Towards nursing competencies in spiritual care
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Learning effects of thematic peer review: a qualitative analysis of reflective journals on spiritual care

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Abstract

This study describes the learning effects of thematic peer-review discussion groups (Hendriksen, 2002) on developing nursing students’ competence in providing spiritual care. It also discusses the factors that might influence the learning process. The method of peer review is a form of reflective learning based on the theory of experiential learning (Kolb, 1984). It was part of an educational programme on spiritual care in nursing for third-year undergraduate nursing students from two nursing schools in the Netherlands. Reflective journals (n = 203) - kept by students throughout the peer-review process - were analysed qualitatively and grouped into themes. The analysis shows that students reflect on spirituality in the context of personal experiences in nursing practice. In addition, they discuss the nursing process and organizational aspects of spiritual care. The results show that the first two phases in the experiential learning cycle appear prominently, they are ‘inclusion of actual experience’ and ‘reflecting on this experience’. The phases of ‘abstraction of experience’ and ‘experimenting with new behaviour’ are less evident. We will discuss possible explanations for these findings according to factors related to education, the students and the tutors and make recommendations for follow-up research.
Introduction

Although education is seen as an important condition for developing nurses’ competence in providing spiritual care, there is no systematic embedding of spiritual care in nursing education (Ross, 2006; McSherry, 2006; Van Leeuwen et al. 2006). There is a growing concern for the educational aspects of spiritual care in nursing.

First, there is concern for the proper competencies needed by nurses in order to provide spiritual care (Van Leeuwen & Cusveller, 2004; Baldacchino, 2006). This points to the way nurses engage their personality in relationship to patients and the role their personal spirituality plays in that relationship. It seems that nurses are expected to be capable of providing spiritual care in the nursing process and to be able to contribute to the organizational aspects of spiritual care.

A second area of study concerns the content of nursing education with regard to spiritual care. These studies show that in general a combination of educational strategies is applied, focusing on the development of knowledge, communication skills and attitude (Highfield et al. 2000; Shih et al. 2001; Marr et al. 2007). Other studies describe specific educational methods in reflective learning (Bush, 1999; Souter, 2003; Mitchell et al., 2006). Personal reflection has been seen as an essential skill in the learning process regarding spiritual care (Greenstreet, 1999; White, 2006; Van Leeuwen & Cusveller, 2004; Van Leeuwen et al. 2006).

A third area is formed by studies concerning the effects of education. In general, they show the effects of education in spiritual care on personal spiritual development and the development of professional competencies in the nurse. Some studies deal with the application of specific educational programmes (Hoover, 2002; Milligan, 2004; Wasner et al. 2005; Sandor et al. 2006; Lovanio & Wallace, 2007). Other studies consider the influence of nursing curricula in general (Pesut, 2002; Meyer, 2003).

The studies on specific educational programmes in spiritual care used a mix of educational strategies. However, the literature does not make clear what effect these methods have. The above-mentioned studies on reflective methods (Bush,
1999; Souter, 2003; Mitchell et al. 2006) are examples of studies describing the content of the method and guidelines for its application from a theoretical point of view. They do not describe the practical effects of application. To gain more insight into the learning effects of specific educational strategies on the development of competence in the provision of spiritual care in nursing, research into these specific strategies seems necessary. Our study contributes to that research by focusing on the following questions:

• what is the content of the written reflections that students brought to the guided thematic peer-review sessions?
• which learning effects do students ascribe to these peer-review discussions?
• which factors relate to a particular learning effect?

Method

This study involves document analysis of reflective journals written by students for guided thematic peer-review sessions. These so-called non-elicited documents were not written upon the request of the researchers, as this factor had led to potential bias and data distortion in a previous study. (Denzin & Lincoln, 1994).

The applied method of guided thematic peer-review groups

Guided thematic peer review was part of a module dealing with spirituality and spiritual care provision in nursing. Peer review is a form of collegial support in which students discuss work-related issues and advise each other (Hendriksen, 2002). This method is based on the experiential learning model (Kolb, 1984) which contains:

• inclusion of actual experiences
• reflection on these experiences
• abstraction of these experiences into general terms
• directing and testing alternative strategies in new conditions
Peer review is an adequate method to shape the reflective process with regard to spirituality and spiritual care. White (2006) states that - according to the learning process involved in spirituality and spiritual care - a reflective, experiential approach encourages the integration of theory into practice. He recommends the use of group learning and group reflection, particularly because spiritual matters are difficult to articulate, they may be emotionally challenging and that learning from and with each other may be effective. The peer-review groups were guided by senior lecturers.

Peer review took place in groups of four to six students and consisted of four three-hour sessions. Orientation took place during the first session in which students’ starting points were discussed on the basis of an individually written self-reflective report using the competency profile for spiritual care (Van Leeuwen & Cusveller, 2004). After discussing these self-reflections, themes were set for the follow-up session. Prior to each follow-up session, students were to submit to all the other participants of the group their written reflections on both the previous discussion and the next theme to be discussed. Students were undertaking internships throughout the duration of the peer-review sessions (10 weeks).

Sample

This study includes 203 written journals (response 74%) from nine peer-review groups. A total of 39 third-year students from two nursing schools in the Netherlands were involved (ages ranged from 19 to 25 years). Not all journals were included because some students were unable to attend all of the sessions (e.g. due to illness). Only after completion of all the peer-review sessions were students approached and asked to share their journals, which led to the unfortunate discovery of the fact that some students had, by that time, destroyed their journals.
Data collection method

After completion of the module, one of the researchers approached students in writing, providing information on the study and requesting permission to use the student’s peer-review material for research purposes. Students were free to object to the use of their journals. None of the students objected and the journals were subsequently handed to the researcher involved in data analysis who rendered the material anonymous to allow for a masked study (Denzin & Lincoln, 2000).

Data analysis

The method of analysis as outlined by Baarda et al. (2005) was employed during qualitative analysis. This method involves the following steps:

- sorting the text contained in the reflective journals in terms of relevance. Only information pertaining to practical and organizational aspects of the discussion was removed from the journals
- splitting relevant text into fragments
- labelling fragments using an open-coding system
- arranging and reducing labels
- defining key labels and their subsequent dimensions
- determining validity of the labelling. To this end, material from a single group was kept separate to serve as a control. This material was read by the researcher after completion of the analysis process, after which the researcher checked whether the control contents could be placed within the existing key label overview. No further themes emerged, and saturation of research data was established
- determining intersubjectivity between researchers throughout the evaluation process. To achieve this, the researchers separately analysed one set of peer-review journals and discussed the individually formulated key labels. It was concluded that there was sufficient agreement concerning data interpretation and the labels as attributed. The remaining reflective journals were divided among the researchers
Validity and reliability

Kwalitan software was used for qualitative analysis (Peters, 2000). The research group met on a regular basis to monitor the progress and content of the analysis. Literal citations from students’ reflective journals have been included in this study report to illustrate the formulated key labels and dimensions. Citations were coded to ensure a wide-ranging selection. The analytical procedure used also ensured the validity and reliability of the qualitative analysis as described in the literature (Lincoln and Guba, 1985; Maso & Smaling, 1998).

Results

The results are shown using key labels and their corresponding dimensions as derived from the analysis. First they describe the actual themes that emerged during guided thematic peer review and, secondly, the effects of guided thematic peer review as indicated by students.

Use of self-respect in relation to personal and contrasting spirituality

Use of self-respect relates to the way in which students handle their personal characteristics in, for example, relating to a patient or colleague (Van Leeuwen & Cusveller, 2004). The following dimensions may be identified: handling (coping with) one’s own (Christian) spirituality, coping with feelings, managing personal circumstances and dealing with contrasting beliefs.

Handling one’s own spirituality

Students show insecurity in handling their personal spirituality and specifically their own Christian identity. Various students have difficulty handling their personal faith during contact with patients. Students with a strong Christian conviction want to relate their faith to others, while realizing that evangelism is not a part of the nursing profession. Students indicated that they felt supported by their faith and wished the same for their patients. Discussions focused on the difficulty that students experienced in dealing with the (Christian) convictions of patients. This raises questions for students.
Student: A woman has to choose: either believe that her deceased grandchild has gone to hell or renounce her faith from which she derives her identity. How could her church make her believe this or act on this belief? (group I - segment 3)

Coping with feelings of uncertainty
Students point out that they are afraid of saying the wrong thing in communicating with patients. They often write that they have no answers and feel their own shortcomings. They are insecure when it comes to discussing spirituality and often do not have answers to questions, and this gives rise to feelings of inadequacy. They become aware of needing to assume a sense of humility toward patients. Students also describe feelings of contentment and encouragement in actual conversations on spirituality with patients.

Student: At that moment I really did not know what to do or to say. Do I ask enough questions? (group e, segment 11)

Role of personal life experiences
Being confronted with one’s personal circumstances surfaced as a result of facing complex situations with patients. Talking about spirituality also meant confronting personally intense experiences for some students.

Student: I never thought that my move away from my home church would have such an influence on a conversation with a patient (group I, segment 13)

Dealing with contrasting faiths
Guilt feelings appeared with regard to this topic, as students felt they had to deny their own faith when offering support to a patient with a contrasting faith. Students wondered whether they were allowed to discuss religion with patients, and whether they were allowed to help in rituals such as reading the Koran or praying. Students generally agreed that one should not impose one’s own opinion on patients.

Student: I found it difficult to read the Koran to a Muslim patient as it runs counter to my own faith (group k, segment 2)
Provision of spiritual care

The following dimensions emerged: recognition of spiritual issues, attitudinal skills, nursing interventions and nurse responsibility.

Recognition of spiritual issues
An important point is increased awareness. Students tend to think ‘too big’ whereas spiritual issues are often noted in small things. By asking patients how they perceive their illness, one allows them to voice their spiritual questions and needs. Questions of life and death, illness and suffering are among the most common.

Student: When people are faced with illness, they are close to their own spirituality. They might ask such questions as ‘why is this happening to me, am I being punished?’ (group k, segment 14)

Attitudinal aspects
Students become aware of the importance of such attitudinal aspects as adopting an attentive attitude and showing respect. They realize that discussing spirituality with a patient is a way of being close, which emphasizes the importance of creating a secure environment and showing mutual trust.

Student: Listening is important. No matter how quickly you want to find a solution, you don’t have that solution (group h, segment 2)

Nursing interventions
Numerous suggestions and practical tips are provided in the peer-review sessions. These are used by students to support them in the provision of spiritual care. Students recognize the importance of communicating personal boundaries. Students also pointed to the fact that they tended to offer solutions whereas they needed to learn that this is not always appropriate or possible.

Student: To ask existential questions etc. is really important, although it is scary at times. You do need to indicate your personal boundaries in these matters (group d, segment 1)
Nursing responsibilities for spiritual care
There is ongoing discussion of the professional boundaries for nurses with respect to spiritual care provision and when referral is appropriate. ‘Professional responsibility’ was the discussion topic in several peer-review groups. Various nursing models were used as frames of reference to help label the spiritual needs of patients and to process these in the anamnesis and a nursing care plan.

Student: We need to look at spirituality in a more professional light because spiritual care provision is part of the nursing profession’ (group k, segment 11)

Student: The Neuman Systems Model also encompasses the spiritual aspects of each human being. The spiritual variable should be included in creating an anamnesis (group e, segment 2)

Organizational aspects of spiritual care
As well as mentioning patient-bound conditions, students also included situations relating to organizational aspects in their journals.

Attention to spiritual care in the nursing process
Students note that there is little time for spirituality in everyday practice. Within the nursing department they point to such issues as the lack of a policy for spiritual care and the lack of attention paid to it throughout the nursing process. Lack of time is seen as a problem in spiritual care provision. The need to prioritize is emphasized here.

Student: It has not been incorporated into the nursing process yet. It’s left up to each nurse (or not)? (tutor k, segment 5)

Colleagues
Students perceive a lack of understanding and knowledge, as well as prejudice against spirituality. They point out that when trying to discuss spirituality you should show sensitivity. During the peer-review sessions students became aware of the impact of ward culture on spirituality. Students attach importance to open
discussion of spirituality with colleagues, and to paying attention to matters of spirituality during shift changes.

Student: According to my mentor, spirituality gets little attention because patients are admitted for only short stays. She said that patients will let us know if they need to talk about spiritual issues and problems (group k, segment 3)

The learning effect of guided thematic peer review

The learning effects as indicated by students may be summarized using these dimensions: i. gaining awareness, ii. developing self-confidence with respect to aspects of spiritual care provision and iii. developing a change-directed attitude toward spiritual care.

Gaining awareness
Students stated that peer review increased their awareness of personal spirituality and the place of spirituality in care provision. The learning effect was that students became aware of the spiritual care they were providing without actually realizing it. When spirituality was given the attention it deserved it led to an increased awareness of their involvement in spiritual care.

Student: I think it is now easier for me to talk to a Muslim about religion. I can be more meaningful to a patient and I won’t only be supporting patients who share my own religion’ (group a, segment 2)

Developing confidence
Students claimed that the peer-review sessions made them more confident of being able to enter into conversations about spiritual matters. Students said that discussing practical situations was helpful and this made them feel better able to cope with difficult situations.

Student: I’m learning to look at myself and my own attitude to this topic. I’m noticing personal growth (development) and I’m opening up to others (group a, segment 5)
Change-directed attitude

Several students described their new undertakings on the ward with regard to spiritual care. Peer review had given them the necessary foundation.

Student: I’m implementing an existing guideline on spiritual care on the ward (group e, segment 2)

Conclusion and discussion

The analysis clearly shows that the students’ learning process points to several professional aspects of spiritual care. The peer-review method seems initially to stimulate an increase in self-awareness to such effect that students gain confidence in their role as a provider of spiritual care. Some students also show a change-directed attitude. These results are confirmed by White (2006) and Rankin & DeLashmutt (2007) who also identified enhanced awareness and personal development regarding personal spirituality among participants of group discussions. They state that the participants were able to reflect on the spiritual aspects of specific practical experiences in relation to their personal spirituality. This was also shown by the reflective journals in this study in which students raised questions about their own Christian beliefs. The process of gaining awareness of personal spirituality is claimed to be an essential prerequisite for the provision of spiritual care (McSherry, 2006; Van Leeuwen et al. 2006). This aspect can be considered to be the professional nursing competence described by Van Leeuwen & Cusveller (2004) as ‘use of self’. Using the competency profile for self-evaluation at the start of the sessions enhanced spiritual care in such things as nursing interventions and organizational or institutional aspects (Van Leeuwen & Cusveller, 2004) and led to a more focused content of the peer-review sessions. This is in line with the findings of Rankin & DeLashmutt (2007), who conclude in their evaluation of an educational course on spiritual care that topic-focused discussion fosters the application of reflective thinking on such difficult concepts as spirituality and spiritual care. This confirms the usefulness of the thematic peer-review groups applied in this study.
This study makes clear that the peer-review discussions focus primarily on the first phases of the experiential learning model (Kolb, 1984) because they mention the entry of actual experience into reflection and opinion formation. This parallels findings from an analysis of reflective journals by Chirema (2007) who concluded that students reflect on the level of ‘attending’ and ‘feeling’ in their journals. The reflective journals show less of the integrative phase, during which students learn to detach themselves from actual experience, form abstract concepts and generalize the subject matter. In some cases there was evidence to suggest a relationship between a systematic approach to spiritual care through the use of nursing models and the nursing process. Testing new behaviour in practice is shown in topics such as ‘feeling more confident’ and ‘commitment’. The journals report very few instances of new behaviour applied to nursing practice. It could be that students have not yet been adequately trained to reflect on this. In this context, Glaze (2002) emphasizes that the reflective capacity of students shows several developmental phases, starting with being confronted by the need to reflect and ending with the integration of reflection into personal actions. Developing competence in the provision of spiritual care possibly requires an internalized form of reflection in which abstraction and experimentation are integral to the student’s basic skill palette.

Additionally, Donovan (2007) states that adequate preparation of students and continuing guidance by tutors is important for successful reflection. He draws these conclusions from an implementation study on reflection. Consequently, in our study we selected the guided peer-review model. We expected tutor guidance to stimulate the process of experiential learning, as described by White (2006). The analysis of the reflective journals was not directed at the tutor’s role. Thus the students’ reflections barely addressed the tutor’s role. It seems, however, that the tutor’s role is important, particularly with regard to providing content during the abstraction and experimentation phases of the learning process. The number of group discussions that took place (four) may also have played a role in the finding that students did not complete the reflective cycle. Analogous to supervision processes (Siegers, 2002), a longer cycle with a greater number of discussions might be introduced.
Another possible explanation is that the students involved in this study were all in the stage of adolescence, during which abstract and reflective thinking is developing (Erikson, 1982). In that sense it is not surprising that they focused especially on the first two stages of the reflection process (inclusion of actual experiences and reflection on these experiences). This again shows the importance of a guided form of reflective learning, in which a tutor must be able to coach students in the application of the ‘abstraction of these experiences into general terms’ stage as well as ‘directing and testing alternative strategies in new conditions’. Follow-up research could focus on the role of the tutor in the reflective learning process with regard to spiritual care and the application of specific learning strategies to enhance the reflective competence of students. The analyses of the reflective journals showed little or no enhancement of competence with regard to spiritual care in nursing practice. Completing the whole reflection cycle seems essential for developing competency because students will then be capable of reaching the level of abstraction (for example, theorizing about spiritual care) and test alternative behaviour (practice new competencies in spiritual care). Jochemsen & Hegeman (2007) introduce the method of deep reflection, which integrates moral and spiritual knowledge with experience and one’s own spirituality in one’s professional practice.

A final explanation might be the stage of spiritual development in the students. As noted above, the way student nurses cope with spiritual matters in health care practice is especially connected to their personal attitude towards spirituality. In describing the different stages of faith, Fowler (1981) states that individuative-reflective faith begins in the mid-twenties. During this stage the individual takes on personal responsibility for their beliefs and is able to reflect on them. This generates questions about the demands put on students in their late teens and early twenties who, according to Fowler (1981), are still in the synthetic-conventional stage. This stage can be characterized by conformism and a less reflective attitude towards faith and beliefs. Follow-up research should shed more light on the influence of cognitive and spiritual developmental aspects on the development of competencies in student nurses in the provision of spiritual care.
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