NURSING STUDENTS' OPINIONS ABOUT SPIRITUAL NEEDS

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We hereby recommend that the thesis prepared under our supervision by Sister Mary David Johnson entitled Nursing Students' Opinions About Spiritual Needs

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DEDICATION

As a token of my appreciation, I would like to dedicate this paper to the following persons:

My deceased father and living mother who brought me into the world and helped me develop into the woman I am today.

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CHAPTER I

INTRODUCTION

The holistic approach to nursing has been the focus of nursing curriculums for at least the past 20 years. The components of man frequently stressed in the nursing curriculums are the physical, psychological, sociocultural, and developmental. Another component which has always been present in the nursing curriculums but not easily identified is the spiritual variable.

Because the holistic approach to nursing is important, man's spiritual component must be recognized since man is a spiritual being. He is created in the image and likeness of God and in God he finds meaning for life. Man seeks meaning in joy as well as in illness, pain, and suffering.

The spiritual needs are not easily recognized, and therefore, are not spoken to directly in most nursing curriculums. Without adequate guidance and an awareness of spiritual needs, nursing students find difficulty in assessing, planning, and evaluating these needs in clients.

An important factor influencing the spiritual care of clients is the nursing student's religious values. Religious values may affect how the student views the spiritual needs of clients. Primarily the responsibility of nursing students is to assist clients in finding meaning for illness,

pain, and suffering.

Problem Statement

The problem for this study was to determine the relationship between the nursing students' religious values and their opinions about the spiritual needs of the client.

Statement of Purposes

The purposes of this study were to:

1. Determine the religious values of the nursing students.

2. Determine the opinions of the nursing students about the spiritual needs of clients.

3. Determine if there is a relationship between the nursing students' religious values and their opinions about the spiritual needs of clients.

Background and Significance

Today's stress on the care of the whole client is not new. The nursing profession has always implicitly assumed that the whole client was considered when he was identified by all his components. But in practice, while nursing has dealt with the physical and emotional components (Sarosi, 1968), frequently another aspect of nursing, the spiritual aspect, has been neglected.

If spiritual help is mentioned in nursing curriculums, such teaching does not always include practical ways of giving spiritual support (Piepgras, 1968). Rather, such

teaching consists primarily of suggestions about making referrals to a chaplain, sending for a dying client's clergyman, or getting the supplies needed for baptism, anointing of the sick, or circumcision (Dickinson, 1975). Nowhere is the nursing student shown how to relate one-to-one with her* client regarding his* spiritual needs.

The nursing student finds more difficulty in responding to the client's spiritual needs than she does responding to his physical needs. Reasons for this could be that the client's beliefs are different than hers; the client (or student) has never thought through his/her spiritual beliefs; or the client may hesitate discussing religion overtly (Pumphrey, 1977).

One way for the nursing student to relate openly to the client on spiritual matters is to realize the client is basically a religious being seeking someone or something to worship (Fish & Shelly, 1978). His human nature is basically religious in so far as he comes to terms with dimensions of his human experience that can be confronted finally only in a religious context. An example of one of these

*For the sake of simplicity, the feminine pronouns (she/he) will be used in place of both (he/she, him/her) as representing the majority of nursing students. She will represent the nurse. He will represent the client.

dimensions is suffering, both physically and psychologically, and it culminates in death (Cleary, 1974).

The client is a spiritual being because of a relationship with God which is basic to total functioning. Each client has worth and honor in the eyes of God and each client carries the potential to reflect the likeness of his creator as he enters into a dynamic, personal relationship with God (Fish & Shelly).

God created the world and God gives the client life and breath. The client will realize his sonship with the Fatherhood of God when he experiences God as the source of meaning and purpose, love and relatedness, and forgiveness. These three factors contribute to the client's personal relationship with God (Fish & Shelly, 1978).

As a spiritual being the client is naturally a psychosocial being. In relationship with God, self, and others, he thinks, feels, acts, and interacts. He is an individual who needs to live in harmony with God, himself, and other people. Besides being spiritual and psychosocial, the client is also a biological being; so when his physical body is in distress his entire being, including his relationship with God is affected (Fish & Shelly, 1978).

In order to treat the client in a holistic manner, the nursing student must understand that man is a physical, psychosocial, and spiritual being. She must develop a

spiritual nursing relationship with her client which is an interchange between two spiritually aware human beings (Dickinson, 1975).

Many influences--including her family background, education and experience, the institutional policies where she works, and the people with whom she works--have contributed to the nurse's role in spiritual care. Yet none of these factors, alone or in combination, is as strong an influence on her as her own personal system of values, which is based on her confirmed beliefs about God and man. She cannot give to others what she does not possess herself (Fish & Shelly, 1978).

Theoretical Framework

This study was based on interpersonal theory as described by Travelbee (1973). Travelbee (1973) defined nursing as

> an interpersonal process whereby the professional nurse practitioner assists an individual, family, or community to prevent or cope with the experiences of illness and suffering and if necessary, to find meaning in these experiences. (p. 7)

Five assumptions identified by Travelbee are:

1. ...The nurse's beliefs about the nature of the human being will profoundly affect her perception of self and others, and will affect

her ability to achieve relatedness. (p. 1)

2. ...The purpose of nursing is achieved through the establishment of a human-to-human relationship. (p. 16)

3. ...Illness and suffering are spiritual encounters as well as emotional--physical experiences. (p. 61)

4. ...Communication is a process which can enable the nurse to establish a human-to-human relationship and thereby fulfill the purpose of nursing, namely, to assist individuals and families to prevent and to cope with the experience of illness and suffering and, if necessary, to assist them to find meaning in these experiences. (p. 93)

5. ...A human-to-human relationship is established after nurse and recipient of her care have progressed through four preceding interlocking phases. These phases are: (1) the original encounter, (2) emerging identities, (3) empathy, and (4) sympathy. (p. 120)

Before becoming professional nurses, students need assistance in helping the ill clients find meaning in illness, as well as helping them to recover. This can be accomplished if the teachers in nursing believe meaning

can be found in suffering, and if they assist nursing students in arriving at this understanding (Travelbee, 1973).

The school of nursing has a responsibility to initiate discussions of ideas and beliefs about dying and death among nursing students. These students cannot assure they are educated if they have not been exposed to the meaning of suffering, illness, loneliness, and death (Travelbee, 1973).

By or through discussing their thoughts and feelings about the ill, suffering, or dying client, students may begin to clarify their feelings and realize that these feelings represent their beliefs about illness, suffering, and death. Through these discussions, they begin to realize what being human means and can gradually accept their own humanity (Travelbee, 1973).

Travelbee (1973) proposed that nursing students who cultivate and integrate their own values will have valuable qualities to share with their clients:

1. The ability to transcend.

Transcendence means "the ability to get beyond and outside of self in order to perceive and respond to human-ness of the ill, suffering, or dying individual" (Travelbee, 1973, p. 42). She will perceive each individual as a unique human being, and will allow herself to be known as a unique human being by each one of her clients (Travelbee, 1973).

2. Uniqueness:

"A major premise is that there is an utter uniqueness to every human being, each of whom is different from another person" (Travelbee, 1973, p. 23). The nursing student needs to realize this. She will know that she is not acutally caring for clients, but only for individual human beings in need of care and service, and that she is another unique human being who can render assistance for what is needed (Travelbee, 1973).

3. Understanding:

The nursing student with religious values possesses an understanding of human conditions along with a belief that illness can be a self-actualizing experience. She can identify how she feels about caring for the terminally ill; her attitudes will depend to a great extent on her feelings and ideas about death and dying, her religious convictions, her philosophy of death and philosophy of life (Travelbee, 1973).

4. The ability to see and convey meaning:

"It is believed the spiritual values a person holds will determine to a great extent, his perception of illness" (Travelbee, 1973, p. 16). Another belief is that the spiritual values of the nursing student or her philosophical beliefs about illness and suffering will determine the extent to which she will be able to help ill clients find meaning,

or lack of meaning, in these situations. A point which is often overlooked "...is that the spiritual needs of ill persons are best met be the nurse who is spiritually oriented, and demonstrates the tenets of her faith in her behavior" (Travelbee, 1973, p. 126).

The nursing student must understand and know the components of a human being in order to care for her clients who are human beings. A human being is "an unique irreplaceable individual-a-one-time-being in this world, like yet unlike any person who has ever lived or ever will live" (Travelbee, 1973, p. 26). The human being is:

1. A biological organism affected, influenced and changed by heredity, environment, the culture and all of the experience he encounters, confronts, or runs away from.
2. A being possessing the innate ability to transcend the material aspect of his nature--yet imprisoned in his nature--a limited yet unlimited individual...responsible for the acts of choosing and deciding, which alter and affect the process of becoming, or transition and change in one's own life or in the lives of others.
3. ...A thinking organism, capable or rational, logical, illogical, "either-or," "black-white"

dichotomized thinking.

4. An individual possessing the ability to know others, yet never completely being able to understand another human being.
5. An individual who knows that one day he will die. He knows that he will die but, for the most part this knowledge remains abstract and theoretical.
6. The human being that affirms and denies, acknowledges and rejects, believes and disbelieves that life's culminating experience will happen to him (Travelbee, 1973, p. 26-27).

A nursing student is also a human being sharing the human condition of all people. These common links of humanity bind all people together so what is affecting one is ultimately affecting all others (Travelbee, 1973).

The human beings for which the nursing student will be caring are human beings who are suffering. Suffering refers to

> a feeling of displeasure which ranges from simple transitory mental, physical, or spiritual discomfort to extreme anguish, namely, the malignant phases of despairful "not caring", and the terminal phase of apathetic indifference. (Travelbee, 1973, p. 62)

In order for the nursing student to assist the client in finding meaning in suffering, she herself must see meaning in suffering (Travelbee, 1973).

The client's hope will provide the greatest strength for bearing his burdens of suffering, illness, and disability. The client's cultural beliefs and his religious convictions will also influence how he accepts suffering. The client who is able to cope with his sufferings because of his religious convictions will not need to talk about his convictions because he lives them (Travelbee, 1973).

When the client is suffering, whether physically, mentally, or spiritually, there is a need for the nursing student to be concerned. She must assist her client in maintaining hope and avoiding hopelessness. This can be accomplished by being available, willing to help, listening to anxieties and fears, and attempting to grasp the meaning of illness and suffering in her client's experience (Travelbee, 1973).

The nursing student will find difficulty in assisting the ill client to cope with illness and suffering or to find meaning in illness and suffering if the student herself does not have any idea regarding the attitudes of the ill client concerning his illness. This will be resolved if she listens to what the client is communicating. When the nursing

student can perceive her client as an unique individual, and when an interaction takes place, meaningful communication will occur (Travelbee, 1973).

The nursing student will demonstrate by her actions that she wants to assist her client because he is an unique human being, not because he is ill and expects care. The nursing student demonstrates this by establishing a human-to-human relationship in nursing which "refers to an experience or series of experiences between the human being who is the nurse and the ill person, or individual in need of the services of the nurse" (Travelbee, 1973, p. 16-67).

By therapeutic use of self, nursing students can develop a human-to-human relationship. The students will use their personalities consciously and in full awareness for the benefit of establishing relatedness and for the structuring of nursing intervention. This will require self-sight, self-understanding, and an understanding of the dynamics of human behavior. Therapeutic use of self will give them ability to interpret their own behavior and the behavior of others, and the ability to perform effectively in nursing situations. When they therapeutically use themselves they show their clients that they respect each one of them and realize that each person is a one-time-being in this world and therefore, is irreplaceable (Travelbee, 1973).

Hypothesis

The following null hypothesis was formulated:

There is no significan relationship between the nursing students' religious values and their opinions about the spiritual needs of the clients.

Definition of Terms

For the purposes of this study, the following terms were defined:

1. Client - A complex, unique human being created in the image and likeness of God with physical, psychological, sociocultural, developmental, and spiritual needs, one or more of which are not being met.
2. Nursing student - A complex, unique human being created in the image and likeness of God who is a junior nursing student currently enrolled in a baccalaureate nursing program.
3. Value - "A set of personal beliefs and attitudes about truth, beauty, worth of any thought, object, or behavior" (Simon, 1972, p. 13).
4. Religious value - Any value experience that is "grasped in its significance for the total meaning of life" (Spranger, 1928, p. 210).
5. Spiritual needs - "the lack of any factor or

factors necessary to establish and/or maintain a dynamic, personal relationship with God" (Stallwood, 1975, p. 1088).

6. Opinion - "A belief based on what seems to be true; judgment" (Webster, 1974, p. 499).

Limitations

The following limitations were identified:

1. Each individual has unique religious values which possibly cannot be measured.
2. Each individual has unique opinions about the spiritual needs of clients which possibly cannot be measured.
3. The emphasis that the nursing curriculum places on the spiritual component of man cannot be controlled.

Delimitations

The following delimitations were identified:

1. The sample included only juniors in nursing who were enrolled in a state supported baccalaureate nursing program.
2. The sample consisted of those persons who consented to participate.

Assumptions

Assumptions of this study are the following:

1. Man is a spiritual being.
2. The client and the nursing student are human beings created in the image and likeness of God.
3. The spiritual component of the client is as important for the client's well-being as the physical, psychological, sociocultural, and developmental components.

Summary

The present study was conducted to determine the relationship between the nursing students' religious values and their opinions about the spiritual needs of the client. Chapter two consists of a review of the literature. Five concepts are included: (1) human being, (2) nursing, (3) values, (4) spiritual needs, and (5) the meaning of illness and suffering. The third chapter presents the collection of data and the sampling procedure. The Study of Values and the Spiritual Needs Opinionnaire are discussed and the sample is described. Chapter four is concerned with analysis of the data. The Spearman rank order correlation coefficient and the *t*-test were used to correlate the two instruments. Chapter five is the summary, conclusions, and recommendations for future research in the spiritual needs of the clients.

CHAPTER II

REVIEW OF LITERATURE

The review of literature is divided into five subheadings. The subheadings include: (1) human being, (2) nursing, (3) values, (4) spiritual needs, and (5) the meaning of illness and suffering. In this study, as in life, both the nursing student and the client are considered human beings. Included in the literature under nursing will be therapeutic use of self and relationships. In the section under values the religious value will be stressed.

Human Being

The origin of the human being can be found in chapter 1 of Genesis. "In the beginning when God created the heavens and the earth, the earth was a formless wasteland, and darkness covered the abyss, while a mighty wind swept over the waters" (Genesis, 1:1-2). God then made the light and darkness. He created the water, land, and sky. He created trees and plants. All this God saw as good. God added birds, fish, and animals to the land.

> Then God said: "let us make men in our image, after our likeness. Let them have dominion over the fish of the sea, the birds of the air, and the cattle, and over all the wild animals and all the creatures

that crawl on the ground". God created man in his image; in the divine image he created him, male and female he created them...God looked at everything he had made, and he found it very good. (Genesis, 1:26-27;31)

Barnett (1972), when writing The Universe and Dr. Einstein, identified science's realization that there was a Higher Being than man and that God did create everything.

> In the evolution of scientific thought, one fact has become impressively clear: there is no mystery beyond itself. All highroads of the intellect, all byways of theory and conjecture lead ultimately to an abyss the human ingenuity can never span. For man is enchained by the very condition of his being, his finiteness and involvement in nature. The farther he extends his horizons, the more vividly he recognizes the fact that, as the physicist Niels Bohr puts it, "We are both spectators and actors in the great drama of existence." Man is thus his own greatest mystery. He does not understand the vast veiled universe in which he has been cast for reason that he does not understand himself. He comprehends but little of his organic processes and even less of his unique capacity to perceive the world about him, to reason and to dream. Least of all does he under-

> stand his noblest and most mysterious faculty: the ability to transcend himself and perceive himself in the act of perception.
>
> Man's inescapable impasse is that he himself is part of the world he seeks to explore; his body and proud brain are mosaics of the same elemental particles that compose the dark, drifting clouds of interstellar space; he is, in final analysis, merely an ephemeral conformation of the primordial space-time field. Standing midway between macrocosm and microcosm he finds barriers on every side and can perhaps but marvel, as St. Paul did nineteen hundred years ago, that "the world was created by the word of God, so that what is seen was made out of things which do not appear". (p. 117-118)

Allport (1955) presented how different sciences view the human being. The Sociologist sees the human as part of the family, group, and nation; while the Anthropologist believes the human being to be part of a culture. The Theologian focuses on the spiritual aspect of the human being and relates the spiritual aspect of the human being to a divine scheme. The Psychologist is concerned with the whole of the human being and identifies how each system is related to the others. The Neo-Thomists see the human

being as a striving, rational being moving toward or backing from an ideal of perfection resulting from the human's gift of freedom. Regardless of how different professionals define the human being, Allport (1955) implied that

> each person is an idiom unto himself, an apparent violation of the syntax of the species. An idiom develops in its own peculiar context, and this context must be understood in order to comprehend the idiom. Yet at the same time, idioms are not entirely lawless and arbitrary; indeed they can be known for what they are only by comparing them with the syntax of the species. (p. 19)

Fromm (1960) described the concept of human being by saying each human shares the essential qualities of all other human beings, but still each human being is unique and different from every other human being. Each human has different talents, dispositions, and different body structures. When the human being recognizes and affirms these differences, he/she develops into the person he/she has the potential to become. "The human being is always in the process of becoming, evolving, or changing" (Travelbee, 1973, p. 27)

Frankl (1962) believed the human being not only exists but rather decides what his/her existence will be and what he/she will become in the moment to follow. Frankl (1962)

declared the "human being is a self-transcending being" (p. 132).

Existentialism is another field of philosophy that identifies the human being. The fundamental characteristics of Existentialism are to stay close to the concrete and avoid abstractions. Existentialism does not want to become a system and would rather "be" than "think". The Existentialist studies the human being in the concrete actuality of the being's existence. The human being has the responsibility of forming his/her own self. Existentialism stresses the human being's freedom, and that by using this freedom the human is forever becoming. What changes in the human being, according to the Existentialists, as the I or the essence of the human being, not just the personality (Clemence, 1966).

Jourard (1971) also identified how the Existential Phenomenologist would view the human being. The human would be one that makes a specific view of the world, time, and space happen or come to be. The human being causes actions which change the world for himself/herself and others. The human being also makes projects, plans, invents, and creates things that will be disclosed for the world to appreciate (Jourard, 1971).

Jones (1978) proposed that the qualities of the human being which are body, soul, and spirit, are not outside each other but within each other. Israel (1977) claimed that the human being is difficult to define, especially in terms of only physical characteristics. Using only the physical characteristics and believing that the physical aspects are the absolute source of the human, forces the definition of being to include only the earthly life; death of the body would mean extinction of the human being's existence.

Israel (1977) further showed that the human being is more than body by presenting the concept of the mind. Included in the concept of the mind are the thinking intellect, emotional feelings, and cognitive perceptions along with deep moral ideals. Because of these attributes the human being can respond to life's challenges: aging, disease, death, life, and self-transcendence (Israel, 1977).

Israel (1977) questioned if there is anything about the human being that is permanent. The answer to his question is both yes and no. The most important lasting aspect of personality is the inner core of response to the profound issues of life. This inner core does not change in essence but deepens, grows, and is the peak of the human mind. Religions call the inner core the soul.

Hellwig (1978) spoke of soul, spirit, and self-consciousness as being embedded in and flowing from the physiological actions of the body. As the human body grows, motor skills and speech develop and the intellectual and spiritual activities advance and provide possibilities of freedom. But the intellectual and spiritual activities cannot be experienced unless embedded in the physiological actions of the brain and nervous system. Hellwig (1978) stated,

> The human person is not an incorporated soul but a living body whose life is spiritual. The body is not an outer shell to be husked off and discarded when the inner kernel, the soul, is ripe. Rather the body is the expression of personal existence. It gives that existence its actual dimension, and particularly its relational possibilities. (p. 57)

Breeman (1974) distinguished between the human being and God. The human being is separate in various ways. Time--one minute comes after the other and extends for the human being, while God lives in one present now having no separation. Eternity--God has the whole of time compressed into one moment which lasts forever. Space--the human being can only extend so far, but God is completely one. Love--the human being's love is divided, but God does not measure

love; God is love (Breeman, 1974).

God's gift of love is given to the human being. The gift of love is the gift of life. Burghardt (1974) elaborated on the gift of life by saying the gift of life was a gift of love because life has a distinct kind of existence. The human being shares life with everything on earth: plants, birds, fish, and beasts. What makes the human being human is the twin power the human shares with God. The human has the power to know and the freedom to love. The human being is someone, a person, like God. "That is why human life is so sacred" (Burghardt, 1974, p. 108). O'Rourke (1974) explained the sacredness of human life when he said,

> Because men and women are created in the image and likeness of God, and because God is the Creator of life, each human person has a dignity which transcends life. The holiness or sanctity of each person arises not from what he or she will ever do or ever be, not from the quality of life, but simply from the fact that God has given him or her human life. The value of human life derives from the value that God places upon it, not from the measure of value or respect it receives from human beings. In addition, the fact that Christ became man and died for each person emphasizes why the dignity and sanctity

of human life is an important truth of Christian revelation. (p. 54)

In the concept of holistic care, the human being is seen as a unique individual integrated with aspects of aliveness: physical, mental, emotional, and spiritual. Holistic care views spiritual growth as a high priority, believing that a healthy state results when the human being is alert to higher levels of consciousness (Brallier, 1978).

The nursing student as one of the health care ministers has a unique opportunity and added responsibility to communicate the truth concerning the sacredness of the human being (O'Rourke, 1974). Each human being that enters the hospital or community setting is maturing, is becoming a fuller person, for God is actively participating in the life of that human being (Tortorici, 1974). When the human being dies, his/her being will return to the dirt from which the body came, but his/her soul will live forever. Because of the uniqueness of the human being a person can never be replaced (Sullivan, 1967).

Nursing

Henderson (1970) related that in 1940 a certain college offered a unique course in nursing which was client-centered and was arranged around nursing problems rather than disease and medical diagnoses. The stress was on comprehensive care

in the hospital and follow-up care away from the hospital.

This focus on comprehensive care still continues today. Bevis (1978) stated nursing is striving to build a nursing model that speaks to nursing's domain of practice in the health care delivery system. This practice involves caring for thw whole human being. The nursing domain of practice includes the client before, during, and after health problems.

Fuller (1978) supported the holistic approach to nursing by saying the focus is on the health of the whole human being in relation with his environment. Fuller (1978) remarked that the theories and concepts that are developing include the integrity of the human being. Fuller (1978) further stressed that the common goal of nursing is service to human beings who need nursing care.

Partridge (1978), being concerned about the nursing profession, listed three tenets that are relevant to nursing:

1. Nursing is a human service. This means more than services directed toward human beings; rather, it implies that our practice is concerned with humans and is humanizing. Nursing should humanize both the client and the provider. Whether in teaching, practice,

> research, or administration, nursing should be concerned about the humanity of those involved.
>
> 2. The basis of professional authority is knowledge.
>
> 3. Nursing is an applied profession. (p. 360)

These three tenets agree with the holistic approach to nursing.

The school of nursing will stress comprehensive nursing care, provided this concept agrees with the philosophy developed by the nursing division. Each nursing program develops a philosophy from which the curriculum is built and the nursing students are educated. The philosophy of nursing of Mary College (1978) is directed toward the holistic approach to nursing regarding both the client and the nursing student.

> The person, a complex, bio-psycho, spiritual, social being with corresponding basic needs, is self-directing and self-actualizing, constantly in process and constantly becoming. By coping, controlling and adapting to internal and external forces, the person, unique and individual, strives for wholeness and quality. The person is further recognized to be a relational, interpersonal being, desiring to reach out to other individuals, to groups, and to all

society, thus interacting with self, with God, with other persons, and with the environment. (p. 36)

As in the entire college so, too, in the Nursing Division does the teaching-learning process permeate the student's life. It occurs in the Judaeo-Christian tradition and in the spirit of Benedict where there is a concern for the whole person, a love for learning, appreciation for the arts and for the sciences, a balance of service, prayer, and leisure, an openness to change that is future-oriented, a freedom from the servitude of things and the art of making good use of them, a respect for the environment, a commitment to the need for community that nurtures wisdom and peace and justice, that recognizes effective communication for maintaining true interrelatedness, that allows for weakness and limitation, but at the same time calls for independent thinking, leadership, and a resulting fullness of personhood. (p. 39)

Czmowski (1974) explained that the profession of nursing is involved in meeting the health care needs of clients with a variety of values and lifestyles. Because of these differences nursing educators assist the nursing student in identifying her own values. By identifying and developing deep

values, the nursing student is prepared for practicing nursing in a society that is rapidly changing and has many value differences (Czmowski, 1974).

With deep values and a sound philosophy of nursing, the nursing student will commit herself to the nursing profession which is

> an interpersonal process whereby the professional nurse practitioner assists an individual, family, or community to prevent or cope with the experience of illness and suffering and if necessary to find meaning in these experiences. (Travelbee, 1973, p. 7)

Henderson (1969) spoke to the same idea by saying the role of the nurse is to help the client understand himself, change conditions that caused his illness, and accept those situations that cannot be changed.

According to Fleeger (1977) nurses have a role in the health care ministry in restoring health. If unable to re-store health, the nurse assists the client in maintaining wholeness during illness or dying.

Simone (1971) has described the role of a Christian nurse. The Christian nurse helps the client find peace and security through the orientation of life and death. The Christian nurse does this by deepening her own convictions

of faith and love in a personal God and by assisting her client to reach an awareness of God's love. Jourard (1971) has said, "nursing is a special case of loving" (p. 207). This sharing can develop through a human-to-human relationship.

In developing the human-to-human relationship, the nursing student uses herself therapeutically. Simms and Lindberg (1978) defined the therapeutic use of self in nursing to mean a "direct personal involvement" (p. 128). This personal involvement requires a certain amount of risk, as do all interpersonal relationships. This risk can be diminished if the nursing student understands herself and realizes that nursing is basically a human-to-human relationship (Simms & Lindberg, 1978).

Rogers (1961) found that to be more effective in a helping relationship, the therapist must accept herself first. Rogers (1961) defined a helping relationship as "one in which one of the participants intends that there should come about, in one or both parties, more appreciation of, more expression of, more functional use of the latent inner resources of the individual" (p. 40).

Jourard (1971) looked at self-disclosure in developing relationships and identified three consequences which follow when human beings disclose themselves to each other.

1. They learn the intent to which they are similar, one to the other, and the extent to which they differ from one another in thoughts, feelings, hopes, reactions to the past, etc.
2. They learn of the other man's needs, enabling them to help him or to ensure that his needs will not be met.
3. They learn the extent to which this man accords with or deviates from moral and ethical standards. (p. 5)

Jourard (1971) did a study in 1958 at which time he found that nursing students who disclosed themselves to their parents and peers were better able to establish close communicative relations with clients when in the clinical areas than low-disclosing students.

To evaluate the importance of therapeutic communication a study was done by Foster (1974). The purpose of this study was to determine the effect of interpersonal communication on urinary sodium-potassium ratio, an adrenal cortex stress indicator. The hypothesis was that therapeutic communication would decrease stres. If stress is decreased there is less aldosterone secreted and the urinary sodium-potassium ratio rises. One group received communication while the control group did not. The instruments used were

Spielberger State-Anxiety Test and three 12-hour urine tests for sodium, potassium, creatinine, and vanillymandelic acid. The results of the study showed no statistically significant differences between the group receiving interpersonal communications and the control group in the sodium-potassium ratios, vanillymandelic acid values, and the Spielberger State-Anxiety Test scores. The groups were, therefore, thought to be comparable in the degree of stress they were experiencing initially. The results of the study suggested that urine sodium-potassium ratio is a valid index for body's biochemical response to stress and is reflective of client's welfare.

Gold (1978) stated that "communication is a people process" (p. 72), and identified the three elements which provide the base for the communication process. These elements are intent, meaning, and message. Intent refers to the purpose which is to effect change in the environment, self and others. The greater the awareness of the intent or purpose, the more therapeutic the communication will be. Meaning refers to the person's response to a single symbol or set of symbols. Meaning is learned and can change with experience. The last element, messages, are physical realities. "In order for messages to generate meaning, they must be coded, have content, and be in syntactical arrange-

ment" (p. 77). An important factor in communication, according to Gold (1978) is that meaningful communication occurs when each person is perceived as a unique human being.

Jourard (1971) described what a well-nursed client is and what a general nursing practitioner is. The well-nursed client is one who is as comfortable as his condition allows, knowing why he developed his illness and what is being done for him. He feels his nurse really cares about what happens to him and that she knows him as a unique person. His nurse takes time to learn about him, and he knows that he has informed the nurse about himself. The nurse and the client have communicated.

Jourard (1971) proposed that the general nursing practitioner is a human who can have empathic contact with any client who is ill regardless of age, race, religion, or morals. The nurse cares about human beings by wanting to know about the client, how to help the client and by wanting to be an effective change agent in the client's recovery. This type of nurse is open to her own experiences concerning the client and herself. This nurse never assumes she knows the client until she has become acquainted with the reality of the client and the client's inner experience. Jourard (1971) believed that the quality of the nurse-client relationship has an effect on the client's

recovery rate, saying direct contact with a client "somehow increases his sense of being a worthwhile individual person, and this experience inspirits him--it does something to the body which helps it throw off illness" (p. 206).

Henderson (October, 1969) described the qualities needed in a graduate of an educational program if excellence was to be developed. The qualities are a potential for intellectual, emotional, and spiritual growth in the student.

> Excellence in nursing is dependent upon what the candidate brings to it, and that it can be measured by the quality of the individual's personal life, by...her contributions as a member of a community, as well as by the professional services she offers society. Excellence...suggests the well-rounded, or complete, person. (p. 2134)

Values

According to Steele and Harmon (1979), "A value is an affective disposition toward a person, object, or idea" (p. 1). Values symbolize a way of life, give direction for life, and make a difference in living. Some values are shared with other human beings, while other values are very individual and cannot be shared. These are personal values and these values vary from one human to another human being.

Steele and Harmon (1979) also described values as intrinsic or extrinsic. Those values that relate to survival are intrinsic while extrinsic values originate from outside and are not essential for survival.

Raths, Harmin, and Simon (1966) claimed "there is an assumption in the value theory...that humans can arrive at values by an intelligent process of choosing, prizing, and behaving" (p. 10). Derived from this assumption is the idea that the human who has unclean values is without directions for his life; he does not know what to do with his time, energy, and his very self. As the human has experiences he develops, grows, and learns. From these experiences come guidelines for behavior. These guidelines give direction to life and can be called values. Values reveal to the human what to do with his time and energy (Raths, Harmin, & Simon, 1966).

Raths, Harmin, & Simon (1966) have proposed seven requirements which are needed if a value is to result. These requirements are as follows:

1. Choosing freely - Values must be freely selected if they are to be really valued.
2. Choosing from among alternatives - Only when a choice is possible...do we say a value can result.

3. Choosing after thoughtful consideration of each alternative.
4. Prizing and cherishing - When we value something, it has a positive tone....Values flow from choices that we are glad to make.
5. Affirming - When we have chosen something freely, after consideration of the alternatives, and when we are proud of our choice,...we are likely to affirm that choice when asked about it.
6. Acting upon choices - When we have a value, it shows up in aspects of our living.
7. Repeating - When something reaches the stage of a value it is very likely to reappear on a number of occasions in the life of the person who holds it. (p. 28-29)

The forming of these values is personal and involves a life-long process, for the developing of values is not completed in childhood. As times change, as the human being changes, the learning of how to value takes place (Raths, Harmin, & Simon, 1966).

Czmowski (1974) supports the seven requirements needed for a value to form by stating a value develops from a process involving both a cognitive and an affective component. The intellectual process is concerned with the evaluation of

the alternatives, and the choosing of one of the alternatives. The affective aspect influences the cognitive process and choice.

In the nursing profession there are a variety of value choices available. The nursing student needs to be clear about her values and then be consistent in acting and conducting out her professed duties. In a human-centered profession, what the nursing student values and how she integrates these values into her nursing profession will influence her concept of the profession and the quality of service she gives (Coletta, 1978).

Coletta (1978) suggested values clarification might be a method each nurse could use to identify feelings, assess importance of the feelings, and decide whether or not to act on the value. Uustal (1978) affirmed Values Clarification by saying, "the aim of Values Clarification...usefulness lies in the fact that it provides us with a meaningful process for discovering ourselves what we value" (p. 2062).

To identify the relationship of values in students and faculty, a study was done to compare the values of nursing and other student groups and to consider the relatioship of nursing students' values to faculty values. Two instruments were used: The Allport, Vernon, and Lindzey Study of Values and the Survey of Interpersonal Values. The subjects

included students in all four years of college and faculty members from several different schools. The total number was 507. The results showed there were significant differences between nursing students' values and the values in the female college population. The social and benevolence values were the two values that were higher in nursing students. The nursing students, however, were lower in the conformity value. There was also a difference between nursing students and students in each other field. Again the social value scores were higher in the nursing students. There were no significant differences between juniors and seniors in any school except in school B, where seniors had higher religious values than the juniors (O'Neill, 1975).

When comparing student-faculty value patterns in each school there was a noticable similarity based on rank order correlation coefficients. However, the similarity of the student-faculty value patterns had a tendency toward senior year regression. The least number of value differences occurred between junior students and faculty. This indicated the values of junior students were more similar to the values of the faculty. There was no consistent pattern of student-faculty values and the size of the institution. There did seem to be greater student-faculty value patterns in school B, the largest institution. Investigation of student

academic potential and value similarity to the faculty showed that junior and senior students with highest academic potential on admission did have values more similar to faculty. The study also found that "the nursing students and faculty had highly similar value patterns however, significant differences were revealed between most student groups and the faculty on the separate values" (O'Neill, 1975, p. 179).

The implication for nursing from this study is that attention should be given to students with different values, not to induce change, but to work with the student's reference and assist the students in developing their own value system. The inference from the study pointed to the fact that the more meaningful the interaction between students and faculty, the more students' values and faculty values will reinforce or compliment each other (O'Neill, 1975).

Fromm (1960) suggested that value judgments determine humans' actions, and upon the validity of these actions lies the human beings' mental health and happiness. Fromm (1960) said, "man cannot live without values and norms" (p. 5).

One of the values the human being finds difficulty in living without is the religious value. Spranger (1928)

said:

> Life is an alternating play of experiences whose content depends upon two factors: Fate, in the broadest sense of the term, and the soul structure of the experiencing subjects. These experiences contain values in varying degrees, in other words, the meaning of each experience sounds a value-tone in the mind of the individual. If...an isolated value experience, no matter how subjective, is grasped for its significance for the total meaning of life, it has religious emphasis. (p. 210)

Spranger (1928) implied that religious value being experienced as the final significance of the human being's existence is the highest value which the human can experience. According to Spranger (1928) religious objects are the objective contexts where the deepest value experiences are created, and religion is "that inclusive concept of objective--mental forms in which these value relations are expressed as dogmas or cults" (p. 210). The world is considered a religious concept because the world is the total of all contexts of being and meaning which act upon the human being's soul. Spranger (1928) explained the meaning of the world in greater detail by stating,

> The meaning of the world, that is, of the whole can therefore only be experienced by the religious attitude. In religious terminology, God is that final being who is the meaning of the world, or is created mentally as that which endows it with meaning....God is the objective principle which is thought of as the object of the highest personal value experience. (p. 211)

Spranger (1928) believed the essence of religiosity is revealed in the search for the highest value of mental life so the receiving of this religious Good is always felt as salvation. "A religious man is he whose whole mental structure is permanently directed to the creation of the highest and absolutely satisfying value experience" (p. 213). Spranger (1928) presented three main types of religious man.

1. Immanent mysticism is an absolute affirmation of life since it finds indications of God in all positive life-values. This type of man is a universalist.
2. If the relation is negative, we have the transcendental mystic.
3. Intermediary religious type...usually...is a combination of both basic forms. Thus a type

> develops which confronts both affirmatively and negatively every region of life.(p. 213; 218)

Spranger (1928) wrote that love seems to be most closely joined with the religious value. Spranger (1928) also identified that a religious value has a double sense: first

> as its own species of value which may appear in specific objects and may thus be experienced.... The second meaning is the more important one: namely, that values from other zones become religious as soon as they are related to the final meaning of life. (p. 285)

Allport (1955) also wrote on religion. Allport remarked,

> The development of religious sentiment...cannot be known in terms of its many empirical origins. It is not a mere matter of dependency or of reliving the family and cultural configuration; nor is it an exclusively rational system of belief.... The developed religious sentiment is the synthesis of these and many other factors, all of which forms a comprehensive attitude whose function it is to relate the individual meaningfully to the whole of Being. (p. 94)

Allport (1955) said religion involves reason, faith, and

love, and becomes morally true for the human being. Religion strengthens the human against the inward roads of anxiety, doubt, and despair, and gives the human being the forward drive that helps him at any stage of becoming to relate himself in a meaningful way to the totality of Being.

Henderson (1969) remarked that if religious practice is necessary to a human's well-being in health, religious practice is even more necessary when the human being is ill. Wheelock (1976), too, saw the role religion plays in health. He said religious ideas and values may have either a positive or negative effect on the life of the human being. Wheelock (1976) believed that the client who has obtained excellent religious instructions and has formed a deep and meaningful relationship with God, understanding that God is a loving, merciful Father, will have inner resources and values which will help him in the healing process. This help varies: sometimes the assistance is a matter of not losing hope, having the will to live, or the courage to face surgery. No matter what the reason is, the religious aspect of the human being cannot be forgotten. To ignore the part religion plays in health is to ignore one aspect of the client that might integrate the other components of the human being (Wheelock, 1976).

Spiritual Needs

A spiritual need according to Stallwood (1957) is "the lack of any factor or factors necessary to establish and/or maintain a dynamic, personal relationship with God" (p. 1088). This relationship between God and man is found in the scripture and has two definite elements. The first is the relationship between God the Creator and the human being, his creature. The second is that the human being is created in God's image (Fish & Shelly, 1978).

Youtz (1950) investigated psychosomatic medicine and revealed that emphasis on the whole human being was bringing a new focus into nursing. The focus was the need to understand the spiritual aspect of the client as well as the physical and mental variables. Patey (1977) held that the physical and the spiritual components need not be seen as inevitably in conflict. Patey (1977) stated there is no definite dividing line between the physical, the mental, and the spiritual, but that each one is dependent on the other component.

Brallier (1978) disclosed that most, if not all, practitioners of holistic health care believe that the human being is more than cells organized to make up a physical body. The holistic health practitioners believe the human being has a spirit that co-exists with the physical body and

spirit is the energizer of the body.

Hoyman (1975) has developed a model which provides direction for a holistic approach to nursing. The model is entitled the Ecologic-system model. In the model are included four dimensions which cannot be separated. They are "physical factors, mental health, social well-being, and spiritual faith" (p. 509).

Concerning spiritual faith Hoyman (1975) said the human being has a need, probably even a penetrating hunger for a more spiritual outlook on life. Hoyman (1975) continued to say that

> Human health involves a struggle to achieve a meaningful relationship with the universe and life. For us to ignore man's psychospiritual nature in developing our model of health would be to deal with a caricature of man - with modern man dehumanized. (p. 511)

Hubert (1963) posed many questions concerning the nursing students and the care for the client's spiritual needs. Hubert (1963) wondered if the nursing student really understood her responsibility for implementing spiritual care, if the nursing student recognized the spiritual needs, and if the student hesitated including this need in her care plan. Hubert (1963) found when observing care plans and care studies of the nursing student, and when having discussions

with the student she was able to perceive the physical, social, and psychological variables of the client and would feel relatively comfortable in meeting these needs, but would rarely identify a spiritual need.

Hubert (1963) claimed the nursing instructor must provide guidelines for appropriate interventions regarding spiritual care. Hubert (1963) identified four convictions which would help the student in acquiring skills for meeting the spiritual needs of clients.

1. The nurse mirrors God to her patient to the extent that she shows loving concern for his welfare and gives a human service to him.
2. The providence of God is continuously operative in own life and in the lives of others.
3. The nurse has a role to fill in life that no one else can fill; a job to do that she alone can do. The nurse knows that for the patient she may be the one providential contact that will help him find God or at least help to know Him better and to love Him more.
4. The nurse cannot give to others what she herself does not have. A meaningful and moving conviction of the profound dignity of man and of other supernatural values can be achieved

> only through prayer, meditation, self-discipline, and dedication to the duties of life. (p. 29)

McCormack (1976) realized the importance of the nurse to have time for meditation and reflection and she called these times religious experiences. McCormack (1976) proposed that the nurse needs an area for solitude where she can visualize the most, consolidate the most, and live the most deeply. The nurse needs to penetrate her center, experience her roots. She needs to take time for herself.

Maslow (1977) and May (1977) both spoke of religious experiences. Maslow named the experience a peak-experience and stressed that all or almost all human beings have or can have the experience. Maslow (1977) identified two religious types: the peakers and the non-peakers. The peakers "have private, personal, transcendent, core-religious experiences easily and often and who accept them and make use of them" (p. 29). Maslow (1977) said the non-peakers repress or suppress the experience which prevents the non-peakers from using the experience for therapy, personal growth, and fulfillment. May (1977) on the other hand, named the experience a spiritual experience. May (1977) stated, "spiritual experience acts like a window. It seems to be a clarification of perception; an insight into the nature of how-things-

really-are" (p. 85). The spiritual experience involves more than personal and interpersonal satisfaction because it pertains to the most underlying perceptions the human being can have of himself/herself in relation to reality.

Fish and Shelly (1978) noted that rarely are there clear signs and sypmtoms of spiritual needs. Wheelock (1975) related the client's spiritual needs to his personal belief in and relationship with God along with rites, tenets, and regulations of the religious denomination of which the client is a member. "These include, but are not limited to, forms of prayer and worship, sacraments, preparations for death and burial, rituals, holy days, and dietary regulations" (Wheelock, 1975, p. 58). Besides the above mentioned needs, the client and the family need spiritual comfort, consolation, and support.

Peipgras (1968) identified spiritual need indicators in clients. The client will indicate his need by talking about the subject in a casual or even amusing way. This is to test the reactions of the nurse. The second indicator is a client who is able to cope with the spiritual topic but will give off emotional clues. A third indicator is a client with an inevitable outcome who has intimated his belief. Another indicator is a client who is a nominal believer and is faced with an undesirable situation such as another job,

chronic alcoholism, and impending divorce. The last example is an adolescent who is a church member and is subject to mood swings. He/she is questioning his/her self-confidence and the ability to build a meaningful future.

Wheelock (1976) identified a group of clients who would have spiritual problems. These clients are the chronic pessimist, the drug dependent client, and the client with an altered body image. According to Wheelock (1976) religion has identified with these conditions and has helped in therapeutic ways. These clients have need for faith, hope, courage, trust, and self-esteem. These clients need a desire for transcendence, beauty, and peace. These clients need assistance in order to see an openness in life. Wheelock (1976) stated, "These needs could be called self-actualization, man's search for meaning, or a host of other psychological terms, but fundamentally, these needs are religious problems" (p. 59).

Fish and Shelly (1978) have shown how the spiritual needs can be met by using the nursing process. In order to assess the spiritual needs, the nurse must interpret the clues the client gives. These clues can be found in the attitudes of the client, the behavior of the client, what the client verbalizes, the interpersonal relationships of the client, and the client's environment. Once the nurse

has assessed these clues, she interprets the meaning of the clues. Fish and Shelly (1978) said the best time to assess the client's spiritual needs is during the morning and evening care. Fish and Shelly (1978) indicated the plan that is developed to meet the spiritual needs of the client should be recorded on the Kardex, and in the plan the nurse should identify the best person to meet the spiritual needs of the client. Sometimes the nurse is the best person; sometimes the chaplain is the only one who can help, and sometimes it is a member of the family.

Fish and Shelly (1978) stated two principles to remember when providing spiritual interventions. The first principle is to remember that each client is a unique human being with a variety of needs; and each one of the needs must be assessed, knowing the focus should be on God and the client's relationship with Him. The second principle is that in order to meet the spiritual needs of the client, the nurse needs to evaluate her own relationship with God. Fish and Shelly (1978) listed four resources available for the nurse to use when implementing spiritual care of the client. They are:

1. The use of self,
2. The use of Prayer,
3. The use of Scripture and

4. Referral to clergy. (p. 69)

The last step in the nursing process is evaluation. Fish & Shelly (1978) said when evaluating the outcomes of the spiritual need interventions, the nurse observes the client's affect and behavior to see if a change has occurred. If a change has taken place, the nurse interprets the change to see if the goal has been met (Fish & Shelly, 1978).

When the nurse uses prayer and scripture as interventions to meet the client's spiritual needs, the focus and dependence should be directed to God. The most helpful prayer is a short statement to God about the client's fears, trials, hopes and thanks (Fish & Shelly, 1978).

Lucas (1978) wrote about healing and praying with the terminally ill client. The healing person will have an understanding of self-identity so her own feelings will not be confused with the client's feelings. The healing person will know when to speak and when not to speak; when to pray and when not to pray. She will have a sense of timing, an ear for listening, and will know how to use prayer. "Prayer is an opportunity for intimacy, for closing the gap, and a request for warmth" (p. 66). Prayer can be a threat, however, for those clients who do not trust others, and this includes God. The healing person will know this. All persons can be healing persons according to Lucas (1978).

"Symbolically, a nurse who prays with a patient or family provides a 'highway' for God's presence to be realized by the patient and family. This is a reminder that God has not abandoned any person" (p. 67).

Hubert (1963) identified some means that the nurse can use to assist or support the client in restoring, maintaining, or growing in a beautiful, healthy relationship with God, himself, and with others. These ways are:

1. By kindness...
2. By frequent contacts...
3. By her attitude toward the great truths of human existence: life, suffering, old-age, and death....
4. By encouraging wholesome reading...
5. By prayer. (p. 29-30)

Burghardt (1974) realized the need for providing spiritual care in the health care delivery system and what qualities were needed to provide that care. Burghardt (1974) stated,

> A theology of the health apostolate will remain sterile without a spirituality of the health apostolate - without spiritual people. Your commitment to this most Christian of causes, the redemption of the whole man, will be vital and

> effective only if you believe not merely in man but also in God; only if you pray as well as work; only if with every syllable and gesture you preach not man's death but the Lord's death for man - until He comes. (p. 21)

The Meaning of Illness and Suffering

The World Health Organization indicated that "health encompasses the whole man, his total fitness for living, maintaining a state of physical, emotional, spiritual and social well-being, not merely the absence of disease" (Fleeger, 1977, p. 1). For this reason the nurse is actively involved in attaining, maintaining, or restoring the physical, emotional, social, and spiritual wholeness of each client.

Jones (1978) noted that illness and wellness were relative states, never absolute, always changing. The healthy client is one who can adapt successfully to any stressor that has disturbed his homeostasis, while illness represents an alteration in a client's homeostasis that affects his total well-being.

Reading (1977) distinguished the difference between illness and disease by defining illness as that which the client suffers from, complains of, or troubles him. Illness arouses his perception that something is wrong with

his body. He experiences pain, distress, and disablement; this leads him to seek medical assistance. Disease, on the other hand, refers to structured disorders of the client's tissues and organs that provide signs of illness. The Doctor is the one who identifies the disease, while the client is the one who perceives illness as real (Reading, 1977).

Each client responds to a given episode of a disease or injury in a unique manner. All of the client's past experiences, especially experiences related to past illnesses, will influence his reaction to disease. Lipowski (1969) stated, "Disease and the suffering that it usually causes are universal components of human existence" (p. 1202). Wheelock (1969) agreed suffering is natural for all of human life and Sarosi (1968) stated, "Paths to wholeness, health, are characterized by the encounters of painful experience, not by escape" (p. 362).

If pain and suffering cannot be escaped, the client needs to see meaning in suffering if he is going to continue to live a life of wholeness. Frankl (1962) spoke of the need of seeing meaning in suffering.

> If there is a meaning in life at all, then there must be a meaning in suffering. Suffering is an ineradicable part of life, even as fate and death. Without suffering and death human life cannot be

> complete. The way in which man accepts his fate and all the suffering it entails, the way in which he takes up his cross, gives him ample opportunity - even under the most difficult circumstances - to add a deeper meaning to this life. (p. 67)

Evely (1966) believed the only way to endure suffering is to understand Christ's suffering. Cleary (1975) described Christ's suffering by saying Christ's example of suffering can be seen in the Passion, Death, and Resurrection. Christ's suffering and death were not easy for Him. In the Garden of Gethsemane, He prayed, "My Father if it is possible, let this cup pass me by," but He also acknowledged the time was ready for offering a supreme act of love and trust in God: "let it be as You would have it, not as I" (Matthew 26:39). Christ then died. "Once again Jesus cried out in a loud voice, and then gave up his spirit" (Matthew 27:50).

Suffering can be a means of growth for the client if he turns to God and admits his helplessness and his total need for Him (Porath, 1972). For this reason God permits the client to suffer, for the suffering allows him to become more fully dependent upon God, the client's Beginning and final End (Harrity, 1973). For the client to accept suffering as a means to growth, faith is needed. Faith is when the client says he does understand and he does believe there is a mean-

ing (Evely, 1970). Faith for the client becomes a living faith when the client integrates the meaning of his existence around his belief in Christ (Porath, 1972).

Besides faith, a client needs courage to find meaning in suffering. True courage refers to the ability to overcome. True courage is an attitude. True courage does not ignore suffering, but with true courage the client can accept pain and suffering because of a higher value (Bovet, 1973). Travelbee (1973) defined courage as "the ability to realize one's inadequacies and fears and yet to persevere towards one's goals, even though there may be little or no certainty that the individual will be able to attain the object of his hope" (p. 80).

Besides faith, a client needs hope in order to endure and find meaning in illness and suffering. When the client finds hope, meaning, purpose, and value in his existence he is inspirited (Jourard, 1971).

Vaillot (1970) believed a client who has hope will use his suffering and illness to grow into being. Hope does not stop at objects; hope reaches out to being. The client who hopes reaches out and beyond himself. Hope starts when the client has used all his resources and he draws on the strength of others. The client who needs help has hope in another (Vaillot, 1970). Here hope can be related to trust.

Trust means "the assured belief that other individuals are capable of assisting in times of distress and will probably do so" (Travelbee, 1973, p. 80).

The trustworthy person the client sees often is the nurse. Her role is to help ill clients find meaning in illness and suffering or assist them in accepting the reality (Travelbee, 1972). The nurse must realize this, because the client is ill he will be more sensitive to other persons' influence. The client will be in need of support from the nurse; the one who will make God's love to him present (Simone, 1971).

The trusting nurse will also need the gift of caring. Gold (1978) stated that caring depends upon the worth the nurse attributes to the client regardless of the values or behavior the client has. Caring involves honesty and courage. Caring depends upon the giving of self. When the nurse cares for the client, this feeling arouses a response in the client because the nurse has extended herself toward him. A caring nurse will also have empathy which "is the ability to live with others in a sensitive and understanding manner" (Dickinson, 1975, p. 1792).

The care of the client is a duty given to the nurse by the Lord. The care of the sick is one way the nurse fulfills the second commandment given her by the Lord, namely

to love her neighbors as herself (Brungs, 1979).

Summary

In the review of the literature, five concepts identified in the theoretical framework were discussed. The five concepts included: (1) human being, (2) nursing, (3) values, (4) spiritual needs, and (5) the meaning of illness and suffering. The model illustrates the relationship of the concepts discussed (appendix A).

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The study was conducted to determine if a relationship existed between the religious values of nursing students and their opinions about the spiritual needs of clients. According to Reynolds (1977), "the goal of descriptive statistical procedures is to describe some characteristic of an event or phenomenon" (p. 121); therefore, this study was a descriptive survey to describe the problem.

Setting

The setting for this study was a state supported baccalaureate nursing program in a large southwestern metropolitan area. The total enrollment of nursing students in the program at the time of the study was 157. A total of 90 junior nursing students were enrolled. Agency permission to conduct this study was obtained from the school of nursing prior to the collection of data.

Population and Sample

The population consisted of 90 junior nursing students. Convenience sampling was used. The junior nursing students while attending a nursing class were asked who would like to participate in the study. Those who volunteered remained

after class. Of the 90, 52 subjects participated by completing the two tests; however, four subjects did not answer the statements according to the correct format, one did not complete the personal data, and six did not answer all the questions. The final sample for this study included 41--40 females and 1 male. The sex, age, religious affiliation, and the degree of participation in religion was collected with each subject to describe personal data about the sample.

Protection of Human Subjects

For this study the collection of data started upon the receipt of written approval from the Human Research Committee at the Texas Woman's University (appendix B) and permission from the school involved (appendix C). Before the subjects volunteered to participate in the study, the subjects were informed by the instructor that the two tests they would be taking would be measuring their values and their opinions about the spiritual needs of the client. The subjects were told that number coding would be used instead of names to assure confidentiality. They were told they could withdraw at any time during the study and their grade would not be affected by participation or nonparticipation in the study. After the students had agreed to participate in the study, the consent form which identified the purpose

of the investigation, the risks involved in the study, and the potential benefits to nursing (appendix D), was signed by the subjects and placed in an envelope. The subjects the proceeded to complete the two written tests.

Instruments

Two instruments were used for this study. The Study of Values by Allport, Vernon, and Lindzey (1970) was used to measure the religious values of the nursing students while the Spiritual Needs Opinionnaire measured their opinions about the spiritual needs of clients.

Study of Values

The Study of Values measures six basic interests or motives in personality: theoretical, economic, aesthetic, social, political, and religious. The reliability for the Study of Values is a split-half reliability for each of the basic interests: "theoretical .84, economic .93, aesthetic .89, social .90, political .87, and religious .95" (Allport, Vernon, & Lindzey, 1970, p. 9). These data were obtained from a sample of 100 subjects. The mean reliability is .90. An item analysis was conducted using data obtained from a group of 780 subjects of both sexes from six different colleges. The item analysis "shows a positive correlation for each item with the total score of its value, significant at the .01 level of confidence" (Allport, Vernon, & Lindzey,

1970, p. 9). Using the test-retest method, mean reliability for another two groups was .89 and .88, respectively (Allport, Vernon, & Lindzey, 1970).

The validity of the test can be derived from examining the scores of groups whose characteristics are known. For example, women on the average would be more religious, social, and aesthetic while students in engineering would be high in theoretical and economic values. Gee has provided illustrative occupational differences that support these expectations (Allport, Vernon, & Lindzey, 1970, p. 14-15). Surveys done by Cantril and Allport (1933) and by Duffy (1940) on the original form of the test also provide external validation (Allport, Vernon, & Lindzey, 1970, p. 13).

The scale for the Study of Values is designed primarily for college students and adults who have had some college work. The two-part test consists of a number of questions based on familiar situations. In Part I each question has two alternative answers. There is a total of 120 answers; 20 of these questions refer to each value. The Study of Values will measure the relative strength of each value but not the total amount of "value energy" (Allport, Vernon, & Lindzey, 1970, p. 8).

Spiritual Needs Opinionnaire

The Spiritual Needs Opinionnaire was developed after consultation with other professional nurses and after reviewing the literature pertaining to the spiritual needs of clients. The instrument includes 16 items. The opinionnaire measures positivity of opinions of the nursing students about the spiritual needs of clients. The subject responds "yes" or "no" to each item. The responses to each statement are weighted so that the higher the score, the more positive the response. There is one negatively phrased item which was reversed in the scoring process.

The content validity of the instrument was evaluated by a panel of three experts. Each expert had a background in theology, education, and psychology, respectively. In order to use the statements, two of the three experts had to identify that each item measured an opinion about the spiritual needs of clients and that the statement was concise, clear, and free of ambivalence. Two of the three experts agreed that 16 of the 22 items met the criteria; therefore, the Spiritual Needs Opinionnaire consisted of 16 items. This opinionnaire differentiates between the nursing students having positive opinions about the spiritual needs of clients and the nursing students having negative opinions concerning the spiritual needs of clients.

Data Collection

The data were collected by using the Study of Values by Allport, Vernon, and Lindzey (1970) and the Spiritual Needs Opinionnaire. The agency was contacted and arrangements were made for an instructor to administer the tests after a nursing class. The participating instructor was given the verbal and written directions (appendices E & F) for the two tests along with the consent forms and the two instruments (appendix G). The instructor administered the tests to junior nursing students who volunteered to participate. The consent forms were signed and placed in an envelope before the tests were given to the students. Both scales were completed by the nursing students at one time. The time allotted was approximately 20 minutes for the Study of Values Scale and 10 minutes for the Spiritual Needs Opinionnaire. After the tests were completed, the instructor placed them in an envelope which was given to the investigator. Number coding was used instead of names on the tests to assure confidentiality.

Treatment of Data

To analyze the data obtained from the Study of Values and the Spiritual Needs Opinionnaire, the Spearman rank order correlation coefficient and the *t*-test were used. The Spearman's measurement compares the ranking on "two sets of

scores by taking the difference and then adding, and finally manipulating the measure so that..." a value can be determined (Blalock, 1972, p. 416). The t-test is used to determine if a difference is due to sheer chance or is large enough to be significant (Balsley, 1970, p. 54), or the significance of the correlation coefficient (p. 192-193). To describe the entire distribution of the ages, the Study of Values scores, and the Spiritual Needs Opinionnaire scores, the measures of central tendency and the range of each category was determined. The percentage was calculated for the religious affiliations and active and inactive participation in religion.

Summary

The setting for the study was identified and the sample was described in this chapter. Also described in this section were the two instruments used in the study. The chapter also identified how the data were collected and treated.

CHAPTER IV

ANALYSIS OF DATA

The problem of this study was to determine the relationship between the nursing students' religious values and their opinions about the spiritual needs of the client. A descriptive survey was employed to answer the problem statement. The purposes of this study were to determine the religious values of the nursing students, to determine the opinions of the nursing students about the spiritual needs of clients, and to determine if there was a relationship between the nursing students' religious values and their opinions about the spiritual needs of clients.

An analysis and interpretation of the data collected during the study will be divided into three sections. The three sections to be presented are: the description of personal data, analysis and interpretation of data, and additional findings.

Description of Personal Data

The personal data collected for this study included sex, age, religious affiliation, and the degree of participation in religion. The sample included 40 females and one male. The range, mean, median, and mode of the ages were

determined. The subjects' ages ranged from 19 to 48 years. The mean age for the sample was 23.1 years, while the median age was 20.5 years. The mode for the ages was 20 years.

The professed religious affiliation data noted that of the 41 subjects nine were Catholics, nine were Baptists, eight were Methodists, three were Presbyterians, two belonged to the Assembly of God church, and eight belonged to other denominations. Table 1 presents a comparison of the religious preferences.

Table 1 reveals 22% of the subjects were Catholic and Baptist, while 20% of the sample were Methodist. There were 7% of the subjects that professed they were Presbyterian and 5% that professed to belong to the Assembly of God Church. Each of the other religious denominations made up 2.4% of the total sample.

The personal data concerning the subjects' participation in their religion was determined by having the subjects check active or inactive according to their participation. Table 2 presents the subjects' participation in religion.

Those subjects professing to be active were 58.6% compared to 39% that were inactive. One subject was partially active, one subject professed no religious affiliation but was active, and one subject stated no religion and was not active.

Table 1

Religious Preference of Subjects

Religion	Number	Percentage
Catholic	9	22%
Baptist	9	22
Methodist	8	20
Presbyterian	3	7
Assembly of God	2	5
Lutheran	1	2.4
LDS-Mormon	1	2.4
Jewish	1	2.4
Church of Christ	1	2.4
Episcopalian	1	2.4
Disciple of Christ	1	2.4
Bible Church	1	2.4
Jewish/Yoga	1	2.4
Not Affiliated	1	2.4
No Religion	1	2.4

Table 2

Subjects Active or Inactive Participation in Religion

Religion	Active	Inactive	Partially
Catholic	4	4	1
Baptist	5	4	
Methodist	4	4	
Presbyterian	2	1	
Assembly of God	2		
Lutheran	1		
LDS-Mormon	1		
Jewish		1	
Church of Christ	1		
Episcopalian	1		
Disciple of Christ		1	
Bible Church	1		
Jewish/Yoga	1		
Not Affiliated	1		
No Religion		1	

Analysis and Interpretation of Data

The null hypothesis for this study stated, there is no significant relationship between the nursing students' religious values and their opinions about the spiritual needs of the client. Two instruments were used to determine if there was a relationship. The instrument used to determine the subjects' religious values was the Study of Values by Allport, Vernon, and Lindzey (1970). To measure the subjects' opinions about the spiritual needs of the client, a 16-item opinionnaire was used.

To describe the entire distribution of the Study of Value scores and the Spiritual Needs Opinionnaire scores, the measure of central tendency and the range of each category was determined. The subjects' scores on the religious value ranged from 30-58. The average score for the Study of Values is 40 (Allport, Vernon, and Lindzey, 1970, p. 8). The mean for the religious value scores for the sample was 44.95. The subjects' scores on the Spiritual Needs Opinionnaire ranged from 10-16; the possible range of scores for this instrument was 0-16. The mean for the sample was 13.93.

After calculating the results of the Study of Values and the Spiritual Needs Opinionnaire, the Spearman rank order correlation coefficient statistical test was used to

correlates scores on the Study of Values with those of the Spiritual Needs Opinionnaire. In order to evaluate the results in the study, the Spearman rank order correlation coefficient measurements were identified. A value that approached zero meant there was no relationship. A value that approached a + 1.0 was in perfect agreement, while a value that approached a - 1.0 was in perfect disagreement (Blalock, 1972).

The results from the Spearman rank order correlation coefficient revealed $r_s = .0698$. The correlation coefficient for this study approached zero; therefore, no significant statistical relationship was found between the nursing students' religious values and their opinions about the spiritual needs of the client.

A *t*-test was also used to further support the Spearman rank order correlation coefficient value. The *t*-test was evaluated at a .05 level of significance. The finding for the *t*-test was $t = .435$ which signified there was only a 25% to 40% chance of the relationship ever happening. The *t*-test also showed no statistical evidence that there was a significant relationship between the nursing students' religious values and their opinions about the spiritual needs of the client.

To depict graphically the correlation between the

Study of Values scores and the Spiritual Needs Opinionnaire scores, a scatter diagram was drawn. Table 3 presents the scatter diagram. The diagram further illustrates no relationship between the Study of Values scores and the Spiritual Needs Opinionnaire scores.

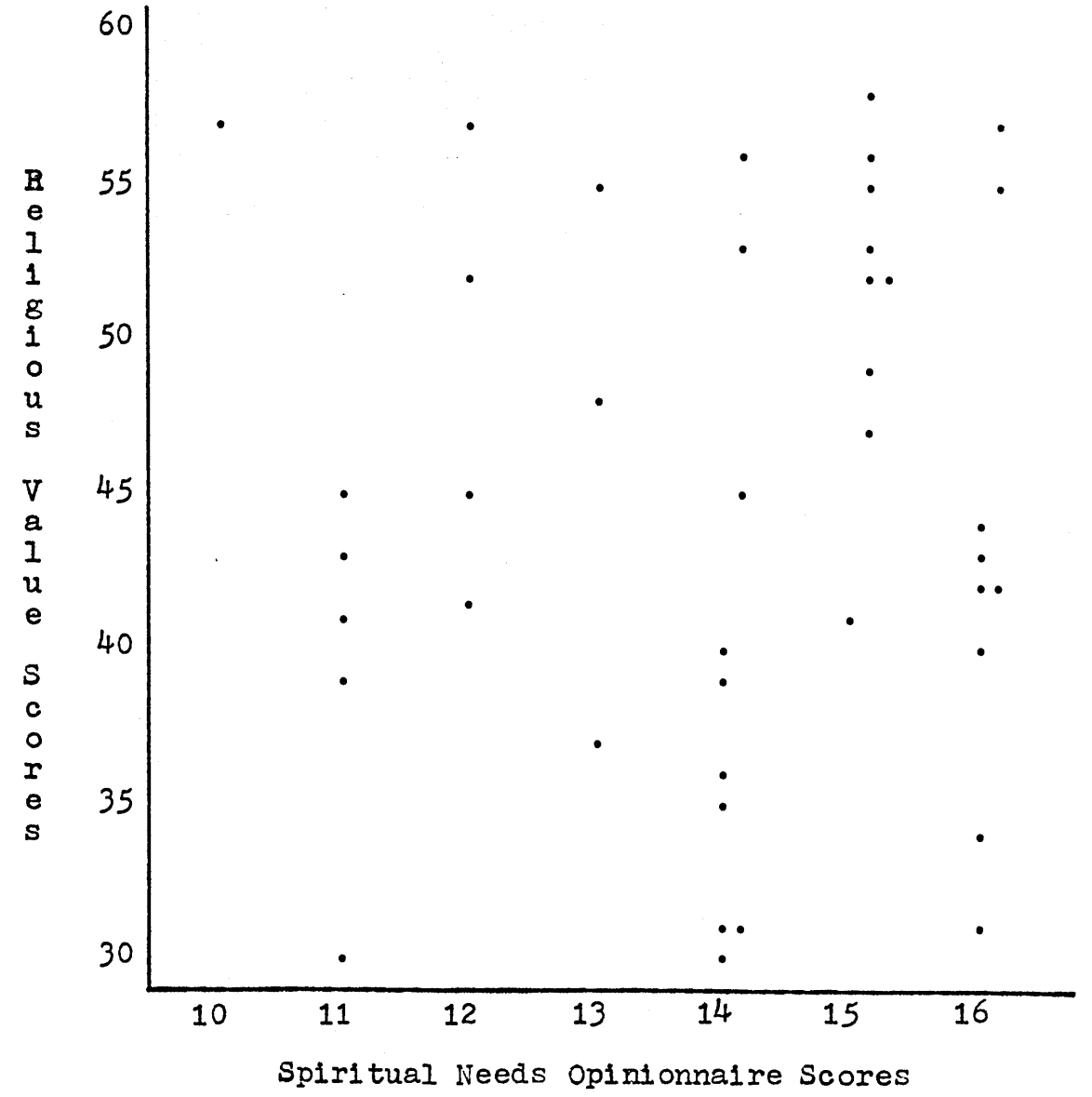
Additional Findings

According to the Study of Values by Allport, Vernon, and Lindzey (1970), the female scores on the religious value reveal that the average scores for all females range from 37-50 with the outstanding scores 56 or above and the low religious value scores ranging 31 or below. For the male, the average religious value scores range from 32-44 with the outstanding high scores ranging 51 or above and low religious value scores ranging from 26 or below. In this study the religious value scores represent 40 female subjects and one male subject. Table 4 presents the religious value scores of the subjects of this study compared to the religious value scores as reported by Allport, Vernon, and Lindzey (1970).

Table 4 shows that 59% of the female subjects were in the average range according to Allport, Vernon, and Lindzey's religious value scores. There were 24% in the outstandingly high range. Only 9.7% of the subjects including the male were in the distinctively high range,

Table 3

Scatter Diagram



while 7.3% were in the distinctively low range.

Table 4

Comparison of Subjects' Religious Value Scores to Ranges of Religious Value Scores as Reported by Allport, Vernon, Lindzey

Study Subjects	Ranges of Religious Value Scores as Reported by Allport, Vernon, and Lindzey				
	Distinctively High 57 or Above	Outstandingly High 51-56	Average 37-50	Distinctively Low 31 or Below	Total
Female Number	3	10	24	3	40
Female Percent	7.3%	24%	59%	7.3%	97.6%
Male Number	1	NA	NA	NA	1
Male Percent	2.4%	NA	NA	NA	2.4%

NA = Not Applicable

Summary

The problem for this study was to determine the relationship between the nursing students' religious values and their opinions about the spiritual needs of the client. After 41 volunteer junior nursing students had completed the Study of Values test and the Spiritual Needs Opinion-

naire, the Spearman rank order correlation coefficient statistical test was used to correlate the scores from the two tests. The *t*-test was also used. As a result of this study using the two instruments and the two statistical tests, the null hypothesis was not rejected which stated there is no significant relationship between the nursing students' religious values and their opinions about the spiritual needs of the client.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS, RECOMMENDATIONS

A summary of the complete study and conclusions derived from the study are described in this chapter. The implication for nursing which resulted from this study is included in this section along with the recommendations for further research in religious values and spiritual needs of the client.

Summary

A descriptive survey was conducted to determine the relationship between the nursing students' religious values and their opinions about the spiritual needs of the client. Three purposes were identified: to determine the religious values of the nursing students, to determine the opinions of the nursing students about the spiritual needs of clients, and to determine if there was a relationship between the nursing students' religious values and their opinions about the spiritual needs of clients. A null hypothesis was formulated which stated there is no significant relationship between the nursing students' religious values and their opinions about the spiritual needs of clients. The Study of Values by Allport, Vernon, and

Lindzey (1970) and the Spiritual Needs Opinionnaire were used to investigate the problem statement. The Spearman rank order correlation coefficient statistical analysis was used to correlate the scores obtained from the two instruments.

The theoretical framework for this study was based on interpersonal theory as described by Travelbee (1973). From this framework five concepts were identified: (1) human being, (2) nursing, (3) values, (4) spiritual needs, and (5) the meaning of illness and suffering. These five concepts were addressed in the review of literature.

The sample for this study was 41 junior nursing students who were currently enrolled within a baccalaureate nursing program. A convenience sampling was used. The sample included 40 females and one male nursing students.

After receiving agency permission, an instructor who administered the two tests was given verbal and written directions. Before the subjects volunteered to participate in the study, the subjects were informed by the instructor that the two tests they would be completing would measure their values and their opinions about the spiritual needs of the client. The subjects were told that number coding would be used instead of names to assure confidentiality. They were assured they could withdraw at any time during the

study and their grade would not be affected. After the students had agreed to participate in the study, the consent form was signed by each subject and placed in an envelope. The instructor then gave each nursing student the Study of Values test and the Spiritual Needs Opinionnaire. Before beginning, the directions were explained for each one of the tests. On completion, the subjects brought the two tests to the instructor, who placed the tests into an envelope which was then given to the investigator.

An analysis and interpretation of the data collected during the study was divided into three sections. The three sections presented were description of personal data which included sex, age, religious affiliation, and the degree of participation in religion; analysis and interpretation of data, and additional findings. The ages of the subjects were discussed according to variability and measures of central tendency. The findings showed the subjects' ages ranged from 19-48 years. The mean age for the sample was 23.1 years, while the median age was 20.5 years. The mode for the ages was 20 years. The professed religious affiliation data noted that of the 41 subjects, nine were Catholics, nine were Baptists, eight were Methodists, three were Presbyterians, two belonged to the Assembly of God church, and eight belonged to other denominations. Those subjects

professing to be active in their religion were 58.6% compared to 39% that professed to be inactive.

The Spearman rank order correlation coefficient statistical test was used to correlate the Study of Values with the Spiritual Needs Opinionnaire. The results from the Spearman rank order correlation coefficient was $r_s = .0698$. The correlation coefficient for this study approached zero; therefore, no significant statistical relationship was found between the nursing students' religious values and their opinions about the spiritual needs of the client. A *t*-test was also used to support the Spearman rank order correlation coefficient value. As a result of this study using the two instruments and the two statistical tests, the null hypothesis was not rejected which stated there is no significant relationship between the nursing students' religious values and their opinions about the spiritual needs of the client.

Conclusions

Several conclusions were derived from this study. One is there was no significant statistical relationship between the nursing students' religious values and their opinions about the spiritual needs of clients. This could have resulted because the two instruments were not sensitive to the variables being measured. Secondly, the hypothesis being tested is difficult to measure using a pencil and paper

test. The hypothesis might better have been measured by observation of students' actual perfromance in meeting the client's spiritual needs.

Implications

As a result of this study, one implication for nursing resulted. For future research a better means of measuring religious values and spiritual needs of clients should be utilized.

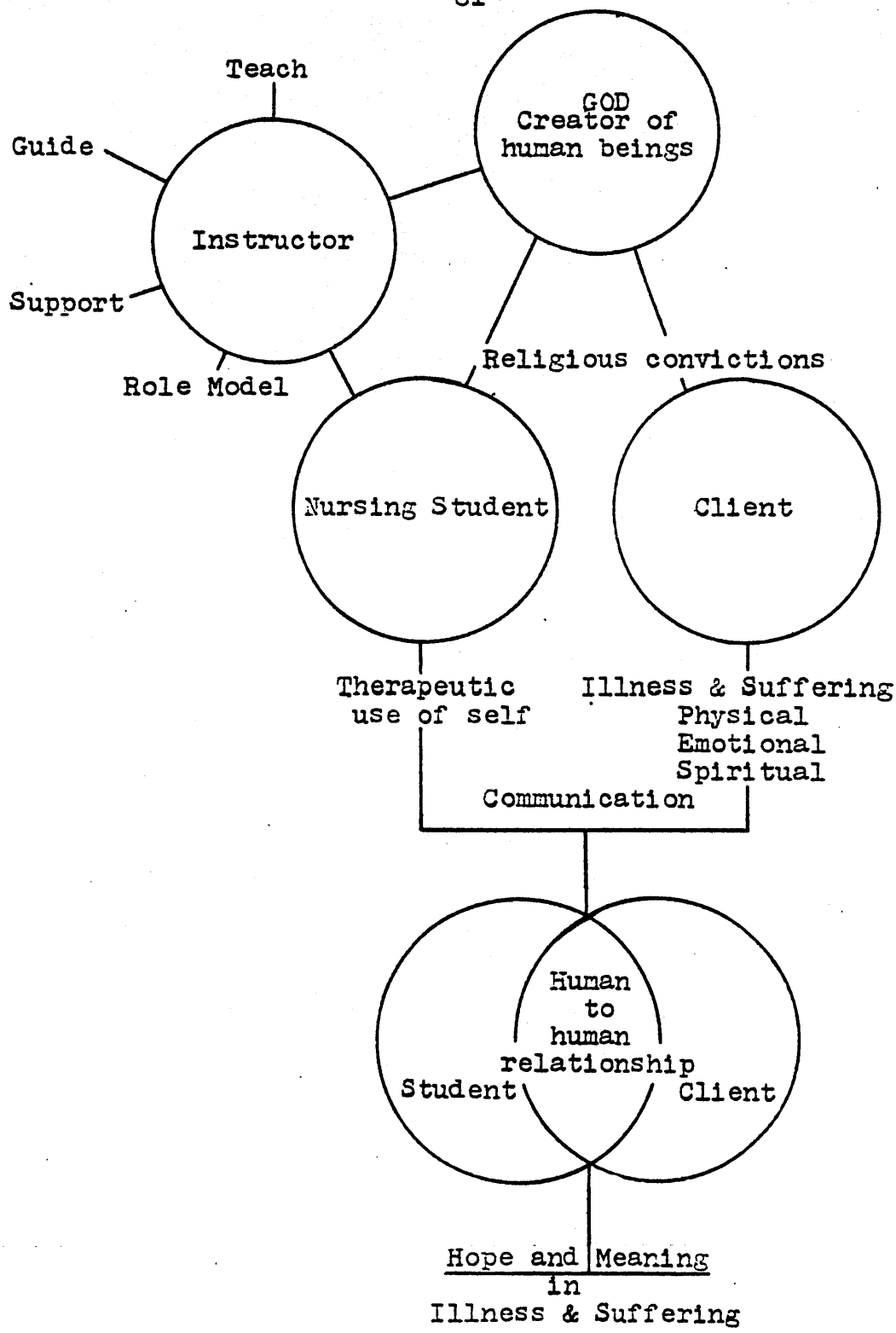
Recommendations

The recommendations resulting from this study are:

1. To replicate this study on the same students when they are seniors.
2. To compare nursing students' religious values and opinions about the spiritual needs of clients with church affiliated and non-church affiliated nursing programs.
3. To do a study with nursing students using only an instrument that would measure the religious value and another instrument measuring only opinions about spiritual needs of clients.

APPENDIX A

Model


Teach
Guide
Instructor
Support
Role Model
GOD
Creator of
human beings
Religious convictions
Nursing Student
Client
Therapeutic
use of self
Illness & Suffering
Physical
Emotional
Spiritual
Communication
Human
to
human
relationship
Student
Client
Hope and Meaning
in
Illness & Suffering

EXPLANATION OF MODEL

God created human beings. The instructor, the nursing student, and the client are all human beings created by Him. When these three persons realize their own giftedness is from God they develop religious convictions. Because of these convictions they bring their own values with them as they relate to each other.

The instructor will teach, guide, support, and be a role model for the student. The nursing student will use her humanness in a therapeutic way which will allow the client to feel free to express his concerns about his illness and suffering. From this encounter meaningful communication will take place and a human-to-human relationship will develop. As a result of this human-to-human relationship the client will be able to find hope and meaning in his illness and suffering.

APPENDIX B

Permission for the Study

Human Research

TEXAS WOMAN'S UNIVERSITY

DENTON, TEXAS 76204

THE GRADUATE SCHOOL

June 27, 1979

Sister Mary David Johnson
5909 Harry Hines Boulevard
Saint Paul's Hospital
Dallas, Texas 75235

Dear Sister:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Phyllis Bridges

Phyllis Bridges
Dean of the Graduate School

PB:cn

cc Dr. Beth Vaughan-Wrobel
Dr. Anne Gudmundsen
Graduate Office

TEXAS WOMAN'S UNIVERSITY

Human Research Committee

Name of Investigator: Sister Mary David Johnson Center: Dallas

Address: 5909 Harry Hines Blvd. Date: 5/17/79

Dallas, Texas 75235

Dear Ms. Johnson:

Your study entitled Nursing Students' Opinions Toward Spiritual Needs has been reviewed by a committee of the Human Research Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education and Welfare regulations require that written consents must be obtained from all human subjects in your studies. These forms must be kept on file by you.

Furthermore, should your project change, another review by the Committee is required, according to DHEW regulations.

Sincerely,

Estelle D. Zaruk

Chairman, Human Research
Review Committee

at Dallas.

APPENDIX C

Agency Permission

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Texas 75235

HOUSTON CENTER
1130 M.S. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE _____

GRANTS TO Sister Mary David Johnson

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

To determine the relationship between the nursing students' religious values and their opinions toward the spiritual needs of the client.

The conditions mutually agreed upon are as follows:

1. The agency (~~may~~) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (~~may~~) (may not) be identified in the final report.
3. The agency (~~wants~~) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (~~unwilling~~) to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date June 7, 1979

Betty Hooks Assistant Dean
Signature of Agency Personnel

Sister Mary David Johnson
Signature of Student

Ruth C. Vaughan-Wolfe, R.N. Ed.D.
Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original - Student; first copy - agency; second copy - T.W.U. College of Nursing.

APPENDIX D

Consent Form

TEXAS WOMAN'S UNIVERSITY

Consent to Act as a Subject for Research and Investigation:

(The following information is to be read by the subject)

1. I hereby authorize Sister Mary David Johnson

to perform the following investigation: In order to determine the relationship between the nursing students' religious values and their opinions toward the spiritual needs of the client two tests will be given: Study of Values and a Spiritual Needs Opinionnaire.

2. The procedure of investigation listed in Paragraph 1 has been explained to me by Instructor

3. I understand that the procedures or investigations described in Paragraph 1 involve the following possible risks or discomforts:
   1. The collected data may be misinterpreted by those who read the results of the study.
   2. The student may fear loss of anonymity.
   3. The student may be embarrassed because of his/her religious values or lack of religious values.

4. I understand that the procedures and investigations described in Paragraph 1 have the following potential benefits to myself and/or others:
   This study may help to identify spiritual needs which can be incorporated into nursing programs which will provide the student with knowledge and guidance and benefit patient care.

5. An offer to answer all of my questions regarding the study has been made. If alternative procedures are more advantageous to me, they have been explained. I understand that I may terminate my participation in the study at any time.

_____ _____

Student's signature date

APPENDIX E

Verbal Directions

VERBAL INSTRUCTIONS FOR INSTRUCTOR

INFORM STUDENTS:

1. The study is being done by a student in the graduate nursing program.
2. The problem for this study is to determine the relationship between the nursing students' religious values and their opinions about the spiritual needs of the client.
3. Those who participate will be asked to sign a consent form, and answer value and opinion statements on two tests. Number coding and not names will be used on the tests to assure confidentiality.
4. Who would like to volunteer? If you volunteer, you have the right to withdraw at any time during the study and your grade will not be affected.
5. Have the students sign consent form and return to instructor. Place consent form in envelope.
6. Those students who sign and return the consent form to the instructor will then be given the two tests.
7. Explain directions for the Study of Values on pages two and seven. Ask if there are any questions.
8. Explain directions for the Spiritual Needs Opinionnaire. Ask if there are any questions.

9. After completing both tests the student will return the tests to the instructor.
10. The instructor will place the tests in the envelope which will be given to the investigator.

APPENDIX F

Written Directions

WRITTEN DIRECTIONS

CODE NUMBER_____

PROFESSED RELIGIOUS AFFILIATION_____
(specific)

AGE_____

ACTIVE:_____

SEX_____

INACTIVE:_____

The two tests that you will be filling out pertain to your values and your opinions about the spiritual needs of clients.

Directions:

1. Do not put your name on the tests.
2. Please read carefully the consent form and sign your name on line provided for subject's signature.
3. Read the given directions for each test before filling out the responses.
4. Twenty minutes will be allotted for the Study of Values and ten minutes for the Spiritual Needs Opinionnaire. If more time is needed you may have the time.
5. When finished with both tests give them to the instructor.
6. Thank you for your assistance.

APPENDIX G

Instrument

SPIRITUAL NEEDS OPINIONNAIRE CODE NUMBER_____

Below is a list of statements concerning the spiritual needs of clients. Please read all the statements very carefully and respond to each one of them on the basis of your own opinion toward the client's spiritual needs. Read each statement, and if you agree check "yes". If you disagree, check "no".

		YES	NO
1	It is important for the client to believe there is a higher spiritual being.		
2	A client's belief in a Supreme Spiritual Being may have a positive effect on his coping ability.		
3	Spiritual needs of the client can be assessed by the nurse.		
4	Nursing curriculums stress holistic care, therefore, the spiritual aspects of the client's care should be included.		
5	Each client's spiritual beliefs are as important as the nurse's spiritual beliefs.		
6	The nurse can assist the client in meeting his spiritual needs by listening.		
7	The spiritual needs of the client are highly personal and, therefore, should not be included in the nursing care plan.		
8	Prayer and scripture are ways the client can develop a relationship with God.		
9	The spiritual needs of the client are as necessary to meet as his physical and emotional needs.		
10	Prayer can be a means which will help the client accept his pain.		

		YES	NO
11	The nurse should include the spiritual needs of the client in her nursing care plan.		
12	There is more to meeting the spiritual needs of the client than ritual and ceremony.		
13	Helping the client find meaning in his illness and suffering are ways of meeting his spiritual needs.		
14	The client's religious beliefs can affect his attitude toward treatment.		
15	Suffering and pain can lead the client to God.		
16	The client needs a close relationship with God in order to find meaning in his illness and suffering.		

APPENDIX H

Tabluation of the Subjects' Answers on the Spiritual Needs Opinionnaire and Raw Data

Tabulation of the Subjects' Answers

on the Spiritual Needs Opinionnaire

		YES	NO
1	It is important for the client to believe there is a higher spiritual being.	31	10
2	A client's belief in a Supreme Spiritual Being may have a positive effect on his coping ability.	41	0
3	Spiritual needs of the client can be assessed by the nurse.	33	8
4	Nursing curriculums stress holistic care, therefore, the spiritual aspects of the client's care should be included.	38	3
5	Each client's spiritual beliefs are as important as the nurse's spiritual beliefs.	38	3
6	The nurse can assist the client in meeting his spiritual needs by listening.	40	1
7	The spiritual needs of the client are highly personal and, therefore, should not be included in the nursing care plan.	4	37
8	Prayer and scripture are ways the client can develop a relationship with God.	39	2
9	The spiritual needs of the client are as necessary to meet as his physical and emotional needs.	35	6
10	Prayer can be a means which will help the client accept his pain.	40	1
11	The nurse should include the spiritual needs of the client in her nursing care plan.	35	6
12	There is more to meeting the spiritual needs of the client than ritual and ceremony.	40	1

		YES	NO
13	Helping the client find meaning in his illness and suffering are ways of meeting his spiritual needs.	28	13
14	The client's religious beliefs can affect his attitude toward treatment.	41	0
15	Suffering and pain can lead the client to God.	29	12
16	The client needs a close relationship with God in order to find meaning in his illness and suffering.	25	16

RAW DATA

Code	Religion Score	Spiritual Score	Religion Rank	Spiritual Rank	D_i	D_i^2
1	57	16	3	5	2	4
2	36	14	34	23.5	-10.5	110.25
3	31	14	39.5	23.5	-16	256
4	42	16	24.5	5	-19.5	380.25
5	52	15	13.5	14	.5	.25
6	55	16	8	5	- 3	9
7	40	14	29.5	23.5	- 6	36
8	53	14	11	23.5	12.5	156.25
9	56	14	5.5	23.5	18	324
10	45	11	19.5	38	18.5	342.25
11	57	12	3	33.5	30.5	930.25
12	58	15	1	14	13	169
13	52	15	13.5	14	.5	.25
14	43	16	22.5	5	-17.5	306.25
15	49	15	15.5	14	- 1.5	2.25
16	55	15	8	14	6	36
17	57	10	3	41	38	1,444
18	55	13	8	30	22	484
19	43	11	22.5	38	15.5	240.25
20	41	15	27.5	14	-13.5	182.25

Code	Religion Score	Spiritual Score	Religion Rank	Spiritual Rank	D_i	D_i^2
21	32	14	37.5	23.5	-14.0	196
22	37	13	33	30	- 3	9
23	40	16	29.5	5	-24.5	600.25
24	47	15	17	14	- 3	9
25	34	16	36	5	-31	961
26	41	11	27.5	38	10.5	110.25
27	42	16	24.5	5	-19.5	380.25
28	53	15	11	14	3	9
29	44	16	21	5	-16	256
30	39	11	31.5	38	6.5	42.25
31	32	14	37.5	23.5	-14	196
32	53	12	11	11	33.5	506.25
33	39	14	31.5	23.5	- 8	64
34	45	14	19.5	23.5	4	16
35	45.5	12	18	33.5	15.5	240.25
36	49	13	15.5	30	14.5	210.25
37	31	16	39.5	5	-34.5	1,190.25
38	56	15	5.5	14	8.5	72.25
39	30	11	41	38	- 3	9
40	41.5	12	26	33.5	7.5	56.25
41	35	14	35	23.5	-11.5	132.25
				Total	00	10,678.50

REFERENCES CITED

Allport, G. W. Becoming Basic Considerations for a Psychology of Personality. New Haven: Yale University Press, 1955.

Allport, G. W., Vernon, P. E., & Lindzey, G. Study of Values Manual (3rd ed.). Boston: Houghton Mifflin Company, 1970.

Balsley, H. L. Quantitative Research Methods for Business and Economics. New York: Random House, Inc., 1970.

Barnett, L. The Universe and Dr. Einstein (5th printing). New York: Bantam Book, 1972.

Bevis, E. O. Curriculum Building in Nursing a Process (2nd ed.). St. Louis: The C. V. Mosby Company, 1978.

Blalock, H. M. Social Statistics (2nd ed.). New York: McGraw-Hill Book Company, 1972.

Bovet, T. Human Attitudes Toward Suffering (B Jager, trans.). Humanitus, February 1973, IX(1), 5-20.

Brallier, L. W. The Nurse as Holistic Health Practitioner Expanding the Role Again. Nursing Clinics of North America, December 1978, 13, 643-655.

Breemen, P. G. As Bread That is Broken. Denville, New Jersey: Dimension Books, Inc., 1974.

Brungs, R. Biomedical Challenges: Should "Human" be Redefined? Hospital Progress, June 1979, 60(6), 55-60.

Burghardt, W. J. Is Anyone Listening? Does Anyone Care? In K. O'Rourke (Ed.), The Mission of Healing. St. Louis: The Catholic Hospital Association, 1974, 107-118.

Burghardt, W. J. Toward a Theology of the Health Apostolate. In K. O'Rourke (Ed.), The Mission of Healing. St. Louis: The Catholic Hospital Association, 1974, 11-21.

Cleary, F. Suffering in Biblical Perspective. In K. O'Rourke (Ed.), The Mission of Healing. St. Louis: The Catholic Hospital Association, 1974.

Cleary, F. On Death and Afterlife: A Biblical and Theological Interpretation. Hospital Progress. December 1975, 56(12), 40-44.

Clemence, M. Existentialism: A Philosophy of Commitment. American Journal of Nursing, 66, 500-505.

Coletta, S. Values Clarification in Nursing: Why? American Journal of Nursing, December 1978, 78, 2057.

Czmowski, M. Value Teaching in Nursing Education. Nursing Forum, 1974, XII, 192-206.

Dickinson, C. The Search for Spiritual Meaning. American Journal of Nursing, October 1975, 75, 1789-1793.

Evely, L. Suffering. New York: A Doubleday & Company, Inc., 1966.

Evely, L. Our Prayer. New York: Herder & Herder, Inc., 1970.

Fish, S. & Shelly, J. Spiritual Care: The Nurse's Role (2nd ed.). Illinois: Inter Varsity Press, 1978.

Fleeger, R. Toward a Christian Philosophy of Nursing. The Nurses Lamp, May 1977, XXVIII(5), 1-3.

Foster, S. P. An Adrenal Measure of Evaluating Nursing Effectiveness. Nursing Research, March-April 1974, 23, 118-122.

Frankl, V. E. Man's Search for Meaning: An Introduction to Logotherapy (Rev. ed.). United States: Beacon Press, 1962.

Fromm, E. Man for Himself (14th printing). New York: Rinehart and Company, Incorporated, 1960.

Fuller, S. S. Holistic Man and the Science and Practice of Nursing. Nursing Outlook, November 1978, 26, 700-704.

Gold, H. W. Caretaking, Giving Care, Caring For, Caring. In L. M. Simms & J. B. Lindberg, The Nurse Person. New York: Harper & Row, 1978, 105-111.

Gold, H. W. Communicating with Others One to One. In L. M. Simms & J. B. Lindberg, The Nurse Person. New York: Harper & Row, 1978, 71-78.

Harrity, M. Thoughts on Suffering, Sorrow, and Death. Indiana: Our Sunday Visitor, Inc., 1973.

Hellwig, M. K. What are They Saying About Death and Christian Hope? New York: Paulist Press, 1978.

Henderson, V. Basic Principles of Nursing Care (Rev. ed.). New York: Albert J. Phiebig, Inc., 1969.

Henderson, V. Excellence in Nursing. American Journal of Nursing, October 1969, 69, 2133-2137.

Henderson, V. The Nature of Nursing. A Definition and Its Implication for Practice, Research, and Education (4th printing). New York: The Macmillan Company, 1970.

Hoyman, H. S. Rethinking an Ecologic-System Model of Man's Health, Disease, Aging, Death. The Journal of School Health, November 1975, XLV, 509-518.

Hubert, M. Spiritual Care for Every Patient. The Journal of Nursing Education, May-June 1963, 2(2), 9-11;29-31.

Israel, M. The Spirit of Man. Nursing Mirror, December 29, 1977, 145(pt. 3), 20-21.

Jones, P. S. An Adaptation Model for Nursing Practice. American Journal of Nursing, November 1978, 78, 1900-1906.

Jourard, S. M. The Transparent Self (Rev. ed.). New York: Litton Educational Publishing, Inc., 1971.

Lipowski, Z. J. Psychosocial Aspects of Disease. Annals of Internal Medicine, December 1969, 71, 1197-1206.

Lucas, M. A. Praying with the Terminally Ill. Hospital Progress, March 1978, 59(3), 66-70.

Maslow, A. H. Religious, Values, and Peak Experiences (reprinted). New York: Viking Press, Inc., 1977.

May G. G. The Psychodynamics of Spirituality: A follow-up. The Journal of Pastoral Care, June 1977, XXXI, 84-90.

McCormack, M. Is Religion Viable Today? AORN Journal, March 1976, 23, 646-654.

O'Neill, M. F. A Study of Nursing Student Values. International Journal of Nursing Studies, 1975, 12(3), 175-181.

O'Rourke, K. D. Is Your Health Facility Catholic? In K. O'Rourke (Ed.), The Mission of Healing. St. Louis: The Catholic Hospital Association, 1974.

Partridge, K. B. Nursing Values in a Changing Society. Nursing Outlook, June 1978, 26, 356-360

Patey, E. H. Sacred & The Secular. Nursing Mirror, November 10, 1977, 145(3), 25-26.

Piepgras, R. The Other Dimension: Spiritual Help. American Journal of Nursing, December 1968, 68, 2610-2613.

Porath, T. Humanizing the Sacrament of the Sick. Hospital Progress, July 1972, 53(7), 45-47.

Pumphrey, J. B. Recognizing Your Patients' Spiritual Needs. Nursing 77, December 1977, 7(2), 64-70.

Raths, L. E., Harmin, M., & Simon, S. B. Values and Teaching: Working with Values in the Classroom. Columbus, Ohio: Charles E. Merrill Publishing Co., 1966.

Reading, A. Illness and Disease. Medical Clinics of North America, July 1977, 61, 703-710.

Reynolds, P. D. A Primer in Theory Construction. Indianapolis: Bobb-Merrill Educational Publishing, 1977.

Rogers, C. R. On Becoming a Person (10th sentry ed.). Boston: Houghton Mifflin Company, 1961.

Sarosi, G. A Critical Theory: The Nurse as a Fully Human Person. Nursing Forum, 1968, VII, 349-362.

Simms, L. M., & Lindberg, J. B. The Nurse Person. New York: Harper & Row, Publishers, 1978.

Simon, B. S., Howe, L. W., & Kischenbaum. Values Clarification: A Handbook Practical Strategies for Teachers and Students. New York: Hart Publishing Co., 1972, p. 13 (S. S. Coletta. Values Clarification in Nursing: Why? American Journal of Nursing, December 1978, 78, 2057-2063).

Simone, M. Demands on the Christian Nurse. Hospital Progress, August 1971, 52(8), 43-46.

Spranger, E. Types of Men: The Psychology and Ethics of Personality (5th ed. P. J. Pigois, trans.). Halle: Max Niemeyer Verlag, 1928.

Stallwood, J. Spiritual Dimensions of Nursing Practice in Clinical Nursing (3rd ed.). New York: Macmillan, 1975 p. 1088 (S. Fish & J. Shelly. Spiritual Care: The Nurse's Role. Illinois: Inter Varsity Press, 1978.)

Steele, S. M., & Harmon, V. M. Values Clarification in Nursing. New York: Appleton-Century-Crafts, 1979.

Sullivan, G. Philosophy of Life Shapes Nursing Care. Hospital Progress, February 1967, 48(2), 110-114; 119-120.

The New American Bible. New Jersey: Catholic Publishers, Inc., 1971.

The Philosophy Document for the Division of Nursing of Mary College. Self Study. Bismarck, North Dakota: Mary College, 1978.

Tortorici, J. The Catholic Hospital: Catalyst in the Health Care Crisis. In K. O'Rourke (Ed.), The Mission of Healing. St. Louis: The Catholic Hospital Association, 1974.

Travelbee, J. To Find Meaning in Illness. Nursing 72, December 1972, 2(12), 6-8.

Travelbee, J. Interpersonal Aspects of Nursing (2nd ed.). Philadelphia: F. A. Davis Company, 1973.

Uustal, D. B. Values Clarification in Nursing: Application to Practice. American Journal of Nursing, December 1978, 78, 2058-2063.

Vaillot, M. C. Hope: The Restoration of Being. American Journal of Nursing, February 1970, 70, 268-273.

Webster, N. Webster's New School and Office Dictionary (Rev. ed.). Connecticut: Fawcett Publications, Inc., 1974.

Wheelock, R. D. Health Care Ministries. St. Louis: The Catholic Hospital Association, 1975.

Wheelock, R. D. Religion and Medicine: Partners in Health. Hospital Progress, June 1976, 58-61.

Youtz, I. R. The Patient's Spiritual Needs. American Journal of Nursing, February 1950, 50, 64.

BIBLIOGRAPHY

Arnold, H. M. I-Thou. American Journal of Nursing, December 1970, 70, 2554-2556.

Bayer, M., & Brandner, P. Nurse Patient Peer Practice. American Journal of Nursing, January 1977, 77, 86-90.

Bowker, J. Suffering and the Origins of Religion. Humanitas, February 1973, IX(1), 111-122.

Brink, P. J. Patientology: Just Another ology? Nursing Outlook, September 1979, 26, 574-575.

Butler, M. N. How can Today's Nursing Student Influence the Quality of Patient Care? Imprint, October 1976, 23, 46; 53.

Cornell, A. Why Religion is Essential to Total Health. Life and Health, March 1978, 93, 18-19.

Dean, D. G. Alienation: Its Meaning and Measurement. American Sociological Review, October 1961, 26, 753-758.

Dewey, B. R. Kierkegaard on Suffering: Promise and Lack of Fulfillment in Life's Stages. Humanitas, February 1973, IX(1), 21-45.

Ferlic, A. Existential Approach to Nursing. Nursing Outlook, October 1968, 16, 30-33.

Fleeger, R., & Van Heulelem, J. The Patient's Spiritual Needs - A Part of Nursing Diagnosis. The Nurses Lamp, March 1977, XXVIII(4), 1-4.

Gray, R. Dealing with Dying. Nursing 73, June 1973, 73, 26-31.

Heagle, J. A Contemporary Meditation on Hope. Illinois: The Thomas More Press, 1975.

Henderson, V. We've "Come a Long Way", but What of the Direction? Nursing Research, May-June 1977, 26, 163-164.

Hurley, M. J. Symbiosis: Science and Man. Hospital Progress, September 1975, 56(9), 73-75.

Jadot, J. The Church and the Sacredness of Life. Hospital Progress, September 1975, 56(9), 70-72.

Laney, L. M. Hope as a Healer. Nursing Outlook, January 1969, 17, 45-46.

Larson, R. S., & Larson, D. C. Values and Faith - Clarifying Exercises for Family and Church Groups. Minnesota: Winston Press, 1976.

Laufman, L., & Weinstein, J. Values and Prevention. Health Values: Achieving High Level Wellness, September-October 1978, 2(5), 270-273.

May, G. G. The Psychodynamics of Spirituality. The Journal of Pastoral Care, June 1974, XXVIII, 84-91.

Mooney, J. Attachment/Separation in the Nurse-Patient Relationship. Nursing Forum, 1976, 15, 259-264.

Morris, K., & Foerster, J. D. Team Work: Nurse and Chaplain. American Journal of Nursing, December 1972, 72, 2197-2199.

Phillips, C. Meeting Your Patients' Religious Needs. RN, March 1959, 22(3), 44-55.

Raciappa, J. D. A Total Ministry. American Journal of Nursing, April 1973, 73, 645.

Schlotfeldt, R. M. Nursing Research: Reflection of Values. Nursing Research, January-February 1977, 26, 4-9.

Shaw, M. E., & Wright, J. M. Scales for the Measurement of Attitudes. New York: McGraw-Hill Book Company, 1967.

Shetland, M. L. The Responsibility of the Professional School for Preparing Nurses for Ethical, Moral and Humanistic Practice. Nursing Forum, 1969, VIII, 17-27.

Simon, S. Caring, Feeling, Touching. Illinois: Argus Communication, 1976.

Switzer, D. K. Human Suffering in Grief: Factors Affecting Intensity and Morbidity. Humanitas, February 1973, IX(1), 47-67.

Tubesing, D. A. Wholistic Health. New York: Human Sciences Press, 1979.

Weil, S. Waiting for God. New York: Harper and Row, 1973. (Originally published, 1951.)

Wilson, R. W. Religiosity and Health: Implications for Health Promotion. Health Values: Achieving High Level Wellness, May-June 1978, 2, 144-146.