THE NURSE'S RELIGIOSITY AND ATTITUDE TOWARD GIVING SPIRITUAL CARE

A THESIS

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CHAPTER 1

INTRODUCTION

The place of religion in the nurse's personal life will influence his or her feelings about religion in the lives of patients (Kelly, 1975). Glock and Stark (1973) defined religiosity as all the conceivable ways in which an individual can be religious.

Religiosity has five components. The first is experiential. It is assumed in all religions that a religious person will at one time or another experience special feelings or direct knowledge of ultimate reality (e.g., the "presence" or nearness of God). The second is ideological. This is an adherence to a core of beliefs essential to religious life. The third is ritualistic. This refers specifically to religious activities prescribed by all formal religions, such as prayer and fasting. The fourth is intellectual or knowledge about the tenets of the faith. The last is consequential, which is the effects of religiosity on an individual's life, e.g., doing of "good works" and displaying "love of neighbor" (Glock & Stark, 1973, pp. 631-632).

The nurse is the person most readily available when patients need to talk about their physical, emotional,

or spiritual concerns. Hopefully, she has established a climate and relationship with patients that encourages them to express their fears, their need for help, and the facts of their illness that have created emotional and spiritual problems. These problems may concern the interruption of their habits of worship, undermine their faith, or create new spiritual needs.

The more personal spirituality nurses display and the more comfortable they are in discussing spiritual matters, the more likely it will be for patients and their families to confide in them (Beland & Passos, 1975). Contemporary nursing literature stresses the need for nurses to care for the whole person, which is holistic nursing care. This includes a spiritual aspect and, according to the way the terms are used, includes a religious aspect (Henderson & Nite, 1978).

Vaillot interpreted the term "spiritual" as:

> the essential principal influencing us. Spiritual, although it might, does not necessarily mean religious: it also includes the psychological. The spiritual is opposed to the biological and mechanical, whose laws it may modify. (Cited in Henderson & Nite, 1978, p. 1052)

Spiritual values are based on the religious beliefs of the culture in which the personality is formed. The extent to which nurses are informed about the religions to

which their patients subscribe affects the patients' inclination to talk to them about religious needs or concerns. The purpose of this research was to determine if the religiosity of the nurse affects his or her attitude toward the provision of spiritual care to patients.

Problem Statement

The value of spiritual care as a component of nursing care has long been overlooked, therefore, this study investigated this question: Is there a relationship between the nurse's religiosity and the nurse's attitude toward providing spiritual care to patients?

Justification of Problem

O'Connell and Duffey (cited in Chaska, 1978) reviewed research studies published in Nursing Research from 1970-1975. Not one report related to spiritual needs was discovered. Religion, faith, or spiritual values are integral parts of human life. It is an inescapable function of nurses to recognize this (Henderson & Nite, 1978).

Beland and Passos (1975) defined spiritual needs as any factor necessary to establish and maintain a person's dynamic personal relationship with God (as defined by that individual). Every person has a basic need for such a relationship, and out of this to experience:

1. Forgiveness--from God, self, and others.

2. Love--not conditional, but "in spite of," from God, self, and others.

3. Hope.

4. Trust--faith in someone outside of self.

5. Meaning and purpose in life (Beland & Passos, 1975, p. 1088).

The nine major living religions claim more than half of the world's population as members. These religions of the world include Christianity, Islamism/Muslim, Hinduism, Confucianism, Buddhism, Shintoism, Taoism, Judaism, and Zoroastrianism (Kelly, 1975). The remaining population belongs to primitive religions or has no religious affiliation. Nevertheless, all people have value systems that are the basis of their being.

Crisis life situations related to illness, trauma, death, birth, marriage, or divorce may cause one to have to evaluate his value system, which is composed of his religious and spiritual resources. The extent to which nurses can recognize the commonalities and differences in religions determines their ability to recognize the individuality of people of all faiths, and to help them with problems related to religion or spiritual values.

To adequately meet patient's spiritual needs, all nurses should attempt to enhance their knowledge and skills in this area of nursing. Some available methods to accomplish this objective are to join the Nurses' Christian Fellowship or similar organizations. Participation in multidisciplinary groups composed of psychiatrists, psychologists, chaplains, social workers, nurses, and other health care providers may also be helpful.

Strategies that nurses can use in helping people meet their spiritual needs are to identify their own values, spiritual needs, and religious beliefs and learn as much as possible about other living religions. They may also listen with interest to anything patients or families say about their ethical values, spiritual needs, or religious beliefs. They may also learn to administer the sacraments which are appropriate for lay persons to administer in emergencies. They can be prepared to read prayers or other religious literature at the request of patients or their families or work with others in health agencies to see that there are suitable resources for religious observances. When people express the wish to see a spiritual advisor, the nurse may communicate this need to an appropriate person. During religious advisors'

visits, nurses can see that as much privacy as possible is provided.

Participation in inter-disciplinary conferences that deal with religious freedom may be of spiritual assistance. The opportunity to serve without regard to creed helps provide a productive spiritual environment.

Theoretical Framework

The theoretical framework for this study was symbolic interaction theory, which was introduced by Mead in 1934 and simplified and clarified by Blumer in 1969. The first premise of symbolic interactionism is that "human beings act toward things on the basis of the meaning that things have for them" (Blumer, 1969, p. 2). The second premise is that a thing's meaning "is derived from, or arises out of, the social interaction with one's fellows" (Blumer, 1969, p. 2). The third premise is that "these meanings are handled in, and modified through, an interpretive process used by the person dealing with the things he encounters" (Blumer, 1969, p. 2). Interaction between the nurse and the patient is an example of the application of these premises.

Nurse-patient interaction influences the behavior and perceptions of the nurse and the patient. Individual

interpretation of the interactions can result in a change process for both participants.

Interactions may be symbolic or nonsymbolic (for example, reflexes). However, it is the symbolic ones which involve the process of interpretation. Another characteristic of this kind of interaction is that it is comprised of gestures and responses to the meaning of those gestures (Mead, 1934).

> A gesture is any part or aspect of an ongoing action that signifies the larger act of which it is a part. . . . Such things as requests, orders, commands, cues, and declarations are gestures that convey to the person who recognizes them as an idea of the intention and plan of forthcoming action for the individual who presents them. (Blumer, 1969, p. 9)

Thus, one responds to the activities and intentions of others. Related to this study, the nurse's religiosity may affect her behavior and perception toward the need to meet the patient's spiritual needs.

An additional basic concept of symbolic interactionism relates to the nature of human society--that individuals may act singly or collectively, on behalf of, or as representatives of others, and that human groups exist in action (Blumer, 1969). The existence of group life presupposes interaction among group members. This relates the theory to families and other groups, allowing for their importance in influencing the individual.

Interaction is a process that "forms human conduct instead of being merely a means or a setting for the expression or release of human conduct" (Blumer, 1969, p. 8).

The place of religion in the nurse's personal life will influence his or her feelings about religion in the lives of patients (Kelly, 1975). This is an example of the application of the first premise of symbolic interactionism, which is that "human beings act toward things on the basis of the meaning that things have for them" (Blumer, 1969, p. 2).

Blumer (1969) presented the second premise that a thing's meaning "is derived from or arises out of, the social interaction with one's fellows" (p. 2). Related to this study in order to promote optimal nurse-patient interaction related to spiritual care, the nurse needs to give consideration to how the patient perceives and interprets her behavior as she performs in the areas of religious and spiritual care. The third premise is that "these meanings are handled in, and modified through, an interpretive process used by the person dealing with things he encounters" (Blumer, 1969, p. 2). This premise is based on the fact that the patient's ability to verbalize spiritual needs may be affected by how he interprets the nurse's religiosity from former interactions with her.

In summary, there are three basic premises in Blumer's (1969) symbolic interaction theory. The key concepts of the premises are that actions are based on meanings, meanings are derived from interactions, and an interpretive process individualizes these meanings.

Assumptions

For the purpose of this study, the following assumptions were made.

1. Spiritual care is a component of nursing care.
2. Written expression of the provision of spiritual care is the equivalent of the overt behavior.
3. Nurses' religiosity comes from past interaction with family members, peers, and exposure to formal or informal religious practices.
4. The nurses' spiritual care interventions result from past experiences related to religious expressions/ interactions.

Hypothesis

The following hypothesis was tested for this study: Nurses who score high on the Religious Attitude Inventory will score high on the Patient Spiritual Need Index.

Definition of Terms

The following terms were defined for use in this study.

1. Attitude--a relatively enduring organization of beliefs around an object, subject, or concept, that predisposes one to respond in some preferential manner (Rokeach, 1968).

2. Religious attitude--the knowledge, the beliefs, and behavior one expresses concerning his religion.

3. Spiritual care--assisting a person to establish and/or maintain relationship with God (Fish & Shelly, 1978).

4. Attitude toward spiritual care--the score obtained on the Patient Spiritual Need Index.

5. Religiosity--all the conceivable ways in which an individual can be religious (Glock & Stark, 1973). The five basic dimensions of religiosity are:

   a. Experiential--at some time the religious person will experience special feelings or direct knowledge of the "presence" or "nearness of God."

   b. Ideological--adherence to a core of beliefs is essential to the religious life.

c. Ritualistic--specifically religious activities prescribed by all formal religions, such as prayer and fasting.

d. Intellectual--knowledgeable about the tenets of his faith.

e. Consequential--effects of religiosity in an individual's life, e.g., doing of "good works," displaying "love of neighbor."

6. Religiosity--the score obtained on the Religious Attitude Inventory.

7. Professional registered nurse--a graduate nurse who has passed the professional nurse licensure examination and is qualified to practice nursing in the United States.

Limitations

The limitations in this study were:

1. The study was conducted in only one geographic area.

2. The study population was composed only of Christians.

Summary

Knowledgeable assessment of spiritual needs and the ability to implement skillful interventions from the

literature to help patients meet these needs was presented as a goal for all nurses. Some suggested activities that nurses may implement to help people meet their spiritual needs are included. The problem of this study was to determine if there is a relationship between the nurse's religiosity and the nurse's attitude toward providing spiritual care to patients.

CHAPTER 2

REVIEW OF LITERATURE

The concepts applied to the theoretical framework that were chosen for this study included nurses' religious values and patients' spiritual needs. The literature review discusses these concepts.

Nursing and Religious Values

Allport (1950) contended that scholars in theology and the psychology of religion have postulated for many years that religious tradition and belief may be important in providing an individual with a sense of purpose, well-being, value, and belonging. Wilson (1979) maintained that religiosity may promote health. He also stated that evidence suggesting a relationship between religion and health provided credibility to the idea that religiosity promoted wellness and quality in life.

Wheelock (1976) stated that life is an unending series of emotions comprised of stresses, frustrations, anxieties, and occasional loss and grief. Religion has dealt with these situations for centuries and reflect the individual's need for faith, hope, courage, trust, self-esteem, a sense of direction, and an openness to life's problems. These

needs may be referred to as man's search for meaning, self-actualization, or other psychological terms, but they are basically religion's problems. Wheelock further stated that the way organized religion has influenced an individual's development and his perception of God can directly affect his state of health.

Selye (1974) alluded to the fact that investigators with no vested interest in religion have demonstrated that religious ideas and values are an important component of the health of an individual. Anspaugh and Signan (1980), in an article about religion and sexuality, contended that no element of society directly or indirectly influences sexual value systems and behavioral patterns more than the church.

Culture can affect whatever a person believes to be true or right about any aspect of his life (Brink, 1976). What people believe is expressed in their behavior and can be evaluated by observing and listening to them. This is included in the nursing process which includes talking to people,asking questions, and observing what they do and when.

The nurse's philosophy concerning life is part of her value system and will effect her provision of spiritual care. Clouser (1973) asserted that life is created by God.

Man has no authority over life, which is a gift from God. Therefore, health care professionals must practice good stewardship of life. Life is for human use, but it is only on loan from God.

Nurses can only meet the needs of others if their own needs are being met (Fish & Shelly, 1978). In order to meet patients' and families' spiritual needs, one must practice health maintenance related to one's own physical, emotional, and spiritual well-being. Good physical and mental health practices plus spiritually nurturing activities can help achieve these goals. A sense of belongingness and togetherness, support and encouragement from one's peers, and experiencing the love and concern of others enriches the nurse's personality and provides a foundation from which she ministers to patients' needs. Personal spiritually nurturing activities in which the nurse may engage are church affiliation, personal and shared prayer, Bible study, and small group fellowship.

The Christian nurse who is interested in increasing the practice of her faith can use study of scripture to view the world and to deal with problems from God's perspective. Worship, praise, thanksgiving, confession, intercession, and petition comprise prayer which is one's response to God. It is a verbal recognition of man's

humanity and one's need for God. Prayer is saying "I can't, but God can through me" (Fish & Shelly, 1978, p. 140).

Some loss, separation, failure, or crisis has occurred in each life. Individuals tend to repress painful experiences, which may leave unresolved feelings of anger, pain, or guilt. The nurse who prayerfully examines these experiences may derive personal peace as well as insights needed to assist patients with their needs. Fish and Shelly (1978) noted that what one has learned about oneself, God, and other people through past experiences can be constructive.

Nurses' feelings can affect the objective quality of psychological and other assessments. Each individual perceives the world differently because of varied life experiences and interpretations (Snyder & Wilson, 1977). Bindschadler (1976) contended that feelings are felt with no respect for "should's" or "shouldn'ts." Professionalism does not mean cold, unemotional, or uninvolved. It means warm and emotional caring and being able to set limits.

Working through unresolved personal emotions may require the emotional support and assistance of a trusted friend, a minister, or a professional counselor. Positive outcomes of the nurse's ministry to patients' needs are

dependent on how effectively the nurse uses her coping abilities to solve her own problems.

The four major resources available to the nurse for meeting spiritual needs of patients are (a) the use of self, (b) the use of prayer, (c) the use of scripture, and (d) referral to the clergy (Fish & Shelly, 1978). The evaluation of one whose spiritual needs are usually met is evidenced by the appearance of a normal healthy person who displays emotions appropriate to the situation. There is evidence of a strong realistic self-image, warm interpersonal relationships, a sense of mission in life, and a confident trust-relationship with God (Fish & Shelly, 1978).

Simms and Lindberg (1978) contended that the holistic concept of man is seldom applied to the nurse person. The holistic nature of the nurse person implies the need for growth, development, and learning to use the self in the interpersonal activities of nursing care as the nurse attempts to assess and meet the patient's needs.

Of value to the nurse to use as a basis for spiritual intervention at the patient's level of faith is an understanding of the goals in religious values clarification. The first goal is to understand a person's beliefs about and involvement with God and religious practices. The second goal is to determine the extent to which a person's

religious practices serve as a resource for faith and to deal with life. The third goal is to assess whether a person's resources for hope and strength are founded on reality. The final goal is to give a person an opportunity to accept spiritual help (Fish & Shelly, 1978).

Patients' Spiritual Needs

Diekelmann (1977) stated that the last developmental task for the elderly includes helping the individual accept the inevitability of death and preparing for it. Increased interest in religion is also evidenced. Blazer and Palmore (1976) supported these contentions in a longitudinal study which analyzed the religious activities and attitudes of the aging. They reported that there is a significant correlation between religion and happiness and feelings of usefulness and adjustment in older persons. These feelings tended to increase with aging.

Wilson-Barnett and Carrigy (1978) maintained that extensive research studies have provided increasing evidence supporting the fact that hospitalization is a stressful experience for patients. They conducted a longitudinal study of factors causing distress, specifically anxiety and depression, among medical ward patients. The findings of the study showed that patients who are likely to suffer high anxiety and depression levels during

hospitalization can be identified. This information can be the basis for nursing interventions.

Shepard (1978) contended that the care of the terminally-ill and dying is deficient. He stated that emphasis on the treatment of disease rather than the whole person could be a reason. The staff's orientation toward cure rather than palliative measures which meet the everyday needs of patients is also a factor. The psychological inability to deal with the dying who seek caring as well as curing requires a change in the attitudes and approaches of health care providers. Patients have communicated what they consider good treatment. It includes the doctor and other health care personnel sitting down with them, answering their questions, and helping them deal with their fears. Other considerations for the dying include an environment that alleviates pain and provides for the physical, emotional, spiritual, and social needs of the patient and his family.

Kozier and Erb (1979) held that spiritual preferences relate to a desire to understand one's relationship to the universe as well as the eventual direction and meaning of life. The spiritual beliefs that most people possess provide guidance related to mores and ethical values. Beliefs also serve as an integrating force in society and

provide inner strengths that are closely associated with emotional and physical health.

Religious and spiritual beliefs help some people to adapt to crisis and stressful situations. Various beliefs are held by people related to illness and religion. Some people question religion in an attempt to find the answer as to why they are ill; others consider illness a test of faith; while still others feel it is punishment for their sins.

Prayer, promise, and penance can be used to attempt to counteract illness by patients and their families. Religious beliefs can effect how one accepts illness, the course of illness, and its treatment (Kozier & Erb, 1979).

Religious Development

Parents' attitudes towards moral codes and religion convey to children what is considered right and wrong. Superego (conscience) development is also related to moral and religious development. A very strict superego can yield a self-righteous, intolerant personality, while underdevelopment may result in a sociopathic personality. Adolescents, by 16 years of age, usually decide whether to accept the family religion or experience their own religious awakening such as being saved or converted (Kozier & Erb, 1979).

Young adults usually develop a more mature attitude toward religion as they strive to answer their children's questions. Middle-aged adults tend to have more time for church groups and religious activities after their family responsibilities lessen. A mature religious philosophy can assist the elderly individual to accept life's challenges, to participate in various activities, and to have feelings of self-worth. It also helps them accept the inevitability of one's death or the death of a spouse (Kozier & Erb, 1979).

Meeting Spiritual Needs

Often it is the nurse who identifies a patient's spiritual needs and makes the appropriate referral. Information about a patient's religion is usually present in the hospital admission record and may be recorded in the nursing history. The nurse may ask the patient if he follows a religious philosophy and if he would like a visit from the clergy. It is imperative that the nurse respect the patient's wishes related to spiritual care ministry and that she not impose her values on him.

Westberg (1955) listed nine groups of people who have been identified as possible candidates for pastoral care. This list can serve as a general guide for the nurse, but

individual assessment is necessary for specific intervention.

Potential recipients include patients who are lonely and receive few visitors, those who express fear and anxiety, and individuals whose illnesses are related to emotional or religious attitudes. Patients facing surgery, changes in life-style following illness, or injury are also possible recipients. Patients who are preoccupied with the relationship of their religion and health, those who are unable to have their pastor visit or who would not normally receive pastoral care, extend the candidate list. Individuals whose illnesses have social implications and patients who are dying complete the enumeration of candidates most likely in need of pastoral care.

Meeting the spiritual needs of patients and their families is a function that is shared by nurses and members of the clergy such as priests, rabbis, and ministers. The nurse's role in ministering to the spiritual needs of patients and their families includes assisting them to see meaning in their lives, to accept reality, and to discover practical solutions to problems. These objectives can be accomplished through the use of the nurse-patient and nurse-family relationships.

If the nurse feels uncomfortable when asked to assist the patient spiritually, she should secure assistance from the appropriate clergyman and not feel guilty because of her inability to personally meet the patient's needs (Kozier & Erb, 1979).

Providing spiritual assistance involves support, which consists of being accepting of the individual regardless of his beliefs, awareness of and sensitivity to his verbal and nonverbal communications as well as emotional tone. Empathetic understanding of the patient and his feelings leads to acceptance of the person without expressing approval or disapproval. When the nurse identifies patients who are vulnerable to feelings of helplessness and fear of the unknown, nursing interventions such as explanations of hospital facilities and procedures can be implemented. Psychological care activities by the nurse may also be necessary to allay the patient's apprehension. Other aspects of spiritual intervention include reaffirming the person's strengths, providing understanding, listening, and helping the individual develop emotionally (Kozier & Erb, 1979).

The Clergy

Many hospitals have chaplains of different faiths who assist patients, families, and institutional staff

with their spiritual needs. Nursing units are provided with on-call lists of clergy to contact when necessary.

The chaplain performs varied functions. Newly-admitted patients may be visited and an assessment of their spiritual needs performed. Other spiritual activites include reading spiritual literature aloud, offering the sacraments, or visiting as the patient's situation requires. Regular religious services held in chapels and quiet rooms may be available to patients or families (Kozier & Erb, 1979).

The spiritual well-being of patients is enhanced by collaborative activities between the nurse and religious practitioners. Lumpp (1973) referred to these activities as synergism. She stated that situations that enhance the spiritual dimensions of patient care should be viewed with a "diagnostic" rather than a "judgmental" approach. This approach asks "why does the situation exist and can it be changed?" rather than applying a label of "good" or "bad" to it (p. 34).

Attributes required by persons who participate in the spiritual care of patients include psychological energy and time to be present at times of grief and crisis, the ability and willingness to listen, and the ability to put people at ease. Pastoral care personnel

can participate and have input into patient care on nursing units by participating in team conferences and making written notation of whether or not a patient is receiving spiritual support (Lumpp, 1973).

Interdisciplinary collaboration occurs when the nurse informs the chaplain which special patients are to be seen. The chaplain is prevented from making inadvertent remarks by having information that the nurse provides. Examples include age, religion, diagnosis, occupation, attending physician, any special concerns, and nursing observations (Morris & Foerster, 1972).

When the chaplain, nurse, and physician function as a team several positive outcomes result. The chaplain is at ease and conveys his confidence to the patient. The sense of team consciousness benefits the physician and the nurse and strengthens their awareness of the spiritual aspect of patient care (Morris & Foerster, 1972).

Morris and Foerster (1972) stated that the team has an obligation to the family to make the transition of the patient, as he returns to full or partial function or capacity, as smooth as possible. The re-establishment of normal relationships can also be aided by the team members.

The relationship of religion and spiritual needs to the provision of holistic nursing care to patients has been documented by Blazer and Palmore (1976), Fish and Shelly (1978), Piepgras (1968), and Wheelock (1976). Piepgras (1968) felt that there is a difference in emotional support, which is one's relationship to himself and his environment and spiritual help which concerns one's relationship to a higher being. Emotional support can help one cope with crisis situations. It may be a willingness to listen with an attitude of concern or to help the individual develop a philosophy that will help accept the tragedy. The spiritual relationship is personal. It is an "I-You" or "God-Man" situation and each believer stands alone before his God (Piepgras, 1968, p. 2612).

Summary

Literature relating to the religiosity of nurses and patients was reviewed. Components of identifying and meeting client's needs along the religious dimension were discussed. Collaborative activities among health team members were shown in articulation with pastoral efforts. The chapter concluded with the fundamental statement of the Christian ethic.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The classification of this study is a descriptive correlational survey. Abdellah and Levine (1979) stated that in descriptive studies the research is primarily concerned with obtaining accurate and meaningful descriptions of the phenomena under study. A correlational survey (Fox, 1976) collects data on more than one variable from one group of respondents with the intent of estimating the magnitude of the relationships between the variables. Fox (1976) suggested "descriptive statistics called correlations as the procedures that seek to provide a numerical estimate of the magnitude of the relationship between two sets of data" (p. 97).

The design is the one-group posttest only, which involves making observations on persons who have undergone a treatment and then only after they have received it (Cook & Campbell, 1979). Deficiencies in this design are that it lacks pretest observations, and there is an absence of a control group. However, these deficiencies are minimized when, "contextual knowledge is already rich, even if impressionistic; and intelligent presumptions

can be made about what this group would have been like without X" (Cook & Campbell, 1979, p. 96).

The independent variable, nurses' religious attitudes as measured by the Religious Attitude Inventory, is compared to the dependent variable, the nurse's provision of spiritual care to patients as measured by the Patient Spiritual Need Index. Cook and Campbell's (1979) conception of signed causes supplants pretesting and supports use of the One Group Posttest-Only design.

Setting

The setting chosen for this study was an 800-bed tax-supported hospital located in a Southwestern metropolitan area. This general hospital is a major teaching facility and offers a wide variety of health care services.

Population and Sample

The sample consisted of registered nurses who are licensed to practice pfofessional nursing in the State of Texas. Other criteria included: the nurse be engaged in nursing or nursing-related activities at an accredited secondary health care facility and he or she adheres to a Christian ethic. The selection of a sample of 30 subjects excluding the pilot study population was by the convenience method. In the convenience sampling method, subjects are

selected because they happen to be available for participation in the study at a certain time. It represents a nonprobability sample and although there is an element of randomness in the entry of the subjects into the study, they were not included as participants using a designated procedure. Thirty subjects who met the criteria and agreed to participate in the study constituted the sample.

Protection of Human Subjects

The proposed study was submitted to the Texas Woman's University Human Rights Committee for review and permission to conduct the research investigation (Appendix A). The Human Subjects Review Committee of the facility used also reviewed the study in order to secure permission for the use of their premises and personnel (Appendix B).

Individual rights were maintained by informing prospective subjects of the nature and expectations of participation. The subjects received written information on the consent form that the two questionnaires they were completing would measure their religious attitude and their opinion concerning the provision of spiritual care to patients. The participants were also informed that the confidentiality of their replies would be protected by using a coding system rather than names. The fact

that they could withdraw at any time from the study without penalty related to their job was also included. The subjects signed a consent form which was placed in an envelope (Appendix C). They were then given the demographic questionnaire, the Religious Attitude Inventory, and the Patient Spiritual Need Index to complete. The explanation of the study was included in the consent form. The instructions were given on each questionnaire.

Instruments

Three instruments were used for data collection. The first was the Demographic Data Questionnaire (Appendix D) developed by the investigator. It elicited information related to age, sex, marital status, nursing education, and religious affiliation. This information was collected for the purpose of describing the sample.

The second instrument was the Patient Spiritual Need Index (Appendix E) developed by Fish and Shelly (1978). The Index contains eight statements citing religious activities the authors felt important for the nurse to perform. The items were modified to correspond with the substitution of a Likert scale for the original scale. Permission to use and adapt the Index was obtained from the authors (Appendix F).

The third instrument was the Religious Attitude Inventory (Appendix G). The Inventory was developed by Broen in 1956. It contains 58 items that test important factors within the concept of "religiosity." Two factors, "nearness to God" and "fundamentalism-humanitarianism," and identifiable and the inventory purportedly measures these two dimensions, as well as general religiosity and differential religious emphasis. Reliability for the Religious Attitude Inventory was established when 10 to 14 days after initial testing a second Q-sort was performed by a randomly sampled quarter of the original group of sorters. The test-retest correlation coefficient was .81. Broen presented this procedure for the elimination of items as evidence of validity for his study. Permission to use this instrument as published was obtained from the author (Appendix H).

Data Collection

Pilot Study

The problem of the study was to determine if there is a relationship between the nurse's religiosity and the nurse's attitude toward providing spiritual care to patients. A descriptive correlational study was executed to investigate the problem.

Polit and Hungler (1978) suggested that it is advisable to carry out a pilot study or trial run of the major study. The function of the pilot study for this research investigation was to obtain information to improve the project. The three instruments that were used were assessed to determine if the respondents understood the questions and directions. The amount of time needed to complete the questionnaires was also evaluated. A pilot study with five subjects from the chosen population was done. The subjects possessed the same characteristics as those in the projected sample.

The questionnaires and their directions were understood by the respondents. The instruments took approximately 30-40 minutes to complete. There was no evidence to indicate a need for any changes.

Main Study

After permission was obtained from Texas Woman's University Human Subjects Review Committee and from the hospital where the research was conducted, the appropriate administrative personnel were contacted. The study was explained to them by the investigator and arrangements for meetings with the nurses was planned.

The administrators were oriented to the study and the data-gathering instruments.

Nurses on various medical-surgical units of the participating hospital were given an explanation of the study and asked to participate. Confidentiality was assured and consent forms were signed by the subjects. These forms were placed in an envelope. Packets containing the three instruments and a self-addressed envelope were distributed to the participants. The instruments were individually completed by the subjects and returned in one week to the researcher in the envelope provided.

Treatment of Data

Summary enumeration and percentage was used to report the demographic data collected to provide sample description. The determination of whether or not a relationship existed between the variables selected for study was accomplished using analysis of variance (ANOVA). The analysis of variance (ANOVA) is a statistical test of significance of the results of a study of the effect on the dependent variable, providing spiritual care to patients, of the independent variable, the nurse's religiosity. The variables were tested simultaneously.

CHAPTER 4

ANALYSIS OF DATA

A descriptive correlational survey was performed to study the problem of determining if there is a relationship between the nurse's religiosity and the nurse's attitude toward providing spiritual care to patients. Leedy (1974) stated that correlations are statistical descriptions that describe the strength and bond of the relationship between one variable and the other. The hypothesis that was tested was: Nurses who score high on the Religious Attitude Inventory, which tested the nurse's religiosity, would score high on the Patient Spiritual Need Index, which tested the nurse's attitude toward the provision of spiritual care to patients.

The analysis and interpretation of data collected was a description of the demographic data in numerical and percentage format. The results of findings of the other two instruments used were analyzed and interpreted using analysis of variance.

Description of Sample

The demographic data collected were age, sex, race, marital status, nursing education, and religious affiliation. The sample included 29 females, 97%, and 1 male, 3%, for a total of 30 subjects (see Table 1).

Table 1

Description of Sample by Sex

Subject	Number	Percent
Male	1	3
Female	29	97
Total	30	100

Distribution of subjects by age fell into the following groups. Two were 18-24 years, representing 6%, 26 were 25-45 years, which is 88%, and in the over-45-year group 2, representing 6% (see Table 2)

Table 2

Distribution of Subjects by Age

Age	Number	Percent
18-24	2	6
25-45	26	88
Over 45	2	6
Total	30	100

Considering the subjects by race, 20, or 67%, were Caucasian. There were 8 Blacks, or 26%, and 2 Mexican-Americans, which represented 7% (see Table 3).

Table 3

Distribution of Subjects by Race

Race	Number	Percent
Caucasian	20	67
Black	8	26
Mexican-American	2	7
Total	30	100

The findings regarding marital status were 10 married, or 33%. Thirteen were single, or 44%, 6 were divorced, or 20%, and 1 separated, or 3% (see Table 4).

Aligned according to nursing education , one was a diploma graduate, which represented 3%, and Associate Degree Nursing education was represented by two subjects, which was 7%. Twenty-one subjects were baccalaureate graduates, or 70% of the subjects. There were five Master's prepared nurses representing 17%, and one in the "other" category equalling 3% (see Table 5).

Table 4

Distribution of Subjects by Marital Status

Marital Status	Number	Percent
Married	10	33
Single	13	44
Divorced	6	20
Separated	1	3
Total	30	100

Table 5

Distribution of Subjects by Nursing Education

Nursing Education	Number	Percent
Diploma	1	3
Associate Degree	2	7
Baccalaureate	21	70
Master's	5	17
Other	1	3
Total	30	100

The final demographic category was religious affiliation. The sample had 22 Protestants, or 73.3%, and 4 Catholics, or 13.3%. There were no Jews and four

subjects in the "other" category, representing 13.4% (see Table 6).

Table 6

Distribution of Subjects by Religious Affiliation

Religious Affiliation	Number	Percent
Protestant	22	73.3
Catholic	4	13.3
Jewish	0	0.0
Other	4	13.4
Total	30	100.0

Findings of the Study

The test used to determine the relationship of the Religious Attitude Inventory score to the Patient-Spiritual Need Index score was the analysis of variance (ANOVA). The ANOVA pielded $p = 0.036$, which indicates that a relationship exists between the Religious Attitude Inventory score and the Patient Spiritual Need Index score. The hypothesis is accepted as stated. The correlation coefficient, $r = .38$, measures the extent of association between the two scores. The relationship expressed by $r = .38$, indicates the position the data occupies related to the value +1 or -1 in this study.

Next, the regression equation associated with these data indicate that the slope was .18 and positive. The positive slope indicates that the Religious Attitude Inventory score correlates positively with the Patient Spiritual Need Index score. A graphic representation of the regression line is shown in Figure 1.

An analysis and interpretation of the pilot study data disclosed that four subjects were in the 25-45-year age range and 1 was over 45 years of age. All five subjects were Caucasian. Three of the subjects were married and two were single. The nursing education category indicated that three had baccalaureate degrees, one had a bachelor's degree in a field other than nursing, and one had a Master's in Nursing degree. The religious affiliations of the respondents were four Protestants and one Catholic.

The mean score of the Religious Attitude Inventory was 48.00. The standard deviation was 8.33. The Patient Spiritual Need Index had a mean score of 31.20 based on a score range of 8-40, and a standard deviation of 6.10 (see Table 7). The pilot study evidenced $\underline{r} = .15$ ($\underline{p} = .813$), which indicated there was no relationship between the Religious Attitude Inventory and the Patient

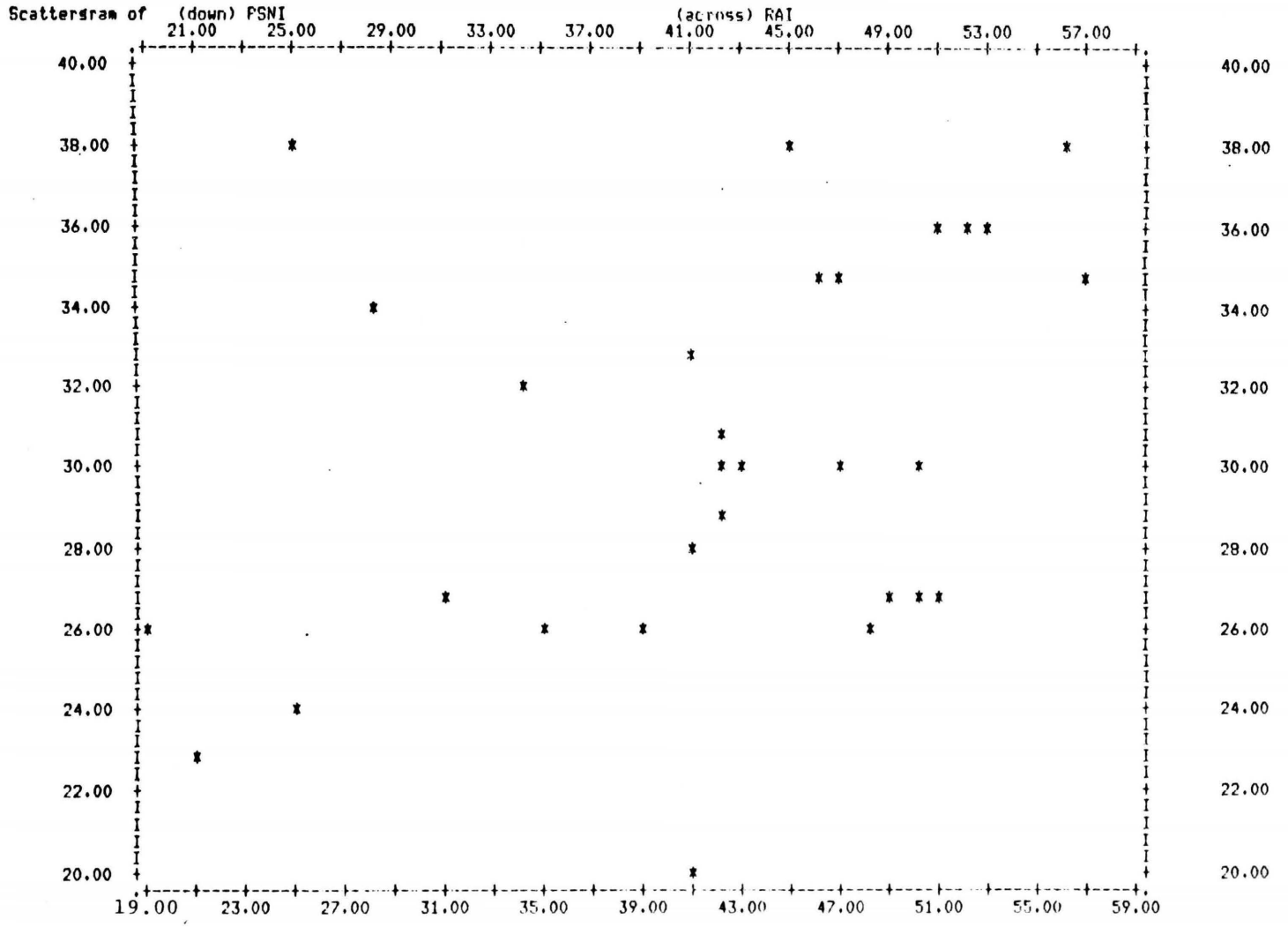

Figure 1. Correlation of the Scores on the Religious Attitude Inventory and the Patient Spiritual Need Index.

Table 7

Demographic Data, Patient Spiritual Need Index, and Religious Attitude Inventory Scores of Pilot Study

ID	Age	Sex	Race	Marital Status	Nursing Education	Religious Affiliation	RAI	PSNI
A'	3	2	1	1	3	1	49	38
B'	2	2	1	2	4	1	57	24
C'	2	2	1	2	6	1	54	36
D'	2	2	1	1	3	1	44	32
E'	2	2	1	1	3	2	35	26
						Mean	48.00	31.20
						Standard Deviation	8.33	6.10

Spiritual Need Index scores. It should be remembered that the sample size for the pilot study was small ($N = 5$).

The test score means for the pilot study and main study are displayed in Table 8. The values obtained, while not nearly identical, do appear to represent a degree of similarity and suggest additional confidence in the validity and reliability of the instruments used.

Table 8

Comparison of Pilot and Study Means

	Pilot	Study
Patient Spiritual Need Index	31.20	30.43
Religious Attitude Inventory	48.00	41.70
N =	5	30

Summary of Findings

In this chapter the summation of the demogprahic data has been presented. The results of hypothesis testing using analysis of variance permitted acceptance of the study hypothesis as stated. The chapter concluded with the observation that the mean scores of the pilot study were sufficiently comparable to the mean scores of the main study to suggest additional confidence in the validity and reliability of the instruments used.

CHAPTER 5

SUMMARY OF THE STUDY

This investigation was conducted to determine if there is a relationship between the nurse's religiosity and the nurse's attitude toward providing spiritual care to patients. The hypothesis, which was tested and supported as stated, was: Nurses who score high on the Religious Attitude Inventory will score high on the Patient Spiritual Need Index.

A summary of the investigation with accompanying conclusions are described in this chapter. The implications for nursing that result from the study are presented in this section. Recommendations for further research related to nurses meeting the spiritual needs of patients are also included.

Summary

A descriptive, correlational survey was conducted to determine if there is a relationship between the nurse's religiosity and the nurse's attitude toward providing spiritual care to patients. The hypothesis, affirmatively stated, was formulated to test whether

the nurses who scored high on the Religious Attitude Inventory would score high on the Patient Spiritual Need Index. A positive correlation was demonstrated when the correlation coefficient evidenced that $r = .38$.

The sample size for this investigation was 30 registered nurses who were currently engaged in nursing or nursing-related activities. They subscribed to the Christian ethic and were selected using the convenience sampling technique. The sample was composed of one male and 29 females.

Discussion of Findings

The first premise of Mead's (1934) symbolic interaction theory that was simplified by Blumer (1969) was the theoretical framework for this study. It stated that human beings act toward things on the basis of the meaning that things have for them (Blumer, 1969). The hypothesis of this study was supported. It was postulated that nurses who evidenced high religiosity by receiving a high score on the Religious Attitude Inventory (Broen, 1956) would receive high scores on the Patient Spiritual Needs Index, which indicates recognition of the spiritual needs of patients. These positively correlated outcomes supported the prediction of symbolic interaction theory in a suppositive format. Two concepts related to

this theoretical framework were identified: (a) nursing and religious values and (b) patient's spiritual needs. The literature reviewed was based on these concepts.

Conclusions and Implications

In light of the results of this study, several conclusions can be drawn. Primary among these is the finding that personal religiosity has a bearing on nurses' attitudes towards the giving of spiritual care to patients. While a positive or negative attitude towards an activity does not necessarily mean that the activity will or will not be done in congruence with the attitude, it does suggest that performance of the activity can be modified along the dimensions of the attitude.

The literature reviewed supports the human need for religious associations. The findings of O'Connell and Duffey (1978) that no studies had been conducted in nursing from 1970 to 1975 related to spiritual needs of patients and the paucity of studies since then demonstrates the profession's reticence to deal with a human need at least in print. The majority of raw scores on the Religious Attitude Inventory and the Patient Spiritual Need Index fell in the upper third range. From this it is assumed that nurses do possess personal religiosity and positive

attitudes towards patients' spiritual needs. Yet, there are unknown factors operating that deter nurses from expanding knowledge in this area of nursing intervention.

The scores obtained on the Patient Spiritual Needs Index indicated nurses were favorably disposed toward meeting patients' spiritual needs in a suppositive situation. Their behavior in actual practice could be decidedly different.

As a result of the outcome of this study, it is suggested that nurses should assess the spiritual needs of patients to determine by their verbal or nonverbal cues whether nursing interventions are required. In order for nurses to be comfortable in this realm of practice, specific curricular and course content should be geared to this topic.

The study of transcultural nursing with emphasis on the religious and cultural mores of various ethnic groups would also be helpful. The stress on ecumenical religious practice would also be benefitted.

Recommendations for Further Study

Two recommendations logically were derived from this study.

1. The study be repeated with a larger sample to verify the results obtained. Further, analyses along

demographic dimensions be carried out to determine whether or not the findings are uniformly distributed throughout the nursing population.

2. A correlational study be done to determine the extent to which the suppositive findings of this study convert to nursing behaviors. Should the findings be such that nurses of high religiosity and positive attitudes towards meeting patient needs score low on actual performances, an explanatory study would be mandated to identify the deterrent forces.

APPENDIX A

TEXAS WOMAN'S UNIVERSITY
Box 23717, TWU Station
Denton, Texas 76204

1810 Inwood Road
Dallas Inwood Campus

HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: Myrtle V. Davis Center: Dallas

Address: 1810 Inwood Road Date: 7/2/80

Dallas, Texas 75235

Dear Mrs. Davis:

Your study entitled Relation of Nurse's Religious Attitude to Giving Spiritual Care

has been reviewed by a committee of the Human Subjects 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 typically require that signatures indicating informed consent be obtained from all human subjects in your studies. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to DHEW regulations, another review by the Committee is required if your project changes.

Any special provisions pertaining to your study are noted below:

____ Add to informed consent form: No medical service or compensation is provided to subjects by the University as a result of injury from participation in research.

____ Add to informed consent form: I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

____ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

____ Other:

__X__ No special provisions apply.

Sincerely,

E. Kurtz

Chairman, Human Subjects
Review Committee

at Dallas

PK/smu/3/7/80

APPENDIX B

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Parkland Hospital

GRANTS TO Myrtle Davis, R.N.
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.

The problem of this study is to determine the relation of the nurse's religious attitude to giving spiritual care to patients. The sample will consist of a minimum of thirty nurses whose ages range from 21 to 60 years. They are engaged in nursing or nursing related activities in a secondary health care facility.

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: July 22, 1980

Myrtle V Davis
Signature of Student

Signature of Agency Personnel

Lois Haugh
Signature of Faculty Advisor

*Fill out & sign three copies to be distributed as follows: Original - Student; First copy - Agency; Second copy - TWU College of Nursing.

APPENDIX C

Consent Form
TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

(Form A -- Written presentation to subject)

Consent to Act as a Subject for Research and Investigation:

The following information is to be read to or read by the subject. One copy of this form, signed and witnessed, must be given to each subject. A second copy must be retained by the investigator for filing with the Chairman of the Human Subjects Review Committee. A third copy may be made for the investigator's files.

1. I hereby authorize Myrtle Davis
(Name of person(s) who will perform procedure(s) or investigation(s)

to perform the following procedure(s) or investigation(s): (Describe in detail)

This is a study to determine the relation of the nurse's religious attitude to giving spiritual care to patients. You will be asked to complete one demographic instrument and a Patient Spiritual Index and the Religious Attitude Inventory. The instruments will provide information about your opinion concerning patients' spiritual needs and nurses' religious attitudes. There are no right or wrong answers. You are asked to respond according to your actual belief.

Please follow the directions written on each instrument. There is no time limit to complete the instruments. Your name will not be on any of these instruments to maintain anonymity.

2. The procedure or investigation listed in Paragraph 1 has been explained to me by _____.
(Name)

3. (a) I understand that the procedures or investigations described in Paragraph 1 involve the following possible risks or discomforts: (Describe in detail)

1. It will take a period of time to read and complete each instrument.
2. Although measures have been taken to properly execute the processing of data, an improper release of data may occur.

(Form A - Continuation)

3. (b) I understand that the procedures and investigations described in Paragraph 1 have the following potential benefits to myself and/or others:

to make a contribution to research by evaluating personal religious attitudes and identifying some nurses' attitudes toward providing spiritual care to patients.

(c) I understand that - No medical service or compensation is provided to subjects by the university as a result of injury from participation in research.

4. 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.

_____ _____

Subject's Signature Date

(If the subject is a minor, or otherwise unable to sign, complete the following:)

Subject is a minor (age___), or is unable to sign because:

Signatures (one required)

_____ _____

Father Date

_____ _____

Mother Date

_____ _____

Guardian Date

_____ _____

Witness (one required) Date

APPENDIX D

DEMOGRAPHIC DATA

Directions: Please check the appropriate blanks.

Age: 18-24_____ 25-45 _____ Over 45_____

Sex: M_____ F_____

Race: Caucasian_____ Black_____ Other_____

Mexican-American_____

Marital Status: Married_____

Single_____

Divorced_____

Separated_____

Nursing Education:

Diploma_____ Master's _____

B.S.N._____ Ph.D._____

A.D.N._____

Other (please specify)_____

Religious Affiliation:

Protestant_____

Catholic_____

Jewish_____

Other_____

APPENDIX E

PATIENT SPIRITUAL NEED INDEX

Directions: Please circle the number below each statement that best describes your opinion of how important it is for a nurse to perform the action described.

1. Listen to a patient talk about God and his religious beliefs.

   (Minimum) 1 2 3 4 5 (Maximum)

2. Refer patient to clergyman.

   (Minimum) 1 2 3 4 5 (Maximum)

3. Encourage the patient to talk about anything that is bothering him.

   (Minimum) 1 2 3 4 5 (Maximum)

4. Read scripture to patient.

   (Minimum) 1 2 3 4 5 (Maximum)

5. Talk with a patient about God and religious beliefs.

   (Minimum) 1 2 3 4 5 (Maximum)

6. Pray with patient.

   (Minimum) 1 2 3 4 5 (Maximum)

7. Show kindness, concern, and cheerfulness when giving care.

   (Minimum) 1 2 3 4 5 (Maximum)

8. Obtain scripture or other religious material for the patient.

   (Minimum) 1 2 3 4 5 (Maximum)

Please list any other exmaples of spiritual care activities you feel it is appropriate for the nurse to perform.

9. Other_____

_____

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APPENDIX F

InterVarsity Press
box F
Downers Grove, Illinois 60515

312 964-5700

division of
Inter-Varsity Christian Fellowship
of the United States of America

ivp

August 4, 1980

Ms. Myrtle Davis
5889 Oak St. Ext.
Lowellville, OH 44436

Dear Ms. Davis:

Thank you for your letter of July 28 requesting permission to reprint page 153 from Spiritual Care: The Nurse's Role to include in your research project.

We are happy to give you this permission. Please use the following credit line:

> Taken from Spiritual Care: The Nurse's Role by Sharon Fish and Judith Allen Shelly. ©1978 by Inter-Varsity Christian Fellowship of the USA and used by permission of InterVarsity Press.

Thank you for honoring our copyright.

Sincerely,

Ruth Bowman

Ruth Bowman
Editorial Assistant

db

APPENDIX G

RELIGIOUS ATTITUDE INVENTORY

Directions: Circle the A if you agree with a statement; circle the D if you disagree with the statement. Make a choice for each statement. (We have found that people are able to answer all the items.) Do not spend too much time on any one statement.

A D 1. God is constantly with us.
A D 2. Christ died for sinners.
A D 3. The Ten Commandments were good for people of olden times but are really not applicable to modern life.
A D 4. There is really no such a place as Hell.
A D 5. Miracles are performed by the power of God even today.
A D 6. It is through the righteousness of Jesus Christ and not because of our work works that we are made righteous before God.
A D 7. Dancing is a sin.
A D 8. Christ's simple message of concern for your fellow man has been twisted by the superstitious mysticism of such men as Paul.
A D 9. God can be approached directly by all believers.
A D 10. The death of Christ on the cross was necessary to blot out man's sin and make him acceptable in the eyes of God.
A D 11. It was too bad that Christ died so young or He could have been a greater power for good.
A D 12. "God" is an abstract concept roughly equivalent to the concept "nature."
A D 13. God exists in all of us.
A D 14. Man is born in sin.
A D 15. The wearing of fashionable dress and worldly adornment should be discontiued because it tends to gratify and encourage pride.
A D 16. Man's essential nature is good.
A D 17. I am sometimes very conscious of the presence of God.
A D 18. Man is by nature sinful and unclean.
A D 19. All public places of amusement should be closed on Sunday.
A D 20. The stores of miracles in the Bible are like the parables in that they have some deeper meaning or moral but are not to be taken literally.

A D 21. God is very real to me.
A D 22. The Bible is the word of God and must be believed in its entirety.
A D 23. I believe in God but I am not sure what I believe about him.
A D 24. Man has a spark of the divine in him which must be made to blossom more fully.
A D 25. When in doubt it's best to stop and ask God what to do.
A D 26. Sin brings forth the wrath of God.
A D 27. A person should follow his own conscience in deciding right and wrong.
A D 28. The most important idea in religion is the golden rule.
A D 29. God should be asked about all important matters.
A D 30. The wrath of God is a terrible thing.
A D 31. It is more important to love your neighbor than to keep the Ten Commandments.
A D 32. The scriptures should be interpreted with the constant exercise of reason.
A D 33. Because of His presence we can know that God exists.
A D 34. Everyone will be called before God at the judgment day to answer for his sins.
A D 35. Man's idea of God is quite vague.
A D 36. Reason is not depraved and untrustworthy for then the natural foundations of religion which rest upon it, would fall.
A D 37. Miracles are sometimes performed by persons in close communion with God.
A D 38. Everyone has sinned and deserves punishment for his sins.
A D 39. The church is important because it is an effective agency for organizing the social life of a community.
A D 40. My faith in God is complete for "though He slay me yet will I trust Him."
A D 41. No one should question the authority of the Bible.
A D 42. The content of various doctrines is unimportant. What really matters is that they help those who believe in them to lead better lives.
A D 43. When the scriptures are interpreted with reason they will be found to be consistent with themselves and with nature.
A D 44. Because of his terrible sinfulness, man has been eternally damned unless he accepts Christ as his savior.

A D 45. Religion is a search for understanding, truth, love and beauty in human life.
A D 46. True love of God is shown in obedience to His moral laws.
A D 47. Every person born into this world deserves God's wrath and damnation.
A D 48. If we live as pure lives as we can, God will forgive our sins.
A D 49. The world is full of condemned sinners.
A D 50. Persons who are in close contact with the Holy Spirit can and do at times speak in unknown tongues.
A D 51. The Devil can enter a man's body and take control.
A D 52. The people of the world must repent before it is too late and they find themselves in Hell.
A D 53. No one who has experienced God like I have could doubt His existence.
A D 54. The Christian must lead a strict life, away from worldly amusements.
A D 55. In his natural state of sin, man is too evil to communicate with God.
A D 56. Christ was not divine but his teachings and the example set by his life are invaluable.
A D 57. The question of Christ's divinity is unimportant; it is his teachings that matter.
A D 58. God is the final judge of our behavior but I do not believe that He is as punishing as some seem to say He is.

APPENDIX H

5889 Oak St. Ext.
Lowellville, Ohio 44436
August 11, 1980

Dr. W.E. Broen,Jr.
25134 Malibu Road
Malibu, California 90265

Dear Dr. Broen:

I would like to conduct a study to determine the relation of the Nurse's Religious ~~Attitudes to giving spiritual~~ care to patients.

One of the instruments I would like to use to obtain data for this study is the Religious Attitude Inventory in"A Factor Analytic Study of Religious Attitudes," doctoral dissertation, University of Minnesota, 1956 for which you hold the copyright.

To confirm the permission you granted me to use the instrument in our phone conversation August 11, 1980 please sign the consent form.

I grant Myrtle Davis permission to use the Religious Attitude Inventory for her research investigation.

Dr. W.E. Broen Jr.

Dr. W.E. Broen,Jr.

Thank you for your time and cooperation.

Sincerely yours,

Myrtle Davis, R.N.

Myrtle Davis,R.N.

P.S. Self addressed envelop and form enclosed for return.

Best Wishes.
W.E. Broen Jr.

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