has to do with the sacred. To understand Zinnbauers’ definition of spirituality one has to know what he means with the sacred:

The sacred refers to the holy, those things “set apart” from the ordinary, worthy of veneration and reverence. The sacred includes concepts of God, the divine and the transcendent. However, it is not limited to higher powers. It also includes objects that become sanctified by virtue of their association with, or representation of the holy. (Zinnbauer, Pargament, & Scott, 1999. p. 907)

The sacred can be a person, an object, a principle, or a concept that transcends itself, and perception of the sacred raises feelings of respect, reverence, and devotion. Thus, Zinnbauer meant that *spirituality is a broader construct* than religiousness and that it has the advantage of following recent trends by believers and psychologists who have characterized the term spirituality in this way. He noted that it provides a link to other disciplines that have begun to investigate spiritual phenomena without acknowledging the long history of research within the psychology of religion (Pargament et al., 2005). Nursing is one of those disciplines. For example, Rudolfsson, Berggren, and da Silva (2014) argued that “within the nursing context, spiritual needs and spirituality should be seen as a broad concept encompassing religion but not equated with it” (p. 64).

Numerous categories for describing spirituality have emerged from various studies (Gleason, 1998; Bartel, 2004, as cited in Austin, 2006). These categories include a sense of the holy, actions of the holy, beliefs and practices, affective responses, personal responsibility, community, meaning, vocation, hope, grief, humor, forgiveness, courage, virtue, and beauty (Austin, 2006).

At a 2009 U.S. national conference on improving the quality of spiritual care in palliative care settings consensus was reached on a definition for spirituality. They agreed that: “Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred (Puchalski et al. 2009, p. 25).”

Subsequently, according to Selman, Young, Vermandere, Stirling, and Leget (2014), the European Association for Palliative Care (EAPC), a taskforce representing 35 countries, discussed this definition in relation to European culture in an effort to develop spiritual care in the European context by drawing on the experience of others. Building upon the WHO definition of palliative care, there was much discussion about the definition of spiritual care, yet the spiritual field is multidimensional. EAPC discussed existential challenges, value-based considerations, and attitudes, and reached consensus on the following definition of spirituality:

Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or sacred. (Selman, et al., 2014)

As demonstrated above, there is still no universally accepted definition for, or consensus on, the concept of spirituality (Rykkje et al., 2013). This highlights the need for further research to understand this complex concept. However, in this study, the researcher chose to apply the broader concept of spirituality, including both religious and secular understandings of the concept.

1.4.6 Religiousness

Traditionally spirituality was part of religiousness, until secularization began in the last century. Religiousness was broad enough to include the spiritual, and it encompassed both individual and institutional beliefs and activities (Turner, Lukoff, Barnhouse, & Lu, 1995). Religiousness viewed from different approaches means different things for different people in

the same way spirituality does. Baucal and Zittoun (2013) took a *sociocultural approach* to religion and examined people's religious experiences. They found that people are not "religious" or having a "religious experience" but are engaged in activities, thoughts, or emotions inspired by socially constructed systems. Religion offers symbolic systems that provide people with a variety of opportunities for real and inner dialogues, and people become inspired to create their own systems of meaning making. Further, religious elements help to support different types of dialogues, such as with self, with a distant or imaginary other, with groups, and between groups. People look for individual elements that can be used as symbolic resources, for example, engaging in religious practices such as taking part in bible studies or joining home or singing groups can support one's sense of belonging. Baucal and Zittoun (2013) examined whether individuals or groups use religious experiences as resources to achieve something significant to them. They discussed how religion participates in human meaning making and emphasized the importance of the historical and cultural contexts of religion (Baucal & Zittoun, 2013).

Pargament (1997), from a *psychological point of view*, argued that religion is oriented around the sacred. The sacred includes the divine and beliefs with various practices and feelings, and relationships associated with the divine. Religion involves building things people care about, and changing and holding on to things tied in various ways to the sacred. Moreover, Pargament defined religiousness as "a search for significance in ways related to the sacred" (Pargament et al., 2005, p. 36). The concept of *search*, people being goal oriented and engaged in the pursuit of whatever they hold important, while *significance* is a phenomenological construct that involves the experience of caring, attraction, or attachment. It also is related to things that are significant to people and to what is important to the individual, institution, and culture. For an explanation of the *sacred*, please see the discussion on page 23. Furthermore, social scientific research claims that there is both a substantive and a functional approach to religion (Pargament, 1997). The substantive approach focuses on the beliefs, emotions, practices, and relationships of individuals in relation to a higher power or divine being. The functional approach, on the other hand, emphasizes the function religion serves in the life of the individual.

For Pargament, *religiousness is the broader concept*, and it addresses a wide range of goals with all aspects of human functioning, sacred and profane. While spirituality is only a search for the sacred, religiousness is a process through which people seek to discover, hold on to,

and, when necessary, transform whatever they hold sacred in their lives (Pargament et al., 2005). He argued that religiousness is the broader concept because it will maintain continuity with a century of research and scholarship within the psychology of religion, and he pointed out the dangers of elevating spirituality as the broader concept, as Zinnbauer does. One of these dangers is the polarization of religiousness and spirituality. Spirituality then represents the individual and broader perspectives as the good, and religiousness represents the institutional as the bad. Another danger is that the sacred may be lost, for example, when words such as “fulfilling,” “moving,” “important,” or “worthwhile” substitute spirituality. According to Pargament, those words are not equal with spirituality unless they involve the consideration of the sacred. Zinnbauer defined religiousness as a personal or group search for the sacred that unfolds within a traditional sacred context. This is similar to the definitions of Pargament in that they both emphasize the dependency of the context and both include the sacred (Pargament et al., 2005).

When spirituality was differentiated from religiousness, it retained some of the elements formally included within religiousness, such as transcendence, supernatural phenomena, sensitivity, and meaningfulness (Spilka & McIntosh, 1996). Recent definitions of religiousness have become more narrow and institutionalized, and involved with means and methods, rituals, prescribed behavior, and theology. Koenig, McCullough, and Larson (2001) differentiated religion from spirituality and believed religion has to do with institutional doctrines, rituals, and different traditions. It is focused on community and can be observed, measured, and organized. In contrast, spirituality is individualistic, less visible, more subjective, and emotionally oriented. In addition, evidence suggests that religiousness and spirituality describe in part different concepts, but are inherently intertwined. Both concepts are multidimensional, multilevel, and complex constructions. They are related to biological, affective, cognitive, moral, relational personality or self-identity, sociocultural, and global phenomena (Koenig, McCullough, & Larson, 2001).

According to Zinnbauer and Pargament, researchers should investigate both spirituality and religiousness in the same study, and the concepts need to be explored within the same context. In the research study conducted by Pargament et al. (2005), religiousness was associated with higher levels of authority, religious orthodoxy, parental religious attendance, self-righteousness, and church attendance, while spirituality was associated with mystical experiences and described in personal or experiential terms, such as belief in God or a higher

power. Religiousness and spirituality did not differ in the nature of the sacred. However, spirituality is the favored term to describe individual experiences (Pargament et al., 2005). Nursing professionals need to understand patients' individual experiences of spirituality and their needs, thus the favored term in nursing is "spirituality including religiousness."

1.4.7 Personal Beliefs

Cultural background and environment influence a person's belief system, and an awareness of own values and beliefs can help people to cope with difficult issues in their lives (Puchalski & Ferrel, 2010). In an article on spirituality, religiousness, and personal beliefs, Fleck and Skevington (2007) noted that "personal beliefs may function as a strategy to cope with life problems, since they give meaning to human behavior and hypothetically influence quality of life" (p. 67). Personal beliefs encompass the basics of human existence, which is that individual's view of life and way of comprising reality, sensitivity, human dignity, and ethics (Stifoss-Hanssen & Kallenberg, 1998).

Jeffner (1981) defined belief by three different components. The first is people's assumptions about humanity and the world, and the second the valuations and criteria that help people differentiate between good and evil, between what is valuable and worthless. The last is people's basic demeanor, the attitude of hope, trust, despair, and pessimism their view of life provides (Jeffner, 1981). In other words, personal beliefs play a significant role in how people manage their lives and values.

1.4.8 The Understanding of the Spiritual Dimension Employed in this Thesis

After having explored both spirituality and religiousness from various angles, including nursing, sociology, and psychology, the researcher agrees with Zinnbauer, who declared *spirituality as a broad concept* including religious aspects. In addition, Baucal and Zittou's (2013) opinion that both concepts have to be examined to understand *the sacred* and that religiousness seems to be declining in popularity influenced the understanding of the spiritual dimension employed in this thesis. In addition, the researcher included existential questions in the spiritual dimension, which were understood with both religious and nonreligious worldviews, consistent with Stifoss-Hansen and Kallenberg (1998). Moreover, the definition formulated by EAPC and supported by the WHO's definition, which includes both *transcendence* and the sacred (Selman et al., 2014), is suitable for the European context and

thus suitable for this thesis. The WHOQOL-SRPB field-test instrument highlights the importance of survey respondents answering questions from their own view of life, which might include different worldviews.

In summary, in this thesis, the spiritual dimension implies the concepts of spirituality, religiousness, and personal beliefs and forms part of holistic care, which means caring for the whole person by considering the person's physical, psychological, social, and spiritual needs. The spiritual dimension is a natural facet of the interpersonal elements of nursing represented by the *high touch* much needed to balance the *high tech* to achieve holistic nursing. The spiritual dimension is understood as a wide dimension that includes religious and existential phenomenological views of life.

1.5 Presentation of the WHOQOL-SRPB Field-Test Instrument

The WHOQOL-SRPB is an international and intercultural survey used to measure quality of life and spirituality, religiousness, and personal beliefs, modeled on the Delphi method. Throughout the last half century, the World Health Organization Quality of Life (WHOQOL) Group has developed various instruments and modules to assess quality of life in groups of healthy and sick people. Measuring quality of life with the WHOQOL-100 module indicated that the four questions in the view of life area influenced many of the other areas of life. This caused growing interest in how a person's view of life influences his or her quality of life in different cultures. Knowing that people worldwide express many forms of spirituality, the WHOQOL Group believed there was a need for a spirituality measurement suitable for different cultures, religions, and spiritual groups (WHO, 2006). The Group developed a module measuring spirituality, religiousness, and personal beliefs (SRPB) using the *Delphi method*. The Delphi method is based on corporate information from a range of culturally diverse centers, and the technique is designed as a group communication process that aims to achieve a convergence of opinions on a specific real-world issue (Hsu & Sandford, 2007).

The WHOQOL-SRPB field-test instrument was developed using a group of experts in the field of health, religion, and psychology, who were also representative of the major beliefs worldwide and who generated concepts of spirituality, religiousness, and personal beliefs. The experts explained the different ways their beliefs affected their quality of life. Brainstorming

and conceptual mapping of these ideas followed, and small working groups were formed to write definitions and sample items. After the meeting of experts, a series of 92 focus groups were conducted with 701 participants across 15 culturally diverse centers. Pilot testing was done at 18 sites in different countries (Saxena, O’Connell, & Underwood, 2002). The WHOQOL-SRPB field-test instrument entails eight different facets with four question each: connectedness to a spiritual being or force, meaning in life, awe, wholeness and integration, spiritual strength, inner peace/serenity/harmony, hope and optimism, and faith (WHO, 1995). Fleck and Skevington (2007) noted that the philosophy underpinning the development of the WHOQOL-SRPB derived from a quality of life perspective, specifically having a profound belief—religious or not—that could give transcendental meaning to life and to daily activities.

1.6 Examining Literature Concerning Spirituality

During the research process, different literature searches were conducted at various times. The search strategy involved using the keywords “spirituality,” “holistic nursing,” “WHOQOL-SRPB,” “health,” “nursing care,” and “spiritual coping,” and the PubMed, SveMed+, CINAHL, OVID Nursing Database, PsycINFO, and Google Scholar databases were searched. The choice of articles was based on the focus of the different papers completed in support of this thesis, such as the spiritual dimension (Paper I); spirituality, religiousness, and personal beliefs (Paper II); the definition of spirituality (Paper III); and spiritual coping (Paper IV). Similarly, the research question of this thesis was a search focus. In this section, research where the WHOQOL-SRPB field-test instrument was applied is assessed to compare the results of other studies with the results of this study.

In addition, literature concerning the spiritual dimension in relation to holistic nursing and health was reviewed. In December 2015, a new literature search was undertaken to examine some of the recent publications from Scandinavian countries, as Scandinavia is described as a secular society. This time, the search was limited to the preceding five years, focusing on spirituality, health, and Scandinavia, and the search instruments used were the OVID Nursing Database and PsycINFO. This search indicated that although many articles had been written about spirituality in Scandinavia, few combined spirituality and health. Nevertheless, there seems to be an increased interest in spirituality, religion, and health among researchers. Articles related to holistic nursing and health and spiritual coping were reviewed. In

combination, these studies helped to reveal the knowledge gaps that support the need for this thesis.

1.6.1 Research Involving the Application of the WHOQOL-SRPB Field-Test Instrument

In a study conducted in Britain, O'Connell and Skevington (2005) examined whether spirituality, religion, and personal beliefs were important issues related to quality of life and well-being. The WHOQOL-SRPB was applied to healthy and sick individuals, who also participated in focus group interviews. The instrument included spirituality, religiousness, and personal beliefs categorized as eight facets measuring different characteristics of the concepts. The focus groups discussed and rated the importance of each facet. Facets shown to give meaning to all the groups were *spiritual strength*, *meaning in life*, and *inner peace*. The results of the study underscored the importance of including SRPB in the concept of health-related quality of life (O'Connell & Skevington, 2005).

Also in Britain, Burkhardt and Nagai-Jacobsen (2002) explored the current state of peoples' religious, moral, and spiritual beliefs. The field-test instrument was applied to identify different religious groups, which were subsequently invited to participate in focus groups and to answer SRPB-focused questions based on the WHOQOL questionnaire. Nine groups of healthy individuals and two groups of patients, 55 people total, volunteered to participate. The findings showed that some of the facets of the instrument had a Christian bias with religious orientation, such as the facet "spiritual connection," which made them less relevant for atheists and agnostics. Despite this finding, the overall evidence from the study encouraged the inclusion of those variables related to spirituality, religiousness, and personal beliefs within QOL instruments to provide a fuller holistic assessment of well-being (Burkhardt & Nagai-Jacobsen, 2002).

Moreover, research was conducted in Italy to test quality of life regarding spiritual activities performed at a rehabilitation hospital (Boero & Squazzoni, 2005). The sample was 116 health care workers who completed the field-test instrument and questions in WHOQOL-100 related to the spirituality/personal values facets, which encompassed four questions or items. The results showed that those who considered themselves religious showed higher scores on all aspects of the questionnaire. Better physical health corresponds to better QOL in the domain of spirituality. They suggested that a positive approach to life and disease through religion and spirituality may be of great help and may increase quality of life.

An international cross-cultural study tested the WHOQOL-SRPB field-test instrument in 18 countries with 5,087 people in relation to WHOQOL-100 (WHO, 2006). It was found that spirituality, religiousness, and personal beliefs facets correlated highly with WHOQOL domains, which are physical, psychological, independence, social, environmental, and spiritual. The strongest correlation was with the psychological and social domains. The study highlighted differences in quality of life in different groups. Older people reported greater faith, inner peace, spiritual strength, wholeness, and spiritual connection, and younger people reported being more hopeful and optimistic. For those who reported the poorest health, the SRPB domain was most important (WHO, 2006).

The different studies in which the WHOQOL-SRPB field-test instrument were applied showed that it is valuable for exposing the importance of and raising awareness of the spiritual dimension in health care. One study indicated that the instrument has a Christian bias and is thus unsuitable for atheists and agnostics. Furthermore, religious people obtained higher scores, which means spirituality increases their quality of life. The international study showed differences in relation to age—older people reported greater faith, inner peace, inner strength, wholeness, and spiritual connection, while younger people had higher scores on hope and optimism. Nevertheless, it was shown to be a useful instrument for measuring people's relation to their own spirituality, religiousness, and personal beliefs.

The WHOQOL-SRPB field-test instrument has been criticized for being too broad in defining spirituality and religiousness (Moreira-Almeida & Koenig, 2006). Moreira-Almeida and Koenig (2006) compared the instrument with numerous other scales measuring spiritual well-being and noted that all the comparison scales included questions about psychological well-being and mental health. The authors questioned the inclusion of constructs such as meaning in life and other altruistic activities, as these activities may be related to spirituality, but this is not necessarily the case. Their major concern was that spirituality is likely related to mental health, as it is defined by positive human characteristics already defined by mental health, and they contended that including both is tautological. In addition, they emphasized that spirituality and religion should always involve relationships with the sacred or the transcendent. Despite their criticism, Moreira-Almeida and Koenig (2006) expressed gratitude for the development of the instrument because it highlights the importance of the spiritual dimension.

Fleck and Skevington (2007), as members of the WHOQOL-SRPB Group, responded to the criticism. They underlined that WHOQOL-SRPB differs from other scales in the way it was developed, which is one of its main powers. The concepts were developed cross-culturally by international consensus, using the Delphi method of collecting focus group impressions, in this case from 18 centers worldwide. In response to the criticism regarding including psychological well-being questions, they pointed out that spirituality, religiousness, and personal beliefs are highly subjective concepts and agreed that they are not easy to measure. Therefore, they are measuring them with items that are characteristics and indicators of the concepts. They further emphasized that their philosophy behind the development of the instrument was that having a profound belief—religious or not—can give transcendental meaning to life and assist with coping with life crises. Moreover, the WHOQOL-SRPB Group is of the opinion that those with agnostic and atheist views also have a spiritual life.

The WHOQOL-SRPB is a pioneering design in the health measurement of SRPB and QOL; as such, it is a work in progress that needs continuous revision (Fleck & Skevington, 2007). Despite the criticism of the instrument, the researcher of this thesis chose to use it, as the contrasting view holds that it is a global assessment of an often-excluded dimension and that its development using the Delphi method of consensus was positive (Saxena *et al.*, 2002). Further, it includes both a qualitative and a quantitative approach, and it is suitable for atheists and people with divergent worldviews, which is important in a secular and increasingly multicultural country.

1.6.2 Spirituality in Relation to Holistic Nursing and Health

Many researchers have acknowledged the correlation between spirituality, holistic nursing, and health (Berglund, Westin, Svanström, & Sundler, 2012; Rykkje *et al.*, 2013; Oman & Thoresen, 2002; Koenig *et al.*, 2001; Kvande, Klöckner, Moksnes, & Espnes, 2015; Santavirta, Raholm, Eriksson, & Lindholm, 2004; Sørensen *et al.*, 2012). For example, Berglund *et al.* (2012) explored whether suffering is caused by inadequate spiritual care. Patients described increased suffering when they felt neglected, overlooked or objectified, and not cared for. Nursing must also involve the spiritual dimensions to see the whole person. In the study conducted by Berglund *et al.* (2012), many patients indicated that health professionals often see only the disease and not the patient as a whole person.

Rykkje et al. (2013) showed that religiousness was an important part of spirituality. They found that for older people, *childhood faith*, that is, the religious faith inherited as part of their family and cultural background, counted as a resource. According to Rykkje et al. (2013), nursing care of the whole person must include providing physical, social, psychological, and spiritual care. Additionally, all nurses should be able to provide some degree of spiritual care that supports spiritual, religious, and personal beliefs, but always according to the patient's desires. Patients who receive spiritual care feel that they have been seen and met as a whole person, which helps maintain human dignity and thereby improves health (Rykkje et al., 2013).

Oman and Thoresen (2002) explained the correlation between spirituality and health by identifying four pathways leading to better health: health behaviors, psychological states, coping, and social support. Similarly, Koenig et al. (2001) reviewed research on spirituality related to health and examined both positive and negative outcomes on mental health and physical health during the last 100 years. They explained how religion and spirituality have influenced health, and discussed the clinical implications for health professionals. They raised important questions: what does it mean that spirituality and religiosity have a positive influence on physical and mental health, and how can it be explained and what are the consequences for individuals?

According to Koenig, Ing, and Carson (2012), there seems to be reasons to believe that the relationship between religion and health is mediated rather than direct in some cases. The positive influence could be explained in part by the development of patients' diseases and other mediating factors such as better health behavior, lower stress levels, and greater social support (Koenig et al., 2012). The negative outcomes could, for example, be worsening depression because God did not intervene, anxiety caused by feelings of being condemned, or self-blame for accidents or diseases. Koenig et al. (2001) argued that many of the negative outcomes of spirituality could also be explained by mediating or contextual factors.

Kvande et al. (2015) noted that, in relation to the correlation between spirituality and health, values grounded early in life, such as lifestyle, social support, coping, and mental health, are important and can be influential and act as mediating factors. Santavirta et al. (2004) claimed that the spiritual dimension might have health improving potential. They found that spiritual care seldom is identified or attended to, and to improve care and reduce unnecessary suffering

in nursing, the spiritual and existential dimensions need to be accentuated and addressed (Santavirta et al., 2004).

A study conducted in Norway showed how religious activities and blood pressure interrelate (Sørensen et al., 2011), specifically that religious activities were associated with lower systolic and diastolic blood pressure. These findings are consistent with a study from Denmark (la Cour, Avlund, & Schultz-Larsen, 2006) and one from North America (Gillum & Ingram, 2006). Although the differences in blood pressure were small, it was speculated that the reduction likely would reduce cardiovascular disease by 10–20% (Sørensen et al., 2011).

It is reasonable to argue that the research studies discussed revealed how spirituality can be a resource in holistic nursing to see the whole person. It seems to have a positive influence on health and seems to reduce suffering, and spiritual engagement could probably reduce the risk of cardiovascular disease. Thus, many reasons exist for integrating spirituality into health care. Nevertheless, the literature supports the view that there seems to be inadequate spiritual care in clinical practice and therefore justifies the need for this research, which hopes to contribute by increasing knowledge about the complex concept of the spiritual dimension.

1.6.3 Spirituality in Relation to Holistic Nursing and Health in Scandinavia

Although spirituality has been researched extensively, few studies combine spirituality and health. Nevertheless, there seems to be an increased interest in spirituality/religion in relation to health among researchers (La Cour & Hvidt, 2010; Rudolfsson et al., 2014; Ødbehr et al., 2014; Tornøe et al., 2014; Haug et al. 2015; Giske & Cone, 2015). A study in which spirituality was interpreted as “meaning making” investigated the relationship between spirituality, religiosity, and health in Scandinavia. The study cited findings from a research by Grønvald, Pedersen and Jensen (2006) that cancer patients felt their religious and spiritual needs were not addressed satisfactorily during their hospitalization (la Cour & Hvidt, 2010). Studies conducted by Rudolfsson et al. (2014) and Ødbehr et al. (2014) showed how spirituality forms part of health care and holistic care. Rudolfsson et al. (2014) completed a literature review with the aim to describe what impact spirituality and spiritual values have on nursing. The authors distinguished between cultural, existential, and religious spirituality. Overall, their findings indicated that patients, staff members, former caregivers, and family members experienced spirituality as inclusive, fluid, and personal. In addition, the study

emphasized the value of “being with,” which in the caring context refers to two people meeting and represents high touch. In this type of meeting, spiritual values are essential. Rudolfsson et al. (2014) further found that spirituality embraced many perspectives at different levels of awareness and that nurses need to be aware of their own spirituality to provide spiritual care. However, the nurses and caregivers who participated in their study were afraid their workload would increase if they had to work also with their own values. The authors concluded that spiritual values in nursing were closely intertwined with the concept of caring and should be the guiding inspiration for all nurses (Rudolfsson et al., 2014).

Ødbehr et al. (2014) carried out a research study in Norway to investigate nurses’ and care workers’ experience of spiritual needs in patients with dementia in nursing homes. They conducted eight focus group interviews, and the analysis exposed three themes: the need for serenity and inner peace, the need for affirmation, and the need to express faith and beliefs. Ødbehr et al. (2014) found that nurses felt uneasy about discussing religious questions with their patients, and that nurses’ and care workers’ unfamiliarity with religious practices and difficulty talking about death reduced the quality of holistic care. Furthermore, the authors argued that there is a need to develop greater knowledge of the spiritual needs of patients with dementia.

Tornøe et al. (2014) examined whether nurses could alleviate suffering by providing spiritual care. The spiritual and existential care hospice nurses provided for the dying were examined using a narrative approach and by interviewing eight nurses. The nurses discussed their experiences of providing spiritual and existential nursing care, and the findings of the study exposed two themes, namely consolation and sensing. The findings indicated that nurses had mixed feelings about their ability to provide spiritual and existential care and that the level of care offered depended on their life experiences and personal beliefs. Additionally, the nurses viewed it as an ethical dilemma and wondered how they could encourage patients to open up and share their stress without violating their dignity and autonomy. The researchers concluded that by comforting patients and identifying spiritual and existential distress, which involves a high degree of sensitivity and courage, nurses have the opportunity to alleviate spiritual and existential suffering (Tornøe et al., 2014).

Haug et al. (2015) investigated how older people cope with incurable cancer, specifically how they experience the existential meaning-making function in their daily life from a life span

perspective. The researchers identified several resilience factors that helped patients cope with their new situations. A common understanding of resilience is that it is a process for adaptation to adversity. It can, for example, involve having a specialized health care system with person-centered palliative care. The researchers found that experiences from life history and meaning in life were factors that influence a persons' resilience and that resilience factors remained unchanged over a life span. The patients' existential meaning-making systems were interrelated and closely linked to those factors. Processes of both the resilience factors and existential meaning-making systems were found to be resources and important for patients in the adaptation process of living with incurable cancer and aging. This study confirms the importance of including existential meaning-making questions in the assessment of every patient's health history (Haug et al. 2015).

Furthermore, Giske and Cone (2015) aimed to identify the healing paths involved when nurses consider patients' spirituality in diverse health care settings. Their findings revealed the healing paths to be tuning in on spirituality, uncovering deep concerns, and facilitating the healing process. The nurses' main concern was to alleviate the patient's pain and suffering. In addition, the researchers found that spirituality is about deep things in life, or important and significant things, and it is part of the whole person. Spirituality affects how patients face health issues and life crises in all areas of nursing care. The findings show that certain conditions influence nurses' assessment of patients' spiritual needs, such as nurses' willingness to move outside their own comfort zones and build trustful relationships with their patients. Giske and Cone (2015) further found that nurses did attend to patients' spiritual needs through compassion when they recognized the suffering of the soul. The nurses saw the calmness of their patients when they experienced peace of mind and were astonished. The authors emphasized that it is a leader's responsibility to integrate spirituality in patient care (Giske & Cone, 2015).

Schmidt (2009) described leaders who took responsibility in her book about spiritual care in nursing, *Do You Have Time for It?* The leaders at her workplace agreed that spiritual care was the responsibility of nursing professionals. They realized that the item "view of life/faith" had disappeared from the admission documentation form. Although it had previously been included, it was removed several years earlier because it had seldom been documented. The leaders reintroduced the item at the end of the admission documentation form and determined a method to include spiritual care in the procedural handbook. Including this facet in standard

procedures helps to place patients' spiritual or existential needs on the agenda, and the leaders took this action in an attempt to understand patients' values by listening, observing, and being there for them. The guidelines included, for example, using open questions—such as, What is important for you right now?—and listening to patients and providing them with the relevant spiritual literature such as the Bible, a psalm book, the Koran and other religious literature. Similarly, it was important to compile a list of priests and other representatives of various religions and faith organizations. By conducting a spiritual assessment on all patients at admission, all personnel became more aware of patients' spiritual needs, and spiritual matters were no longer taboo but instead became part of procedure (Schmidt, 2009).

The studies discussed in this section revealed inadequate spiritual support for patients and uncovered how health professionals could experience an ethical dilemma about assessing patients' spiritual needs while wishing to reduce spiritual and existential suffering. Moreover, health professionals feared that this would increase their workload when they in addition would have to work with their own spirituality. Many health professionals do not feel comfortable discussing spiritual issues, which reduces the quality of holistic nursing. This situation highlights the complexity that surrounds the spiritual dimension in clinical practice and, in this context, the lack of competence among health professionals. Furthermore, this knowledge indicates the need for additional research linked directly to practice. It seems the institution of health care needs to develop a more empathetic attitude and to train nurses on how to talk about spiritual matters regardless of their own beliefs. With this thesis, the researcher hopes to contribute to solving the problems related to spiritual support.

1.6.4 Spiritual/Religious Coping

Pargament (1997) argued that religion and coping are separable concepts but related phenomena, and he identified three types of religious coping: self-directing, deferring, and collaborative coping. However, his theory has been criticized for building mostly on quantitative research, for excluding the term “existential” from his definition of religion, and for focusing on the influence of religion on coping (Batson & Schoenrade, 1991; Stifoss-Hanssen & Kallenberg, 1998; Ekedahl & Wengström, 2006; Ganzevoort, 1998).

According to Spilka, Kojetin, and McIntosh (1985), whether a stressful event will be understood and interpreted from a religious or nonreligious perspective depends on three things: the nature of the person, the nature of the event, and the nature of the context.

Religious/spiritual coping in chronic illness may reduce the risk of permanent disability and help combat the symptom burden, which may lead to increased independence and quality of life (Harvey, 2006; Rowe & Allen, 2004). Furthermore, some individuals become more spiritually aware during illness through prayer and self-reflection (Albaugh, 2003; Baldacchino, Borg, Muscat, & Sturgeon, 2012; Prince-Paul, 2008). This awareness may influence illness perception, and may lead to spiritual growth and adaptation to life events by using spiritual coping strategies (Baldacchino, 2003; Van Leeuwen, Tiesinga, Jochemasen, & Post, 2007). Koenig (1998) reported that religious coping strategies were stronger predictors of positive health outcomes compared with nonreligious strategies. Another study found that religious coping enhances well-being even when dealing with everyday problems (Kvande et al., 2015).

Torbjørnsen (2011), in a study on religious coping strategies in patients with Hodgkin's disease, found that both religious and nonreligious strategies were used, but that religious support from God or other higher powers through prayer, meditation, and divine presence were most effective. It provided both comfort and strength in the patients' battle with serious disease. His study increases the understanding that spirituality and religiousness are important parts of an individual's coping capacity (Torbjørnsen, 2011).

Park (2006) investigated the role religious coping played in relation to stress-related growth. Stress-related growth (SRG) is the positive changes in life that occur after coping with life-threatening situations. She explored the link between religion and SRG and identified several contributing factors, namely personality characteristics, external resources (social support), particular coping strategies, and religion. The strongest factor was religion. Both *intrinsic religiousness*, or individuals' faith "master motive" in life, and *external religiousness*, or faith that is more functional, such as religious participation, were factors linked to this type of growth (Park, 2006). Although her result can be criticized as limited because the context derives from a specific culture, it supports other research with the same result. Positive health outcomes may increase when religious and spiritual strategies are included in coping (Pargament, Smith, Koenig, & Perez, 1998). Those studies point toward positive outcomes of spiritual/religious coping and suggest that religious coping strategies are more effectual than nonreligious strategies.

The research studies reviewed and the research discussed in previous sections indicate that there is a positive connection between spirituality and health and that a knowledge gap exists concerning the spiritual dimension in clinical nursing (Koslander, 2008; Delgado, 2005; O'Brien, 2013; Rykkje et al., 2013; Baldacchino, 2003). The knowledge gap seems to be threefold: (1) There is a shortage of spiritual support for patients, which results in unnecessary suffering and decreased quality of life. (2) There is complexity surrounding the spiritual dimension that may cause insecurity among health care workers on how to meet their patients' spiritual needs. (3) Health professionals' low competence in the spiritual dimension, contributes to insecurity. Similarly, Selman et al. (2014) identified a knowledge gap while conducting an international survey of palliative care. They recognized it as barriers to spiritual care. They asked physicians, nurses, and chaplains—807 respondents total—to prioritize areas for further research, and the respondents highlighted three research questions: (1) How can staff be encouraged to discuss spiritual matters? (2) How do we identify patients and family members with spiritual needs? (3) How should we respond to spiritual distress or needs? (Selman et al., 2014) Overall, this exposes a lack of knowledge and a need among health professionals to work with their own values and view of life. In addition, Giske and Cone (2015) emphasized the importance of nurses showing a willingness to leave their own comfort zones and build trustful relationships with their patients. Through this thesis, the researcher hopes to contribute to filling some of these knowledge gaps.

1.7 Aims and Research Questions

The researcher's own experiences of the lack of interpersonal values, or *high touch*, and the historical development of nursing as a science established the background for this study. The emphasis on *high tech* due to technological developments and nursing research uncovering the need for spirituality further contributed. Therefore, the purpose of this thesis was to explore the spiritual dimension in nursing in Norway and Malta. To focus on the spiritual dimension, a questionnaire measuring spirituality, religiousness, and personal beliefs—the WHOQOL-SRPB field-test instrument—was translated and validated. In addition, the researcher aimed to investigate healthy and unhealthy individuals' understanding of the spiritual dimension and its importance in holistic nursing and in coping with illness. Consequently, the main research question was

How do patients and health professionals understand the spiritual dimension in relation to illness coping and holistic nursing?

The main research question was refined using subquestions derived from the four published papers included in this thesis:

1. Does the Norwegian translation of the WHOQOL-SRPB module and its items capture meaning among healthy and sick individuals in a Norwegian context? (Paper I)
2. What meaning does a Norwegian sample of healthy and sick individuals ascribe to the words “spirituality,” “religiousness,” and “personal beliefs”? (Paper II)
3. What meaning do four groups of nurses and two groups of caregivers from Malta and Norway ascribe to the term “spirituality” from the Christian perspective, and what are the comparisons? (Paper III)
4. How is the spiritual dimension of coping adopted by seven groups of clients with chronic illness receiving rehabilitation services in Norway and Malta, and what are the comparisons? (Paper IV).

2. Theoretical Framework

This chapter examines different nursing theories and a taxonomy of spirituality, which provided the theoretical framework for the papers included and for this thesis.

2.1 Eriksson's Caritative Caring Model

Eriksson's (2002) caritative caring theory resonates with the spiritual theme of this study. Caritative caring has its origin in the concepts of love and charity. The mission of caritative caring is serving life and health and alleviating suffering. The patient is viewed as an entity made up of the body, soul, and spirit. According to Eriksson (2002), when a nurse meets a suffering human being, compassion is to be a natural consequence. For her, suffering was closely related to health, and when suffering was bearable, health would develop. Thus, a caring relationship with a suffering person characterized by responsibility and by a desire to do good would alleviate suffering. All caring occurs in a relationship between a patient and a caregiver. The deepest ethical motive for caring involves respect for the absolute dignity of the human being (Eriksson, 2002).

Eriksson described health as becoming healthy, which is a dynamic movement toward entity and wholeness. Eriksson further referred to health as a movement between different levels; that is, the external objective level of health *as doing*, the existential level of health *as being*, and the level *of becoming* in health. The objective level of health, *doing*, refers to having health, judging one's health based on external, objective criteria, and attempting to live a healthy life. The existential level, *being*, refers to attempting to find balance and harmony in life and the level *of becoming* in health, being a dynamic movement toward integrity and wholeness. For Eriksson, health was more than the absence of illness. She included holistic nursing in her caring philosophy, which means caring for the whole person including the physical, psychological, and spiritual aspects (Eriksson, 2002, 2007; Kirkevold, 1998). This thesis aligns with Eriksson's definition of holistic nursing as seeing the whole person.

2.2 The Neuman Systems Model

The Neuman Systems Model (1972) is a model for teaching the total person approach to patient problems (Neuman & Fawcett, 2012). A client should be looked upon as an individual, family, group, and community. Interacting variables are physiological, psychological, sociocultural, developmental, and spiritual, and all variables are interrelated. Neuman and Fawcett (2012) states that Neuman's System Model describe spirituality as an essential variable that is an element of each individual's basic structure, enabling optimal wellness, health, and stability. Furthermore, Neuman's theory is based on the individual's relationship with and reaction to stress, and the individual's reconstitution factors.

Stressors are any environmental forces that can affect the stability of the system. She described prevention against imbalance in the systems as *primary*, *secondary*, and *tertiary* interventions. The *primary* intervention is the nursing intervention before the system reacts to stressors, while the *secondary* intervention occurs after the reaction to stressors and works to prevent damage and/or remove the stressor. The *tertiary* intervention takes place after the system has been treated, and it offers support to facilitate reconstitution. Nursing is concerned with the whole person and with the different variables that influence a person's response to the stressors. This system model is a holistic, system-based approach to nursing, supporting the needs of the spiritual dimension (Neuman & Fawcett, 2012).

2.3 McSherry's Taxonomy of Spirituality

McSherry (2007) derived his taxonomy of spirituality and its attendant descriptors from a grounded theory research study involving health care professionals, patients, and healthy individuals. The study implied that an individual's worldview determines his or her definition of spirituality. An individual's worldview is not fixed or rigid and may change during the person's life span, for example, because of illness or emotional stress. Thus, the individual uniquely defines spirituality. The orders of the descriptors of the taxonomy developed in this study are dynamic, as they are determined by the individual in line with that individual's worldview or religious beliefs. They represent two forms of spirituality, *the traditional*, represented by theistic and religious forms such as belief in a god or attending religious activities, and *the postmodern*, represented by the phenomenological and existential forms

such as meaning and purpose, creativity, and relationships. In addition, an individual may combine the different forms of spirituality. The different descriptors are

- *Theistic*—belief in a supreme being, cosmological arguments, not necessarily a “God” but a deity
- *Religious Affiliation*—belief in a God, undertaking certain religious practices, customs, and rituals
- *Language*—individuals may use certain language when defining spirituality, such as inner strength and inner peace
- *Cultural, political, social ideologies* —an individual may subscribe to a particular political position or social ideology that influence their attitudes and behaviours, dependent upon world faith/religious tenets
- *Phenomenological*—one learns about life by living and learning from a variety of situations.
- *Existential*—a semantic philosophy of life and of being, finding purpose and fulfilment in all of life’s events
- *Quality of life*—although quality of life is not explicit in definitions, it is implicit.
- *Mystical*—relationship between the transcendent interpersonal, transpersonal life after death (McSherry, 2007, p. 34)

The taxonomy highlights the subjective and personal nature of the spiritual dimension. In Papers III and IV, the taxonomy is discussed further, comparing Norway with Malta when different cultures shape how spirituality is understood.

3. Material and Methods

This chapter provides an overview of the background of the mixed method through a description and illustration (Figure 1) of the design. In addition, the material, instrument, sampling process, data collection, sample, and analysis methods are discussed. The chapter concludes with an explanation of the ethical considerations of the research.

3.1. Mixed Method

In this section, the rationale is discussed for using the mixed method and the specific analytical components chosen. This includes a discussion of the quantitative and qualitative approaches, the background and philosophical influence of the study, and the justification for using the focus group method. Furthermore, the level of interaction, relative priority, timing, and procedure for mixing the quantitative and qualitative approaches, are explained.

3.1.1 The Rationale for Using the Mixed Method Approach

The term “mixed methods” implies that several research methods are applied in a complementary manner to achieve the optimum answer to the research question (Borglin, 2015). It has its roots in pragmatism, or the practical application of ideas by acting on them to test them in human experience. The focus is on what works at the time, and researchers are free to choose suitable methods and combine them.

The pragmatic researcher attempts to provide the best understanding of a research problem and investigates only those questions that benefit the majority of the population (Creswell & Zhang, 2009). The Office of Behavioral and Social Sciences Research and the National Institutes of Health commissioned the leading team of Creswell, Klassen, Plano Clark, and Smith (2011) to create a guide outlining how to develop and evaluate mixed methods research applications. The researchers found that “a pragmatic perspective draws on employing ‘what works,’ using diverse approaches, giving primacy to the importance of the research problem and question, and valuing both objective and subjective knowledge” (Creswell et al., 2011. p. 4). The advantages of the mixed method are that it is practical, strengthens credibility, and increases trustworthiness (Grønmo, 1985).

A mixed method was chosen in this thesis due to the complexity of the spirituality, religiousness, and personal beliefs phenomenon. The research question could be examined from different perspectives using mixed methods, which increased the depth and consistency of the methodological procedure (Borglin, 2015). The mixed method approach taken in this thesis included quantitative research involving a survey and qualitative research involving focus groups in two different cultural settings, Norway and Malta.

3.1.2 The Rationale for Using the Quantitative Approach

The quantitative approach was used to describe variables and examine relationships between the different variables in the translated instrument for validation. These variables were measured, and they yielded numeric data that could be analyzed statistically. The purpose was to provide a context for the inquiry about the spiritual dimension—it provided an overview and assessment of patients' and health professionals' self-reported understanding of the spiritual dimension. During the survey, the participants' individual voices emerged through the self-reporting of data. Moreover, using a quantitative method made it possible to compare the results with other larger international studies that have used the same instrument, for example, O'Connell and Skevington (2005).

3.1.3 The Rationale for Using the Qualitative Approach

The rationale for using a qualitative component was twofold: First, it formed part of the field-test instrument translation process through the cognitive interviews conducted in focus groups. Second, through the expanded interviews, it was possible to examine the participants' understanding of the complexity of the spiritual dimension to uncover meanings ascribed to the different concepts related to spirituality, religiousness, and personal beliefs, that is, their lived experiences.

The philosophy of phenomenology was helpful for understanding the participants' lived experiences. Husserl emphasized that phenomenology concerns understanding lived experiences and that it contends that all experiences are intentional and directed toward things through particular concepts in the world (Jeanrond, 1994). The findings from this thesis showed that the participants' own experiences were directed toward the concepts of spirituality, religiousness, and personal beliefs. The participants together reflected in focus

groups about their own situations and lives. Thus, the *hermeneutic tradition* was influential in interpreting the meaning participants ascribed to the spiritual dimension. Hermeneutics, the theory of understanding and interpreting the meaning of human expressions, life, and existence (Riis & Berzano, 2012), is useful when a problem exists of understanding, for example, a text or an artwork (Jeanrond, 1994). To understand a text, the text and the reader need to come together.

Habermas (1973) noted that the hermeneutical understanding has limitations. The understanding depends on both the preknowledge, which all understanding begins with, and communicative competence. Communicative competence was considered in this thesis when the researcher experienced varied levels of communicative competence in interview participants. The hermeneutic circle, which refers to the interplay between self-understanding and understanding the world, was a helpful tool for analyzing the text that had been transcribed verbatim. Understanding the whole in terms of preknowledge and then understanding each individual part by referencing the whole increases and deepens the knowledge of the whole (Ramberg & Gjesdal, 2005). Consequently, the method of analysis employed in this research was thematic content analysis performed with the aid of the hermeneutic circle.

3.1.4 The Rationale for Using Focus Groups

The focus group as qualitative method was used in this thesis because it promotes interaction within the groups, which produces data and insights that would remain buried without the dynamics of the group (Lindlof & Taylor, 2002). This method has been criticized for poorly reported sample size, and arguments have been made for explaining group size (Carlsen & Glenton, 2011). Additionally, group pressure could silence individual voices (McLafferty, 2004), and problems with facilitation techniques and design (number of groups, heterogeneity versus homogeneity) have been stressed. It has further been noted that the skills of the moderator and assistant moderator are key to conducting successful focus groups (Mansell, Bennett, Northway, Mead, & Moseley, 2004). With these criticisms in mind, the researcher made every effort to diligently report both sample size and the reasons for choosing the specific size. In addition, the influence of the moderators is discussed in the Discussion chapter.

3.1.5 The Procedure for Mixing Quantitative and Qualitative Components

When planning mixed method research, one must consider several important questions, particularly those related to establishing the most suitable method of combining the various analytic components. To this end, one must consider the level of interaction, relative priority, timing, and procedure for mixing the components (Creswell et al., 2011). In this thesis, the level of interaction was independent, meaning the two methods were mixed mainly at the point of overall interpretation when conclusions were drawn during the discussion of the results. The qualitative aspect of the research was afforded relative priority due to the facts required to answer the research question, specifically in relation to the meaning and importance of the spiritual dimension. Furthermore, the methods were used concurrently—that is, both were implemented in a single phase of the study during the data collection (Borglin, 2015). Finally, the procedure for mixing the different components was implemented during the validation of the translated survey and during the interpretation of the participants' understanding of the factors or dimension of spirituality under investigation.

Various mixed method designs have been used in health sciences, sociology, and education. According to Creswell et al. (2011), there are four main designs: the convergent or parallel, explanatory or sequential, embedded, and multiphase design. The difference depends on where in the process the methods have been integrated—during analysis, interpretation, or reporting. In this thesis, the convergent or parallel design was implemented. This design is characterized by concurrent data collection, where the researcher collects quantitative and qualitative data simultaneously but keeps it separate during analysis, first integrating it during the overarching interpretation and discussion of results (Creswell et al., 2011).

The convergent design was selected for this study because quantitative and qualitative data were collected once from an identical sample. The patients in the sample suffered from different diseases and had experienced different treatments, and their personal experiences of spiritual support or lack of spiritual care varied. To broaden the scope of respondents' background experiences, the data collection occurred in varied health care settings. Data was kept separately and was analyzed using different methods. Similarly, findings were interpreted separately. However, the integration of the quantitative and qualitative approach took place in the Discussion section in Paper I. Papers II, III, and IV, had only a qualitative approach. The main point of integration in this thesis occurred in the overarching

interpretation and discussion of findings. The mixed method approach was deemed an efficient tool for answering the research question.

3.2 Research Design

This mixed method study employed a convergent comparative design, as explained above. Data was collected from an identical sample, which means the same participants were involved in the quantitative and qualitative data collection. The participants were categorized into two groups, namely the patient group and the health professional group. By using the quantitative approach, it was possible to examine the relationships between the groups and the variables of the WHOQOL-SRPB field-test instrument. By using the qualitative approach, it was possible to obtain a comprehensive understanding of the concepts.

Moreover, the researcher wished to compare participants from Norway with participants from Malta, one of the most traditional Catholic countries in Europe. This was intended to derive information from a religious context different from the context of Norway, which increases the capacity for generalization (Riis & Berzano, 2012). In addition, a comparative study was conducted to address the lack of comparative studies about spirituality involving more than one group (McSherry, 2007). Employing mixed methods combined the strengths of each method to answer the research questions.

The research on which this thesis is based involved three distinct steps:

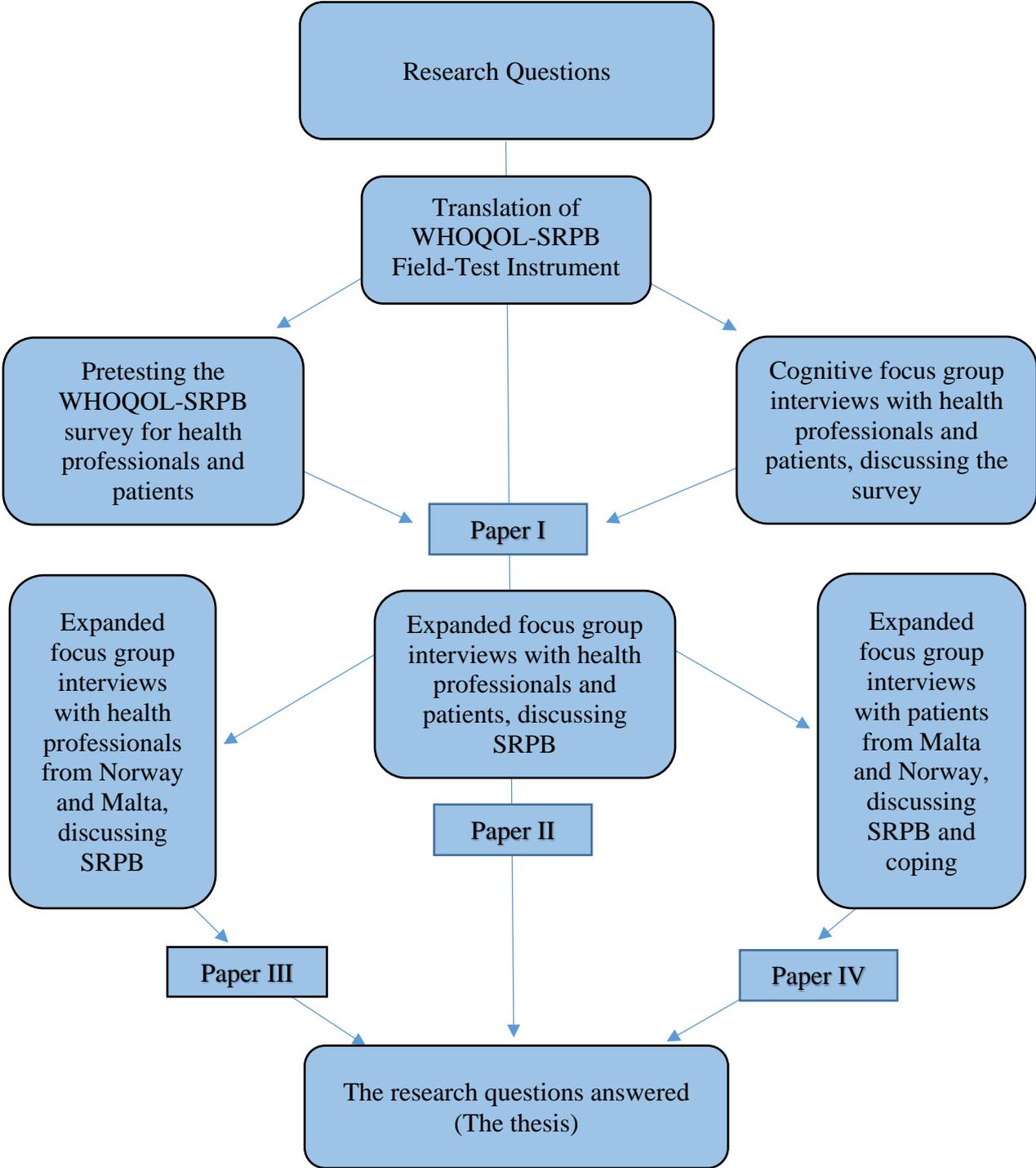
First, the translation of the WHOQOL-SRPB field-test instrument using a quantitative approach, namely a survey, and a qualitative approach, namely cognitive testing in focus groups (Paper I);

Second, exploring patients' and health professionals' understanding of the spiritual dimension in Norway using a qualitative approach (Paper II); and

Third, comparing Norway and Malta using a qualitative approach. This encompassed exploring (1) health professionals' understanding of spirituality, commonalities, and differences (Paper III), and (2) spiritual coping experienced by clients with chronic illness in Norway and Malta (Paper IV).

Figure 1 provides a visual representation of the research design.

Figure 1. Convergent Comparative Research Design



3.3 Material

In the subsequent sections, the translation of the survey, the sampling process, the samples, and the collection of the quantitative and qualitative data are presented.

3.3.1 Translation of the WHOQOL-SRPB Field-Test Instrument

The preparatory work for the focus group interviews began with translation of the survey into Norwegian. The translation methodology was based on the WHO's (2004) standardized translation protocol described in Paper I. The aim of the translation process is achieving versions of QOL instruments in different languages that are conceptually equal in various cultures. The instrument should be equally natural and acceptable and should perform in the same practical manner in different cultures. The focus was on cross-cultural and conceptual, rather than on linguistic and literal equivalence.

The translation method involved forward translation, consensus by an expert panel, back translation, pretesting and cognitive interviewing, and creating a final version. For the cognitive interviewing, a minimum of five focus groups was recommended, with groups including both healthy and sick individuals and with a group of health professionals. When forming groups, it was essential to focusing on gender equality and including people of various ages, socioeconomic backgrounds, and faith communities. However, it was stated that religious, spiritual, or personal beliefs were to be representative of the country involved (WHO, 2006).

The researcher and one associate professor in nursing performed the forward translations from English into Norwegian. Both were familiar with terminology related to spiritual issues and proficient in the Norwegian language. Subsequently, an expert panel consisting of a lecturer in nursing with a background in nursing and pastoral care, a professor in nursing with a background in instrument development and translation, a research director with a background in nursing and project administration, and the researcher reviewed the translation. The expert panel negotiated the most appropriate consensus version. A native-English speaker who did not have access to the original English version performed the back translation. Following the guidelines set out in the translation methodology, the expert panel and the back translator discussed discrepancies between the original text and the back translation with the researcher

until consensus was reached. Finally, pretesting and cognitive interviewing were performed on focus groups.

3.3.2 Sampling Process

Purposive, or judgmental, sampling (Burns & Grove, 2001) was implemented, with an identical sample used for both the quantitative and the qualitative strands. The purpose was to apply the WHOQOL-SRPB field-test instrument to ill and healthy individuals and to interview them in focus groups. Due to the researcher's background as a nurse and familiarity with the research field, patients were recruited to represent the participants who were ill and health professionals were selected to represent healthy people. To control bias, the criteria from the WHOQOL-SRPB translation methodology were used. Only those who met the criteria were accepted into the study. Eligible participants were required to be 18 years old or older, have no apparent memory or fatigue problems, and able to read, write, and communicate clearly. The exclusion criteria were seriously ill individuals, those with cognitive problems, those who were easily fatigued, and those with hearing, speaking, and writing problems. In accordance with the WHOQOL-SRPB translation methodology, data was to be collected from focus groups consisting of five to 10 participants. A minimum of five groups was recommended.

For recruitment purposes, letters of invitation were posted to the administrators at institutions in Southeast Norway that had formal collaboration contracts with the university college heading the study. The administrators delegated responsibility to unit administrators, who identified specific contact nurses. The contact nurses received information regarding the study: a short information sheet about the study, copies of the WHOQOL-SRPB field-test instrument, and focus group guidelines. To maintain participant confidentiality and control bias, the contact nurses identified potential volunteer participants based on the inclusion and exclusion criteria.

The same procedures were performed in Malta as in Norway to obtain comparison data, as reported in Papers III and IV. Each focus group was carried out separately in both countries. As preparation for the focus group interviews, all participants were asked in advance to fill out the WHOQOL-SRPB field-test instrument and a demographic data sheet. In Norway, two hospitals, two rehabilitation centers, and four nursing homes were invited to participate in the

research, and one hospital, two rehabilitation centers, and two nursing homes agreed to take part; this represented both rural areas and larger cities. Six focus groups were conducted, with five to six participants in each group. In Malta, two hospitals, one acute general hospital and one psychiatric hospital, were invited to participate, and all agreed to take part. Ten focus groups were conducted, with eight to 10 participants in each group.

Planning and conducting a focus group with patients can be time consuming. In Norway, the researcher had trouble during data collection, especially with recruiting patients for the focus group interviews. Patients were often occupied with different examinations, and their time on the wards was short, with many being released within three days of having an operation. For example, on one surgical ward, the researcher was invited to present the study, and patients volunteered to participate in a focus group three times, but each time the researcher faced obstacles such as examinations and treatments. Many of the patients moved to rehabilitation centers after dismissal from the hospital. Thus, the researcher contacted the chief of a rehabilitation center for permission to conduct a focus group with patients at that center. The center expressed interest and invited the researcher to present the study at a meeting for the personnel. The researcher was also free to walk around among the patients and present the research study to them, and a contact nurse selected participants for the focus group from those who volunteered to participate based on the inclusion and exclusion criteria. At another institution, the contact nurse forgot to include a patient who wanted to participate.

One focus group at a nursing home was dismissed from the research because the contact nurse had not considered the inclusion and exclusion criteria. In addition, at one rehabilitation center, the contact nurse assigned health professionals to participate in a focus group. Consequently, participants had not even opened the invitation envelopes and had not completed the questionnaire in advance. The participants were informed that participation was voluntary, but none left. The group used the first 10 minutes of the interview to fill out the survey and demographic data sheet.

On the other hand, in Malta, more patients, health professionals, and informal caregivers volunteered to participate, and they were accepted after consultation with the Research Ethics Committee. That participants were recruited from a Catholic country with less privacy surrounding spirituality could explain the relative ease of recruiting participants. Therefore, the groups were larger and more group sessions were conducted in Malta than in Norway.

3.3.3 Data Collection

Data was collected using an identical sample; thus, the same sample was used to collect the quantitative and qualitative data, with data collection carried out once per group in Norway and once per group in Malta. The guidelines followed were recommended by the WHOQOL Group. See Appendix 3: Semi-structured interview guide.

Collecting quantitative data

The WHOQOL-SRPB field-test instrument, a survey that includes demographic questions, was used to collect quantitative data. The focus group participants completed the survey in preparation for the focus group interviews. Demographic variables were age, gender, marital status, and education, and the field-test instrument contained variables measuring spirituality, religiousness, and personal beliefs, called facets. The variables were connectedness to a spiritual being or force, meaning in life, experience of awe, wholeness and integration, spiritual strength, inner peace/serenity/harmony, hope/optimism, and faith. The researcher conducted six focus groups in Norway within two months: three groups with patients with five participants in each group, and three groups with health professionals with six participants in each group, which yielded 33 cases in total. The purpose was to explore a pattern of association between the concepts of spirituality, religiousness, personal beliefs, and coping, and between patients and health professionals.

Collecting qualitative data

During the focus group interviews, the qualitative data also was collected. The researchers in Norway and Malta were the moderators of all the focus groups, and each group included an observer who was a specialized nurse. The moderator directed the discussion and summarized the major points. The observer monitored the group, managed the technical equipment, and assisted the moderator, particularly with refreshments. The discussions were conducted in Norwegian and Maltese, respectively, to increase understanding and ease expression of ideas. In both countries, frequent summaries were provided during focus group sessions. To validate what was said in the focus groups, summaries of the main understanding of the concepts were fed back to the participants at the end of the sessions. Each institution accommodated the focus group interviews on its premises.

The group discussion began with familiarizing the group members with one another. This was followed by an open discussion about the understanding the participants attached to the terms

“spirituality,” “religiousness,” and “personal beliefs.” the expanded interviews. The researcher began with this aspect of the interviews to ensure that the participants were influenced as little as possible by the questions in the survey. In the later part of the interviews, the researcher explained that the purpose of conducting focus groups was also to discuss ideas and raise questions regarding the translated WHOQOL-SRPB field-test instrument to evaluate its relevance and conceptual clarity and to assess the wording of the items. In addition, the participants were free to recommend changes.

The participants discussed the first question and, by ranking each item separately, they checked if the items captured meanings relevant in the Norwegian context. Furthermore, they suggested additional items for inclusion and openly shared their perceptions. At the conclusion of each session, the moderators briefly summarized the discussion points and asked for further comments to ensure reliability. The participants’ understanding of the various concepts was recorded according to the interview guidelines. Directly after the focus group sessions, the moderators and observers also wrote short summaries of the major points and functional issues related to the meeting.

3.3.4 Presentation of the Participants

In Norway, three focus groups were conducted with patients, one at a nursing home and two at rehabilitation centers, with five participants in each group. The patients had been diagnosed with burnout syndrome, orthopedic disease, heart disease, arthritis, and gout. Three focus groups were conducted with health professionals, from one hospital, one rehabilitation center, and one nursing home, with six participants in each group.

In Malta, seven focus groups were conducted with patients who had been diagnosed with lower limb amputation, chronic heart diseases, and osteoarthritis, from one acute general hospital and one psychiatric hospital. In addition, three focus groups were conducted with health professionals and informal caregivers from the same clinics. Participants’ demographic information is shown in Table 1.

Table 1**Demographics in Norway and Malta**

	Norway		Malta	
Demographics	Patient <i>N</i> = 15	Health prof. <i>N</i> = 18	Patient <i>N</i> = 44	Health prof. <i>N</i> = 29
Gender: female	62%	89%	65%	65%
Age: 31–50		55%		40%
: 51–70	18.8%	44.5%	44%	60%
: 71–90	75%		56%	
Marital status				
Married	25%	5.6%	34.1%	58.6%
Single	12.5%	0 %	13.6%	24.1%
Widowed/divorced	56.3%	94.4%	52.3%	17.2%
Education: secondary school or higher	73.3%	70%	30%	65%
Perceived religious person				
Not at all/low	6.2%	16.7%	6.8%	13.8%
Moderately	56.3%	44.4%	31.8%	44.8%
High/very high	37.5%	38.9%	61.4%	41.4%

3.4 Methods

In this section, the analysis methods used for the quantitative and qualitative analyses, and a table presenting Bernard's thematic content analysis are provided.

3.4.1 Quantitative Analysis

In this thesis, the researcher employed the WHOQOL-SRPB field-test instrument. All 33 of the focus group participants completed the questionnaire. Quantitative data was registered based on a codebook in collaboration with the international study center of the WHOQOL Group (WHO, 1995). The Group recommend that if more than 20% of responses on a questionnaire are missing, the data should be discarded, and when one item is missing, it

should be substituted with the mean within the same facet. When more than two items are missing, the facet is not calculated. The mean within the same subscale replaces the missing values. The researcher adhered to these guidelines.

The data files were analyzed using SPSS Version 17.0 statistical software, and data analysis was performed using a descriptive approach with frequencies of variables related to the sample. Frequency distribution was used to describe the characteristics of the variables and to organize data. In addition, analyses were employed to explore differences between groups in relation to sociodemographic variables, which mainly were nominal variables but included some interval variables such as registering age. Moreover, the WHOQOL-SRPB questionnaire contained ordinal variables with four indicators for each variable in a Likert scale; therefore, several items were summarized in a score. Mean scores and standard deviation for each facet were measured to find a central tendency. Independent *t* tests were applied to assess the mean differences between the six focus groups in relation to the different spirituality, religiousness, and personal beliefs facets. The questionnaire contained eight different facets, which makes up the different variables (see Paper I).

3.4.2 Qualitative Analysis

The qualitative data included two kinds of data from the focus group interviews and was analyzed using two approaches.

Expanded focus group interviews (Part 1)

The expanded part of the focus group interviews, which was the first part, followed a phenomenological approach. This approach was taken to understand and capture the hidden meaning of spirituality, religiousness, and personal beliefs. Grbich (2004) observed that phenomenology allows the researcher to understand the essence of the experience and know how to make sense of this understanding. The focus group approach helps capture the understanding of a phenomenon, as people develop understanding through interaction and discussion with each other (Bryman, 2015).

The participants discussed their understanding of the various concepts while reflecting on their own experiences to make sense of the concepts. They inspired each other and stimulated group interaction, which produced data that would not have been captured without the

dynamics of the group. This is reported in Paper II. The researcher transcribed the interviews verbatim. According to Malterud (2003), transcription is the first part of the analysis, and therefore it is desirable that the researcher complete this task. The transcribed interviews contributed a text to interpret, understand, and analyze.

Thematic content analysis was employed. Content analysis is a set of methods for systematically coding and analyzing qualitative data to explore explicit and covert meanings in text and to test hypotheses about texts (Bernard & Ryan, 2009). It means to reflect on (1) the main points of the text, (2) the information that was surprising and the reasons it was surprising, and (3) what was confusing and why. Bernard and Ryan (2009) endorsed consideration of the following questions in the interpretation and understanding process: How do we understand? How much do we understand? What are our conditions for understanding?

In this qualitative approach, Burnard's (1991) thematic content analysis was adopted (see Table 2). It is a systematic process of analyzing data, and its strength is that it is suitable for processing large volumes of data and deals with text in a quantitative manner with the goal of reducing and defining the material (Franzosi, 2010). Thematic content analysis enables the researcher to answer question about what is on the mind of his or her interviewees. The adoption of Burnard's framework provided a rigorous and systematic process of data analysis, which contributed important reliability to the findings. In addition, the hermeneutic circle was of importance and helpful in analyzing the transcribed text from the focus group interviews. The thematic content analysis method involves reading the entire text several times to become immersed in the data. Subsequently, the researcher should navigate to various parts of the text, in this case the categories, and then move back and forth while working with the contents. The hermeneutic circle thus is helpful in identifying the themes and subthemes of the text with the intention of increasing understanding.

Table 2**Thematic Content Analysis (Burnard, 1991)**

1	Notes are made after each interview
2	Transcripts are read through and notes are made
3	Transcripts are read through again and categories are written down—open coding
4	Grouping similar categories and collapsing into broader categories
5	Finalizing the list of categories
6	Inter-rater reliability testing—a colleague is invited to generate category systems independently
7	Checking that the final list covers all aspects of the interviews
8	Highlighting transcript segment according to categories
9	Coded sections are cut out of the transcript while a copy is kept for reference
10	The cut out sections are pasted onto sheets headed with the appropriate headings and sub-headings
11	Selected respondents are asked to check the appropriateness of the category system—this was not possible due to time constraints
12	Keeping the coded transcripts, list of categories, and the audiotaped interviews at hand when writing up the project
13	Keeping close to the original meanings and contexts in writing up
14	Linking and comparing the data with the literature

The researcher and the second author of Papers I and II read the notes and transcripts repeatedly to immerse themselves in the data and understand the information. After repeated readings, the transcripts were again read, and headings and subcategories were written down, a process known as open coding. The headings and categories from the open coding were condensed and refined. Similar categories were grouped together and collapsed to produce broader categories. Those categories contributed the themes. The researcher and the second author discussed and agreed on the final list of categories and themes. They carried out data analyses separately. Frequent summaries were provided during the focus group sessions and of the main themes. To validate the understanding of what was said in the focus groups, the summaries were fed back to the participants at the end of the sessions. This was recorded in Papers I and II. The comparative data from participants in Malta was analyzed in the same way, by using Bernard's framework, and recorded in Papers III and IV.

Cognitive interviews (Part 2)

The cognitive interviews to validate the WHOQOL-SRPB field-test instrument following translation using the WHOQOL Group's (1995a) translation methodology, which was the second part of the focus group interviews, followed a qualitative approach. This involved focus group participants reflecting on each question of the translated WHOQOL-SRPB field-test instrument. The participants discussed and commented on whether the items in the questionnaire captured meaning in a Norwegian context or whether the questions needed adjustment to do so (see Paper I). This part of the transcribed interviews was analyzed using the *systematic text condensation approach* (Malterud, 2003).

The analyses began with thoroughly reading the transcript to obtain an overview. Comments from each focus group were categorized into main topics sorted according to each facet and item of the questionnaire. The topics were combined into tables representing all six focus groups, and the content was condensed and summarized. The researcher and the second author checked the tables against the transcript as quality control. The criteria for changing the wording in the translated questionnaire were based on at least three groups recommending the same change. After the researcher and the second author reached consensus, the changes were implemented in the translated Norwegian final version of the WHOQOL-SRPB field-test instrument (Appendix 4), as reported in Paper I.

3.5 Ethical Considerations

This research required data from both patients and health professionals to answer the research question, which required the ethics committee's approval. An application was sent to the Regional Ethics Committee for Medical Health Research Ethics (REC), South-East Norway (reference number 2.2007.524); the application was approved (Appendix 1). Participation in the research was voluntary, and the participants' anonymity and confidentiality were maintained by following the procedures described in the enclosed information letter (Appendix 2). The questionnaires were numbers coded to prevent revealing the names of the participants. Informed consent given voluntarily and by a person who had been adequately informed was the precondition for participation (Flick, 2006). Thus, participants were required to provide written consent to participate in the study and formal oral consent regarding the confidentiality of any information forthcoming from the discussions in the focus

groups (Appendix 2). Permission to use an audio recorder was obtained verbally, with the agreement that it would be turned off when requested. Participants were informed of their right to withdraw from the study at any time, even during the focus group discussions. The audio recordings and the transcribed data were stored in a locked cabinet. The computer data was stored under a password known only to the researcher. Upon completion of the research, the data will be saved for two years before being destroyed.

4. Findings

In this chapter, the four papers and the main findings from this mixed method thesis are presented.

4.1 Paper I

“Translation and Focus Group Testing of WHOQOL Spirituality, Religiousness, and Personal Beliefs Module in Norway”

Background: The World Health Organization Quality of Life, Spirituality, Religiousness and Personal Beliefs module WHOQOL-SRPB field-test instrument was developed to examine how spirituality, religiousness, and personal beliefs are related to quality of life in health and health care.

Objectives: The objective was to describe the translation process of the WHOQOL-SRPB into Norwegian and to address whether the items capture meanings that are relevant to Norwegian perceptions of SRPB among healthy and sick individuals.

Method: The WHOQOL translation methodology was followed, involving forward translation, consensus reached by a panel of experts, back translation, pretesting and cognitive interviewing in focus groups of healthy and sick individuals, and creating the final version. Six focus groups were conducted in different geographical regions in Southeastern Norway: three groups of health professionals ($n = 18$) and three of patients ($n = 15$). In preparation for the interviews, the instrument was applied to the participants, who answered all the questions. The focus group interviews addressed whether the different items of the instrument captured meaning relevant for the Norwegian perception of SRPB. The quantitative data was processed using SPSS version 17.0. The qualitative data was analyzed using the systematic text condensation approach.

Findings from the quantitative approach: The findings showed differences between the six focus groups, and a t test was used to assess mean differences in relation to the WHOQOL-SRPB field-test instrument's different facets. The different facets and items were found to be

culturally relevant. The *internal consistency reliability* of the overall module tested with Cronbach's alpha was high, $\alpha = .93$. Reliability for the individual facets were $\alpha = .89$ for spiritual connection, $\alpha = .79$ for meaning in life, $\alpha = .76$ for experience of awe, $\alpha = .73$ for wholeness and integration, $\alpha = .86$ for spiritual strength, $\alpha = .90$ for inner peace, $\alpha = .67$ for hope and optimism, and $\alpha = .92$ for faith. A high Cronbach's alpha value indicates that some questions were too similar and the section contained too many questions overall. The facets spiritual connection, meaning in life, experiences of awe, and wholeness and integration displayed the strongest discriminatory power. The facet hope and optimism needs further testing to be accepted as consistently reliable. Statistical significance was set at $p < .5$ (see Paper I). Health professionals had higher mean scores, thus they experienced more connection, meaning, awe, and integration in their lives. The lowest mean score rate was found on the facet faith for both groups of participants—patients and health professionals. The facet faith also showed the largest *SD*; therefore, there was a large variation in the data, with some participants rating the questions low and some rating them high.

Findings from the qualitative approach: The findings related to the comments from the focus groups concerning the translation. The comments about whether the questions captured meaning were categorized into main topics for each facet and item. Those topics were condensed and summarized in tables representing each focus group and each facet and item. The criterion for changing the wording in the translated questionnaire was at least three focus groups recommending changes. The facet *experience of awe* underwent three literary changes, *spiritual strength* two, and *meaning, inner peace, and faith*, one change each. The facets *spiritual connection, wholeness and integration, and hope and optimism* did not undergo any changes.

Conclusion: All the focus group participants found the individual items and facets of the WHOQOL-SRPB module relevant in the Norwegian context. However, the results point to some difficulties in comprehension of some of the facets. The facets meaning and purpose in life were discussed together, with similarities and differences between the words “purpose,” “reason,” and “meaning.” The facet experiencing awe was also discussed, and the word “respect” was added. Despite these difficulties, all facets and items on the module SRPB showed equal importance. The entire instrument showed high internal consistency and reliability, as did the individual facets with the exception of the facet hope and optimism.

4.2 Paper II

“Meanings given to Spirituality, Religiousness, and Personal Beliefs: Explored by a Sample in a Norwegian Population”

Background: The spiritual dimension is complex, and research has shown that a high proportion of nurses do not identify the spiritual needs of their patients. Many research studies confirm that spiritual care in nursing is scarce. There is no universal understanding of the terms, what they mean, and how to interpret and understand them. A consequence might be increased suffering for patients.

Objectives: The objective was to explore the meanings given to the words “spirituality,” “religiousness,” and “personal beliefs” in a Norwegian sample of healthy and sick individuals.

Methods: Qualitative data generated from six focus groups were collected in Southeast Norway. The focus groups were comprised of three groups of health professionals ($n = 18$) and three groups of adult patients ($n = 15$). There were five to six participants in each group, recruited from nursing homes, rehabilitation centers, and from one hospital. Following a semi-structured interview guide, there was an open discussion in the focus groups of the meanings of the terms “spirituality,” “religiousness,” and “personal beliefs.” The interviews were recorded and later transcribed verbatim. The analysis method used was thematic content analysis.

Findings: The findings from the six focus groups were combined in this part of the study to generate a broader data set; participants’ meanings ascribed to spirituality, religiousness, and personal beliefs were reported separately. However, the group discussions revealed that their meanings were interwoven. For *spirituality*, four themes emerged, namely something larger than self, experiences of spirituality, multidimensionality, and understandings of beliefs. For *religiousness*, three themes were found, namely different opinions, religious conduct, and faith. For *personal beliefs*, there were two themes: personal value system and development of value systems. The focus group discussions revealed that the participants had difficulties in finding common terminology when expressing their meanings.

Conclusion: The themes and categories identified in the focus group discussions confirm that

spirituality is a multilayered dimension. Many participants described the spiritual dimension with feelings of awe and respect and indicated that it is important in contemporary health care settings.

4.3 Paper III

“Nurses’ and Caregivers’ Definition of Spirituality from the Christian Perspective: A Comparative Study between Malta and Norway”

Background: Spirituality is a complex, multifaceted, holistic concept. There are several definitions of spirituality from the religious tradition toward the secular orientation. It seemed that the aim of this study attracted participants mainly with a Christian orientation in Norway. In Malta, 95 % of the population is Roman Catholic; therefore, it was difficult to recruit people with other worldviews.

Objective: The objective was to explore the meaning of spirituality as perceived by nurses and caregivers and compare the definitions of spirituality between Malta and Norway from a Christian perspective.

Method: This study collected data from six purposive samples of focus group discussions in Malta and in Norway. The thematic content analysis framework guided the analysis. Both studies were manually analyzed. The first and second author met to compare and contrast the findings and to reach consensus of the themes from this comparative study.

Findings: Four themes defined the term *spirituality*: (1) energy, power, and wholeness; (2) beliefs, faith, and values; (3) peaceful connectedness with self, other, nature, and God or a higher power; and (4) finding meaning and purpose in life. The themes underline the importance of acknowledging the individual’s perception of spirituality to deliver holistic care. Included in the definition of spirituality were some commonalities, such as positivity, optimism, love, and harmony in life, regarded as characteristics of spirituality. The differences identified were that the Maltese group emphasized greater connectedness with family and nature, while the Norwegian group identified a category that contained both positive and negative energies of spirituality.

Conclusions: Regardless of cultural differences between Malta and Norway, commonalities were found in the definition of spirituality in nursing. People had vastly different opinions of spirituality; therefore, some participants found it difficult to define. The differences were that the Norwegian participants offered a broader and existential definition of spirituality related to purpose and fulfillment in all life events. In Malta, the participants identified the religious perspective with connectedness with self, other, and God. They used theistic descriptors of spirituality such as a belief in God and religious rituals and customs.

4.4 Paper IV

“Spiritual Coping in Rehabilitation—A Comparative Study: Parts 1 and 2”

Background: Chronic illness, a long-term disease that challenges a person’s physical, psychological, and spiritual well-being, also influences quality of life. Spiritual resources may be a help in the process of coping with and adapting to the changed life situation. Coping may include religious and nonreligious coping strategies.

Objective: The objective was to explore the spiritual dimension of coping adopted by the seven groups of clients with chronic illness receiving in-patient or outpatient rehabilitation services. Another objective was to compare similarities and differences in spiritual coping between Malta and Norway.

Method: Qualitative data was collected through focus group interviews. Seven focus groups of patients with chronic illnesses from in-patient and outpatient rehabilitation services were conducted, with four groups from Malta and three from Norway. The interview guide contained an open-ended question about how spirituality contributed to coping. The probing questions were guided by the WHOQOL-SRPB field-test instrument, which is oriented toward spirituality, religiousness, and personal beliefs. The interviews were conducted in Maltese and Norwegian to enable better expression of experiences and responses. The thematic content analysis framework guided the data analysis. The researchers from Malta and Norway compared, contrasted, and finalized the analyzed data.

Findings: The findings from both countries' participants indicated that spiritual coping includes both religious and existential strategies. The themes and subthemes illustrated the religious affiliation of the participants from both countries, although fewer participants from Norway were part of a religious community. The commonalities were large irrespective of cultural differences between Norway and on Malta, which made it possible to reach an agreement when analyzing the data. The main theme was *spiritual coping strategies*, which could be prayer or other contemplative activities. The subthemes were (1) adopting religious coping strategies, (2) building a relationship with God or a god, and (3) making time for reflection and counting one's blessings. However, only in the Maltese focus groups was the coping strategy "support by others with similar conditions" found.

Conclusion: The findings suggest that the chronic illness itself triggers the use of spiritual coping strategies, as it causes people to ask existential questions. The patients themselves create a balance between their strengths and limitations to adapt to the consequences of chronic illness. Therefore, it is important to assess the use of spiritual coping in the rehabilitation process to provide holistic care and thus decrease the impact of the stressors.

4.5 Main Findings

The main research question was, How do patients and health professionals understand the spiritual dimension in relation to illness coping and holistic nursing? The main findings contribute answering this question. The spiritual dimension was in this thesis described by the concepts of spirituality, religiousness, and personal beliefs.

The overall result from this mixed method research is a translated international questionnaire into Norwegian, the WHOQOL-SRPB field-test instrument. It was found to be culturally relevant and had satisfactory validity in the present sample. In this thesis, the instrument helped to show the importance of the spiritual dimension in health care in relation to quality of life. The analysis showed an overall high mean score, which indicated the importance the participants ascribed to the spiritual dimension while completing the survey. The instructions of the WHOQOL-SRPB field-test instrument emphasized that participants should answer each question in terms of their own belief system, whether it be religious, spiritual, or personal.

The characteristics of spirituality, religiousness, and personal beliefs, represented by the facets, also were recognized in the findings from the expanded focus group interviews. In addition, agreement was found between how the participants answered the survey questions and how the same participants explored meanings of the spiritual dimension in the focus group interviews. For example, the facet faith of the WHOQOL-SRPB instrument, among both patients and health professionals, had the largest standard deviation. Thus, there was a significant difference in participants' answers, with some rating the meaningfulness of faith as very low for their quality of life. Others awarded a high score, indicating that, for them, faith was important for their quality of life. Their answers were in agreement with what the sociodemographic self-rated questions showed.

Many different expressions of the spiritual dimension exist, and this was considered when the instrument was developed (WHO, 2006). This instrument will be valuable for learning about and understanding various cultures' expressions of spirituality. The study confirms the usability of the tool in relation to focus group interviews to discover participants' comprehension of the concepts of spirituality, religiousness, and personal beliefs.

The finding that every one of the participants thought of spirituality as something important was exceptional, and it seemed to be unrelated to whether the participant's background was religious or secular. Different backgrounds were, for example Christian, Islamic, atheist, agnostic, and private religion (a person's own view of life). The importance of spirituality was recognized in both the quantitative and qualitative approaches, with the quantitative survey related to the WHOQOL-SRPB field-test instrument addressing topics such as relationships to spirituality, religiousness, and personal beliefs. The overall mean scores were high; therefore, the participants valued those concepts. In the qualitative approach, the expanded focus group interviews, during which the participants discussed their understanding of the spiritual dimension, highlighted the importance of spirituality through the themes derived through the analysis, specifically finding meaning and purpose in life and peaceful connectedness. The participants expressed in different ways that spirituality is an important part of their lives, for experiencing wholeness and for their quality of life. The spiritual dimension also had to do with what was significant, what was meaningful or gave meaning, such as having a family and children.

Moreover, in trying to define the spiritual dimension, the concepts transcendent and sacred were frequently used. When the participants attempted to define spirituality using phrases such as “it is something beyond myself,” “it is above myself or inside of myself,” or “it is something outside of myself,” they described transcendence. The expression sacred was part of the survey and of the quantitative approach. The facet experiencing awe had four questions related to experiencing awe in different situations, such as from their surroundings, being touched by beauty, experiencing feelings of inspirations, and for things in nature. As this question had a high mean score, the informants did feel awe and respect for those characteristics of spirituality. This was also indicated by the qualitative approach, as the participants of the focus groups expressed awe and respect for the spiritual dimension when talking about spiritual issues. Some expressed it as something tangible that could be either positive or negative.

Patients identified the spiritual dimension, whether understood in religious or existential phenomenological terms, as essential in coping with chronic illness. Many of the patients who participated in the focus groups suffered from chronic illness. They noted the importance of the spiritual dimension when attempting to cope with everyday activities. The broad definition of spirituality, including both religious and phenomenological understandings, which this thesis adopted, means that everyone can experience the spiritual dimension with its concepts of spirituality, religiousness, and personal beliefs.

While participants identified the spiritual dimension as important, they expressed how difficult it was to talk about, as they did not have the vocabulary to express spiritual issues. They experienced the multidimensionality of spirituality and the many different opinions of what it is and means. Hence, it was easier not to talk about it. In addition, health professionals highlighted insecurity and fear of violating the patient’s integrity as a reason for not making spiritual assessments. The patients reported that they were seldom asked about spiritual issues. One even suggested that health professionals could ask “how she was doing inside of her.”

5. Discussion

In this chapter, the methods, and then the results, as well as the theories and research reviewed are discussed to answer the research question and sub-questions. The sub-questions represent the papers included in this thesis. The research question was, How do patients and health professionals understand the spiritual dimension in relation to illness coping and holistic nursing?

The following topics are discussed in this chapter:

1. Discussion of methods
2. The translation process of the WHOQOL-SRPB field-test instrument
3. The spiritual dimension aspect of holistic nursing
4. The importance of the spiritual dimension in nursing
5. The spiritual dimension perceived as transcendent and sacred
6. The existential and phenomenological understanding of the spiritual dimension
7. Spiritual coping strategies activated by chronic illness
8. Barriers to spiritual care in nursing

5.1 Discussion of Methods

This section will start with a discussion of the limitations and consequences of the present study. It will continue with the researcher's reflections on the effectiveness of the chosen design and methods, as well as with an evaluation of the study's reliability and validity.

5.1.1 The Study's Limitations and its Consequences

Limitations of the present study should be kept in mind when discussing the results and considering the implications. First, the Norwegian sample is small (N=33), in relation to the quantitative approach (Paper I), it is a convenience sample and collected at one point in time. It is further purposive in including healthy and sick adults. It is also an identical sample for both the quantitative and the qualitative approach. Convenience sample does not give the opportunity to control for biases, therefore sampling criteria were used to complement. The primary plan was that the sample should include both healthy and sick adult people from different faith communities, various ages and equal gender numbers.

Because of some difficulties in recruiting participants, it was not possible to fully achieve this goal. The sample is therefore not representative of the general population in Norway, since many of the participants were moderately to highly religious and showed an interest in the topics. The sample also has an over-representation of older people and of people living alone and being divorced. In the gender profiling there is an over-representation of women. To some extent, this can be explained by the earlier described problems with recruiting participants from hospitals (3.3.2). The participants were recruited from rehabilitation centers, nursing homes and nursing-care centers with older residents, and where there is often an overrepresentation of women, both among patients and personnel. Generally, in Norway there is a low representation of men in the health professions.

Despite sample limitations, reliability and validity testing of the WHOQOL-SRPB instrument were performed (Paper I pg. 33). Reliability could not be tested by external reliability, which requires measurements at various times, since this sample was collected only once per group. It was therefore only tested by internal reliability. It was tested by Cronbach's alpha because the sample did not have enough statistical power for factor analysis. By this test the overall internal consistency reliability of the instrument was high. This means that the instrument shows sufficiently the differences between the questions, though they may look similar. One of the eight facets of the instrument "hope and optimism" had a low alpha, meaning it needed more testing in order to be consistently reliable. However, the discrepancies in reliability, the instrument was tested for validity, face-validity was carried out and the translated instrument showed a satisfactory validity. More testing is still required in groups with diverse samples in a broader context to strengthen the validity. The results of the present study indicated that WHOQOL-SRPB instrument is culturally relevant in the Norwegian context.

Another limitation that could influence the translation and could be an obstacle for other disciplines in using the instrument (Paper I), is that the expert group for the translation of the WHOQOL-SRPB instrument included only members from the same health care discipline. The findings from the present study can therefore not be generalized for the population at large, but they can be compared with other studies, which have relevance to patients' and health professionals' spirituality. People of moderate to high religiosity, or interested in spirituality, were overrepresented in the sample; nevertheless there was a small diversity of religiosity represented in the focus groups. There were participants representing Christian, Islamic, atheist, agnostic or a private religiosity in the Norwegian groups. The findings from the qualitative approach (Paper II), both that the importance of spirituality and that the

concepts of transcendence and sacredness were frequently used in describing spirituality, could, to a certain extent, be liable by the fact that many of the participants had a religious background.

Another limitation is that the sample of Malta is larger than the one of Norway (Paper III).

Differences in chronic illnesses might also have influenced the findings (Paper IV).

Nevertheless, the participants of the focus groups explained, in both religious and existential phenomenological terms, the spiritual dimension as important when coping with chronic illness.

5.1.2 The Researcher

Although science is supposed to be objective, with the researcher playing a neutral role as the value-free recorder of events, complete objectivity can never be attained (Daston & Galison, 1992). As researcher, I do have opinions and pre-existing knowledge. The motivating force for this thesis was my experience that spiritual care was scarce in practical nursing. This knowledge came from experience as a researcher, teacher, and nursing practitioner.

Throughout my nursing education in Sweden, strict value neutrality was taught, which made me suppress my personal beliefs. However, according to Leenderts (2014), no one can be neutral, and one's own view of life will shine through.

To ensure that I would not influence the sampling process for the focus groups, contact nurses did the sampling. I was the moderator of the focus groups, and I introduced myself to the participants first in the initial stage of the interviews. As moderator, I had chosen the topical steering and the dynamic role described by Flick (2006). Because the interviews involved multiple topics, such as spirituality, religiousness, and personal beliefs, the role of the moderator had to be more than a formal direction role. Consequently, I used the interview guide to steer the discussions toward deeper levels of the specific topics and to introduce new topics. To stimulate and support the group dynamics, I used probes and other interventions.

The documentation of the focus group sessions showed the groups variation of need for probes or other interventions to stimulate and support the dynamics in the discussions. For example, in one focus group with health professionals, I had to ask participants to relate to their own experiences with spiritual care for patients to stimulate the discussion. This enabled them to share their personal understanding of the concepts of spirituality, religiousness, and personal beliefs. In another group, two participants were dominating the discussion, so I had

to include everyone by asking those who remained silent for their opinions. One participant responded that she liked to listen to and learn from the others. Nevertheless, the atmosphere in the group session was pleasant and inclusive, and all group members agreed on the group's conclusion. My involvement as moderator varied in the different groups, but I always aimed for as little intervention as possible to avoid influencing the discussions.

5.1.3 Design

A convergent comparative design was applied, which means qualitative and quantitative data were collected simultaneously. The comparative aspect related to comparing two cultures. Data was collected as an identical sample for both the quantitative and qualitative approach. The study participants were categorized in two groups, as patients and health professionals. Through this design, it was possible to examine the relationships between groups and the variables of the WHOQOL-SRPB field-test instrument. When the characteristics of a study are comparable to other research, generalizability increases (Riis & Berzano, 2012). This was important, as only 33 participants completed the survey. However, due to the small sample size ($N = 33$), the results of the study cannot be generalized, and factor analysis could not be completed. On the other hand, a solid design was presented with a narrow aim—the combination of participants that was specified comprised healthy and sick individuals with special criteria for inclusion. The guidelines of the WHOQOL Group (WHO, 2004) were followed, and the Group's appraisals were considered. Moreover, the dialogue in the focus groups was inclusive and informative. Several data analysis strategies were employed, and this combination of strategies gave the study reported in this thesis a strong information power (Malterud, Siersma, & Guassora, 2015).

Although the analysis revealed trends that were compared with other international studies, a larger survey sample would have yielded a larger data set, which would have allowed generalization. The comparative study of Norway and Malta provided information in a religious context different from the context of Norway. The groups from Malta were larger, which may have influenced the results to some degree. The interviews were performed in each country's official, native language, and the translation into English may have caused some facts to be misunderstood.

Furthermore, forming homogenous focus groups was challenging, as women and older people were overrepresented. This is partly due to fewer men working as health professionals and

more women being patients in nursing homes and rehabilitation centers. However, this study design seemed suitable for answering the research question, and gathering information from different groups and cultures was beneficial.

5.1.4 Mixed Methods

The integration of quantitative and qualitative research methods provided the opportunity to view the research question from different angles and to increase the credibility and reliability of the findings. Mixed method designs involve varying levels of interaction and priority of methods, timing, and mixing procedures. In this research, the convergent parallel design was employed, with the integration of the strands taking place in *the translation of the WHOQOL-SRPB field-test instrument* in the discussion of the final version (Paper I). In *the other studies that comprise this thesis* (Papers II, III, and IV), only the qualitative strand was present. The qualitative and quantitative strands were integrated only in the overarching discussion of the results.

It could have been beneficial to integrate the components earlier, as the quantitative survey responses could have been used as elective factors in the sampling process for the focus groups. This could have made it possible to draw participants that were more culturally diverse and that held varying views of life, and it could have guided the invitation of focus group participants in relation to age and gender. In addition, all focus group participants had completed the survey and received information on the different facets and items, which may have influenced the results of the expanded interviews. Nevertheless, the method used seemed helpful in answering the research question.

5.1.5 Reliability

Reliability concerns the consistency of a variable, and it can be measured via *external* and/or *internal consistency*. The design limited the potential for *external reliability*, which assesses whether a measure is stable over time and thus requires measurements at various times and comparison to identify variation. In this research, this was unnecessary because an existing questionnaire was translated rather than a new questionnaire being developed. *Internal reliability* was tested using Cronbach's alpha, or split-half reliability. This analysis is recommended when multiple items are measured, and the answer of each question is aggregated to form an overall score (Bryman, 2015). The WHOQOL-SRPB questionnaire

contains facets with four questions on each, which are summarized to create one score for each facet; therefore, Cronbach's alpha was suitable for testing reliability. The test shows whether the indicators relate to the same factor and whether coherence exists between them. The *internal consistency reliability* of the overall module tested with Cronbach's alpha was high, $\alpha = .93$. The facet hope and optimism needs further testing for acceptance as consistently reliable. A high Cronbach's alpha means that some questions were too similar and that there were too many questions overall. This information was relayed to the WHOQOL-SRPB Group, which have published a condensed form of the instrument (Skevington et al., 2013).

To assess the dependability of qualitative data, Flick (2006) recommend checking the origin of the data in terms of the content of the statement and of when the interpretation begins. This was done in several steps. First, interviews were audio recorded and transcribed verbatim by the researcher, and, second, both the researcher and second author of Papers I and II had access to the transcribed text of the interviews at the data analysis stage. Furthermore, Flick (2006) advised checking the interview procedures, which the researcher accomplished by following the WHOQOL Group's semi-structured interview guide, and checking the documentation of the research process. The research process was well documented, and Burnard's (1991) systematic thematic content analysis was employed, which contributed to reliability.

5.1.6 Validity

Validity regards whether a variable really measures what it is supposed to measure. Variables have to be reliable before they can be tested for validity (Bergman, 2008). Despite the limitation that one of the eight facets of the WHOQOL-SRPB field-test instrument needed more testing to be consistently reliable, face-validity was carried out. It is a measurement to endorse that the translated instrument measures what it is supposed to measure. The expert group discussed the translated items and reached consensus on the Norwegian words used for the various items. Moreover, the focus groups discussed each item of the instrument and indicated whether it was understandable, and provided feedback to the researcher. In each focus group and at the conclusion of the expanded interviews, the moderator summarized the discussions and fed the summaries back to the groups for validation. The results pointed towards a satisfactory validity in the present sample, although further reliability and validity

testing with a diverse sample will be suggested for future research. Factor analysis that examines interrelationships was not performed because the sample was too small.

5.2 The Translation and Validation Process of the WHOQOL-SRPB Field-Test Instrument

One of the main results of this research is a translated and validated Norwegian version of the WHOQOL-SRPB field-test instrument. The instrument can be used in the Norwegian context for not only measuring spirituality but also to help focus on the spiritual dimension in nursing. The translation followed the directions set out by the WHO (2004), but the researcher faced several challenges during the translation process.

The greatest challenge in the translation work was to find suitable Norwegian words for the items that matched with the English original instrument and that made sense in the Norwegian cultural context. Each question and item was discussed by the expert panel and later by six focus groups. The expert panel consisted of a lecturer in nursing with a background in nursing and pastoral care, a professor in nursing with a background in instrument development and translation, and a research director with a background in nursing and project administration. The expert panel's comments resulted in several changes to the translated version of the instrument applied in this research. Pretesting of the instrument was carried out by applying it to the 33 people that had volunteered to take part in the focus group interviews. The results were statistically analyzed using SPSS version 17.0, and they are described in Paper I. Some are repeated here to compare them with the results of other studies.

Health professionals had higher mean scores than patients on the facets spiritual connection, meaning in life, experience of awe, and wholeness/integration. In O'Connell and Skevington's (2005) study conducted in Britain, the facets spiritual strength, meaning in life, and inner peace were most important to all groups. The facet meaning in life seemed to be important for both the Norwegian and British participants, which, in terms of McSherry's taxonomy (2007), showed that both countries answered from a postmodern viewpoint, or an existential phenomenological understanding of spirituality. Boero and Squazzoni's (2005) study conducted in Italy indicated that religious people obtained higher overall scores on the instrument. This can be explained by Italy being a religious predominantly Catholic country, where people have a more traditional theistic and religious understanding of spirituality.

In another British study conducted by Burkhardt and Nagai-Jacobsen (2002), it was found that the facet spiritual connection caused a Christian bias, and the researchers argued that those questions were not suitable for atheists to answer. Despite this, they still recommended the instrument for use, noting that it is important for developing fuller holistic health care. In an international cross-cultural study conducted by the WHOQOL SRPB Group (WHO, 2006), a difference between younger and older people was found. Their results indicated that the facet spiritual connection and wholeness had higher scores among older people; in contrast, in the study carried out for this thesis, health professionals scored highest, and the health professional participants were younger than the members of the patient groups.

Many of the differences found in the studies reviewed might be explained to some extent by the different contexts. However, all recommend that the WHOQOL-SRPB field-test instrument be included in research on quality of life and wellness. Thus, it is reasonable to conclude that the instrument makes an important contribution to assessing wholeness in holistic nursing. Eriksson (2007), in her caring philosophy, emphasized wholeness as important for holistic nursing.

The focus group discussions during the cognitive interviewing stage showed that certain words needed to be changed and others added to clarify several items in the Norwegian context, such as meaning and purpose in life, experiencing awe, and spiritual strength. Patients' and health professionals' understanding of the concepts of SRPB were largely similar, but one patient focus group questioned whether one could replace all the concepts of *SRPB* with the concept *view of life*. They stated that both spirituality and religiousness were included in *view of life* but that the phrase itself was less private and threatening than *SRPB*. The Norwegian word for spirituality, "*åndelighet*," was understood as meaning only religiousness, which many people understand as being religious. However, the changes suggested by that focus group could not be performed, as at least three focus groups had to agree for a request to result in a change of items or words in the instrument. Molzahn *et al.* (2012) also recognized this discussion of the best concept for understanding view of life and, while exploring values and belief systems, found that some people would rather be asked about "the big questions in life" than labeling them with the concept of spirituality.

The WHOQOL-SRPB field-test instrument has been criticized for measuring not only spiritual but also psychological items and for defining the spiritual dimension too broadly

(Moreira-Almeida & Koenig, 2006). This criticism is based on the inclusion in the instrument of questions about meaning in life and altruistic activities for mental well-being although they do not measure spirituality. Critics contend that this is a tautology because they define spirituality by positive human characteristics used in defining mental well-being. Fleck and Skevington (2007), members of the WHOQOL-SRPB Group, responded to this critique by explaining that spirituality and religiousness are highly subjective concepts and difficult to measure. The WHOQOL-SRPB module therefore measures the spiritual dimension with items that are characteristics and indicators of the concepts. Furthermore, Fleck and Skevington referred to the development of the instrument by consensus derived from focus group impressions from 18 centers worldwide. The researcher and several other researchers in the field agree that spirituality and religiousness are complex concepts that are difficult to measure or define (la Cour & Hvidt, 2012; Austin, 2006).

The themes that emerged in the qualitative analysis of this research aligned with the facets of the instrument, the quantitative approach (Paper II and III), which supports the view that the WHOQOL-SRPB field-test instrument is an important contributor to increased understanding of the spiritual dimension. This in itself will promote holistic care to enhance health and quality of life. The focus group participants in this research provided feedback on how their participation in the focus groups increased their focus on the spiritual dimension on their wards. The findings suggest that focus on spirituality in nursing increases by measuring it. Thus, the instrument can be used to increase focus on the spiritual dimension in clinical practice.

5.3 The Spiritual Dimension as Part of Holistic Nursing

The findings from this research showed that the spiritual dimension forms part of holistic care and is in fact intertwined with nursing care. This is exemplified by participant comments such as “Spirituality means wholeness and balance,” and “Spirituality is something we all need to be whole.” According to Eriksson (2007), holistic care is understood as care for the physical, psychological, social, and spiritual dimensions of a human being. Moreover, Rudolfsson et al. (2014) noted that spirituality is part of nursing and not something added to it. When patients felt that their spiritual needs had not been met, they felt that they had not been seen and met as whole persons (Tornøe et al., 2014; Ødbehr et al., 2014; Haug et al., 2015; Koslander et al.,

2008). Nursing is a relationship that involves interaction between the nurse and patient. Enhancing the interaction requires interpersonal skills, and health professionals have to focus on the human elements of care, the *high touch*.

Furthermore, Berglund et al. (2012) concluded that providing holistic care decreases suffering. When patients experience relief from their suffering, they provide positive feedback to health professionals, who then experience greater job satisfaction. Patients want to be seen as whole persons, as underscored by one of the participants, who said, “Why can’t they ask about how I am doing inside of me?” According to several nurse theorists, the spiritual dimension thus is interwoven with the concept of nursing and is inseparable from it. Eriksson (2007) declared in her caring philosophy that caring for the whole person includes spiritual support, while Roy mentioned relationships with *the world* and *with God* (Roy & Andrews, 1999). Similarly, Neuman (2002) pointed out in her system model that spirituality is an essential variable of each individual’s basic structure, which enables optimal wellness, health, and stability. Consequently, the spiritual dimension is an integrated part of nursing and inseparable from holistic nursing (Bush & Bruni, 2008).

5.4 The Importance of the Spiritual Dimension in Nursing

A key finding in this research was that spirituality is important in nursing. Both patients and health professionals in Norway and Malta articulated this. Spirituality with the wider definition, including both the existential and religious understandings (Stifoss Hansen & Kallenberg, 1998), was valued as a necessity, something that provides strength, is a resource, and offers a sense of security to both patients and health professionals. According to one participant, “Everyone has spirituality, and it is important for everyone,” while another noted, “Spirituality influences my nursing care; it helps me in my effort to comfort patients in difficult times.” Some of the statements made by participants highlight the wider definition of spirituality, for example, “Spirituality is not only related to God. It can be related to many things, which may mean different things for different people.” The participants discussed many different thoughts about and meanings of spirituality, and its importance. It seemed to be independent of background or view of life. The backgrounds in this thesis include a Norwegian society considered secularized, where spirituality and religion seems to be privatized, and the context of Malta, where 95% of the population are registered Roman

Catholics and where spirituality is a natural part of life (Leenderts, 2014; Gouder, 1996).

The finding that spirituality is important aligns with the research of Boero and Squazzoni (2005), who found that the majority of participants in their study appreciated that someone took care of the spiritual dimension of a suffering person. The participants felt that health professionals should be able to care for patients' spiritual needs. Likewise, Molzahn et al. (2015) emphasized the importance of spirituality for people living with serious illness and presumably in various stages of crises, and McSherry (2007) confirmed that peoples' different beliefs or worldviews could be a resource. In addition, Delgado (2005), in her international literature review, stressed that spirituality is a powerful resource for health professionals when providing holistic care. Even Florence Nightingale contended that the ideal is that all care should be care of the whole person, and she drew on her own spirituality for strength in her work among the soldiers in the Crimean War (Delgado, 2005). In this study, the focus group participants expressed appreciation for being able to share and discuss these things in the focus groups.

The importance of the spiritual dimension in nursing also has been accentuated by research on spirituality that revealed a positive connection between spirituality and health. Spiritual and religious involvement might lead to positive outcomes such as better health and well-being, and enhanced quality of life (Oman & Thoresen, 2002; Koenig et al., 2001; Sørensen et al., 2011). Numerous attempts have been made to explain the positive outcomes, and some researchers have questioned these outcomes (Koenig, 2012). Mediating factors such as lifestyle, social support, and coping can explain the positive connection between spirituality and health to some degree (Kvande et al., 2015).

In this context, it is of value to recognize that patients are in various stages of crises. The reaction to and proceeding in crisis often includes the spiritual dimension. This is a further reason why spiritual care needs to be an essential part of holistic care. According to Cullberg's (1994) crisis theory, in the chock phase when people might say, "It is God punishing me," spiritual care is to *be with*. In the reaction phase, the person attempts to find reasons for the situation by asking, "Why me God?" Here, nurses provide spiritual care by listening to and supporting the patient. In the repair phase, the person attempts to find a way of repairing him or herself and wants to talk, and the nurse must be available. In the reorientation phase, the person is ready to grasp his or her new situation and begin living

again (Cullberg, 1994).

The processing of crisis typically includes spiritual issues. It is therefore important that nurses assess their patients' spiritual needs instead of avoiding those issues because of a perceived risk of negative outcomes associated with spiritual and religious involvement. Koenig (2012) found in his literature reviews that certain negative outcomes, such as increased guilt and fear of punishment and damnation from focusing on sin, could lead to depression and anxiety. Nevertheless, those negative outcomes were not found in the majority of the studies. Some negative outcomes can be explained by both depression and anxiety often driving people toward religion as a way to cope.

5.5 The Spiritual Dimension Perceived as Transcendent and Sacred

The results from this research represented by the theme *something larger than self* reflect the participants' understanding of spirituality as something *transcendent* (Paper II). It is expressed in different ways, such as "a dimension beyond the ordinary" and "something between one's feelings," and it is related to "something within them," "something large and high," and "something that transcends what is present" (Paper II). The participants had different backgrounds, such as being Christian, Muslim, or agnostic, or having a self-made view of life. A participant described the self-made view of life as follows: "I take a little from here and there and make up my own view of life."

McSherry and Cash (2004) acknowledged that nurses who did not believe in God but believed in forces beyond themselves also experienced the transcendent. Likewise, la Cour and Hvidt (2012) regarded the transcendent as an important aspect of spirituality. They expressed concern that the concept of spirituality had become too wide through individual understandings and discussed whether spirituality as a concept has lost its worth. They stressed that, for meaningful conversations to take place, spirituality had to be defined, and the context specified. Furthermore, they emphasized that a definition should always comprise a possibility of another reality than the already known (la Cour & Hvidt, 2012). For EAPC, transcendence also is an important part of its definitions:

Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and

transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or sacred. (Selman *et al.*, 2014)

In contrast, transcendence was not part of Narayanasamy's (2006) definition of spirituality, which held that spirituality is the very essence that gives meaning and purpose to one's existence. Neither is it part of Stifoss-Hansen and Kallenberg's (1998) definition. Their understanding of spirituality was that the spiritual dimension is an umbrella term that covers the existential questions of both religious and secular nature and that view of life and faith develop when individuals are working with those questions.

Moreover, the participants in this research experienced spirituality as something *sacred* when they discussed the different concepts of the spiritual dimension from a qualitative approach in the focus groups. They expressed respect for and awe of spirituality and felt there was something fragile about it. This also was found in the quantitative approach through the facet experiencing awe, which contained four questions. Those questions had a high mean score, indicating that the participants connected awe with spirituality. According to both Zinnbauer and Pargament, from a psychological view, the sacred is important for defining spirituality. Pargament feared that the sacred would disappear with a multidimensional understanding of spirituality (Pargament *et al.*, 2005). Although the results of this research represent mainly a nursing point of view, it showed that the sacred formed part of the understanding of the spiritual dimension for most participants, despite the multidimensional understanding of spirituality represented by this research. In the context of nursing care, this means that many patients might be thinking of the transcendent and might have a relationship with the sacred in their understanding of spirituality. This emphasizes the necessity to include the spiritual dimension in holistic nursing and for nurses to become comfortable talking about spiritual issues.

5.6 Existential and Phenomenological Understanding of the Spiritual Dimension

The research results indicate a phenomenological and existential understanding of spirituality. The phenomenological understanding emerged when participants shared their lived experiences, which defined their spirituality. The participants' way of finding meaning and purpose through various events exposed their existential understanding, which was further

underscored by the theme *multidimensionality*, which comprised the subthemes *a wide perspective* and *different meanings*, that emerged from the analysis of the focus group interviews. Further, different understandings of spirituality were identified, including meaning and purpose in life, connectedness with self, wholeness, balance, meditation, and yoga (Paper II).

The results of this thesis showed that the focus group participants understood spirituality in a manner similar to the facets of the WHOQOL-SRPB field-test instrument, which are dimensions of spirituality such as connectedness to a spiritual being or force, meaning in life, awe, wholeness and integration, spiritual strength, inner peace/serenity/harmony, hope/optimism, and faith. This convergence of the quantitative and qualitative results increases the likelihood that the facets are relevant for measuring spirituality in the Norwegian context. In Molzahn et al.'s (2012) study, the findings were also compared with the different dimensions represented by the facets of the WHOQOL-SRPB field-test instrument, but the participants talked broadly about spirituality, and had not distinguished the different concepts.

Furthermore, this aligns with McSherry's (2007) research and taxonomy representing descriptors of spirituality. The descriptors indicate that meaning depends on the individual meanings different people ascribe to spirituality. McSherry explores two forms of spirituality—the *traditional* form with theistic and religious descriptors, and the *postmodern* form with phenomenological and existential descriptors. In the studies conducted to complete this thesis, the difference between a secular and a religious country were obvious when the participants described spirituality. In the Maltese study, most of the findings present the *traditional form*, or a religious and theistic view of life, with participants making comments such as, "Spirituality is much deeper than religiosity," and "I believe that I have to search further [for] the spirit of God within me." Another example is, "Praying to God every morning and evening gives me strength as I feel protected by a good father." In Norway, the participants were more inclined toward the *postmodern form*, where people's view of life is inspired by existential and phenomenological strands. One participant explained spirituality in the following way: "Spirituality means having meaningful experiences and having a good life, family, and children." Another said, "Today one can create one's own view of life by taking a little from here and there." Spirituality was also expressed as, "Maybe spirituality is related to astrology, the sun, and/or the moon." This thesis represents many varied suggestions of the

meanings of spirituality, which accentuates health professionals' need to be open to diverse views of life and requires a broad competence.

5.7 Spiritual Coping Strategies Activated by Chronic Illness

The findings of the comparative section of the research, generated from the patient focus groups, reveal one main theme and three subthemes. *Spiritual coping strategies* was the main theme, and the first subtheme was *adopting religious coping strategies* such as engaging in prayer, attending church, and providing support and optimism. The participants were attempting to preserve that which was significant to them. The second subtheme was the participants' *relationship with God*, which seemed to help them to adapt to their chronic illness by transforming their circumstances (Pargament, 1997). One participant said, "When I choose to believe that now my dad was at rest, I was able to find meaning in the past hard times. It gave me power and helped me to cope in my life." The third subtheme was *time for reflection and counting one's blessings*. Here, care from health professionals, support from family, and other assistance counted as blessings. For example, participants stated, "Feeling appreciated is related to spirituality. You don't take things for granted in life; I appreciate the care I receive here," and "It is a blessing living at home with my community." The results from this research showed that spirituality is a resource when patients are coping with chronic diseases.

Pargament, offering a psychological definition of coping, argued that it is a search for significance in a time of stress (Pargament et al., 2005). Significance can be objects, things, feelings and beliefs, or something that gives strength and is important. One of the focus group participants in this research claimed, "To attend a church or to go to a concert gives me help to cope with everyday problems." According to Lazarus and Folkman (1984), it is not the stressor itself but the meaning or significance the person ascribes to the stressor that influences well-being. In coping, people use emotion-focused or problem-focused strategies or a combination of the two (Lazarus & Folkman 1984).

Pargament, who includes spirituality in religiousness, considered coping and religion related phenomena. He identified types of religious coping, such as self-directing, deferring, and collaborative coping (Pargament, 1997). In this research, the focus group participants from

Malta used the deferring coping style, where control was sought *through God*; for example, participants felt secure by maintaining a personal relationship with God. In addition, they used the collaborative coping style, where control was sought *with God*, such as drawing strength from and feeling empowered by praying to God. In Norway, the self-directing coping style, which involves seeking control *through the self*, was apparent; for example, when patients used nonreligious strategies such as feeling appreciated, they did not take things for granted in life.

Moreover, the findings indicate that a positive environment strengthens resistance to the stressors of chronic illness. According to Neuman's (2012) theory, spirituality as an interactive variable is essential and can introduce stability in a stressful situation. Her theory focuses on preventing imbalance and maintains that each individual has reconstitution factors. Prevention refers to nursing interventions that prevent imbalances to occur, and interventions can be either *primary*, *secondary*, or *tertiary* (Neuman & Fawcett, 2012). In light of Neuman's theory, the spiritual support in coping with chronic illness experienced by the study participants discussed in this thesis could be either *secondary*, that is, to help prevent damage caused by stressors, or *tertiary*, that is, to offer support to facilitate reconstitution. Respondents indicated that spiritual support was important for them. This aligns with the views of Torbjørnsen (2011), who found that the most effective coping occurred with religious support, such as through prayer, meditation, and divine presence. In Malta, the Catholic participants experienced religious coping strategies also through support from their dead family members.

5.8 Barriers to Providing Spiritual Care in Nursing

Research underscored the importance of spirituality in health care and its shortage in clinical practice over the last 30 years (Koenig, 2012; Baldacchino, 2003; O'Brien, 2003; Delgado, 2005). Nevertheless, ignorance of spirituality in clinical practice was found in recent research as well (Rykkje et al. 2013; Koslander et al., 2008; Ødbehr et al., 2014). Therefore, it seems the knowledge derived from research has little influence on clinical practice. Thus, the knowledge gap does not stem from a lack of research in general; therefore, this researcher recommends specific future research to focus on the barriers to provide spiritual care.

The integration of *high tech* and *high touch* for a reintroduction of interpersonal values in health care is challenging when new technical issues constantly arise that require *high technical* skills and when the chief virtue is efficiency (Puchalski & Ferrell, 2010). According to Puchalski and Ferrell (2010), when the economic framework in health care resembles that of any efficiency-based industry, it becomes a barrier to the inclusion of spirituality in care. Furthermore, the authors underlined neglecting the understanding of meaning, represented by spirituality in health care. Internal barriers derive from health care professionals themselves through, for example, denial of the transcendent, prejudgments, and insecurity from both patients and health professionals. Because the concept of spirituality is viewed as private, people seldom discuss it (Puchalski & Ferrell, 2010).

Findings from this research showed that respondents experienced spirituality as a private matter, which was the major reason identified for not discussing it. Many of the focus group participants felt that personal beliefs, including varied worldviews, belonged in the private sphere, which became a barrier. They did not talk about spiritual issues because they were afraid of insulting someone or being intrusive. Ødbehr et al.'s (2014) findings support this, as their research results indicated that nurses were uncomfortable talking about religious issues with their patients.

Another barrier identified in this research is that spirituality is a multidimensional concept and difficult to comprehend. The focus group participants found it difficult to define spirituality due to the numerous divergent understandings of the concept. The theme *multidimensionality*, comprising the subthemes *a wide perspective* and *different meanings*, demonstrates this. Spirituality was understood as meaning and purpose in life, connectedness with self, wholeness and balance, and being universal, and it could include prayer, meditation, and yoga (Paper II). This was in line with McSherry's (2007) taxonomy, and both the traditional and phenomenological descriptors of spirituality were distinguished.

The participants concluded that they did not have a common language and adequate knowledge to discuss spiritual issues, which forms a further barrier to providing spiritual care. Many of the participants were unaware of their own sense of spirituality and naturally had not sought more knowledge. Many acknowledged that the process of discussing spirituality in the focus groups had increased their awareness and helped them focus on spiritual issues in their wards. The results from this research underline the importance for health professionals to both

define and develop their own view of life and to thus become comfortable discussing spirituality. The interaction between the participants in the focus group interviews created an atmosphere where they shared their experiences, inspired, and learned from one another. One participant stated, “I have learned by listening to the others in the group.”

According to Tornøe *et al.* (2014), nurses reflected on spirituality as an ethical dilemma and wondered how they could encourage patients to open up and share their distress and worries without violating their dignity and autonomy. Similarly, Ødbehr *et al.* (2014) identified feelings of embarrassment when considering religion in care, which caused religion to be concealed in nursing homes. This is consistent with Giske and Cone’s (2015) discussion about nurses’ willingness and ability to engage with spiritual matters. Nurses have to be willing to leave their own comfort zones and build trustful relationships with patients; that is, nurses have to work with their personal comfort levels regarding spirituality. The nurses’ view of life more than their faith traditions influences the ease with which they address spiritual questions (Giske & Cone, 2015). Additionally, Sæteren *et al.* (2011) noted a great need in clinical practice for nurses to prioritize and increase their consciousness of and competence in the spiritual dimension. They need to be able to respond to the spiritual and existential concerns patients with serious cancer diseases experience. In palliative nursing, this is crucial, as patients at the end of their lives raise existential questions and require health professionals who are prepared for that. Taylor (2013), in research conducted in New Zealand, concluded that training health professionals in spiritual assessment resulted in a higher comfort level when providing spiritual care.

6. Conclusion

The purpose of this research was to explore patients' and health professionals' understanding of the spiritual dimension in Norway and Malta and to understand how patients and health professionals assess the spiritual dimension in their own lives and when coping with illness. To focus on the spiritual dimension, the WHOQOL-SRPB field-test instrument, which measures spirituality, religiousness, and personal beliefs, was translated and validated among patients and health professionals. The translation process suggested by the WHOQOL Group (WHO, 2004) was followed, and discussions indicated that the translated instrument is relevant for the Norwegian context. Moreover, that the overall mean scores were above midpoint showed that the questions were understandable to the participants. Through discussions in the focus groups, the importance of the spiritual dimension in health care was further highlighted. The WHOQOL-SRPB field-test instrument increased the focus on the spiritual dimension, as confirmed by the patient and health professional focus groups in Norway and Malta.

This study and other research studies revealed the need of increased understanding of the spiritual dimension. The spiritual dimension needs to be intertwined with nursing and viewed as a resource to enhance holistic nursing, which will bring wholeness into nursing. Wholeness was an important concept in participants' attempts to define spirituality; many also used the words "transcendent" and "sacred." Patients often have spiritual and existential questions of both religious and secular nature, and they need to be confident that health professionals would be willing to discuss those issues.

A knowledge gap concerning the spiritual dimension in clinical nursing has been revealed, both by this, and other research. Furthermore, this researcher identified several barriers to spirituality in health care, such as health professionals' insufficient competence in this area and the complexity of the spiritual dimension. Because of those barriers, spiritual issues are easily avoided and not discussed, and health professionals discomfort with talking about spiritual issues causes a shortage of spiritual support for patients. When patients struggle with chronic illness, the most helpful coping strategies are spiritual or religious support, although the research participants in this study identified both religious and secular support as helpful. The spiritual dimension needs to be evident in daily nursing practice. Health professionals

need to take care of their own spirituality and require additional education and training on how to assess spiritual needs and how to provide effective spiritual care.

7. Future Research and Implications

7.1 Future Research

The studies reported in this thesis have exposed several gaps in the research knowledge related to the spiritual dimension, which were revealed by both patients and health professionals in clinical nursing and need further investigation. The most significant of these concerns barriers to incorporating spiritual care into holistic care. The researcher suggests further research on these barriers to determine why health professionals and patients seldom discuss spiritual issues despite viewing them as important.

The researcher recommends the translated WHOQOL-SRPB field-test instrument to be further tested for both reliability and validity in diverse samples to strengthen its degree of validity. The instrument could be practical for more extensive screening of patients' spiritual needs. This supports the views of Selman and colleagues (2014), who recommended further research on tools for the screening and assessment of patients' spiritual needs and on conversation models (Selman et al., 2014). Conversation models can be helpful in increasing knowledge about spirituality, religiousness, and personal beliefs. For example as the focus groups sessions conducted as part of the studies discussed in this thesis helped participants to debate spiritual issues.

Furthermore, the researcher recommends conducting qualitative research with focus groups to explore nurses' fear of invading patients' privacy and violating patients' integrity by carrying out spiritual assessments. In addition, the researcher suggests exploring questions about spiritual and existential issues that could violate patients' integrity.

Finally, another interesting topic for further research would be investigating how many patients have experienced perceived rejection because no one asked about their spiritual and existential well-being.

7.2 Implications

Being aware of the present studies limitations the WHOQOL-SRPB field-test instrument can be used to assess the spiritual needs of people with different backgrounds. This is important in Norway, a multicultural country, and in religious countries such as Malta. The instrument can be used in comparative research, as versions exist in a numerous languages, and in education to help focus on the spiritual dimension and increase knowledge among health professionals. In addition, it can help to increase both patients' and health professionals' self-reflection about spiritual concerns. In clinical practice, it is important that health professionals overcome barriers to discussing spiritual issues. In this research, it was found that this instrument helped health professionals increase their knowledge of and willingness to talk about spiritual issues.

When a person experiences a life crisis, spiritual or existential questions arise (Baldacchino et al., 2012; Prince-Paul, 2008). These questions concern the person's existence and the cause of the crisis, and include, "What value does my life have?" "What is the meaning of existence?" and "Why is this happening to me?" When one's existence is threatened, it causes anxiety, and patients need someone to talk to in this situation. According to Berglund et al. (2012), there is a danger that patients will experience increased suffering when spiritual needs are ignored and not addressed. For example, they may feel rejected because no one asked them about their spiritual needs. Empathy is a core value in nursing and part of the nurses' interpersonal skills, or *high touch*. There is a need in clinical practice that *high touch* becomes integrated with *high tech* to balance nursing care.

The barriers to spiritual care in nursing revealed by this and other research demand the improvement of holistic nursing. Increased knowledge about the spiritual dimension is needed to overcome the barriers and improve holistic care. According to Giske and Cone (2015), it is important that health professionals be willing to leave their *comfort zones* and work with their own values. Research confirm that nurses who have developed their own views of life are more comfortable assessing patients' spiritual needs (Rykkje et al., 2013; Ross, 1997). This involves time and effort, and it should be part of nursing education.

A further barrier is that the health care system for decades has promoted neutrality regarding values and view of life (Peppin, 1995). Health professionals had to have a neutral understanding of values in nursing and medicine and respect the values of the patients

(Hoehner, 2006). However, according to Leenderts (2014), to be professional means to use knowledge and skills specific to the profession as well as one's own personality with individual values and attitudes. In this understanding of professionalism, own values and faith form part of a person's personality and are not concealed behind a veil of privacy. Health professionals need to use all of themselves, including their own values and faith, but in a discretionary manner with awareness, wisdom, discernment, and judgement, and only for the benefit of patients (Leenderts, 2014). This underscores the special commitment of being a health care worker.

Value neutrality in health care is slowly changing to *value consciousness*, which is a much needed counterbalance. Hoehner (2006) argued that it is time to bury the myth of value neutrality: "Not only is value neutrality impossible, but the pretense of practicing medicine under its umbrella only undermines a competent caring, and honest patient–physician relationship" (p. 343). It seems that many health professionals still believe being value neutral equates to being professional, but one's values will always influence others (Leenderts, 2014; Aakre, 2016).

Health professionals need to discuss value neutrality as opposed to value consciousness and determine what it means for their work situations. It is important that they define and develop their own life view and consequently become more conscious of and comfortable with discussing spirituality. This supports Travelbee's (1971) opinion that professional nurses are identified by their ability to use themselves therapeutically; that is, nurses have to integrate intellectual knowledge and feelings in the nursing profession. Travelbee further emphasized the importance of commitment. Leaders should focus closely on how they foster openness about spiritual matters in their health care settings. Discussion groups where nurses share their *view of life/faith histories* could contribute to their awareness and/or the development of their personal view of life and may counteract the concept of value neutrality in health care.

This research demonstrated that focus groups concentrating on the spiritual dimension were helpful in initiating self-reflection regarding own values and beliefs. Some nursing education institutions have begun working with those aspects and including *view of life/faith history groups* for students in their curriculums. To overcome the barriers, it is important to implement responsive leadership that takes responsibility for holistic nursing with spiritual care included. Aakre (2016), leader of Nurses Ethical Advice, pointed out that spiritual or

existential care is the most vulnerable of all care and that it has never become standardized despite being a human right.

Schmidt (2009) noted that the leader at the clinic took responsibility and decided to take action about the lack of spiritual needs assessment procedure and the lack of guidelines on how to meet patients' spiritual needs. She described the development of a standardized spiritual assessment procedure that would enable all professionals to carry out these assessments. She recommended that each ward creates its own procedure, with questions to ask at admission, and emphasized the importance of following up with spiritual care.

To assess spiritual needs, it is important to not only question but also observe the patient, as observation can reveal significant information about patients' values and worldview, for example, through literature the person is reading or objects in the environment. However, it is important to ask questions about what those objects mean for the patient and not draw one's own conclusions without listening to the patient. According to Leenderts (2014), observations can easily be misinterpreted; for example, a picture of Jesus on the wall could have been left behind by a previous patient.

Moreover, this research revealed insecurity about sharing own values with others. Many felt it was too private. The problems for health professionals seems to be their own insecurity about assessing spiritual needs because of a lack of knowledge and experience (Molzahn et al. 2012; Giske & Cone, 2015). In addition, nurses and caregivers were afraid their workload would increase if they had to work on their own values as well as care for their patients' spiritual needs (Rudolfsson et al., 2014). The results of Tornøe et al.'s (2014) research confirm this conclusion. Nurses experienced an ethical dilemma about their own ambivalence about whether conducting a spiritual assessment would insult or benefit a person. Health professionals need to reflect upon and discuss ethical dilemmas; therefore, an ethical reflection model may be helpful.

Aadland (2000) described the ethical reflection process: identify the problem, gather sources of evidence, and identify those involved and the context. Subsequently, determine what values and attitudes are involved, ascertain the options available, choose a course of action, and consider the consequences. Finally, implement the ethical decision and document.

Professional counselling groups for discussing ethical dilemmas is much needed for health

professionals, as this provides a space in which they can develop their own view of life. Puchalski and Ferrell (2010) verified the importance of developing own spirituality and training and teaching, which helps people become comfortable discussing spiritual issues.

Because spiritual assessment could cause ethical dilemmas for nurses, it is important to educate health professionals on how to perform a spiritual assessment. This chapter about implications has shown how health professionals can work with their own insecurity in assessing patients' spiritual needs. Health professionals need to see spirituality as a resource that can assist patients in their healing processes. This research suggests that open questions are the least offensive, a view supported by Puchalski and Romer (2000). The following questions could be helpful for spiritual assessment.

- What is important for you now?

This might be a good question during the admission interview, and it is important to follow up with the next question.

- Do you have a specific religious affiliation?
- Is there someone you want us to contact?

The interviewer might want to inform the patient about the opportunity to talk to a chaplain. If the patients declines, it is not a problem, as the communication channel has been established, giving the patient the opportunity to raise the issue later.

With a consciousness of and awareness about spiritual issues, a nurse would be able to address those issues. Research has shown that spiritual care promotes wellness and coping with illness (Oman & Thoresen, 2002; Koenig et al., 2012; Sørensen et al., 2011). When interpersonal care, *high touch*, becomes part of total patient care, patients experience being seen for who they are. This increases patient satisfaction and generates positive feedback through which health professionals experience meaningfulness in their work. That will naturally lead to greater job satisfaction and lower turnover, which eventually will benefit patients by developing health professionals that view them as whole persons.

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