University of Groningen

A critical analysis of scales to measure the attitude of nurses toward spiritual care and the frequency of spiritual nursing care activities

Garssen, Bert; Ebenau, Anne Frederieke; Visser, Anja; Uwland, Nicoline; Groot, Marieke

Published in:
Nursing inquiry

DOI:
[10.1111/nin.12178](https://doi.org/10.1111/nin.12178)

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2017

[Link to publication in University of Groningen/UMCG research database](#)

Citation for published version (APA):

Garssen, B., Ebenau, A. F., Visser, A., Uwland, N., & Groot, M. (2017). A critical analysis of scales to measure the attitude of nurses toward spiritual care and the frequency of spiritual nursing care activities. *Nursing inquiry*, 24(3), 1-9. [e12178]. <https://doi.org/10.1111/nin.12178>

Copyright

Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

The publication may also be distributed here under the terms of Article 25fa of the Dutch Copyright Act, indicated by the "Taverne" license. More information can be found on the University of Groningen website: <https://www.rug.nl/library/open-access/self-archiving-pure/taverne-amendment>.

Take-down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): <http://www.rug.nl/research/portal>. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.

A critical analysis of scales to measure the attitude of nurses toward spiritual care and the frequency of spiritual nursing care activities

Bert Garssen¹ | Anne Frederieke Ebenau^{1,4} | Anja Visser² | Nicoline Uwland³ | Marieke Groot^{1,4}

¹Center for Psycho-Oncology, Helen Dowling Institute, Bilthoven, The Netherlands

²Faculty of Theology and Religious Studies University of Groningen, Groningen, The Netherlands

³Faculty of Behavioral and Movement Sciences, Free University, Amsterdam, The Netherlands

⁴Department Anesthesiology, Pain and Palliative Care/Expertise Center for Palliative Care, Radboud University Medical Center, Nijmegen, The Netherlands

Correspondence

Bert Garssen, Professor Bronkhorstlaan, Center for Psycho-oncology, Helen Dowling Institute, Bilthoven, The Netherlands.
Email: b.garssen@ziggo.nl

Funding information

The work on this review was funded by the Dutch Cancer Society (HDI2010-4871).

Quantitative studies have assessed nurses' attitudes toward and frequency of spiritual care [SC] and which factors are of influence on this attitude and frequency. However, we had doubts about the construct validity of the scales used in these studies. Our objective was to evaluate scales measuring nursing SC. Articles about the development and psychometric evaluation of SC scales have been identified, using, Web of Science, and CINAHL, and evaluated with respect to the psychometric properties and item content of the scales. Item content was evaluated by each of the five authors with respect to the following questions: Does the item (1) reflect a general opinion about SC instead of a personal willingness to offer SC; (2) reflect general psychosocial care instead of specific SC; (3) focus solely on religious care; (4) contain the words 'spiritual' (care/needs/health/strengths, etc.); and (5) contain multiple propositions, or have an unclear meaning? We found eight scales. Psychometric analysis of these scales was often meager and the items of all but one scale suffered from two or more of the five problems described above. This leads us to conclude that many quantitative results in this area are based on findings with questionable scales. Suggestions for improvements are provided.

KEYWORDS

nurse–patient interaction, nursing assessment, quantitative methods, religion, spirituality

1 | INTRODUCTION

Admittance to a hospital can be a crucial event in a person's life. Because of their frequent contact with patients and their immediate availability to hospitalized patients, nurses are in a unique position to help patients with possible existential questions. Such spiritual care is considered an essential component of nursing. The International Council of Nursing identified providing spiritual care as a requisite of quality care (International Council of Nurses, 2012), but how much is this declaration realized in clinical practice? To answer this question, one needs a description of spiritual care, and reliable and valid scales to assess spiritual nursing care.

The National Health Service Education for Scotland defines spiritual care as 'care which recognizes and responds to the needs of the

human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener' (National Health Service Education for Scotland, 2009). Spiritual care is conveyed by being caring and respectful, which can assist the patient to regain meaning and purpose in life, faith or trust, hope, love, and forgiveness (Grant, 2004). These definitions are based on Western notions of spirituality and spiritual care, to which we will delimit this overview. For a description of spiritual care, a definition of spirituality is required. We consider spirituality and religion as overlapping, though separate constructs. Spirituality can include religion, and religion can include spirituality but this is not necessarily so. A main theme in definitions of spirituality is connectedness (Chiu, Emblen, van Hofwegen, Sawatzky, & Meyerhoff, 2004; Dyson, Cobb,

& Forman, 1997; Florczak, 2010; de Jager Meezenbroek et al., 2012): connectedness with oneself, connectedness with the outer world, and connectedness with the transcendent.

Although there is no sharp boundary between (non-spiritual) psychosocial care and spiritual care, the two should be distinguished, if conceptual clarity is sought. Some aspects of psychosocial care, such as attentive listening, can be considered a prerequisite for spiritual care, but is not in itself spiritual care. If a scale used to assess spiritual care mainly includes such items, one may doubt whether it in fact measures what it is supposed to do. Deal and Grassley indicate that 'Spiritual care goes beyond psychosocial. Psychosocial could be just comfort, and spiritual care could be validating and creating a holy atmosphere and treating people very respectfully and acknowledging their beliefs' (Deal & Grassley, 2012, p. 475). In the same line, Taylor argues that 'Some therapeutics (e.g., such as giving a knowing look, actively listening to patient's story, using nonprocedural caring touch) are not uniquely spiritual care, but could be considered psychosocial care or simply caring' (Taylor, 2008; p. 157). The distinction between psychosocial and spiritual care is not only scientifically important, but may also have consequences for nursing practice, because psychosocial and spiritual care ask for different interventions (Highfield & Cason, 1983). The NHSE definition, cited above, does mention 'a sensitive listener', but a restriction is imposed by the first part of the sentence 'care which recognizes and responds to the needs of the human spirit'. The definition of Grant includes the psychosocial elements of 'being caring and respectful', but these are conveyed with the intention to help 'the patient to regain meaning and purpose in life, faith or trust, hope, love, and forgiveness'. For making a distinction with psychosocial care, we will use the following description: The hallmark of spiritual care is the attention for how the patient's expressions are related to her or his life as a whole, and refer to the patient's meaning system. For example, if a nurse asks whether a patient feels emotionally well and—if not—what can be done, she or he is offering psychological care. However, spiritual care is provided when the nurse responds acceptingly and relates the emotion to the significance that the situation has for the patient's sense of identity and a patient's lookback on her or his life.

The majority of nurses consider spiritual care as a fundamental aspect of their profession (Delgado, 2015; Gallison, Xu, Jurgens, & Boyle, 2013; McSherry & Jamieson, 2011). However, a considerable number of nurses experience barriers in providing spiritual care, most often because of a lack of education and training in this field (Delgado, 2015; Hubbell, Woodard, Barksdale-Brown, & Parker, 2006; McSherry & Jamieson, 2011; Ruder, 2013; Stranahan, 2001).

To be able to reduce barriers to spiritual care, one needs accurate data about nurses' activities in this field and the factors that influence this. There are several methods to study this. A direct observation of nursing spiritual care activities would be the best option, but it is difficult to implement and has rarely taken place. The second best option is to directly ask nurses about their activities in this field. This sometimes happens with the use of self-report scales that assess the frequency with which certain spiritual care activities are undertaken. The next option is to ask about nurse's willingness to provide spiritual

care, by asking questions about their personal attitude with respect to delivering spiritual care when needed, stimulating colleagues in thinking about such care where appropriate, hoping for and contributing to a positive climate toward spiritual care in her or his department, and advocating the implementation of training in delivering spiritual care, taking into account that there are sometimes practical barriers. A nurse who shows willingness, as defined above, will be more likely to actually provide spiritual care. Such scales have been used more often and are sometimes referred to as 'perception scales'. The last option also concerns so-called perception scales, but these scales ask nurses about their opinions about the appropriateness and content of spiritual care in general. However, it is uncertain whether an opinion leads to or reflects activities: A nurse may have the opinion that spiritual care is good for patients, but does not apply it her/himself. An example is the item 'I believe nurses can provide spiritual care by arranging a visit by the hospital Chaplain if requested'. This item can be affirmed, while the nurse her/himself has no intention to bring in the chaplain. So, scales that assess opinions, though often used, are not optimally suited to assess the extent to which nurses provide spiritual care.

Some authors of perception scales stated that a high score to their perception scales indicates 'a positive and favorable perception of spiritual care' (Chan et al., 2006; Ozbasaran, Ergul, Temel, Aslan, & Coban, 2011; Turan & Karamanoglu, 2013), but it is not immediately clear whether this means that they assessed the willingness to provide spiritual care or favorable opinions about spiritual care in general. Therefore, one purpose of the present review was to evaluate whether these perception scales assessed nurses' willingness or opinions, to reduce uncertainty about what these scales actually measure (their construct validity). This knowledge will assist researchers in choosing a questionnaire for a new study, or when summarizing quantitative findings from published studies.

Beside the difference between willingness and opinion, the aim of the present review was also to examine four other potential problems with construct validity may arise when constructing a scale to determine how many nurses have a willingness to provide spiritual care and how many nurses regularly provide such care. These potential problems are more fundamental than psychometric tests of the reliability or the convergent/divergent validity of scales. A Spiritual Care scale can be perfectly reliable, distinguishable from other scales or similar to comparable scales, but still not measure a willingness to provide spiritual care and the actual delivery of such care.

As stated, the first potential problem concerns the phrasing of items. Some opinions included seem unrelated to willingness, such as the items 'Spiritual care is an integral component of holistic nursing care' or 'Spiritual care is more than religious care' (items from the SCGS; see below). These are factual opinions: One may agree that spiritual care is part of holistic care, and that spiritual care is more than religious care, but still have the opinion that providing spiritual nursing care is not one's business.

A second potential problem concerns the difficult distinction between (general) psychosocial care and spiritual care. We understand the opinion of spiritually oriented nurses who consider good nursing synonymous with spiritual care. However, there are also nurses with

no interest in spiritual care, but who are friendly, caring, and cheerful. Spiritual care scales would not function properly if these nurses are able to obtain a high score on these scales.

A third potential problem with several of the existing scales is the focus on religion or religious activities. As indicated above, spirituality and religion are related, but separate constructs. Thus, scales assessing spiritual care practices should include more than just religious activities such as praying or referral to clergy. On the other hand, some populations may fully equate spirituality with religion, which may warrant a choice for a spiritual care scale that uses a more religious language. In North America, for example, 61% of the inhabitants consider themselves religious and especially African Americans have been found to associate spirituality mainly with religious aspects (WIN/GIA, 2014). However, in several countries in Western Europe, only a minority considers themselves religious (for instance, only 34%–47% in UK, France, and Germany (WIN/GIA, 2014)). In the Dutch population, 19% consider themselves spiritual, but not religious, which implies that the assessment of spiritual care provision for these people cannot be done adequately if one focusses on religious care practices. The spiritual or religious background of the nurses might also influence the type of spiritual care practices that they feel positively toward and that they practice, which might bias their responses on a spiritual care scale that is phrased in either mainly religious or mainly non-religious terms. To be widely applicable, a questionnaire that transcends specific beliefs is therefore preferable for quantifying the willingness to provide spiritual care and the actual delivery of such care.

The fourth aspect concerns the use of the terms 'spiritual care/strength/health/needs, etc.' in items. Several studies have indicated that people have a wide range of associations with the word 'spirituality' (Zinnbauer, Pargament, & Scott, 1999) and this also applies for nurses with respect to spiritual care activities (Taylor, 2008). A person may simply dislike the word 'spiritual' because he/she associates it with spiritualism or fuzziness and, therefore, not endorse an item on the importance of spiritual care, even though the person does value all the activities and attitudes that SC entails. This example highlights another problem with the use of the term 'spiritual care' in questionnaire items: It is unclear what the respondent considers to be SC. The respondent's personal definition might differ substantially from the definition of the scale constructors (and users) and, thus, the respondent's answers will not reflect what the researchers intent to measure. Words that have different meanings to respondents should be either omitted or explained. More appropriate would be items such as 'A patient who is speaking about the meaning of his or her life should be given full attention'. If 'spiritual care' is still used in the wording of items, a short explanation of this concept should be provided in the header of the scale.

A fifth potential problem is that some items might contain multiple propositions, such as 'I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient'. Such an item makes it difficult for the respondent to answer, because they might consider some aspects irrelevant to spiritual care. Relatedly, the meaning of an item might be unclear, such as, 'religious beliefs can be a hindrance to health'. In this item, it is not clear what

the relationship is with the willingness to provide spiritual care. Fowler also indicates that items should include a single question, and questions should not include hidden contingencies (Fowler, 1995).

If a scale shows any of these issues, it becomes unclear what findings are obtained with this questionnaire mean. Therefore, the aim of this review is to critically discuss the construct validity of available scales that assess or seem to assess willingness of nurses to provide spiritual care or the frequency with which they offer such care on these five criteria.

2 | METHODS

We searched for articles in Web of Science, PubMed and CINAHL using the title keywords spiritual* OR religi* OR meaning OR existential, in combination with the title word nurs*, AND the title OR topic words questionnaire, scale, OR measurement. We also examined the reference sections of retrieved studies to identify additional relevant studies. Only articles in English were included. We used no limitation with respect to year of publication, but the search ended June 2015.

Included in our review were all scales on spiritual nursing care which psychometric findings had been analyzed and discussed in a publication and/or which scale was used in several studies. So, scales developed for one-time use have been left out. These articles had to have been published in peer-reviewed, English-language journals. We have tried to determine whether these spiritual care scales measured 'willingness' or 'frequency', even if the aim of these scales was described otherwise to eliminate uncertainty, as explained in the introduction.

The extensiveness of classical psychometric tests has been assessed, and the items of the scales have been evaluated by each of the five authors to determine whether the item (1) merely reflects a general opinion about spiritual care, rather than the personal willingness to offer such care; (2) refers to (general) psychosocial care rather than specific spiritual care; (3) refers exclusively to religious (nursing care) activities; (4) used the terms 'spiritual' (care/needs/health/strengths, etc.); and (5) is not suited to be included in a 'willingness' or 'frequency' scale for another reason, especially because the item contains multiple propositions, or the meaning of the item is unclear. Discrepancies between the evaluations of the five raters were discussed, and the collective opinion is presented below. The qualifications of the five evaluators were as follows: BG senior researcher PhD with more than 40 years of experience in research in Health Psychology, including scale development and spirituality; AFE junior psychological researcher MA, with more than 2 years of experience in studies on meaning and palliative care; AV psychological researcher PhD, with more than 8 years of experience in studies on scale development, spirituality, and religion, assistant professor spiritual care; NU psychological researcher MSc, with more than 8 years of experience in studies in spirituality and psychogerontology; MG postdoc researcher, senior lecturer and RN with more than 15 years of experience in nursing and palliative care studies.

3 | RESULTS¹

We found 37 publications describing a study about the development of a nursing spiritual care scale or using such a scale. Eight different scales were described in these studies that are discussed below.

3.1 | The Oncology Nurse Spiritual Care Perspectives Survey (ONSPS) (Taylor, Highfield, & Amenta, 1994)

This scale aimed to assess 'cancer nurses' attitudes and beliefs regarding spiritual care' (Taylor et al., 1994; p. 479). It includes thirteen Likert-type items with 5-point response options. They reflect two—a priori chosen—content areas: (A) attitudes about spiritual care in nursing practice and (B) how nurses should relate to the spirituality and religiosity of patients. Psychometric analyses of this scale have not been published. Taylor stated that a higher score to part A reflects a more positive attitude toward spiritual care (Taylor et al., 1994, p. 484).

It is not quite clear whether Taylor proposed to use the sumscore to part A of her scale, or the sumscore of all thirteen items. Stranahan used a modified version, called the Nurses Spiritual Care Perspective Scale (NSCPS) (Stranahan, 2001), but her NSCPS—part 2 is virtually identical to the ONSPS. Stranahan did not make a distinction between part A and B, and she clearly indicated that a higher score to all A and B items reflects a favorable attitude toward providing spiritual care (Stranahan, 2001, p. 96).

Our evaluation showed that the ONPS contains no items that describe psychosocial care that is not specifically spiritual care. It also contains relatively few purely religious items, but contains many items including the word 'spiritual' and many items that reflect opinions about instead of willingness to provide spiritual care (See Table 1). In addition, there are some unclear items, such as:

- 'Atheists and agnostics are spiritually healthy'. One may surely assume that some atheists and agnostics are spiritually healthy, whereas others are not. So, what does an answer mean? Do all nurses know what agnostics are? What exactly is 'spiritual health'?

In conclusion, several items of this scale reflect opinions instead of 'willingness' and are ambiguous and/or do not logically reflect the concept to be measured. Many terms are not defined, such as spiritual care, spiritual concerns, spiritual needs, and spiritual health.

3.2 | Spiritual Care Perspectives Survey (SCPS) revised (Taylor et al., 1994)

The SCPS-revised is an adaptation of the ONSPS. There are now ten attitude questions: seven are similar to the A-part of the ONSPS and three questions are added:

1. I provide spiritual care every day at work (1) to rarely or never (5);
2. My ability to provide spiritual care is weak, limited (1) to strong, comprehensive (5);
3. While providing spiritual care, I feelvery uncomfortable (1) to very comfortable (5).

According to Taylor's instructions, the first seven items can be used as a unidimensional scale, the three additional questions can be used separately, but the ten items together can also be used as a unidimensional scale, of which a high score indicates a positive perspective about providing spiritual care (Taylor, Mamier, Bahjri, Anton, & Petersen, 2009, p. 33). The Attitude subscale was used in four studies (Hubbell et al., 2006; Musgrave & McFarlane, 2004; Taylor, Highfield, & Amenta, 1999; Taylor et al., 2009).

Face validity (the subjective impression whether the test covers the concept it purports to measure) of the 10-item SCPS-revised was established by a panel of six experts. Further psychometric testing was performed among a sample of 638 nurses (Taylor et al., 2009). Its unidimensionality was demonstrated using explorative factor analysis, internal consistency was sufficient, and stability was shown in a test-retest reliability study with a 2-week interval. To test convergent validity (how closely measures that theoretically should be related, are in fact related), the correlations with measures of religiosity and spirituality were determined. Measures of both concepts appeared to be related.

A problem with the first of the three added questions is that it concerns a frequency question amidst 'willingness' questions. Item II may reflect a lack of training; not clearly the absence of willingness.

A list of twelve spiritual care activities is added, to be scored on Likert-type scales. This list is identical to the NSCPS—part 1, used in the study of Stranahan (Stranahan, 2001).

The frequency scale was used in two studies (Hubbell et al., 2006; Stranahan, 2001). A problem with this 'frequency subscale' is that seven of the twelve items refer to religious activities. This makes the scale unsuited for use in more secularized countries.

In conclusion, it is positive that the SCPS includes both an attitude and a frequency subscale, but there is doubt about the construct validity of the attitude subscale (see our comments to the ONSPS). Also, the character of most items of the frequency subscale is prevalently religious.

3.3 | Spirituality and Spiritual Care Rating Scale (SSCRS) (McSherry, Draper, & Kendrick, 2002)

The aim of this 17-item scale is to determine what, according to nurses, spiritual care means. The items were—on the basis of factor analysis of data collected among 559 ward-based nurses—divided into four subscales, called Spirituality (5 items), Religiosity (3 items), Spiritual Care (5 items), and Personalized Care (3 items). The items have to be answered on a 5-point Likert Scale. The SSCRS was used in many studies (Cetinkaya, Azak, & Dundar, 2013; Khoshknab,

¹We could not obtain a copy of the Spiritual Care Practice Questionnaire (SCP) (Vance, 2001), despite several attempts to contact the author of this scale and those who have used it. This scale was applied in two studies (Gallison et al., 2013; Ronaldson, Hayes, Aggar, Green, & Carey, 2012).

TABLE 1 Evaluation of nursing scales measuring attitude toward providing spiritual care (SC) and frequency of spiritual care activities

	Total no. of items	Number of items and their percentage that ...				
		Reflects opinions about SC instead of willingness to provide SC ^a	Reflects psychosocial care, not specifically SC	Focuses exclusively on religion	Uses the words 'spiritual'	Unclear meaning ^b
ONSPS by Taylor et al. (1994)	13	12 (92%)	0 (0%)	2 (15%)	11 (85%)	6 (46%)
SCPS by Taylor et al. (1999)						
Frequency (part 1)	12	—	0 (0%)	7 (58%)	5 (42%)	0 (0%)
Attitude (part 2)	10	7 (70%)	0 (0%)	0 (0%)	9 (90%)	4 (40%)
SSCRS by McSherry et al. (2002)—'Spiritual Care' subscale	5	5 (100%)	3 (60%)	0 (0%)	5 (100%)	1 (20%)
SCPPS by Chan et al. (2006)						
Perception scale	7	6 (86%)	2 (29%)	0 (0%)	7 (100%)	2 (29%)
Frequency scale	5	—	0 (0%)	0 (0%)	5 (100%)	0 (0%)
SCI by Burkhart, Schmidt, and Hogan (2011)—Frequency scale	4	—	0 (0%)	0 (0%)	1 (25%)	0 (0%)
SC by Nardi and Rooda (2011)						
Spiritually based nursing therapeutics	15	2 (13%)	8 (53%)	10 (67%)	1 (7%)	8 (53%)
Valuing and supporting others	11	0 (0%)	5 (45%)	6 (55%)	4 (36%)	1 (9%)
Use of spiritually based nursing process	5	0 (0%)	4 (80%)	0 (0%)	1 (20%)	1 (20%)
Use of the metaphysical self	6	3 (50%)	3 (50%)	4 (67%)	0 (0%)	2 (33%)
Individual spiritually based actions	4	2 (50%)	0 (0%)	0 (0%)	0 (0%)	1 (25%)
Spiritually based outcomes	2	0 (0%)	1 (50%)	2 (100%)	0 (0%)	0 (0%)
SCGS by Tiew and Creedy (2012)						
Attributes for spiritual care	9	9 (100%)	0 (0%)	0 (0%)	9 (100%)	0 (0%)
Spiritual care values	5	5 (100%)	0 (0%)	0 (0%)	4 (80%)	2 (40%)
Defining spiritual care	7	7 (100%)	2 (29%)	0 (0%)	7 (100%)	2 (29%)
Spiritual care attitudes	6	5 (83%)	0 (0%)	0 (0%)	6 (100%)	0 (0%)
NSCTS by Mamier and Taylor (2015)—Frequency scale	17	—	3 (18%)	1 (6%)	10 (59%)	1 (6%)

^aThis is not evaluated for 'frequency' scales.

^bIncludes also multiple propositions, asks about concepts probably unknown for many participants, or asks about spirituality—not spiritual care.

Mazaheri, Maddah, & Rahgozar, 2010; van Leeuwen & Schep-Akkerman, 2015; McSherry & Jamieson, 2011; Ozbasaran et al., 2011; Ross et al., 2014; Timmins, Neill, Griffin, Kelly, & De La Cruz, 2014; Wong, Lee, & Lee, 2008; Wu, Liao, & Yeh, 2012; Wu & Lin, 2011; Yilmaz & Gurler, 2014).

The SSCRS is also adapted for use in Persia by the forward-backward translation procedure (Khoshknab et al., 2010). Minor changes were made based on the comments of ten experts, and a 'think aloud' method was used, asking the 13 participating psychiatric nurses to reflect on the questions. The internal consistency was sufficient and a test-retest procedure showed stability. It is unsatisfactory that the authors did not apply a new factor analysis to see whether the same dimensional structure is found as for the English version.

Spiritual Care is the only subscale that represents our area of interest. However, the five items of this subscale reflect opinions that do not necessarily describe a willingness to provide spiritual nursing care,

such as 'I believe nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care' and '... by listening to and allowing patients' time to discuss and explore their fears, anxieties and troubles'. A nurse may assume that spiritual care is not her task, and still confirm—if other nurses would be inclined to provide such care—that the formulated opinions are correct.

The activities mentioned in these items may also be labeled as good psychosocial care, not necessarily spiritual care. In other words, these activities may be part of spiritual care, but cannot be considered typically spiritual care. It would not be much of a problem if such general items would constitute a small minority, but there are only two items that specifically refer to a spiritual/religious theme.

In conclusion, the Spiritual Care subscale includes mainly items that describe opinions about spiritual care, not necessarily reflecting a positive attitude of nurses and too many items that describe actions that are not specifically spiritual care.

3.4 | Spiritual Care Perceptions and Practices Scale (SCPPS) (Chan et al., 2006)

The authors chose twelve items to describe nurses' spiritual care perceptions and practices after having studied the existing literature. Content validity (evaluation whether the test covers all relevant aspects) was evaluated by a panel of three experts and considered appropriate. Test-retest reliability was sufficient as determined by the scores of ten nurses who completed the scale twice within 2 weeks. Two dimensions were distinguished on the basis of a factor analysis of data collected among 193 nurses: Perception toward spiritual care (7 items; 1 = strongly disagree; 5 = strongly agree) and Practice toward spiritual care (5 items; 1 = very unimportant; 5 = very important). For all statements in section one, a high score indicates a positive and favorable perception of spiritual care, and in section two, a high score indicates a positive or favorable spiritual care practice. Internal consistency of both subscales was sufficient. The SCPPS has been used in two studies (Chan, 2010; Turan & Karamanoglu, 2013).

Apparently, Chan revised his scale: Without explanation this later version of the scale includes 10 items, not 12 items (Chan, 2010). A confirmatory factor analysis corroborated the two factor solution, internal consistency of the two subscales was sufficient, and a test-retest among 10 nurses with a 2-week interval showed high stability.

The original 12-item version has been translated into Turkish and back translated into English (Turan & Karamanoglu, 2013). A panel of six experts evaluated every item for distinctiveness, understandability, and appropriateness. The division of items into two dimensions was confirmed by factor analysis, internal consistencies of both subscales were sufficient, and test-retest among ten nurses with a 2-week interval showed high stability.

Perception subscale: Six of the seven items concern opinions that do not clearly reflect the willingness of nurses to provide spiritual care. In our opinion, two items (items 4 and 5) describe psychosocial care that is not specifically spiritual care: 'Nurses can provide spiritual care by showing concern when giving care', and '... by listening to the patients' concerns, discussing and exploring their fears, anxieties and troubles'. Taylor also heavily criticized this scale (Taylor, 2011). Besides her remark—similar to ours—about questions referring to psychosocial care, she also criticized the wording of several items, for instance: 'The item "Spiritual care" is very important to critically ill patients. What does a 'strongly agree' response mean here? That spiritual care is important only and for all the critically ill?'

Activity scale: One of the five items is somewhat vague: 'I try to satisfy spiritual needs of patients and their relatives'. It would be better if an activity scale asks about activities, not about intentions. All items of the Perception and Activity scales include the words 'spiritual care'. The variety of spiritual nursing activities cannot be described in five items, as was done in this subscale.

In conclusion, the scale includes too many questionable items. The activity subscale is too short.

3.5 | Spiritual care inventory (SCI) (Burkhart et al., 2011)

This scale is designed to measure the provision of spiritual care by nurses. The items of this scale were derived from the authors' previous grounded theory study 'to conceptualize the process of nurses who give spiritual care in a clinical setting'. The initial pool of 48 items was factor analyzed using the data of 298 nurses from two hospitals and a school of nursing, which lead to a solution of 17 items, divided into three subscales. The internal consistency of each of the three subscales was sufficient. Answers had to be scored on a 5-point Likert scale, ranging from strongly disagree (1) to strongly agree (5). Higher scores are said to imply a greater tendency to provide spiritual care (Burkhart & Schmidt, 2012). This scale has been used in one study (Burkhart & Schmidt, 2012).

Four items represent the frequency of spiritual care interventions (subscale 'Spiritual Care Interventions'), which is too small a number for a satisfactory assessment of spiritual care practice. The remaining thirteen items describe how nurses reflect on a spiritual care encounter (subscale 'Meaning making') or what they do after such an encounter (subscale 'Faith Rituals'). These items do not assess a nurse's willingness to provide spiritual nursing care, but rather the nurse's reaction after providing spiritual care.

In conclusion, this is a scale that neither satisfactorily assesses a nurse's willingness to provide spiritual care, nor a nurse's spiritual care activities.

3.6 | Spirituality Scale (Nardi & Rooda, 2011)

This scale is said 'to determine the degree of awareness of spirituality and use of nursing strategies to address the patient's spiritual needs while receiving health care' (Nardi & Rooda, 2011). The pool of items is based on a review of books and papers on holistic nursing and spirituality. Concepts were extracted by the two authors and were used to formulate 15 items on therapeutic strategies and behaviors and 28 items on beliefs and values. Scores were obtained from 86 nursing students, and the scores to the belief and values items were factor analyzed, yielding five scales (See Table 1). The Cronbach's alpha for the whole scale was .95, which is of limited importance as it should be determined for each scale separately.

All five subscales showed shortcomings on one or several of our criteria (see Table 1). Many items contained the word 'spirituality' or 'spiritual', and many items asked about opinions instead of willingness. Ten items referred to guidelines (the nursing guidelines NIC, NOC, and NANDA) probably unknown to many participants (23 of the 86 participants said SC was 'not emphasized' in their educational program). Several items used largely identical words (items 3–7 vs. items 38–42; item 10 vs. 27; items 24 vs. item 25). An example is item 40 'I meditate with the patient to aid their healing or wellness process', which is about similar to item 6, saying 'Meditation is used for patient healing', and item 41, saying 'I use private meditation for my patients ...'. Items 40 is preferred, because the 'I' indicates that the nurse herself/himself is using meditation, whereas it is unclear whether the item 6 presents

a general opinion or a willingness or activity of the nurse. An example of a confusing statement is item 8 'Presence and intention is used for healing'. In fact, there are two statements in this item, one about presence and another about intention, and it is unclear what 'using intention to heal' means.

To summarize, the psychometric analyses were meager (too few participants for a factor analysis, use of nursing students—not nurses, no test for internal consistency for subscales, no convergent, and divergent validity tests) and the wording of several items are questionable.

3.7 | Spiritual Care-Giving Scale (SCGS) (Tiew & Creedy, 2012)

The aim of this scale is to measure student nurses' perceptions toward spirituality and spiritual care, divided into attitudes about spiritual care, knowledge, and ability to provide spiritual care, and barriers to providing spiritual care. The pool of items for this scale came from interviews with nursing students, a literature review, and a review of existing scales. The 118 items were evaluated by a panel of six experts, which reduced the pool to 68 items. In a first study among 110 nursing students, the scale was further reduced on the basis of item-total correlations. The reduced scale was tested in a second study, also among nursing students ($N = 745$). A factor analysis yielded 35 items divided into five factors. The scale uses a six-point Likert scale with responses ranging from one (strongly disagree) to six (strongly agree). The SCGS is used in two studies (Tiew, Creedy, & Chan, 2013a; Tiew, Kwee, Creedy, & Chan, 2013b).

A minor problem with this scale is that it has been developed using the scores of nursing students, which makes it uncertain whether the scale is also applicable for nurses in clinical practice. However, a major problem is that most items ask about opinions that do not necessarily reflect willingness to provide spiritual nursing care, such as 'Spiritual care enables the patient to find meaning and purpose in their illness'. Another objection is that the five subscales are not conceptually clear. For instance, the subscales 'Attributes for Spiritual Care' and 'Spiritual Care Values' include opinions about both spirituality and spiritual care. One subscale—Spiritual Perspectives—concerns only items about spirituality, not about spiritual care. The subscale 'Defining Spiritual Care' is said to reflect the notion of 'being present with the patient'. This heading does not seem to fit several items of this scale, such as 'Spiritual care is respecting a patient's religious or personal beliefs'.

The six-item subscale 'Spiritual Care Attitudes' is said to 'explore participants' attitudes toward spirituality and spiritual care-giving' (Tiew & Creedy, 2012, p. 688), which seems closest to our conception of measuring willingness to provide spiritual care. However, all items contain the term 'spiritual', and the scale includes items that do not clearly represent a positive attitude, such as the item 'Spiritual care includes support to help patients observe their religious beliefs' (more an opinion than reflecting willingness; too much focused on religion).

In conclusion, several subscales are conceptually unclear. The 'Spiritual Care Attitudes' subscale is inappropriate to measure a nurse's willingness to provide spiritual interventions herself/himself.

3.8 | Nurse Spiritual Care Therapeutics Scale (NSCTS) (Mamier & Taylor, 2015)

Recently, Mamier and Taylor published the first satisfactory scale to measure the frequency of nursing spiritual care activities.

Criteria for including items were (1) describing an intervention that was appropriate for a nurse to provide, (2) distinctly addressing spirituality or religiosity, and (3) appropriate to use regardless of patient's religious orientation or the absence of it. Seventeen items were selected by an expert panel of nine nurse scholars. Examples of items are as follows: 'Encouraged a patient to talk about what gives his or her life meaning amid illness' and 'Listened to patient talk about spiritual concerns'. A 5-point answering scale was used, going from 1 ('never') to 5 ('very often = more than 12 times'). The quantitative questions were followed up with the question, 'Are there any other spiritual care practices that you have provided?' If yes, the participant has to specify these practices in narrative format.

The psychometric quality was tested in a sample of 554 nurses. Explorative factor analysis yielded a one factor solution. Internal consistency was high. The relationship with measures of religiosity and spirituality was weak to moderate, but always significant, which supports the convergent validity.

Despite the promising character of this scale, there are some weaker aspects. The validity tests are somewhat meager. One would wish to have an independent parallel test of spiritual nursing activities. A direct observation of such activities would be perfect, but may be considered unrealistic. However, one could also ask the patients, who are cared for by the nurse who completed the scale, how often these patients noticed that their spiritual needs had been looked after by this nurse. A test-retest is also missing.

In our view, the items 'Helped a patient have a quiet time or space', and 'after completing a task, remained present just to show caring' do not refer to typically spiritual activities, but they form a small minority among the 17 items. Only one item is typically religious ('Offered to pray with a patient'), but 10 of the 17 items contain the term 'spiritual'.

4 | DISCUSSION

In this critical review, we have assessed eight spiritual nursing care scales to evaluate whether they measure a nurse's willingness to provide spiritual care and the frequency of providing such care. Scales should have sufficient content validity for determining how often spiritual nursing care is provided, which are the barriers and facilitators of such care, and which actions are needed to optimize spiritual nursing care. There appeared to be several problems in these scales, which are summarized in Table 1: (i) Opinions were asked that do not clearly reflect a willingness toward providing spiritual nursing care; (ii) items asked about activities that represent psychosocial care, not specifically spiritual care; (iii) many items referred to religious types of nursing activities; (iv) terms like 'spiritual care', 'spiritual health', 'spiritual strengths', etc. were mentioned without a definition of these terms; and (v) items were sometimes conceptually unclear, contained

multiple propositions, or asked about the nurse's spirituality instead of her/his willingness with respect to and activities in spiritual care.

We conclude therefore that researchers should carefully consider whether the spiritual care scale of their choosing matches their purpose. Table 1 can assist the researcher in this situation. The scale that has showed the best construct validity for the assessment of nurse's attitude toward and engagement in spiritual care practice in a wide population is the recently published NSTS of Mamier and Taylor (Mamier & Taylor, 2015). All other scales showed serious validity problems. Findings of studies that used these questionable scales should be interpreted with caution.

Although subjective judgement may have played a role in the critical review of the scales, several criteria could be strictly objectively scored, especially criteria 3 and 4. The use of five independent raters is considered a further safeguard. The psychometric analyses of the discussed scales were often limited and have been briefly described. We have focused in this review on construct validity, which concerns the most fundamental requirement for a measurement method.

We will present some suggestions that may help in the development of new scales in this areas: Items in 'willingness' scales should preferably use the 'I' or 'me/my' form, to ascertain that an answer reflects the nurse's willingness to provide spiritual care, instead of a general opinion about such care (e.g., 'Spiritual care is a significant part of MY nursing activities'). Items in frequency scales should describe concrete activities as much as possible, instead of using abstract terms, such as 'spiritual care'. Examples are 'Encouraged a patient to talk about what gives his or her life meaning amid illness' (item from the NSTS), or 'Listened actively to a patient's life history' (self-formulated). Only a minority of the items should refer to religious aspects. None or only very few items should refer to caring activities that could also be considered psychosocial care that is not specifically spiritual care. Items should not contain references to various elements of which a person could affirm one, but not the other (Polit & Hungler, 1991; Terwee et al., 2007, p. 284). Validity tests should include a direct comparison between the new instrument and a test that is supposed to measure the same concept, but does so by means of a different method. For a 'willingness' scale, this may be interviews with nurses about their clinical activities that are scored by independent raters on how inclined a nurse is to provide spiritual care. For a 'frequency' scale, this may be a comparison in which patients score how often their nurse showed spiritual care activities. 'Willingness' or 'frequency' scales may be vulnerable to socially desirable responding. Therefore, the inclusion of a social desirability scale is advised in the psychometric analysis. In the process of development, items should be submitted to a group of experts, as was sometimes done, but also to the target population—in this case 'regular nurses'—requiring them to articulate verbally what they think the items are asking, to check whether the items are understood as meant by the developers (Terwee et al., 2007).

The development of better scales is a difficult task, but pivotal. The important question whether spiritual nursing care leads to better outcome, such as patients' emotional well-being, peacefulness,

or satisfaction with care, is not yet quantitatively investigated and requires reliable and valid questionnaires.

ACKNOWLEDGEMENTS

The work on this review was funded by the Dutch Cancer Society (HDI2010-4871).

REFERENCES

- Burkhart, L., & Schmidt, W. (2012). Measuring effectiveness of a spiritual care pedagogy in nursing education. *Journal of Professional Nursing, 28*, 315–321.
- Burkhart, L., Schmidt, L., & Hogan, N. (2011). Development and psychometric testing of the Spiritual Care Inventory instrument. *Journal of Advanced Nursing, 67*, 2463–2472.
- Cetinkaya, B., Azak, A., & Dundar, S. A. (2013). Nurses' perceptions of spirituality and spiritual care. *Australian Journal of Advanced Nursing, 31*, 5–10.
- Chan, M. F. (2010). Factors affecting nursing staff in practising spiritual care. *Journal of Clinical Nursing, 19*, 2128–2136.
- Chan, M. F., Chung, L. Y. F., Lee, A. S. C., Wong, W. K., Lee, G. S. C., Lau, C. Y., ... Ng, J. W. S. (2006). Investigating spiritual care perceptions and practice patterns in Hong Kong nurses: Results of a cluster analysis. *Nurse Education Today, 26*, 139–150.
- Chiu, L., Emblen, J. D., van Hofwegen, L., Sawatzky, R., & Meyerhoff, H. (2004). An integrative review of the concept of spirituality in the health sciences. *Western Journal of Nursing Research, 26*, 405–428.
- Deal, B., & Grassley, J. S. (2012). The lived experience of giving spiritual care: A phenomenological study of nephrology nurses working in acute and chronic hemodialysis settings. *Nephrology Nursing Journal, 39*, 471–496.
- Delgado, C. (2015). Nurses' spiritual care practices: Becoming less religious? *Journal of Christian Nursing, 32*, 116–122.
- Dyson, J., Cobb, M., & Forman, D. (1997). The meaning of spirituality: A literature review. *Journal of Advanced Nursing, 26*, 1183–1188.
- Florczak, K. L. (2010). Gathering information on spirituality: From whose perspective? *Nursing Science Quarterly, 23*, 201–205.
- Fowler, F. J. (1995). *Improving survey questions: Design and evaluation* (Applied Research Methods ed.). London: Sage Publications.
- Gallison, B. S., Xu, Y., Jurgens, C. Y., & Boyle, S. M. (2013). Acute care nurses' spiritual care practices. *Journal of Holistic Nursing, 31*, 95–103.
- Grant, D. (2004). Spiritual interventions: How, when, and why nurses use them. *Holistic Nursing Practice, 18*, 36–41.
- Highfield, M. F., & Cason, C. (1983). Spiritual needs of patients: Are they recognized? *Cancer Nursing, 6*, 187–192.
- Hubbell, S. L., Woodard, E. K., Barksdale-Brown, D. J., & Parker, J. S. (2006). Spiritual care practices of nurse practitioners in federally designated nonmetropolitan areas of North Carolina. *Journal of the American Academy of Nurse Practitioners, 18*, 379–385.
- International Council of Nurses. (2012). *Code of ethics*. Geneva: International Council of Nurses.
- de Jager Meezenbroek, E. C., Garssen, B., van den Berg, M., van Dierendonck, D., Visser, A., & Schaufeli, W. B. (2012). Measuring spirituality as a universal human experience: A review of spirituality questionnaires. *Journal of Religion & Health, 51*, 336–354.
- Khoshknab, M. F., Mazaheri, M., Maddah, S. S. B., & Rahgozar, M. (2010). Validation and reliability test of Persian version of The Spirituality and Spiritual Care Rating Scale (SSCRS). *Journal of Clinical Nursing, 19*, 2939–2941.
- van Leeuwen, R., & Schep-Akkerman, A. (2015). Nurses' perceptions of spirituality and spiritual care in different health care settings in the Netherlands. *Religions, 6*, 1346–1357.

- Mamier, I., & Taylor, E. J. (2015). Psychometric evaluation of the Nurse Spiritual Care Therapeutics Scale. *Western Journal of Nursing Research*, 37, 679–694.
- McSherry, W., Draper, P., & Kendrick, D. (2002). The construct validity of a rating scale designed to assess spirituality and spiritual care. *International Journal of Nursing Studies*, 39, 723–734.
- McSherry, W., & Jamieson, S. (2011). An online survey of nurses' perceptions of spirituality and spiritual care. *Journal of Clinical Nursing*, 20, 1757–1767.
- Musgrave, C. F., & McFarlane, E. A. (2004). Israeli oncology nurses' religiosity, spiritual well-being, and attitudes toward spiritual care: A path analysis. *Oncology Nursing Forum*, 31, 321–327.
- Nardi, D., & Rooda, L. (2011). Spirituality-based nursing practice by nursing students: An exploratory study. *Journal of Professional Nursing*, 27, 255–263.
- National Health Service Education for Scotland. (2009). *Spiritual care matters. An introductory resource for all NHS Scotland staff*. National Health Service Education for Scotland: Edinburgh.
- Ozbasaran, F., Ergul, S., Temel, A. B., Aslan, G. G., & Coban, A. (2011). Turkish nurses' perceptions of spirituality and spiritual care. *Journal of Clinical Nursing*, 20, 3102–3110.
- Polit, D. F., & Hungler, B. P. (1991). *Nursing research: Principles and methods*, 4th ed. Philadelphia, PA: J.B. Lippincott Company.
- Ronaldson, S., Hayes, L., Aggar, C., Green, J., & Carey, M. (2012). Spirituality and spiritual caring: Nurses' perspectives and practice in palliative and acute care environments. *Journal of Clinical Nursing*, 21, 2126–2135.
- Ross, L., van Leeuwen, R., Baldacchino, D., Giske, T., McSherry, W., Narayanasamy, A., ... Schep-Akerman, A. (2014). Student nurses perceptions of spirituality and competence in delivering spiritual care: A European pilot study. *Nurse Education Today*, 34, 697–702.
- Ruder, S. (2013). Spirituality in nursing: Nurses' perceptions about providing spiritual care. *Home Healthcare Nurse*, 31, 356–367.
- Stranahan, S. (2001). Spiritual perception, attitudes about spiritual care, and spiritual care practices among nurse practitioners. *Western Journal of Nursing Research*, 23, 90–104.
- Taylor, E. J. (2008). What is spiritual care in nursing? Findings from an exercise in content validity. *Holistic Nursing Practice*, 22, 154–159.
- Taylor, E. J. (2011). Commentary on Chan MF (2010) Factors affecting nursing staff in practicing spiritual care. *Journal of Clinical Nursing* 19, 2128–2136. *Journal of Clinical Nursing*, 20, 299–300.
- Taylor, E. J., Highfield, M., & Amenta, M. (1994). Attitudes and beliefs regarding spiritual care: A survey of cancer nurses. *Cancer Nursing*, 17, 479–487.
- Taylor, E. J., Highfield, M. F., & Amenta, M. (1999). Predictors of oncology and hospice nurses' spiritual care perspectives and practices. *Applied Nursing Research*, 12, 30–37.
- Taylor, E. J., Mamier, I., Bahjri, K., Anton, T., & Petersen, F. (2009). Efficacy of a self-study programme to teach spiritual care. *Journal of Clinical Nursing*, 18, 1131–1140.
- Terwee, C. B., Bot, S. D. M., de Boer, M. R., van der Windt, D. A. W. M., Knol, D. L., Dekker, J., ... de Vet, H. C. W. (2007). Quality criteria were proposed for measurement properties of health status questionnaires. *Journal of Clinical Epidemiology*, 60, 34–42.
- Tiew, L. H., & Creedy, D. K. (2012). Development and preliminary validation of a composite Spiritual Care-Giving Scale. *International Journal of Nursing Studies*, 49, 682–690.
- Tiew, L. H., Creedy, D. K., & Chan, M. F. (2013a). Student nurses' perspectives of spirituality and spiritual care. *Nurse Education Today*, 33, 574–579.
- Tiew, L. H., Kwee, J. H., Creedy, D. K., & Chan, M. F. (2013b). Hospice nurses' perspectives of spirituality. *Journal of Clinical Nursing*, 22, 2923–2933.
- Timmins, F., Neill, F., Griffin, M. Q., Kelly, J., & De La Cruz, E. (2014). Spiritual dimensions of care developing an educational package for hospital nurses in the Republic of Ireland. *Holistic Nursing Practice*, 28, 106–123.
- Turan, T., & Karamanoglu, A. Y. (2013). Determining intensive care unit nurses' perceptions and practice levels of spiritual care in Turkey. *Nursing in Critical Care*, 18, 70–78.
- Vance, D. (2001). Nurses' attitudes towards spirituality and patient care. *MEDSURG Nursing*, 10, 264–268.
- Wong, K. F., Lee, L. Y. K., & Lee, J. K. L. (2008). Hong Kong enrolled nurses' perceptions of spirituality and spiritual care. *International Nursing Review*, 55, 333–340.
- Worldwide Independent Network/Gallup International Association (WIN/GIA). (2014). End of the year survey 2014: Regional and country results. Retrieved from https://en.wikipedia.org/wiki/List_of_countries_by_irreligion; May 2, 2016.
- Wu, L. F., Liao, Y. C., & Yeh, D. C. (2012). Nursing student perceptions of spirituality and spiritual care. *The Journal of Nursing Research*, 20, 219–227.
- Wu, L. F., & Lin, L. Y. (2011). Exploration of clinical nurses' perceptions of spirituality and spiritual care. *The Journal of Nursing Research*, 19, 250–256.
- Yilmaz, M., & Gurler, H. (2014). The efficacy of integrating spirituality into undergraduate nursing curricula. *Nursing Ethics*, 21, 929–945.
- Zinnbauer, B. J., Pargament, K. I., & Scott, A. B. (1999). The emerging meanings of religiousness and spirituality: Problems and prospects. *Journal of Personality*, 67, 889–919.

How to cite this article: Garssen B, Ebenau AF, Visser A, Uwland N, Groot M. A critical analysis of scales to measure the attitude of nurses toward spiritual care and the frequency of spiritual nursing care activities. *Nurs Inq*. 2017;24:e12178. <https://doi.org/10.1111/nin.12178>