The University of San Francisco
USF Scholarship: a digital repository @ Gleeson Library | Geschke Center

Doctor of Nursing Practice (DNP) Projects | Theses, Dissertations, Capstones and Projects

Fall 12-7-2017

Spirituality in Clinical Practice: Recognizing the Importance of Personal Values and Beliefs in Medical Decision-Making

katie lutz
katie.erin.lutz@gmail.com

Follow this and additional works at: https://repository.usfca.edu/dnp

 Part of the Nursing Commons

Recommended Citation
lutz, katie, "Spirituality in Clinical Practice: Recognizing the Importance of Personal Values and Beliefs in Medical Decision-Making" (2017). *Doctor of Nursing Practice (DNP) Projects*. 120.
https://repository.usfca.edu/dnp/120

This Project is brought to you for free and open access by the Theses, Dissertations, Capstones and Projects at USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. It has been accepted for inclusion in Doctor of Nursing Practice (DNP) Projects by an authorized administrator of USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. For more information, please contact repository@usfca.edu.

Spirituality in Clinical Practice: Recognizing the Importance of Personal Values and Beliefs in Medical Decision-Making

Katie Lutz MSN, RN, CNL

University of San Francisco

DNP Chair:

Prabjot Jodie Sandhu DNP, MSN, FNP-C, PA-C, CNL

Director of Clinical Training- Nurse Practitioner Programs

Assistant Professor

DNP Committee Member:

Jo Loomis DNP, FNP-C

Assistant Professor

Table of Contents

Abstract

This Doctor of Nursing Practice (DNP) project addresses the importance of values and beliefs in patient's healthcare decisions. Relying on a holistic theoretical model that accounts for all aspects of the human experience, the focus shifts from standard healthcare delivery to exploration of spiritual values and beliefs. In the past two decades, researchers and healthcare professionals have juxtaposed healthcare and spirituality to broaden the domain of care and enrich the provider and patient experience. Evidence has shown the alliance of spirituality and clinical practice has the potential to improve wellbeing and healthcare outcomes.

Interventions: In a public health setting, a cohort of healthcare professionals participated in three seminars designed to explore the role of spirituality and clinical practice.

Methods: Participants were introduced to spiritual precepts, self-reflection exercises, a spiritual assessment tool, a digital platform for aiding death and dying conversations and a complimentary alternative method (CAM). The validated Multidimensional Measurement of Religious/ Spirituality assessment and the validated Faith, Importance, Community and Address (FICA) spiritual assessment tool were trialed.

Results: Based on the post-test data collection for the seminars, educational content had a positive effect on healthcare professional perceptions of spirituality and clinical practice. Post-test data were scored using a Likert 5-point scale. The observation of a minimum one-point positive change was a primary goal of the educational content. Of the 15 pre- and post-test knowledge and confidence questions, the minimum one-point change occurred 9 times. A two-point change occurred five times and a three-point change occurred for four post-test questions. In addition to the positive data outcomes, at the conclusion of the intervention, key stakeholders were developing plans to create a permanent, employee spirituality awareness group. This result

was in accordance with the project's intention to create a cultural shift, which embraced spirituality in clinical practice.

Conclusion: As clinical practice rises to meet the demands of complexity, cost, and value, spirituality is a potentially useful basis for assessing and developing attitudes and behaviors that support patient quality of life, healthcare utilization, and healthcare professional's wellbeing.

Keywords: *Healthcare professional, physician-patient relationship, advance care planning, spirituality, spiritual care, spiritual need, healthcare outcomes, attitudes and behaviors, barrier.*

> *Not surprisingly, the Church's permission to study the human body included a tacit interdiction against corresponding scientific investigation of man's mind and behavior. For in the eyes of the Church these had more to do with religion and the soul and hence properly remained its domain. –George L. Engel*

Introduction

Background Knowledge

During the Enlightenment, the Catholic Church permitted early anatomists and physiologists to dissect the human body to advance understanding of the inner workings. The intention was to understand the disease state. However, anatomists were cautioned to refrain from examining the brain or the mind as the attitudes, beliefs, behaviors, and practices of men were to remain the sole propriety of religion (Engel, 1977). These curious scientific men, who were to elevate medicine from how it had been practiced since its Greek beginnings obliged the request. The process of separating religion from medicine was gradual and yet it was successful in rooting out any semblance of its historical foundation with religion. It is at this point in history, that it was believed the relationship between health and spirit diverged, in the Western World (Engel, 1977).

In modern history, the relationship between religion and medicine was once again revisited at a convention sponsored by the American Medical Association's (AMA) first Council on Medicine and Religion in 1964 (Astrow, 2013). At the convention, theologian Abraham Heschel presented a talk, calling for a return to medicine's early religious and spiritual roots. Specifically, he urged attendees to consider the physician's own sense of transcendental significance (Astrow, 2013). To treat a person, one must first be a person, Heschel told the assembly (Astrow, 2013; Sulmasy 1999). Since the 1990s, physicians Alan B. Astrow and Daniel P. Sulmasy have echoed Heschel's earlier message of re-integration of spirituality and

medicine within the academic, research, and clinical practice communities. Astrow and Sulmasy have published several articles delineating the relationship between spirituality and medicine and encouraging readers to consider medicine as a spiritual vocation (Astrow, 2013; Sulmasy, 2009; Sulmasy 1999).

To discuss how the schism between spirituality and medicine took place is beyond the scope of this paper; however; it is possible to sum up two reasons why the division occurred. The first cause relates back to medicine's early roots in the Enlightenment or the age of reason. Early medicine grew out of the need to address the behavioral, psychological and social manifestations of disease, Engel (1977) tells us, and medicine evolved once treatment involved less prayer and more scientific analysis. It was the decision to apply principles that were developing at the time, Descartes' philosophical rationalism and Newtonian laws of motion and physics that the biomedical model of care arose. It was the deliberate act to distinguish medicine as a rational, scientific field unlike the superstitious, irrational field of religion and spirituality (Engel, 1977).

In the last half century, a second reason evolved for the rift between religion and medicine, and that is economics as a strong and consistent motivator to rationalize, depersonalize, and medicalize illness (Astrow, 2013). Healthcare makes up 18% of the national GNP or three trillion dollars annually (Astrow, 2013). It is well known, that more is spent per capita in the United States on healthcare compared to any country in the world. In the United States, Astrow points out, healthcare is a business. Like Heschel, Astrow (2013) and Sulmasy (2009, 1999) implore physicians and nurses to leave the economic perspective to the administrators and policy makers. Instead, physicians and nurses are challenged to see their work not as a profession but as a spiritual vocation.

Today, the literature suggests that healthcare professionals, patients, and healthcare systems are impacted by the schism. The effects are psychological and economic. Sulmasy (1999) raises the issue that acknowledgement of healthcare professional suffering is long overdue. With so much being said of spirituality and healthcare, why have so few asked about the spiritual quality of the individuals whose job it is to make healthcare whole again, Sulmasy asks (1999). A British study found 28% of oncologists have a psychiatric disorder (Astrow, 2013). The British study highlighted increased suicide rates, divorce, and professional attrition (Astrow, 2013). These incidences are attributable to depersonalization, emotional depletion, and compassion fatigue (Astrow, 2013). Similarly, in one study 15% of acute care nurses were found to suffer compassion fatigue (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010).

Patients suffer spiritual distress and uncertainty around their medical illnesses (Anandarajah & Hight, 2001; Stephenson & Berry, 2014). Spiritual distress is the loss of meaning, belief, values, hope, and connection to others and the transcendent, leading to a numinous crisis with the power to negatively affect physical and mental health (Anandarajah & Hight, 2001). Uncertainty is the subjective, psychological experience of living without a working schema to provide context and meaning to one's life (Stephenson & Berry, 2014). Uncertainty occurs when an individual's beliefs fail to explain life events. There are various documented reactions to spiritual distress and uncertainty: anger and loneliness (Scott, Law, Brodeur, Salerno, Thomas, & McMillan, 2014); depression (Pearce, Coan, Herndon, Koenig, & Abernathy, 2012); and decline in physical function (Fitchett, 1999; Pargament, Koenig, Tarakeshwar & Hahn, 2004).

On an economic scale, projections of increased health utilization at end of life calculate to 1.4 billion (Balboni, et. al, 2011). The prospective, multi-site study demonstrated that failure

to attend to spiritual care needs led to the receipt of more aggressive and prolonged medical care hence increased healthcare dollars (Balboni et al., 2011). Others attempt to explain that hospitalization provokes existential concern in patients and families when grief, loss, and uncertainty about the future are most felt (Hodge and Wolosin, 2014). According to Stephenson & Berry (2014), it is the perceived loss of time laden with uncertainty that determines whether the patient and surrogates will follow the path of medical futility.

The per capita costs of delivering healthcare in the U.S. is not unmatched by the extraordinary costs of end of life care. According to the 2014 Dartmouth Atlas national average, in that year, Medicare spent a total of $69,289 in the last two years of life per beneficiary with $30,127 alone in hospital costs (Dartmouth Atlas of Healthcare, 2014). In one well-known study, spiritual care was associated with better patient quality of life and demonstrated the potential for cost savings at end of life (Balboni et al., 2010). When spiritual care was taught to a group of palliative care professionals, significant and sustained results were found regarding participants self-perceived compassion to their dying patients (Wasner, Longaker, Fegg, & Borasio, 2005).

Healthcare professional wellbeing, patient quality of life, and health care utilization have been significantly affected by the spirituality and healthcare divergence. Sulmasy (1999) felt the suffering of healthcare professionals was the first step in re-personalizing healthcare. Astrow (2013) and others encourage reflective practice or defining the source of one's commitments through exploration of transcendental ideals including personal beliefs and values (Best, Butow, & Olver, 2015; Knapp, Gottlieb, & Handelsman, 2017; Sulmasy, 2002). Astrow and Sulmasy engaged healthcare professionals on reflective practice in an inter-professional series at St. Vincent's Hospital in Manhattan in 2000 (Astrow, 2013). It was not an intended research study. The effort was born out of the need to create an informal forum for physicians, nurses, social

workers, chaplains, and psychologists to discuss core values and share in their sources of spiritual inspiration (Astrow, 2013).

Well-designed studies have tested the effects of healthcare professional self-reflection and introduction of spiritual care towards measured states of wellbeing and quality of life, for both healthcare professionals and patients. Spiritual care is the facilitation of the self-identified beliefs, meaning, values, sources of strength, and life goals through a spiritual history which solicits practices, community support, and thoughts on medical-decision making (Puchalski, 2001; Anandarajah & Hight, 2001). Studies demonstrate attendance to spiritual care leads to decreased depression (Pearce et al., 2012); overall patient satisfaction (Astrow, Wexler, Texeira, He & Sulmasy, 2007; Pearce et al., 2012), improved quality of life (Balboni et al., 2010; Kang et al., 2012); increased healthcare professional wellbeing (Wasner et al., 2005) and lower health care utilization and costs (Balboni et al., 2011).

A second body of work by researchers and essayists (Churchill, 2014; Isaac, Hay, & Lubetkin, 2016; Maugans, 1996; Puchalski, Lunsford, Harris, & Niller, 2006; Sulmasy, 2002, 2009) suggest advance care planning in the context of spirituality is beneficial. Puchalski (2000) affirms that spiritual care lends naturally to health care and advance care planning conversations between healthcare professional, family, and patient. This is made possible by obtaining a spiritual assessment, an evaluation where deeper meaning can be found (Puchalski, 2000). Churchill (2014) aptly states that when advance care directives are appreciated for their spiritual and ritualistic significance as “expressions of a deeper understanding of one’s role and place in a sacred order” (p.760) more than likely advance care directives will reserve an important place in healthcare.

Problem Description

Setting. The site for the spirituality and clinical practice intervention was chosen for the groundwork accomplished by a former doctoral student in the spring of 2017. Previously identified as a high need setting, the project implemented an advance care planning intervention focused on northern California Marin County's homeless. A previous DNP student engaged healthcare professionals in educational sessions aimed at increasing awareness, confidence, and intention to change practice in the ascertainment of health literate advance care planning documents. Overall, the student's intervention resulted in a positive response (Hubbell, 2017). During the needs assessment phase, the DNP student engaged clients in advance care planning discussions to gain insight into the development of an intervention. Of interest, the student discovered clients were more interested in discussing "concerns, hopes, values for care rather than intervention preferences" (Hubbell, 2017), a point that resounds in the literature (Sudore, Stewart, Knight, McMahan, Feuz, & Miao, 2013). For these reasons, the site was considered ideal for testing the applicability of spiritual care.

The setting was a county agency in the community health and prevention division of social services within the Department of Health & Human Services. The county agency's primary mission was to enhance quality of life, safety, and security of its residents (personal communication, October 19th, 2017). Two branches within the agency oversee the delivery of care and services. The Area Agency on Aging in conjunction with a commission on aging ensure the administration of the Older Americans Act first enacted in 1965 and revised in 2016. It guarantees the provision of services to the elderly to maintain independence and safety. Under the act, an ombudsman investigates public reports of misadministration against agencies and persons that deliver long-term care. Area Agency on Aging is an information and assistance program, which fields and directs calls to either branch for intake and evaluation. A second

branch oversees adult protective services and In Home Support Services (IHSS). In addition to state mandated services several public service programs are managed often in partnership with community leaders.

For scale, the county adult protective services fielded approximately 1,000 new reports of alleged abuse in 2016. Of those, 851 new cases were opened and investigated. Mandate requires a formal response within 10 days based on personal interviews and collateral data. There is no mandated timeframe for concluding a case. Cases may resolve within days or prolong for months. IHSS oversaw the delivery of state funded care to over 1800 recipients provided by over 2,000 providers, who were either a family members of home health aide. A network of social workers and nurses jointly facilitate the delivery of home health services to nearly 3000 clients. The public health professionals that provide health and psychosocial care include 18 county social workers, 4 public health registered nurses, and one public guardian. The patient population consists of adults sixty-five and older, who are marginally housed and others with disability in the form of legal blindness, physical disability, end stage renal disease, cognitive impairment, mental illness and substance abuse.

Labor statistics show a county demographic profile of 20.6% adults over the age of 65, 20.5% adults under the age of eighteen, and the remaining 58.9% of adults between the ages of 18 and 60 years old (Marin Health and Human Services, 2017). At a glance, the county was home to approximately 260,000 individuals in 2016. Resident ethnicity is predominantly white (85.7%) followed by Latino (16.0%), Asian (6.3%), and black (2.8%). Fifty-five percent of the population is educated at a bachelor's degree or higher. In 2015, median gross rent was $1678 and an average median home price was $815,100. Median household income was $93,257 and per capita income was $60, 236. The poverty rate was 7.5%. Between 2011-2015, 5.2% adults

under the age of 65-year-old were living with a disability and 6.2% were without healthcare insurance. In 2012, cost for countywide health and social assistance totaled $2,102,255 annually (Marin Health and Human Services, 2017).

With respect to community health, Marin county exceeds standards comparable to counties within the state and throughout the country for low incidence of asthma (5.8%; Ca 7.5% & U.S. 8.2%), chronic kidney disease (11.6%; Ca 17.9% & U.S. 18.1%), chronic obstructive pulmonary disease (5.4%; Ca 8.9% & U.S. 11.2%), diabetes (15.2%; Ca 25.3% & U.S, 26.5%), hyperlipidemia (38.9%; Ca 41.5% & U.S. 44.6&), hypertension (39.8%; Ca 49.6% & U.S. 55.0%), and depression (12.6%; Ca 14.3% & U.S. 16.7%). Incidence of dementia was comparable with state and national figures (9.3%; Ca 9.3% & U.S. 9.9%). The county did not meet statewide and national county standards for low incidence of atrial fibrillation (9.1%; Ca 7.3% & U.S. 8.1%) and all cause cancer (8.6%; Ca 7.5% & U.S. 7.8%). Psychosocial indicators were met for those living below the poverty level (5.2%; Ca 10.3% & U.S. 9.4&), but not for living alone (30.3%; Ca 23.3% & U.S. 26.6%) or adults with substance abuse issues (20.0%; Ca 16.8%, no U.S. county statistic available). This subset of data applied to adults older than 65 years of age (Marin Health and Human Services, 2017).

According to the Marin Health and Human Services database (2017), the county's current state of homelessness reveals 835 unsheltered individuals living on the streets or in vehicles, anchor outs, or abandoned buildings. In addition, 474 sheltered individuals were living in transitional housing or emergency shelters. The clear majority (60%) of homeless were over the age of twenty-five, 29% were aged 18 to 24 years of age, and 11% were under the age of eighteen. Fourteen percent of those surveyed identified as being lesbian, gay, bisexual, or trans-gendered. African –Americans were overrepresented in the sample, representing 20% of those

surveyed, but constituting only 4% of the county's population. Fourteen percent of homeless had been a ward of state or a foster child. Prior to becoming homeless, 71% had stable housing as a homeowner or renter. Seven percent had been in the penal system prior to their becoming homeless (Marin Health and Human Services, 2015).

These statistics and findings are presented to demonstrate not that the county is unable to rise to meet the needs of its county residents compared to other counties but perhaps there exists a segment of the population whose needs depend exceedingly on available financial resources and the resilience of the county's agency employees for whom this DNP project was geared. Since the 1960s, the national social structure has changed dramatically where dual-income households are the norm and care giving for parents and grandparents is weighed against the demands of modern living, in turn challenging the household structure and work-life balance (Bjasinsky, 1997). These are likely some of the contributing factors which strain the social fabric and make the necessity for public health and social services greater.

PICOT

The literature search was guided by the question: "In a public health setting, how does the introduction of healthcare professional spiritual care training affect attitudes and behaviors regarding clinical practice? To answer this question, the following electronic databases were searched: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, American Theological Library Association (ALTA Religion Database), Psychological Information Database (PsycINFO), (SocINDEX), and Fusion. The search terms used were ('healthcare professional' OR 'physician-patient relationship) AND ('homeless') AND ('elderly') AND (advance care planning') AND ('spirituality' OR 'spiritual care' OR 'spiritual need*') AND ('healthcare outcomes' OR 'attitudes and behaviors' OR 'barrier'). Inclusion

criteria were English language, adult age group (50-64, 65 and over), and publications dated after 1990.

The total number of articles found across all six databases was 54 articles, including research, editorial, and book extracts. Among the articles, some were speculative in nature, others were theoretical, consensus projects, and a number were researched based. Articles that were chosen for review addressed the concept and application of spiritual care training. The primary criterion for research was a dependent variable of spiritual care training for healthcare professionals. Studies were included for all healthcare professionals including physicians, registered nurses, social workers, psychologists, palliative care specialists, mid-level management. Each study included instruments of measurement.

Given the vast number of instruments for measuring self-perceived spirituality, wellbeing, quality of life, etc. it was not possible to limit studies to identical instruments. Secondary criteria included an outcome population of healthcare professional wellbeing or patient quality of life. After examination of the results, 10 studies were retained for evidence-based synthesis using the John Hopkins Nursing Evidence Based Practice Research Evidence Appraisal Tool and the John Hopkins Nursing Evidence Based Practice Non-Research Evidence Appraisal Tool (The John Hopkins University) to determine study strength.

Review of Evidence

National Standards. Delivering spiritual care is considered a professional and clinical requirement by several national and international agencies. Since 2001, the Joint Commission (JC) has required a spiritual assessment within hospitals, long-term care facilities, home care organizations, and behavioral health centers (Hodge, 2006). Minimum criteria for spiritual assessment are identification of faith tradition, spiritual beliefs and associated practices. While

the criteria are succinct, the Joint Commission proffered questions to arrive at detailed patient responses. Suggested questions are: "How does the patient express their spirituality? What does suffering mean to the patient? What helps the patient get through this health care experience?" (Hodge, 2006, p. 319). The rationale for requiring a spiritual assessment were: the potential the patient's spirituality may have on the provision of service, respect for the patient's self-determination, practitioner ability to provide culturally sensitive care, and influence of the patient's spirituality on their health.

Similarly, the International Council of Nurses' (ICN) ethical code (2006) requires a provision of care that addresses the values, customs, and spiritual beliefs of the patient. The code also refers to the responsibility of nurses to ensure clinical competence through continued learning and good personal health practices. By the council's definition, personal health includes physical, mental, social, and spiritual wellbeing. The American Nurses Association (ANA) mandates nurse self-care which includes the mitigation of compassion fatigue through diet, exercise, rest, family and personal relationships, and spiritual and religious needs (Lachman, Swanson, & Winland-Brown, 2015). Nurse practitioner core competencies include the incorporation of spiritual beliefs, values, and preferences into the health care plan; management of spiritual and ethical conflict that may arise between patients, families, and caregivers; and the provision of healthcare professional education for spiritually competent and sensitive care (National Organization of Nurse Practitioner Faculties, 2017).

National Consensus. In 2004, leading national researchers in the field of spirituality and healthcare convened to reach a consensus on the definition of spirituality and identify methods for integration of spirituality into all levels and settings of the healthcare continuum. A definition was reached in that same year (Appendix A) and eight domains of care were identified. Most

relevant to the DNP project was the domain of spiritual, religious, and existential aspects of care, which charges healthcare professionals with assessing and addressing spiritual and religious concerns, providing respect for beliefs and practices, and fostering family and community as a source of support (Ferrell et al., 2007). The forum recognized the critical role of spirituality in the healthcare professional-patient dyad and the potential for mutual transformation of each party within a healing relationship; particularly one in which a professional trained in compassionate care, lends to patient self-healing (Puchalski, Vitillo, Hull, & Reller, 2014).

Available Knowledge. In 2015, a novel effort to train healthcare professionals was undertaken by Zolfrank, Trevino, Cadge, Balboni, Thiel, and Fitchett through certified pastoral education (CPE), a designation of chaplains. Massachusetts General Hospital (MGH) created an abbreviated five-month training in pastoral care for healthcare professionals to expand the reach of chaplaincy with the objective of delivering religious and spiritual care to patients (Zolfrank et al., 2015). The aim of the program was to develop the participant's own religious and spiritual beliefs to enhance the delivery of care to patients and family. Didactics included theology, psychology, theory, comparative religion, palliative and end of life care. Three hundred clinical hours were a required feature of the fellowship. Measures were statistically significant for participant's self-report of comfort using religious and spiritual language (29% increase, $p<0.001$); confidence initiating spiritual conversations (61% increase, $p<0.001$); and engaging in prayer with patients (95% increase, $p<0.001$) (Zolfrank et al., 2015) (Appendix E).

A program description and qualitative examination of the MGH clinical pastoral care for healthcare professionals (CPE-HP) was written by two program graduates in Todres, Catlin, and Thiel (2005) (Appendix E). MGH clergy created the CPE-HP program to broaden care delivery intended to address spiritual distress (Todres et al., 2005). One hundred hours of didactic

coursework, examination of case studies, and written exercises on self-reflection and introspection were geared towards major faith traditions, end-of-life care, and ethics. Participants returned to their primary healthcare setting to earn 300 hours of clinical experience. Guided weekly by a pastoral mentor, the participant applied spiritual care principles to their usual patient care for the purpose of becoming comfortable and conversant in addressing spiritual needs. Four qualitative themes were noted: clinical practice became more infused with awareness and meaning; spiritual distress was more easily recognized; intention behind clinical practice was more deliberate; and, the participant himself underwent a spiritual awakening (Todres et al., 2005).

A second study measured the effects of pastoral education for healthcare professional at Boston Children's Hospital. Robinson, Thiel, Shirkey, Zurakowski, and Meyer (2016) featured a one-day intensive on spiritual screening and care plan development, spiritual care provision, and professional development. A sample of 79 volunteer inter-professionals were taught observational skills for detecting and addressing spiritual distress; simulation training on the use of a spiritual assessment tool; and, ethical guidelines for engaging in spiritual practices with patients (Robinson et al., 2016). Researchers measured cumulative spiritual generalist skills, which were the ability to perform a spiritual screening; identification of spiritual strengths, distress, and interventions; development of a spiritual care plan, and documentation of the encounter for other healthcare professional use. There was a statistically significant mean improvement in overall ability to engage in spiritual generalist skills sustained three months after the intervention (Pre-workshop score 50 compared to Post-workshop score 60, $p<0.001$).

Koenig, Perno, and Hamilton (2017) conducted an interdisciplinary spiritual care training program at a faith-based medical facility. In the 12-month long study, nine full-time religious

faith coordinators educated and provided on-going support to participants in the delivery of spiritual care defined as identification of patient's spiritual beliefs and engagement in patient-initiated prayer. The study hypothesized that the frequency of healthcare professional attitudes and behaviors would increase over time due to the long-term, institutionally supported intervention. From baseline scores, researchers found no statistically significant results with regards to attitude towards praying with patients [B=0.035, standard error (SE)=0.024, p=0.0140], but measured statistically significant results for the practice of engaging and encouraging patient's spiritual faith [B=0.112, SE=0.024, p<0.0001].

Wasner, Longaker, Fegg, and Borasio (2005) investigated the effects of a spiritual training program designed for an interdisciplinary sample of palliative care professionals in Germany. Drawing from Tibetan Buddhist philosophy and traditions, the healthcare professional spiritual care program examined professional's reflection on the fear of death; recognition of spiritual suffering; and, response to didactic techniques such as compassionate listening, contemplation, and meditation. The central aim was to elicit reflections and teach practices that provided the benefits of mindful awareness and increased meaning in professional engagement. The six-month program of spiritual care training garnered statistically significant results with regards to compassion for oneself [6.9, standard deviation (SD)=1.4, p<0.01], dying patients [7.9, SD=1.3, p<0.05], family [7.7, SD=1.4, p<0.05], and colleagues [7.9, SD=1.1, p<0.05] (Wasner et al., 2005). Results were sustained over six months.

Yong, Kim, Park, Seo and Swinton (2010) delivered a spiritual care training program to mid-level nursing managers in a South Korean acute care medical facility. A 90-minute weekly session was delivered for five weeks to an intervention group of 24 nursing managers compared to a control group of 27 nursing middle managers, receiving usual care. The program, consisting

of the introduction spiritual care and the demonstration of a holy mantra in daily practice, had been empirically verified in the United States for improvement of healthcare professional spiritual wellbeing (Bormann, Aschbacher, Wetherell, Roesch, & Redwine, 2009). Each week of the program reinforced the concept of single-minded focus on a holy name or word to induce calm and peace in order effectively operate in one's professional role. Statistically significant results were found for spiritual wellbeing [94.6, SD=10.4, $p<0.018$] vs [control group 81.3, SD=12.1, $p<0.018$], spiritual integrity [13.9, SD 2.2, $p<0.003$] vs [control 11.3, SD=1.5, $p<0.003$], and leadership practice [222.5, SD 36.9, $p<0.023$] vs [control 205.0, SD=39.4, $p<0.023$].

Vlasblom, van der Steen, Knol, and Jochemsem (2011) enrolled 44 nurses into an intervention arm, in which a 16-hour spiritual training of spiritual principles, appropriate communication, and consultation was delivered over two months. Nurse knowledge, attitude, behavior, and job satisfaction were surveyed. Patient's perception of sense of wellbeing and perception of care was examined. Post training, nurses demonstrated evidence of inquiring more of spiritual needs with greater ease (69%, $p=0.02$) and this reflected in positive responses from patients in terms of a perception of increased support and receptiveness to spiritual needs (42%, $p=0.006$). Nurse behavior, or prayer conducted with patients (65%, $p=0.40$) and job satisfaction (19.0, SD=13-25, $p=0.44$) did not reach statistical significance.

Lind, Sendelbach, and Steen (2011) conducted a quality improvement project aimed at improving Press Ganey patient satisfaction scores on a standardized hospital survey for the single item of how well healthcare professionals addressed the patient's spiritual and emotional needs during hospitalization. A two-hour spiritual training course was provided to 37 staff nurses on a single progressive care unit with a primary intervention of introduction to the spiritual

assessment tool, HOPE (sources of hope, organized religion, personal spiritual practices, and effects on medical decision-making). Statistical analysis was not conducted for this QI project; rather, patient satisfaction scores for met spiritual needs increased for two quarters post-intervention. In the 3rd quarter, patient satisfaction scores for the progressive care unit to the question: "thinking of our overall care, please rate how well staff addressed your spiritual and emotional needs" (Lind, Sendelbach, & Steen, 2011, p. 89) scored 74% compared to a baseline patient satisfaction score of 62-65%. In that same quarter, the hospital-wide score for the same question was 65%. In the fourth quarter, or six-month post-intervention, the progressive care unit's Press Ganey patient satisfaction score to the same question was 71% compared to the baseline the same baseline score of 62-65% and hospital-wide score of 65%.

In Yang et al.'s study (2017), the FICA spiritual assessment tool was introduced in one, 30-minute spiritual training session to an intervention group drawn from participants allocated from either a palliative care acute care setting or a palliative care home-based primary care setting. The intervention group was tasked with assessing the patient's spiritual needs using the FICA tool, whereas the control group provided usual care. In the analysis, the brief spiritual training had minimum effect on patient quality of life (69.23 and 68.44, $p=0.076$) and minimum effect on patient sense of spiritual wellbeing (32.17 and 33.26, $p=0.84$) in the intervention group compared to the control group, respectively.

Balboni et al., (2010) conducted a prospective study between the years 2002 through 2008. With rolling recruitment, 670 patients were assessed with end-of-life religious coping and quality of life measures, and then followed post mortem to determine receipt of early hospice care. Research staff administered two measures, the first to the patient on admission and the second at two-weeks post-mortem to the caregiver. The study demonstrated that cancer patients

whose caregivers reported met spiritual care needs received hospice care at the end-of-life and less aggressive medical care compared to patients whose caregivers reported patient's spiritual care needs were not met, and therefore received aggressive medical care at the end-of-life [OR 3.53, p=0.003 vs. 0.46, p=0.16] (Balboni et al., 2010). The study demonstrated spiritual care delivered at end of life was associated with a 28% higher rate on a quality of life scale (Balboni et al., 2010).

The literature demonstrates mixed results derived from varying examples of spiritual care training, various subject groups, and diverse aims. When taken together, the results held adequate promise to launch a doctor of nursing practice quality improvement project. This decision was based on the strength of several studies assessed with the John Hopkins evidence-based tools. Of the reviewed studies, the Robinson et al., (2016), Zollfrank et al., (2015), Balboni et al., (2010), Yong et al., (2010), and Wasner et al., (2005) studies demonstrated good study design and statistical significant results (Appendix C). In addition, the DNP project was supported by the JC standards; ICN and ANA codes of ethics; and the 2004 and 2009 U.S. consensus standards, all entreating healthcare professionals to invest in the promotion of spiritual care in clinical practice for healthcare professional and patient wellbeing, increased patient quality of life, and reduced healthcare utilization.

Rationale

The philosophy of modern healthcare relies on the biomedical model (Engels, 1977). According to Engel, the biomedical model "embraces both reductionism, the philosophic view that complex phenomena are ultimately derived from a single primary principle, and mind-body dualism, the doctrine that separates the mental from the somatic" (1977, p. 130). The biomedical model overlooks the ethos of the patient as an individual with holistic needs of biological,

psychological, social and spiritual wellbeing, by emphasizing the scientific method, objectivity, and ethics. To correct for this imbalance, Engel proposed a bio-psychosocial model that would that would address the psychological and social needs related to the health of the individual.

In 2009, after national leading researchers had reached consensus on a spirituality definition and eight areas of focus, the researchers reconvened in a forum and determined that "clinicians by being aware of their own spirituality-including a sense of transcendence, meaning, and purpose, call to service, connectedness to others, and transformation- are more able to be compassionate with their patients" (Puchalski et al., 2014 page 643, para 7). By consensus, the forum designed a new multidisciplinary healthcare professional Model of Spirituality and Compassion as a spiritual care framework for delivering spiritual care to patients. The model illustrated the symbiotic relationship between spirituality and compassion, which occurs during a deliberate effort to engage in sacredness, altruism, intentionality, narrative or humanism, compassionate presence, and the distinct act of eliciting spiritual history, spiritual needs, and care planning (Puchalski et al., 2014, page 644, figure 1). According to the model, patients would experience compassionate and patient-centered care and increased patient satisfaction and sense of wellbeing. Desired outcomes for healthcare professionals would be an increased sense of meaning and purpose in work and spiritual wellbeing, decreased compassion fatigue and burnout (Puchalski et al., 2014).

Six recommendations emerged from the forum in the areas of research, clinical care, education, policy, communication and dissemination, and community engagement (Puchalski et al., 2014). The recommendation for clinical care pertains most to this DNP project. The framework emphasized spiritual care must focus on healthcare professional behavior change (Puchalski et al., 2014). Specific clinical care recommendations were 1) identify best clinical

practices, using clinical tools and spiritual quality indicators 2) integrate spiritual screening history and assessment tools for training and clinical use 3) make a business case for implementation of standards and tools based on readmission rates, patient satisfaction, and staff retention 4) create a long-term plan for the development of health care professional as a spiritual care provider through competencies, policy, and education (Puchalski et al., 2014).

The Model of Spirituality and Compassion has four domains: a) compassionate presence is the intention to be open, connected, and comfortable with uncertainty b) relationship centered care focuses attention on patient's fears, hopes, goals, meaning, values, and beliefs without being agenda driven c) healthcare professional awareness and development of one's own spiritual beliefs, values, practices, and assessment of mortality and d) extrinsic spiritual care which includes recognizing spiritual distress, taking a spiritual assessment, identifying the patient's sources of strength and hope, and incorporating these elements into the patient's holistic healthcare plan (Puchalski et al., 2009). This all–encompassing model was a sound framework for developing spiritual care proficiency when contrasted against the traditional biomedical model, which focuses on the body, sometimes mind, and rarely the spirit.

Sulmasy (1999) reminds healthcare professionals that illness is a spiritual event. It disturbs the physical, mental, emotional, and spiritual balance. For the patient, it raises troubling questions about the transcendent. From this perspective, Sulmasy (1999) suggests that when healthcare professionals can answer for themselves the questions of spirituality and identify sources of meaning, hope, belief, faith, peace, value, and relationship can the healthcare professional aid the patients in answering the questions for themselves. To arrive at some measure of an answer, an evidence-based spirituality and clinical practice pilot will be delivered to healthcare professionals who provide case management to senior adults in a county setting.

Specific Aims

The aim of this DNP project was to conduct an educational pilot, developed from the Model of Spirituality and Compassion, focusing specifically on two domains: a) healthcare professional awareness and development of one's own spiritual beliefs, values, practices, and assessment of mortality and b) extrinsic spiritual care which included recognizing spiritual distress, taking a spiritual assessment, and incorporating these elements into a holistic healthcare plan, including advance care planning. The project provided healthcare professionals the knowledge, skill, and tools to assess the tenets of the spiritual care model.

Specific aims were accomplished by offering the participants an opportunity to fully assess their own spiritual beliefs, values, knowledge and practices and work-related purpose through self-reflection exercises. They were provided the opportunity to meaningfully connect with their peers and to enhance collegiality. The participants were taught the fundamentals of spirituality, spiritual distress, and spiritual assessment to develop a spiritual clinical practice.

The long-term goals of the project were the continued exploration of spiritual themes and practices. It was also the intent of the DNP project for the intervention to lead to an adopted model of spiritual care within the setting. Direct outcomes for the intervention were personal wellbeing, professional growth, and sense of meaning and purpose in work, and decreased compassion fatigue (Puchalski, Vitillo, Hull, & Reller, 2014). A background intention of the project was the development of spiritual care competence in the context of addressing advance care planning goals.

Methods

Context

Stakeholders. Three organizational stakeholders with an interest in the success of a pilot were identified during the macro-system assessment. The three stakeholders and the DNP student developed a shared vision of generating interest among staff members towards increasing awareness of the importance of spirituality and clinical practice. A former nursing supervisor was the DNP student's primary point of contact and advisor for the setting, and the project's first stakeholder. The project aims, intervention, and anticipated outcomes were first presented to the former nursing supervisor, who was an affiliate of the University of San Francisco and key advisor to the previous DNP advance care planning project.

After the former nursing supervisor presented the content to the current supervisor of social work, who had the authority to vet the project, it was confirmed that the project was appropriate to the setting and aligned with the mission and aims of the agency. The social work supervisor was the second stakeholder and instrumental in arranging site visits, observation of multidisciplinary meetings, informational interviews with staff members, and logistics in the delivery of the intervention. The potential for the DNP project to develop into a permanent, long-term fixture of the agency's culture also rested with this stakeholder's vision and investment.

A third key stakeholder was vital to the provision of the project. During the macro-system assessment, the DNP student conducted an informational interview with a mental health public health nurse, who demonstrated a strong interest in spirituality and clinical practice. She was an insightful and well-regarded member of the agency who had not yet discovered the opportunity to infuse spirituality and stress management techniques into the work culture. It was this staff member who served as co-facilitator to the project. As co-facilitator, this stakeholder was key to the delivery of the project and at the project's conclusion; she emerged as the leader in the development of the burgeoning spirituality group.

Through a combined effort, the key stakeholders identified the audience from three departments within the agency: Information and Assessment intake, in home support services (IHSS), and senior peer counseling. Combined, the intended audience consisted of 8 county social workers, 4 county nurses in addition to the current social work supervisor and the former nursing supervisor participating in the project. Based on regulations, participation was on a voluntary basis, not mandated. Up until project delivery, the stakeholders engaged staff members in the benefits of participation. The DNP student continually assessed readiness for change at each site visit to determine the target audience.

Preparation for Intervention: Several personal educational training and shadowing experiences were undertaken in preparation for the intervention. In reviewing the literature, the DNP student learned of the Ignatian Spiritual Project (ISP). The ISP blends the 500-year-old philosophy of Saint Ignatius with principles of First Step recovery (Ferrari, Drexler, & Skarr, 2015). It serves men and women, who are marginally housed and confounded by mental health illness and substance abuse. To serve this population, ISP delivers two-day retreats in major U.S. cities, delivering spiritual principles with the intention to awaken the individual towards recovery and stabilization. Groups are kept small and segregated by gender. At regular intervals, the group re-organizes to maintain momentum and provide ongoing support. The DNP student reached out to the headquarters in Chicago and requested to attend the two-day retreat to be held in her local area. In response, it was learned the retreat was limited to men only. However, the DNP student was put in touch with the local organizer and facilitator for an informational interview.

Part of the DNP intervention was inspired by the informational interview with the local organizer and facilitator. According to the organizer, each participant is aided in building a personal narrative. It is a time of self-reflection, transparency, and ownership. Individual work,

group work, and silence are intermingled with meditation, guided imagery, nature walks, artwork, and studying spiritual texts. Participants are asked to examine their relationship to themselves, others, and a higher power whatever they conceive it to be. As a method to bridge the time between retreats, individuals write letters to their higher power and entrust it with the organizer. Weeks later, after the sacred space of the retreat has passed, participants receive their letter in the mail as a reminder to feel the spark of spiritual renewal.

To simulate the ISP retreat, the DNP student researched spirituality and recovery programs within an academic, tertiary medical facility. Finding several opportunities, she met with a lead chaplain to explain the purpose of the intervention and how attending one of the groups would provide an opportunity to note the structure, content, themes, and materials employed. A second goal was to observe how the chaplain navigated spiritual discussion in a meaningful and respectful manner. After an introductory email to several chaplains, the DNP student contacted a chaplain who was agreeable to the observation. He held a weekly spirituality group for an outpatient sobriety center, which the DNP student was invited to attend. On the day of the group meeting, five middle-aged veterans who were in varying stages of recovery for alcohol or substance abuse were in attendance.

The chaplain opened with a song and the serenity prayer, and then shared spiritual selection. At the selection's conclusion one veteran remarked: "It didn't mention God once." Another group member responded: "He's in between the lines." The DNP student discovered that facilitating a conversation of a spiritual nature required less of the facilitator then had been imagined. The room was filled not just with one holy individual, but a roomful of spiritual individuals. At each segue of the discussion, a member of the group had a profound thought, bible passage from memory, or personal anecdote to share. The conversation sprang to life with

no lulls, awkwardness, or conflict. Death, reincarnation, yoga, near death experiences, prayer, karma, image of God, ego, and cosmic consciousness were all themes.

The DNP student returned to the spirituality group two weeks later. The chaplain had extended an opportunity to facilitate the next meeting with content left to the discretion of the DNP student. Taking cue, the DNP student selected the spiritual assessment "Daily Spiritual Practices" from the Multidimensional Measurement of Religiousness and Spirituality (MMRS) for use in Health Research (Fetzer Institute, 2003). As a second experiment, a gratitude exercise was created based on the Veterans Health Administration's (VHA) "Creating a Gratitude Practice Clinical tool." These instruments were planned for the DNP project. This was an opportunity to test the value of the instruments.

No formal measurement was conducted for the facilitation rather a qualitative evaluation of the participant's and chaplain experience was noted as to the value of the instruments. After the spirituality group meeting, three of the five participants stated that the exercises had "made them think." The chaplain noted that three of the members who generally were non-participatory were uncharacteristically vocal. The DNP student's aim was to assess the participant's reception to the spiritual exercises and gauge the experience of facilitating a group in spiritual dialogue.

The DNP student conducted a small focus group to test the response of all the spiritual assessments, tools, and multimedia planned for the DNP project. The intent was to determine if the tools and instruments were engaging and appropriate in terms of their spiritual and religious language and content. The audience was two social workers, both employed within the public domain like the intervention audience. The focus group spanned four hours and in that time the social workers raised important issues with the material. One objection was to the overt Judeo-Christian bias of the MMRS. An assumption was raised that the MMRS would construct a score

that demonstrated the participant's spiritual strengths and weaknesses, which was not a feature of the instrument. Other feedback shared was that the intended audience might not have any religious or spiritual inclination, which would lead to disinterest or offense. Despite the constructive feedback, the two social workers felt the material was appropriate to the task and audience.

To review the fundamentals of spirituality, spiritual distress, and spiritual assessment the DNP student surveyed an online course offered by the George Washington University Institute for Spirituality and Health. The self-paced course titled Spiritual Assessment and Clinical Practice was available through the spirituality and health online education and resource center or SOERCE. SOERCE is an online platform, which promotes the integration of spirituality and healthcare practice. Funded by The John Templeton Foundation, SOERCE is the brainchild of Christina Puchalski and colleagues. Course content included the description spiritual domains, relevance to clinical settings, spiritual themes, common expressions of spiritual distress, demonstration of spiritual assessments, and relevant barriers to the delivery of spiritual care.

Gap Analysis. To gain insight into the project's macro-system, four site visits took place over the course of one month for collection of data and staff impressions. Using the Dartmouth macro-systems workbook for a specialty clinic as a guide, the setting's purpose, professionals, patients, processes, and patterns were collected (Dartmouth Institute, 2005). Confidential, individual informational interviews were conducted with each of three county social workers and three public health nurses. The DNP student attended one monthly meeting, staffed by representatives from each of the social service departments. Complex cases were discussed, and interdisciplinary collaboration resulted in management recommendations. One site visit consisted of fieldwork, assessing home safety, medication management, independent and activities of daily

living of a couple receiving in home health services. Collectively, the site assessments revealed the strengths and areas of improvement of this macro-system. Assessing the program's current state through the macro-system assessment determined how best to tailor the project.

Lessons learned. While conducting the confidential, staff interviews it was learned that as few as 12 years ago, approximately forty nursing led public health programs were in operation and managed by an equal amount of community health nurses. At the time of this assessment, the three remaining nursing programs were suspended due to funding constraints. Instead, the domain of the nurses was the management of the in-home support services program, which falls under the Social Work division. These nurses managed the delivery of care through a home evaluation and calculation of need depending on independent and dependent activities of daily living. When need exceeds the allotment, a higher level of care was recommended. Responsibility then shifted to the client's family to obtain a higher level of care in the form of independent living facility, assisted living facility, or nursing home. According to the public health nurses, the work was complex due to technical state regulations and due to the challenging circumstances with which their clients lived.

During the macro-system evaluation, it was confirmed that no spirituality and clinical practice program was or had ever been in place. A yoga class was offered for staff wellbeing by a separate county department and in an adjoining building. No formal spiritual assessment tool was used by the social workers; however, all three social workers noted independently that as the first point of contact for Aging and Adult Services they engage in conversations that could be categorized as spiritual in nature. During intake, potential clients were usually in distress due to the circumstances that led the clients to initiate contact with the department. Each social worker managed client distress with psychosocial techniques. All denied initiating, encouraging, or

discerning a conversation in spiritual terms for fear of compromising their professionalism (Appendix D).

Intervention

Process. The intervention was organized into three seminars. Each seminar was designed to increase knowledge and confidence with spirituality and clinical practice, in addition to providing an experience of spiritual growth and connection between the participants. The knowledge and confidence component was demonstrated with educational content and demonstration exercises. Seminar format was organized in a sequential order beginning with the first seminar content of spiritual self-reflection leading to the second seminar on patient self-reflection assessment, and concluding with a third seminar on how healthcare professionals and patients dialogue on the topic of advance care planning.

The experience portion of the seminars was to support staff in recognizing, valuing and preserving the human dimension of their work; to enable staff to experience and connect with core values of belief, meaning, gratitude, and service; and to enable staff to be in relationship with each other in a way that was revelatory and inspiring. In addition, sharing a meal is symbolic of the ties we share with each other and the sacred (Churchill, 2014). A meal connects us socially and spiritually (Churchill, 2014). For this reason, refreshments and tea were offered at each training session as a symbol of gratitude for engaging in the process.

The first seminar addressed self-reflection. Provider self-reflection is a necessary step in the development of a holistic clinical practice (Best, Butow, & Olver, 2015; Knapp, Gottlieb, & Handelsman, 2017; Sulmasy, 2002). To summarize, it is a practice that recognizes the physical, psychological, social, and spiritual needs of the provider to deliver care and address the needs of the patient or client, who is the recipient of that care. Self-reflection is the process of securing

one's own spiritual beliefs and practices and conceptual framework of the transcendent to effectively discuss spirituality (Best, Butow, & Olver, 2015).

The second seminar was an opportunity for participants to explore a method for eliciting the patient's spirituality. In 2000, Puchalski qualitatively distinguished a spiritual assessment from a psychosocial assessment. The person conducting the spiritual assessment would ask a patient whether the illness was punishment from God or for some wrongdoing. Or it might ask where did the patient believe he was going after death. Comparatively, the psycho-social assessment would reflect questions such as how was the patient coping with the illness or how family was dealing with the patient's illness. The second seminar introduced Puchalski's spiritual assessment tool to aid healthcare professional exploration of patient's spirituality.

For this seminar, the Puchalski's Faith, Importance, Community, and Address (FICA) spiritual assessment was selected from 25 spiritual assessment tools in the literature. It is the only spiritual tool to be validated in a research study, case reports, and by expert opinion (Lucchetti, Bassi, Lucchetti, 2013). In her practice as a geriatrician, Puchalski (2000) initiated a spiritual assessment with each advance care planning conversation. Puchalski believed a spiritual assessment was an opportunity to discover what gives the patient's life meaning and to determine under what circumstances the patient would want to die (Puchalski, 2000).

The third seminar culminated in an exercise and discussion of advance care planning, a topic often challenging for patients and healthcare professionals (Best, Butow, & Oliver, 2016; Churchill, 2015; Puchalski, 2000). The third seminar was inspired by Churchill's (2015) perspective that advance care planning (ACP) was more than legal documents, rather ACP was a process laden with sacred meaning. When healthcare professionals recognize the meaning and ritual importance of the documents, then the number and quality of the documents will grow

(Churchill, 2015). Churchill (2015) introduced the digital website, *Death Over Dinner*, as a forum to aid advance care planning discussions. Content from the digital website provided the infrastructure for the third seminar.

First Seminar. The first hour-long seminar was divided by ten minutes of introductions, twenty minutes of background and educational concepts, twenty minutes of self-reflection exercises, and closed with a five-minute meditation and a five-minute question and answer period. The concept of spiritual anchors was woven into the introduction. Spiritual anchors are those items in individual's personal or work lives that are imbued with meaning unique to the owner (VHA, 2017). A spiritual anchor reminds the individual of what matters most, especially during times of distress. During introductions, the participants were asked to describe an object at their desk that they looked at, read, or listened to throughout their workday. It was pointed out these items were spiritual anchors. These are items that ground the individual in their work and supply spiritual inspiration. The objective of the exercise was to demonstrate that perhaps while not realized, each participant engaged daily in a spiritual practice.

Following this introductory subject, a slideshow was presented to provide the audience the learning objectives and activities, key terms, current research findings, and background of the project. The background for the project conveyed spirituality as a potentially absent component of healthcare professional wellbeing, patient quality of life, and advance care planning discussion. Subsequently, the audience was introduced to the bio-psychosocial-spiritual model and the concept of epistemology. Participants were reminded that most healthcare professionals practice within the context of the bio-psychosocial model, a well-known fact evidenced by all social worker and public health nurse participants acknowledging by a show of hands. It was the

deliberate intent to frame the intervention within this established and accepted theoretical model to expand with the spiritual component suggested by Sulmasy (2002).

Epistemology was a relevant educational component to the project since epistemology demonstrated the bio-psychosocial-spiritual underpinnings of how to engage in a spiritually imbued clinical practice. The objective of this knowledge component was to broaden the participant's perspective beyond healthcare's well-known reliance on statistics and expert opinion. The concept was exemplified by eliciting the multiple ways of perceiving, learning, synthesizing, and applying knowledge. The biomedical-psychosocial component was represented by examples of statistics, expert opinion, enculturation, empiricism, heuristics, and instinct.

The spiritual component was represented by examples of humanism, contemplation, reflection, subconscious, collective consciousness, intuition, and serendipity. Emphasizing epistemology types to the participants and the fact that no known research validates any one epistemological type is more valid than the other demonstrated to participants the gap between healthcare and spirituality. It further showed how the chasm between how healthcare professionals practice clinically compared to how some patients express their ways of viewing their illness and how this reflects their medical decision-making.

After the introduction of educational concepts, participants were provided three self-reflection assessments (Appendix L). The self-reflection assessments were carefully selected from a well-known research tool. The Fetzer Institute and leading researchers created the multidimensional measurement religiousness/spirituality (MMRS) for use in health research in 1999, then released a revision in 2003. It is a validated tool for measuring religious and spiritual variables on physical and mental health in health outcomes research. Domains addressed by MMRS are daily spiritual experiences, meaning, values, beliefs, forgiveness, private religious or

spiritual practices, coping, commitment, and support or community. An extensive list of questions explores each of these domains measured against perceived behavioral, social, psychological, and physiological change.

Due to the substantial quantity of themes, the MMRS is administered in its entirety or in individual sections, depending on the interest of study (Fetzer Institute, 1999). The utilization of the tools for the project was to elicit the epistemological themes of reflection and contemplation. Of the MMRS spiritual assessments, the assessments of meaning, values, and daily spiritual practices best aligned with that goal. Once the assessments were completed, an open forum was provided for participants to discuss the experience of completing the spiritual assessments, including what they had learned about themselves. The seminar closed with a meditation led by the co-facilitator.

Second Seminar. The second seminar was divided into a five-minute review of the previous seminar's content and a check-in with participants; thirty minutes of instruction on spiritual concepts; a ten-minute spiritual assessment video; fifteen minutes of interactive, role-playing using the FICA spiritual assessment; and closed with a five-minute meditation. One change was made to the original content of the second seminar. Based on the first seminar's post-test results, the previously established lesson plan was revisited and a clinical practice activity was replaced with a lecture on spirituality. The first seminar post-test feedback demonstrated that most participants expressed interest in learning the fundamentals of spirituality in finer detail.

The revised portion of the second seminar referenced Gary Zukav's, *The Seat of the Soul* (1989), Thomas Moore's, *A Religion of One's Own* (2014), and George Washington's *School of Medicine Institute for Spirituality* online resource "Spiritual Assessment in Clinical Practice."

The spirituality lecture was designed to be interactive in nature. Participants defined spirituality as a process of connecting with the transcendent, with nature, with self and others. When asked, for what purpose? Responses included for comfort, peace, and learning. The concept of spirituality as an immortal soul's journey towards healing, balancing energy, returning karmic debt, and serving the collective consciousness of the Earth was presented (Zukav, 1989). It is through the process of spiritual awareness that individuals realize the soul as an aspect in need of healing descended from the individual's higher spirit. It is when life ends, the collection of experiences, lessons learned, and love shared that the soul returns to its higher self in reunion.

The spiritual purpose to life is to create a more perfect, whole, peaceful, and loving being for having had the Earth-bound experience. With each incarnation, a new desire to learn results in an aspect of the higher spirit descending in the form of a fractal, or soul, to begin a new life. Zukav (1989) explained that spiritual psychology is the study of what is necessary for the soul to heal in a lifetime. individual's lives are based on a "blueprint" of predetermined experiences thought necessary to accomplish a soul's purpose. It is when the personality operates outside of the intended blueprint physical, psychological, emotional, or spiritual dysfunction occurs (Zukav, 1989). Aligning this concept with the project's bio-psychosocial-spiritual theoretical model, disease and disorder reflect the alignment of all these aspects as a blueprint of the soul.

According to Sulmasy (2002) and Puchalski et al. (2010), under the bio-psychosocial-spiritual model everyone has a spiritual history concerning spiritual beliefs, needs, coping, support, and wellbeing. Puchalski (2000) merges these themes into spiritual belief and practice, spiritual community, and relationship to the transcendent. From these categories, the FICA spiritual assessment tool was fashioned (Puchalski, 2000). Intervention participants were shown a video of Christina Puchalski providing the history and collaboration that garnered the FICA

tool. In response to the video, one participant queried what cues signal the client's need for a spiritual assessment. A worksheet containing the results of Balboni, Puchalski, & Peteet's (2014) spiritual themes of spiritual distress was reviewed. The themes exemplified specific statements made by patients that demonstrate a lack of meaning or purpose, existential crisis, hopelessness, despair, grief, shame, anger, abandonment, and need for forgiveness. The presence of these spiritual themes would then trigger a spiritual assessment (Puchalski, 2000).

Following the didactic portion on spirituality and the introduction of a spiritual tool to incorporate into clinical practice, a breakout session consisted of pairs of participants engaging in simulation with the FICA tool. Supplied with a paper version of the tool, each participant used their clinical acumen to delicately navigate all the questions contained within the FICA with a partner. Throughout the session, participant's interactions were observed for fluidity of delivering the assessment, for signs of discomfort or for evidence of word substitution or veering from the spiritual assessment tool content. When the FICA tool was reviewed as a group, each question's meaning was explored, ways to re-phrase content was discovered, and the knowledge that would be garnered from a spiritual assessment was determined. To increase comfort, participants were asked to complete SOERCE's online module "Spiritual Assessment for Clinical Practice." Led by the co-facilitator, the second seminar concluded with an introduction to qigong.

Third seminar. The third seminar consisted of a five-minute reflection on the previous seminar and a query if participants completed the Spiritual Assessment for Clinical Practice online module (three of the four participants confirmed and agreed they had a better understanding of the spiritual assessment), a twenty-five-minute qigong session, and a thirty-

minute session in which selections from the advance care planning death over dinner digital website were viewed and discussed collectively.

Qigong is the ancient Chinese practice of rhythmic movement and deep breathing exercises (Jahnke, Larkey, Rogers, Etnier, & Lin, 2010). Purported qigong physical and mental health benefits are increased bone density, decreased systolic blood pressure, increased physical function, decreased falls, and improved mood symptoms (Jahnke, Larkey, Rogers, Etnier, & Lin, 2008). The co-facilitator, an avid qigong practitioner, had long desired to share her personal spiritual art form, believing the practice would benefit her colleague's wellbeing and enhance their ability to engage their professional work. She reviewed the mental and health benefits of qigong: physical stamina, mental and emotional balance, consciousness raising and reduction of pain, stress, and anger to the seminar participants. Then, she engaged the participants in a full qigong, meditative session.

After the qigong exercise, the audience was directed to the final portion of the project. The online digital platform, *Death Over Dinner,* is a social campaign to advance the conversation of death and dying. Michael Hebb created the platform to normalize the conversation after learning that hardly anyone dies at home (Black & Csikai, 2015). Hebb constructed the website for an individual desiring to have an end-of-life conversation with family and friends, or those who would potentially serve as a surrogate.

By creating a selection of audio, video, and written commentaries on life, death, and dying to accompany a dinner, the stage is set for participant friends and family to understand what a good death means to the individual and host of the dinner. The website's selections range from contemporary philosophers, theologians, scientists, artists, businessmen and women, authors, comedians, and writers. Each selection touches on what brings meaning to the

conversation and lived experience of death and dying be it personal anecdote, the effort to popularize environmental friendly coffins, or determining a singular 'Before I die' goal (www.deathoverdinner.org).

As pre-work, an electronic invitation with four selections embedded was sent for the third seminar. Selections were chosen based on their potential to provoke thought, challenge patterned beliefs, and generate reflection. The following is a brief description of the four selections chosen for the participants. Marcus Daly hand builds coffins. The first coffin he built was for his stillborn child. Death is only a threshold, he tells listeners. In 2013, Tig Notaro, a relatively unknown Los Angeles comedian, ditched her usual act to tell her audience she recently discovered she had breast cancer. Then, her mother died unexpectedly. When her life couldn't get worse, her girlfriend left her. The uncomfortable laughter of an audience waiting for the punch line that never comes is poignant. A New Orleans guerilla artist, Candy Chang, transformed an abandoned building into a giant-sized chalkboard, offering pedestrians a chance to declare to the neighborhood the "thing" they must do before dying. Steve Jobs', 2005 commencement speech to a crowd of university co-eds is painfully ironic given his death at a young age.

Participants requested to view several of the selections as a group. After each selection, the group shared their reflections on a piece or answered the "before I die" question. The overwhelming effect the exercise elicited from participants was to prompt many to discuss their own death experiences, whether patient, friend, or family. Of their own accord, participants took turns discussing a pivotal death experience that left an impression and informed their own definition of a good death. Each shared how she wanted to be taken care of at the end of life, where she believed she was destined to go after death, and to the degree she was comfortable

with the entire process. The third seminar concluded with a reading of Max Ehrmann's 1927 poem, Desiderata, a well-known philosophical poem on how to live one's life.

Responsibility and Communication. The DNP student held primary responsibility for project site selection, design, implementation, evaluation and communication. Agency stakeholders, the current social work and former nursing supervisors, were responsible for coordinating the DNP student's clinical immersions such as shadow experiences, informational interviews, fieldwork experience, and meeting attendance. The social work and nursing stakeholders were responsible for logistics of project delivery such as formal announcement and recruitment, scheduling for three seminars, and reserving conference rooms. Communication was maintained with these key stakeholders and the DNP's advisor on a biweekly basis early in project development and no less than twice weekly during project implementation.

Site feasibility was accomplished by the DNP chair through communication via phone and email with the former nursing supervisor, who was the point of contact to the previous DNP project, regarding interest in a new DNP project centered on spirituality and clinical practice. Subsequently, the DNP student presented the intervention in person along with select materials to further determine feasibility. During the presentation, the DNP student and nursing stakeholder discussed potential strengths, weaknesses, opportunities, and threats to the project such as the perceived need for a focused intervention on wellbeing and spiritual exploration (strength and opportunity), the evidence of the intervention (strength and weakness), and conflict with county policy or regulations (threat). Responsibility for securing organizational support was assumed by the nursing stakeholder who collaborated with the social work stakeholder for targeting a subset of the agency's employees. No conflicts were identified and the project received organizational support (Appendix G).

Work Breakdown Structure. The work breakdown structure (WBS) (Appendix E) was divided into four phases: needs assessment, development, implementation, and evaluation. Each phase was sub-divided into ten critical activities towards the successful delivery of the project and intervention aims. The purpose of the initial needs assessment phase was to identify the work accomplished at the setting by which personnel and the type of clients served. During the needs assessment phase, the relevance of the project content was measured to the setting and its culture to determine the potential receptivity of the audience. It was further determined how the county's demographics and statistics compared to other state counties as described above in the context section. During this phase, the evidence synthesis and early project design and implementation tools were formulated.

Project design and implementation protocols continued into the development phase of the project. The DNP student continued to engage the setting and its personnel through a half-day site visit with the social work and nursing stakeholders and a three-day shadow experience with personnel. During these experiences, a macro-system and current state analysis was achieved with the Dartmouth assessment tool. In addition, participant recruitment through shadowing, interviews and circulation of a marketing flyer was undertaken. During an informational interview, a healthcare professional within the organization was identified and recruited to serve in the role as co-facilitator to enhance adoption and maintenance of the project. The DNP student also engaged in the web-based and in-person didactic and training in spirituality and clinical practice development described in the preparation for intervention section above. A focus group and a pilot test with a spirituality recovery group were conducted. Feedback and observations from the experiences guided the finalization of the intervention methodology and materials.

In the implementation phase, participating staff, seminar dates, and times for the education were confirmed. Authorization for equipment and facilities took place. With the finalization of methodology and intervention materials, evaluation measures and instruments could be defined and created. The DNP student increased communication with the social work and nursing stakeholders from weekly to several times per week to stay abreast of logistic and scheduling changes. The culmination of this phase's activities led to the first educational seminar. After execution of the first seminar, data collection from the first seminar led to an urgent revision of content to reflect audience feedback. Subsequently, a second, tailored educational seminar was conducted based on the needs of the audience.

In the early evaluation phase, the second seminar feedback was considered and no further intervention content was revised. The third and final educational seminar was conducted. Following the completion of the seminars, collected data, adoption and maintenance measures, unintended outcomes, participant feedback, setting evaluation, and ethical concerns were appraised. A complete evaluation on all outcomes and return on investment was compiled based on collected data. Analysis and lessons learned from the three-phased project led to discussions of a future state among stakeholders.

Project Timeline. The project spanned four months, beginning in August 2017 and ending in late November 2017. Project activities correspond to the respective work breakdown phases. In August 2017, needs assessment activities such as evidence synthesis, early project development, and site selection and confirmation took place. In September and early October, other needs assessment phase activities focused on the nature of the site, clients, staff, work delivered, staff perceptions of spiritual care, and recruitment. DNP student training, final project development, focus group and pilot, scheduling and logistics were accomplished during the late

development phase in last half of October 2017. In the early part of November, the implementation phase confirmed participants, equipment, and facilities prior to the first intervention. Feedback and evaluation of measures guided the delivery of the second intervention. An evaluation phase took place in mid-November, where analysis of all measures, feedback, and true intervention impact were analyzed (Appendix F).

SWOT. Strengths, weaknesses, opportunities, and threats analysis lent to a reasonable probability that the intervention would have a favorable impact on the setting (Appendix H). Strengths were demonstrated by a strong theoretical and consensus model basis, which served as the foundations for the intervention, namely the Biopsychosocial-Spiritual model and the Model of Spirituality and Compassion. Adding to the intervention's strength was the setting's multidisciplinary collaboration, the former nursing supervisor and current social work supervisor, and an internal co-facilitator. The project was made possible by the robust supervisory sponsorship for the intervention.

The intervention's most notable weakness was the lack of a similar quality improvement intervention that tested several elements of the consensus recommendations from the literature (Puchalski et al., 2014). It was then necessary to analyze the substantial number of tools available for implementation without having a clear sense of what would work best for the setting. Further, the setting had no existing framework, policy, or standard or practice for the delivery of spiritual care. This could be perceived as either a weakness or strength. It was considered a weakness since two staff interviews revealed no intention to participate in the intervention due to a perceived lack of support from supervision. This, despite reassurance by supervisors that they were in complete support of the project. Knowledge, comfort, and time were moderate barriers to implementation of spiritual care.

Potential opportunities were numerous when drawn from the consensus' spiritual care model (Puchalski et al., 2014). Healthcare professional outcomes that stood to be gained were a renewed sense of meaning and purpose in work; increased sense of personal and spiritual wellbeing; and increased confidence in professional-client relationships. If these healthcare professional benefits were realized, inferences could be made about potential patient outcomes, such as increased sense of wellbeing and healing, sense of compassionate care, and patient satisfaction.

Threats to the intervention were that the intervention was initiated and led by the DNP student, a non-affiliate of the setting. To some degree, the decision by a few staff to decline attendance to spirituality and clinical practice intervention could have been related to this point. Though this is conjecture. A vast amount of material was presented to the participants who could have been perceived as overwhelming and the nature of the spiritual content could have been perceived as sensitive in nature. A single objective was for staff to consider the use of a spiritual assessment tool. Introduction of a tool had the potential to be perceived as additional work. By far the largest threat to the intervention was the perception that inquiring of patient's spiritual beliefs, practices, community, and sources of strength and hope would be considered professionally inappropriate.

Budget. The calculated budget was for a three-seminar pilot project with an average of six participants per seminar. The budget considered direct and indirect costs. Direct costs for the pilot included in-person training and material costs. These costs were estimated at $8,150.00. Indirect costs will be termed in-kind contribution. These costs consisted of equipment, facilities, and personnel salaries. The in-kind contribution was estimated at $120.00. Total estimated costs for this intervention were $8,250 (Appendix J).

Cost-Benefit Analysis. A cost-benefit analysis for a prospective bimonthly spirituality and clinical practice program was calculated for ten participants. The analysis included costs of implementation and estimate of cost savings for two dependent variables: hospitalization costs at end of life and staff turnover. Limiting data and cost points were supplemented by the literature- a necessary function given the novelty of the intervention.

The budget had two components: fixed and variable costs. Fixed costs, which constitute the bulk of fees, included from greatest to least: program development, training, and training materials. A fixed cost of $2,500 for program development is based on time accrued in spirituality training, spirituality group attendance and facilitation, focus group management, informational interviews, macro-system assessment and analysis, and research. Total time for program development equaled 50 hours. Other fixed costs were costs for staff attendance, training materials, and refreshments. A single prospective variable cost was included for education materials at $200. Total intervention costs equaled $5,400.

Cost savings are leveraged to acute care length of stay and staff turnover. Highest in the region, Marin county acute days of care per county decedent were 7.1 in the last six months of life (Dartmouth Atlas, 2014). On average, 46% of individuals die in medical facilities (Black & Csikai, 2015). If the intervention were to affect five percent of the department of aging and adult's 2100 clients, equating to 105 individuals, and reducing inpatient length of stay by one day, then cost savings would amount to $420,000. This is assuming all seven inpatient days take place on a medical floor where the least intensive medical treatment is delivered at a cost of $4,000, which is a minimum average cost per hospital stay (AHRQ, 2013).

According to the literature, social worker turnover within a public entity ranges 20-60% (National Association of Social Work, 2010). Turnover factors include salary, caseload, burnout

or emotional exhaustion, lack of supervisory or coworker support, and lack of organizational commitment to employees (National Association of Social Work, 2010). By instituting a spirituality program to address documented factors of turnover such as emotional exhaustion or perceived lack of support and positive regard, a probability exists the lowest possible predictive rate of 20% from the literature if reduced arbitrarily by 5% to 15% would result in the retention of one staff member at a cost savings of $27,500 in separation, replacement and training costs (Dorch, McCarthy, & Denofrio, 2008).

These were conservative, underestimated figures that managed to convey the cost benefit of instituting a bimonthly spirituality and clinical practice program towards the personal and professional spiritual development of healthcare professionals to enhance staff wellbeing and knowledge as well as address the dearth of advance care planning discussions. For every dollar invested in the spirituality program there is a return on investment of $78 for the end of life hospitalization cost dependent variable. For every dollar spent, there is a return on investment of $5 for the staff retention dependent variable. The total cost savings is estimated at $420,000.

Study of Intervention

Framework. RE-AIM (reach, effectiveness, adoption, implementation, maintenance) was the public health model selected for project evaluation. Its focus is the evaluation of evidence-based interventions, whether physical, psychological, or behavioral towards health promotion and minimization of health risks. The model promotes the idea that environment affects behavior change. The model frames the stages of a project and evaluates processes, effects, and outcomes (King, Glasgow, & Leeman-Castillo, 2010). In the reach category, an estimation is made of the intended audience. This is accomplished through a series of simple calculations. The target population for this intervention was 13 staff members. Of those, 13 were

exposed to recruitment through a flyer. Of those exposed to recruitment, seven staff members responded and all were eligible to participate. Therefore, the recruitment rate was 54%. The percentage of eligible staff was 54%. The minimum targeted rate of attendance was arbitrarily set at 25% of eligible staff.

The second category of the framework, effectiveness, was measured by careful selection of intended outcomes and of a sure method for assessing key outcomes. The targeted individual-level outcomes were to educate the healthcare professional in identifying core beliefs, values, and a spiritual practice; creating a practice for guiding the client/patient in self-reflection, spiritual practice, and advance care planning; and connecting with colleagues. The global outcomes were staff renewed sense of meaning and purpose in professional work life and increased sense of spiritual wellbeing. To determine the effectiveness of the project, outcomes were measured through pre- and post-tests. To increase effectiveness, pre- and post-tests were designed for each seminar and measured three categories of change: knowledge confidence, and experience. The RE-AIM framework also requires an assessment how an intervention will need to be adapted to benefit the participants. To address this point, the pre- and post-tests were designed to elicit seminar feedback. Also, the seminars were scheduled with one or two days between sessions, thus making it possible to incorporate and alter the educational content.

In the adoption stage, the project manager determines which setting would best support, and would be best served by the intervention of. Due to challenging nature of serving a vulnerable, aging population in need, and working within the confines of state mandates and resources, the Department of Aging and Adult Services was premeditated to be an ideal setting for the intervention. During the macro-system assessment, the assumption that the professional

work accomplished at the department had the potential for compassion fatigue, burnout, and turnover was confirmed in interviews and fieldwork.

Secondly, the framework guides the project manager to consider how to develop organizational support for a sustained outcome. To ensure long-term organizational commitment, the data collection and results were geared for the social work supervisor who was identified as the key stakeholder most likely to value individual-level changes. The supervisor had the authority to vet the intervention, provide resources, and mobilize staff to attend the intervention. It also fell under the purview of this individual to determine if the intervention had a future state in the form of a spirituality and clinical practice series or group. To increase the probability of a long-term plan, the social work supervisor was invited to attend one seminar; a co-facilitator was recruited to maintain the effort beyond the three-part seminars; and the final data analysis, favoring a continued spirituality and clinical practice forum, was shared with the key stakeholders.

Implementation asks how consistently the intervention will be delivered to the target population. The premise of the implementation category is that iterations of the intervention occur based on feedback, results, and policies, which lend to an improved and sustained program. There was deliberate effort to stage the intervention over multiple seminars. This was done to cover the substantial amount of material and to build a sequential intervention, allowing for reflection between seminars and modifications to content. The intervention was staged to initially garner participant interest and comfort with spirituality through personal self-reflection. The follow-up seminar built on established participant comfort to consider patient self-reflection. Further, the third seminar was directed to engage the topic of advance care planning, a discussion that has proven to be uncomfortable for both provider and patient (Keary & Moorman, 2015;

Periyakoil, Neri, & Kraemer, 2014). The staged intervention was planned to increase the potential for a long-term program.

Program maintenance refers to the long-term plan to support the intervention over time. It was important to address how the organization would sustain the intervention over time given the DNP student, as project manager, was not an affiliate of the public health agency. Meaning, projects require management by an individual until a future state is solidified. At which point, the project is a permanent fixture in the setting, yet must still be facilitated by an individual. If the individual were not the DNP student or the social work supervisor, the role belonged to someone else. It was for this reason that co-facilitator was recruited to envision a future state with the social work supervisor for a spirituality and clinical practice program beyond the intervention. Preliminarily, the future state was determined to be a regularly occurring, voluntary, and staff oriented program in spirituality and clinical practice, which continued to serve the aim of healthcare professional spiritual wellbeing, sense of purpose and meaning, increased knowledge and skill in spiritual practices with translation to improved patient outcomes of compassionate care, wellbeing, and spiritual care (Appendix K).

Measures

Instruments. Unique pre- and post-tests were constructed for each seminar. The pre-tests contained five questions with questions reflecting content delivered and self-assessed comfort with the content. The post-tests contained ten questions; the first five questions were a duplication of the five pre-test questions. The questions were a measure of knowledge and confidence. The remaining five post-test questions reflected the incidence of self-reflection, engagement with colleagues, and satisfaction with each interactive class. These questions were labeled experience items. A Likert score, ranging 1 = Strongly disagree, 2 = Disagree, 3 =

Neutral, 4 = Agree, and 5 = Strongly agree, scaled the participant's response. The pre-test scoring was dynamic and reflective of the question. For instance, a pre-test question could be phrased with an anticipated Likert score in the direction of 1 = Strongly disagree or a score in the direction of 5 = Strongly Agree. In other words, depending on post-test question phrasing a Likert score of 1 might be more desirable than a Likert score of 5 = Strongly Agree (Appendix P).

Outcomes. Since 2009, the U.S Consensus Project has worked steadily towards a consensus of recommendations on research, education, clinical practice, policy, advocacy, and community engagement for spiritual integration into the predominant healthcare model (Puchalski et al., 2014). The body of leading experts recognized spiritual care as a necessary component of healthcare to offset patient's perception of lack of compassionate care and whole person wellbeing as well as healthcare professional's feeling ill-equipped to manage the suffering of patients and their complex psycho-social, spiritual needs (Puchalski et al., 2014). The consensus' Model of Spirituality and Compassion's patient and healthcare professional outcomes will serve as the project's measures.

Namely, the model's healthcare professional outcomes served as the project's outcomes. They consisted of increased professional sense of meaning and purpose in work and increased sense of spiritual wellbeing and conversely, decreased compassion fatigue and burnout (Puchalski et al., 2014). To operationalize these outcomes the following learning objectives and activities were accomplished. Healthcare professionals were provided the opportunity to:

1) identify core beliefs and values

2) develop a repertoire for a personal spiritual practice

3) create a practice for guiding the client/patient in self-reflection and spiritual practice,

4) develop a construct for facilitating an advance care planning discussion,

5) determine if spirituality has a role in whole health,

6) connect with colleagues in revelatory way, and

7) build a reserve from which to drawn on for well-being in relation to themselves, the people in their lives, and those with whom they work.

Analysis

The primary methods of data analysis were grouped percentage distribution and percent change between pre-and post-tests scores for knowledge items. For the first data analysis method, the goal for grouped percentage distribution was a minimum 50% of the participants to score answers at or above a Likert score of 4 (Agree) or at or below a Likert score of 2 = Disagree, depending on the phrasing of the seminar post-test question. Recalling that some post-test questions were phrased to see a negative trend. For example, certain knowledge and confidence items were queried in a way that a negative trend on the Likert scale was anticipated, such as: “Knowledge and understanding of spiritual matters is a barrier to discussion.” A negative trend was anticipated for this question, thus after seminar two if 50% or more of participants felt the spirituality content of that seminar had improved participant knowledge and understanding, the anticipated post-test response would negatively trend. The grouped percentage distribution goal of 50% was arbitrary. Meeting the 50% goal indicated an improved trend for knowledge and confidence items.

The goal for the post-test knowledge and confidence measures was at least a one-point change on the Likert scale for an arbitrary goal of 30% of participants per seminar. A greater than one-point increase exceeded expectations for the knowledge and confidence measures per

participant for seminar post-test question. If a two-point change occurred, it would imply the content corresponding to the knowledge item was delivered effectively and the participant found the content to be of significance either personally or professionally.

If the 30% goal was met or exceeded, then that seminar's educational content succeeded in improving knowledge and confidence measures affected more than one participant. If a combined two-point increase for greater than 30% of participants was achieved, then the educational content was considered significant in content for most the participants. These percentages were calculated first across individuals and then cumulatively for group percentage per seminar post-test question. Overall, a trend of increased knowledge, confidence and increased experience scores indicated success with the project spirituality and clinical practice content.

Ethical considerations

The University of San Francisco School of Nursing Professions committee vetted the DNP intervention quality improvement project in January 2017. It was approved as an evidence-based change of practice project without the requirement for submission to the University's Institute Review Board (Appendix B). In September 2017, the Supervisor for the department of Information and Assistance (I&A) within the Marin County Department of Aging and Adult Services provided organizational approval for the intervention. The DNP project addressed several national ethical codes and organizational aims. The DNP project addressed the public health services goal outlined by the National Public Health Performance Standards Program (NPHPSP): assure competent public and personal health care workforce and research for new insights and innovative solutions to health problems (CDC, 2014).

The DNP project addressed the national council mandates. The International Council of Nurses' (ICN) ethical code (2006) requires nurses to ensure their clinical competence through continued learning and good personal health practices. Personal health included physical, mental, social, and spiritual wellbeing. The American Nurses Association (ANA) code of ethics mandates nurse self-care which includes the mitigation of compassion fatigue through diet, exercise, rest, family and personal relationships, and spiritual and religious needs (Lachman, Swanson, & Winland-Brown, 2015). Nurse practitioner core competencies include the incorporation of spiritual beliefs, values, and preferences into the health care plan; management of spiritual and ethical conflict that may arise between patients, families, and caregivers; and the provision of healthcare professional education for spiritually competent and sensitive care (National Organization of Nurse Practitioner Faculties, 2017).

Four ethical principles were considered in the delivery of the project. Autonomy, or moral concern owed an individual, was exercised through the request for consent to participate and the request for sessions to be recorded. Non-maleficence, defined as the effort to avoid psychological, moral, emotional, or spiritual distress, and beneficence guided the development of the intervention. It was the joint effort of the DNP student and the co-facilitator, that benefits and harms were moderated during each seminar. Justice was emphasized through the participant's right to a fair and equal role in the intervention (Grace, 2014).

Jesuit spirituality encompasses several principles of which Cura Personalis and Contemplative in Action aligned with the intervention. A 20th century concept, Cura Personalis refers to the deep, abiding regard a teacher has for the student. It translates from Latin as care of the individual (Geger, 2014). It instructs the teacher to engage the student in their affective, moral, and spiritual development as well as guide the student in personal relationships, and

intellectual and social justice pursuits. Contemplative in action is the individual who seeks opportunity to engage others in spiritual conversation for the realization of beliefs, values, and meaning in the transcendent (Geger, 2014).

Results

Through the delivery of three seminars, healthcare professionals were provided the opportunity to:

1) identify core beliefs and values

2) develop a repertoire for a personal spiritual practice

3) create a practice for guiding the client in self-reflection and spiritual practice,

4) develop a construct for facilitating an advance care planning discussion,

5) determine if spirituality has a role in whole health,

6) connect with colleagues in revelatory way, and

7) build a reserve from which to drawn on for well-being in relation to themselves, the people in their lives, and those with whom they work.

The data analysis below demonstrates quantitatively how each of the project aims and measures were met.

The goal for grouped percentage distribution was met with 97% of seminar post-test questions scoring at or above a Likert score of 4 (Agree) or at or below a Likert score of 2 (Disagree). The single exception to the goal was seminar two, post-test question eight where 40% of participants scored strongly agree and 60% scored neutral to the question: “Today’s seminar encouraged me to ask a spiritual question of a colleague if it might help him/her gain spiritual insight” (Appendix O). The DNP student can only surmise professional boundaries to explain the 60% neutral response. In addition, seminar two, post-test question five negatively

trend for 80% of participants, which signified a positive outcome. This was an expected result. Overall, there was a positive trend for grouped percentage distribution knowledge and confidence items.

The second goal was a minimum one-point change for post-test knowledge and confidence items for at least 30% of participants, per seminar. The goal was 60% met. Of the 15 pre- and post-test knowledge and confidence questions, a minimum one-point change occurred 9 times. A two-point change occurred five times and a three-point change occurred for four post-test questions. Expressed in cumulative percentages, one question achieved a 100% post-test change; two post-test questions scored greater than 75%; four post-test questions tallied greater than 40%, and two questions scored 33%. These changes implied content corresponding to the knowledge and confidence items was significant either personally or professionally to participants and the content delivery was effective.

The intervention was judged successful on several points. A minimum goal of 25% staff attendance was met. The actual percent of ‘reach’ into target population for each seminar was 46%, 38%, and 31%, respectively. The 25% attendance rate was an acceptable margin of error given the challenge of sample size and voluntary participation. Three seminars were delivered. The three seminars were adequate in number and length to deliver all intended content to meet the seven intervention aims. In addition, two significant post-test data items measuring the effectiveness of the intervention were 1) Identification of spiritual beliefs, values, and practices and 2) Enhanced well-being and meaningful in professional work rated highly in the post-test quesionnaires. Post-test evaluation of the item for identification of spiritual beliefs, values, and practices resulted in 66% of participants in strong agreement and 33% in agreement. Fifty

percent of participants were in agreement that the intervention had enhanced well-being and aided in the meaningful discovery of professional work.

Discussion

Summary

The seven intervention aims were to assist the healthcare professional in identifying core beliefs and values, developing a repertoire for a personal spiritual practice, creating a practice for guiding the client/patient in self-reflection and spiritual practice, developing a construct for facilitating an advance care planning discussion, determining if spirituality has a role in whole health, connecting with colleagues in revelatory way, and building a reserve from which to draw on for well-being in relation to themselves, the people in their lives, and those with whom they work. These aims were accomplished through a series of seminars with overarching themes of self-reflection of spiritual values, meaning, and beliefs and practices; engagement on how spiritual beliefs and practices would play a role in clinical practice and the delivery of services and care; and, taken together, how these elements lead to meaningful advance care planning. Through these efforts, it was goal of the project to positively affect healthcare professional spiritual wellbeing, sense of purpose and meaning in her professional work, and increased knowledge and skill in spiritual beliefs, values, and practices.

Recalling the project theoretical framework, the Model of Spirituality and Compassion, the domain of compassionate presence, which signifies openness, connectedness, and comfort with spirituality, the corresponding intervention aim was to 1) determine if spirituality has a role in whole health. Corresponding intervention post-test questions that underscored the domain were 1) spirituality plays a role in individual's lives whether they are aware or not (83% strongly agreed, 17% agreed) and 2) the more I discuss spirituality and death the more comfortable I am

(50% strongly agreed, 50% agreed) 3) spirituality helps with compassions fatigue (75% strongly agreed, 25% agreed).

Under the domain of attendance to patient values and beliefs intervention aims were 1) create a practice for guiding the patient in self-reflection and spiritual practice and 2) develop a construct for facilitating an advance care planning discussion. Related intervention post-test questions were 1) the death over dinner series provides an innovative way to conduct end of life discussions (33% strongly agreed, 33% agreed) 2) I see there is a way to address individual's fear of death and dying that was previously thought (25% strongly agreed, 50% agreed) (4) advance care planning might benefit from inclusion of a spiritual discussion (50% strongly agreed, 25% agreed) 4) I plan to experiment with the spiritual class materials in my clinical work (25% strongly agreed, 50% agreed).

Under the domain of healthcare professional awareness and development of one's own spiritual beliefs, values, practices, and assessment of mortality lies the intervention aim of 1) identify core beliefs and values 2) develop a repertoire for a personal spiritual practice 3) connect with colleagues in revelatory way. Related intervention post-test questions were 1) I feel confident in my ability to express my personally held values (66% strongly agreed, 33% agreed) 2) I am able to express how my definition of spirituality gives my life meaning (66% strongly agreed, 33% agreed) 3) I engage in spiritual practices on a daily basis (66% strongly agreed, 33% agreed) (4) I am comfortable engaging in gratitude practice (87% strongly agreed, 17% agreed) 5) I discovered something new about one of my colleagues (83% strongly agreed, 17% agreed).

The last domain of spiritual care was extrinsic spiritual care, which includes recognizing spiritual distress, taking a spiritual assessment, and identifying sources of strength and hope. Corresponding intervention aim were 1) build a reserve from which to drawn on for well-being

in relation to themselves, the people in their lives, and those with whom they work. Core intervention post-test questions that addressed this domain were 1) I am interested in taking a client spiritual history (40% strongly agreed, 20% agreed) 2) I recognize spiritual distress in myself and others (20% strongly agreed, 60% agreed) (2) there is a place for spirituality in my work (83% strongly agreed).

Remaining intervention questions that demonstrated the value of spirituality and clinical practice were 1) I would be interested in continuing a series on spirituality and clinical practice among my colleagues (25% strongly agreed, 50% agreed) (2) it was worthwhile to attend the classes (75% strongly agreed, 25% agreed) 3) research shows spirituality is beneficial to client and patient wellbeing (83% strongly agreed, 17% agreed) 4) content and discussion increased my knowledge of spirituality (17% strongly agreed, 67% agreed) (5) the seminars helped me recognize the meaning and purpose in my professional work (25% strongly agreed, 50% agreed). Other revealing post-test question results were 1) at any one time during the classes, I experienced a sense of spiritual peace (50% strongly agreed, 50% agreed) 2) I have a clear understanding of what spirituality means (20% strongly agreed, 80% agreed).

Interpretation

Best, Butow, and Olver (2016) published a qualitative article on physician's responses to the query of how spirituality was discussed with patients. Several themes emerged from the semi-structured interviews. Participants described the necessary step of personal reflection on spiritual beliefs and mortality in addition to the development of spiritual practice. Participants emphasized the need for continual reflection and self-care to create a sense of ease, which translated to the patient and paved the way for increasingly personal discussions (Best et al., 2016). Recognizing spiritual distress, engaging tentatively and with active listening, then

allowing for silence were methods for facilitating a spiritual discussion that allowed patients to engage in the spiritual work only they could do for themselves (Best et al., 2016). Healthcare professional participants emphasized the value of spiritual care to increase patient coping and quality of care.

Cockell and McSherry (2012) provided a systematic review of international research on spiritual care delivered by the nursing profession. The intent of the review was to provide nurse managers an evidence-base for consideration of spiritual care into an organization's delivery model. Eighty research papers were categorically presented as interventions for nursing education, care of the practitioner, development of a spiritual care standard, identification of a leading spiritual assessment tool, promotion of spiritual care within organizational culture, and identification of need within the field of palliative care and hospice. The authors aimed to address the recently popularized role of spiritual care in context with the rapidly evolving body of literature.

The relationship between spiritual care and advance care planning has not yet been firmed established in the literature or in practice. Chrash, Mulich, and Patton (2011) made an argument for the efficacy of spiritual care and advance care planning by emphasizing advanced practice nurses' (APN) role in holistic assessment of patients and the need to provide the care patients want most at end-of-life, which is to die at home. In the absence of holistic assessment and garnering patient preferences and wishes derived from values and beliefs, patients and surrogates are forced to make decisions of a critical nature at the most pressing and emotional times (Chrash et al., 2011). The authors recognized APN skill and competency as key determinants in bridging the gap between patient expectations and the present reality of end-of-

life care. Holistic assessment with an emphasis on spiritual assessment provides the link to increase quality advance care planning (Chrash et al., 2011).

Limitations

The intervention was limited by sample size derived from a small target population and voluntary participation. In the Reach stage of the RE-AIM public health methodology, efforts to publicize the project resulted in a recruitment rate of 54%. During the implementation stage, the actual percent of Reach into target population for each seminar was 46%, 38%, and 31%, respectively. These figures reveal an additional limitation of the project. There was a seven percent attrition rate per seminar, which correlates to the loss of one participant per seminar. Causes for attrition were annual leave and a medical emergency. Sample size and attrition were not preventable.

Administrative limitations are resources, including budget, personnel, equipment, facilities, and competing interests (Langley, Moen, Nolan, Nolan, Norman, & Provost, 2009). Demonstrating how administrative resources had the potential to inflict a minor limitation on the project, each seminar was one hour in length. The one-hour time allotment took participants away from their duties, therefore the benefit needed to outweigh the cost of attendance. Spiritual care is not yet seen as a strong economic variable (Sulmasy, 1999). However, the social work supervisor felt the benefit would outweigh the cost and required seven of her direct supervisees to be present.

Despite the endorsement of spiritual care by the Joint Commission, the American Nurses Association, and the National Association of Social Work, the project revealed an unexpected critical limitation to a future state, and that was the perception that spiritual care conflicts with professional standards. This was demonstrated in seminar two, question two, in which 60% of

participants agreed, and 20% strongly agreed that 'Maintaining professionalism is a significant barrier to spiritual discussion.' Qualitatively, however, all seminar two participants stated they have spiritual discussions with clients on intake assessments, largely due to the distress the individual is under at the time of the initial phone call. Critical to future efforts is the delineation of current accrediting regulations and professional ethical standards.

Conclusions

Future state. For the intervention to be adopted and maintained over time, the effort requires consistent implementation. There were two ways to accomplish this goal: a grassroots effort driven by staff with supervisory endorsement or administrative mandates of ethical and cultural competence. Of the two options, a grass roots effort is the best option for sustainability (King et al., 2010). In theory, quality improvement should be bottom up or frontline driven, versus top down management strategy. This DNP quality improvement project had a strong probability of developing into a long-term program due largely to the effort of the co-facilitator. At the time of this publication, the co-facilitator and social work supervisor were in preliminary discussion regarding objective, design, and strategies for a spiritual-based program to serve the setting's healthcare professionals.

The true mark of project success was how seriously the healthcare providers took their own spiritual development. Pre-tests, post-tests were calculated and weighed to factor effectiveness, but as Sulmasy (2002) implied, it is the non-measurable units, the ineffable where countless opportunities of meaning were found. It is in meaning, with spirituality and healthcare as vehicles, the acknowledgement of the sacred connection between body, mind, and spirit was made. The intention of the thesis quality improvement project was to create a cultural shift. To a degree, the elements necessary for a cultural shift were already present, most participants self-

identified as spiritual. Pre-test results demonstrated this point with 80% of participants agreeing, and 20% of participants strongly agreeing to the question 'I have a clear understanding of what spirituality means.' Perhaps what was most necessary for the development of clinical spiritual care in this setting was an impetus.

Noble & Jones (2010) noted five themes related to implementation barriers of spiritual training: varied understanding of spirituality, healthcare professional's own ill-defined spirituality, spiritual coping skills, communication, time and priorities, and spiritual care training. In a separate study, advanced practice healthcare professionals cited time, training, priorities, discomfort and uncertainty identifying with patient's revelations, and administrative disciplinary action as obstacles to the delivery of spiritual care (McCauley, Jenckes, Tarpley, Koenig, Yanek, & Becker, 2005). Participants in the McCauley et al., (2005) study felt spirituality had a place in healthcare, although the belief persisted that a fine line between professionalism and proselytizing existed. It was at this juncture the participants were hesitant to engage in spiritual care for fear of violating a professional or ethical standard.

In the case of this DNP project, participants also demonstrated the same professional concern with 20% strongly agreeing and 80% agreeing to the post-test question: "Maintaining professionalism is a significant barrier to spiritual discussion." Further, the post-test cumulative percentage increased for 40% of the participants who demonstrated a change from a pre-test opinion of disagree and neutral to both agreeing professional boundaries were a barrier. However, the fear of offending fellow participants with personal subject matter did not inhibit participation. This was best demonstrated by post-test question scores for questions such as 1) there is a place for spirituality in my work (83% strongly agreed) and 2) I would be interested in

continuing a series on spirituality and clinical practice among my colleagues (25% strongly agreed, 50% agreed).

Project content did not conflict with the participants established belief systems, and the training was sufficient to accomplish learning objectives. Discussing spiritual issues did not trigger known distress related to the project. Building meaningful and trustworthy relationships to engage in collegial spiritual discussion did not pose a challenge for this intervention's participants (Best et al., 2015; Sulmasy, 2009). The DNP project results were similar to several studies both in the evidence table and those discovered subsequently, which support healthcare professional training in spiritual care, both for the individual and for patients.

Promise for a future state was demonstrated with seminar two, question nine which stated 'I enjoy discussing this topic with my colleagues' with 20% agreeing and 80% strongly agreeing.' Other promising post-test responses supporting a long-term program were 1) it was worthwhile to attend the classes (75% strongly agreed, 25% agreed), 2) research shows spirituality is beneficial to client and patient wellbeing (83% strongly agreed, 17% agreed), 3) I feel the classes helped me recognize the meaning and purpose in my professional work, and 4) at any one time during the classes, I experienced a sense of spiritual peace (50% strongly agreed, 50% agreed). It was a goal of the project to serve the research and evidence-based community by having followed long-standing recommendations for integrating healthcare spiritual competence. The project was judged a promising beginning to a future state where a regularly occurring spirituality and clinical practice might launch.

Improvements. Several recommendations would strengthen the replication of the intervention. Attention should be paid to recruitment and attendance, real or perceived barriers, and conflicting interests to increase participation. Accomplishing higher attendance would

involve identifying all potential stakeholders early in planning while determining if and how the intervention correlated to current priorities and conflicts. It would be important to assess organizational policy and procedure for impact.

In terms of materials, tools, and structure, emphasis should be placed on trialing other spiritual assessment tools for identifying values, beliefs, practices, and community in relation to medical-decision making. An additional evidence-based tool to test is the Functional Assessment of Chronic Illness Therapy- Spiritual Wellbeing or FACIT-SP (Brady, Peterman, Fitchett, Mo, & Cella, 1999). A second evidence-based tool for spiritual assessment is the Spirituality and Resilience Assessment or SRA (Kass & Kass, 2000). The SRA holds promise for its ability to gauge spirituality in relation to a healthcare professional's resilience on the job with an attractive interpretive scoring feature that suggests improvements towards spiritual and psychological growth.

An unexpected, and well-received facet of the spirituality and clinical practice intervention was lecture. Lecture was not included in the original design of the intervention due the assumption multiple religious and spiritual constructs would not lend well to in depth discussion of spiritual fundamentals. In addition, since the audience was adult learners a second assumption was made that the participants would benefit from an interactive and open forum structure. As it turned out, participants were eager for deeper spiritual concepts and preferred a lecture type of educational delivery.

Other considerations for improvements were modifications to the FICA spiritual assessment exercise, inclusion of an exercise of personal significance for the participants, and incorporating a spiritual modality, such as the qigong, in each seminar. Regarding improvements with the spiritual assessment exercise, the DNP student would designate more time to the

exercise of taking a spiritual history, perhaps recommending participants take a history of a personal contact to develop comfort outside the intervention setting. A second consideration was the inclusion of a personal exercise such as writing a letter to the participant's higher self, higher power, or write a life review of life goals already attained and life goals not yet accomplished. Such an exercise would provide participants a way to orient themselves to a higher spiritual source, or orient towards a personal future state of meaningful life goals. In conclusion, the co-facilitator's spiritually–oriented qigong practice was well received and would serve as a centering exercise at the opening or closing of each seminar.

Not included in the intervention or body of the thesis, an abbreviated version of the intervention was delivered to six baccalaureate nursing students just as the staff-focused intervention were concluding. The one and one half hour seminar included those fundamental elements that had been received overwhelmingly by the intervention participants. The students engaged with the MMRS questionnaires of values, meaning, and daily spiritual practice. The experience of completing the surveys and select items on the questionnaire were discussed. Subsequently, a lecture based on Zukav's (1989) spiritual principles was delivered with considerable time spent exploring the nursing students working spiritual definitions and concepts as well as personal spiritual experiences. In conclusion, a few selections from the Death over Dinner website were viewed and discussed in detail. Qualitatively, the seminar was well received by the students and perhaps suggests a need in the nursing curriculum.

Other Information

Funding

The DNP student had no external financial sources to report. Any costs accrued were paid for by the student.

References

Agency for Healthcare Research and Quality (AHRQ). (2010). Costs for hospital stays in the United States. *Healthcare Cost and Utilization Project*. Retrieved from https://www.hcup-us.ahrq.gov/reports/statbriefs/sb146.pdf.

Anandarajah, G. & Hight, E. (2001). Spirituality and medical practice: Using the HOPE questions as a practical tool for spiritual assessment. *American Family Physician, 63(1),* 81-89.

Astrow, A.B., Wexler, A., Texeira, K., He, M., & Sulmasy, D. (2007). Is failure to meet spiritual needs associated with cancer patients' perceptions of quality of care and their satisfaction with care? *Journal of Clinical Oncology, 25*, 5753-5757.

Balboni, T., Balboni, B., Paulk, M.E., Phelps, A., Wright, A., Peteet, J., …& Prigerson, H. (2011). Support of cancer patients' spiritual needs and associations with medical care costs at the end of life. *Cancer, 117,* 5883-5391.

Balboni, T.A., Paulk, M.E., Balboni, M.J., Phelps, A.C., Loggers, E.T., Wright, A.A., …& Prigerson, H. (2010). Provision of spiritual care to patients with advanced cancer: Associations with medical care and quality of life near death. *Journal of Clinical Oncology, 28*, 445-452.

Berlinger, N. (2004). Spirituality and medicine: Idiot-proofing the discourse. *Journal of Medicine and Philosophy*, 296), 681-695.

Best, M., Butow, P., & Olver, I. (2015). Creating a safe space: A qualitative inquiry into the way doctors discuss spirituality. *Palliative & Supportive Care*, 14(5), 519-531.

Bjaninsky, M. (1997). Family dynamics: Influencing care of the older adult. *Activities, Adaptation & Aging, 22(4),* 65-72.

Black, K. & Csikai, E. (2015). Dying in the age of choice. *Journal of Social Work in End-of-Life & Palliative Care, 11,* 27-49.

Bormann, J. E., Aschbacher, K., Wetherell, J. L., Roesch, S., & Redwine, L. (2009). Effects of faith/assurance on cortisol levels are enhanced by a spiritual mantram intervention in adults with HIV: A randomized trial. *Journal of Psychosomatic Research 66(2),* 161-171.

Borneman, T., Ferrell, B., & Puchalski, C. (2010). Evaluation of the FICA tool for spiritual assessment. *Journal of Pain and Symptom Management*, 40(2), 163-173.

Center for Disease Control, (2014).

Brady, M.J., Peterman, A.J., Fitchett, G., Mo, M., & Cella, D. (1999). A case for including spirituality in quality of life measurement in oncology. Psycho-Oncology, 8, 417-428.

Chrash, M., Mulich, B., & Paton, C.M. (2011). The APN role in holistic assessment and integration of spiritual assessment for advance care planning. *Journal of the American Academy of Nurse Practitioners, 23,* 530-536.

Churchill, L. (2014). Embracing a broad spirituality in end of life discussion and advance care planning. *Journal of Religion and Health*, 54(2), 759-764.

Cockell, N. & McSherry, W. (2012). Spiritual care in nursing: An overview of published international research. *Journal of Nursing Management, 20,* 958-969.

Dartmouth Atlas of Healthcare. (2014). Medicare spending per decedent by site of care during the last two 345 years of life (DAP_state_data_2014). Retrieved from http://www.dartmouthatlas.org.

Dartmouth Institute for Health Policy and Clinical Practice (2005). *Clinical Microsystems: Assessing, Diagnosing, and Treating your Specialty Care Practice*. Retrieved from http://clinicalmicrosystem.org/knowledge-center/workbooks/.

Dorch, E., McCarthy, M.L., & Denforio, D. (2008). Calculating child welfare separation, replacement, and training costs. *Social Work in Public Health, 23(6),* 39-54.

Duke, G., Yarbrough, S. & Pang, K. (2009). The patient self-determination act: 20 years revisited. *Journal of Nursing Law, 13(4),* 114-123.

Engel, G. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196(4286*), 129-136.

Ferrari, J., Drexler, T., & Skarr, J. (2015). Finding a spiritual home: a pilot study on the effects of a spirituality retreat and loneliness among urban homeless adults. *Psychology*, 6(3), 210-216.

Ferrell., B., Connor, S., Cordes, A., Dahlin, C., Fine, P., Hutton, N., …& Zuroski, K., (2007). The national agenda for quality palliative care: The national consensus project and the national quality forum. *Journal of Pain and Symptom Management, 33(6*), 737-744.

Fetzer Institute. (1999). Multidimensional measurement of religion/spirituality for use in health research. Kalamazoo: National Institute of Health workgroup.

Fitchett, G. (1999). Screening for spiritual risk. *Chaplaincy Today, 15,* 2-12.

Geger, B. (2014). *Cura Personalis: Some Ignatian inspirations*. Retrieved from https://www.xavier.edu/jesuitresource/newsevents/documents/GegerCuraPersonalisFinalDraftSept2014.pdf

Grace, P. (2014). *Nursing Ethics and Professional Responsibility in Advanced Practice.* Burlington: Jones & Bartlett Learning.

Gravell, C. (2013) *Lost and Found: Faith and Spirituality in the Lives of Homeless People*. London: Lemos & Crane Publishers.

Hodge, D. (2006). A template for spiritual assessment: A review of the JCAHO requirements

and guidelines for implementation. *National Association of Social Workers, 51(4),* 317-326.

Hodge, D.R & Wolosin, R. (2014). Spiritual needs and satisfaction with service provision: Mediating pathways among a national sample of hospital inpatients. *Social Work Research, 38(3),* 135-143.

Hubbell, S. (2017). Promotion of advance care planning for individuals experiencing homelessness. (Unpublished doctoral dissertation). University of San Francisco, San Francisco.

International Council of Nurses (2006). *Codes of ethics for nurses*. Retrieved from www.icn.ch/ichcode.pdf.

Isaac, K., Hay, J., & Lubetkin, E. (2016). Incorporating spirituality in primary care. *Journal of Religion and Health*, 55(3), 1065-1073.

Jahnke, R., Larkey, L., Rogers, C., Etnier, J., & Lin, F. (2010). A comprehensive review of the health benefits of qigong and tai chi. American Journal of Health Promotion, 24(6), 1-25.

Kalache, A., Aboderin, I, & Hoskins, I. (2002). Bulletin of the World Health Organization, 80(3), 243-250.

Kang, J., Shin, D.W., Choi, J.Y., Park, C.H., Baek, Y.J., Mo, H.N., et al. (2012). Addressing the religious needs of dying patients by health care staff in Korea: Patient perspectives in a multi-religious Asian country. *Psycho-Oncology, 21,* 274-381.

Kass, J. & Kass, L. (2000). Spirituality and resilience assessment packet. *Institute of Psychosocial Maturation*. Retrieved from http://www.resilientworldview.org/documents/SAMPLESRAENGLISH.pdf

Keary, S. & Moorman, S. M. (2015). Patient-physician end-of-life discussion in the routine

care of Medicare beneficiaries. *Journal of Aging and Health, 27(6),* 983-1002.

King, D., Glasgow, R., & Leeman-Castillo, B. (2010). Reaiming RE-AIM: Using the model to plan, implement, and evaluate the effects of environmental change approaches to enhancing population health. *American Journal of Public Health*, 100(11), 2076-2084.

Knapp, S., Gottlieb, M., Handelsman, M. (2017). Enhancing professionalism through self-reflection. *Professional Psychology: Research and Practice, 48(3),* 167-174.

Knopf-Amelung, S. & Jenkins, D. (2013). Identifying US veterans who access services from health care for the homeless clinics. *Journal of Public Health*, 103(s2), 216.

Ko, E., Kwak, J., & Nelson-Baker, H. (2014). What constitutes a good and bad death?: Perspectives of homeless older adults. *Death Studies,* 39(7), 422-432.

Ko, E. & Nelson-Becker, H. (2014). Does end-of-life decision making matter?: Perspectives of older homeless adults. *American Journal of Hospice and Palliative Medicine,* 31(2), 183-188.

Koenig, H., Perno, K., & Hamilton, T. (2017). Effects of a 12-month educational intervention on outpatient clinicians' attitudes and behaviors concerning spiritual practices with patients. *Advances in Medical Education and Practice*, 8, 129-139.

Kuczewski, M. (2007). Talking about spirituality in the clinical setting: Can being a professional require being personal? *American Journal of Bioethics,* 7(7), 4-11.

Lachman, V., Swanson, E., & Winland-Brown, J. (2015). The new 'Code of ethics for nurses with interpretive statements' (2015): Practical Clinical Application, Part II. *MEDSURG Nursing, 24(5),* 363-368.

Langley, G., Moen, R., Nolan, K., Nolan, T., Norman, C., & Provost, L. (2009). *The*

improvement guide: A practical approach to enhancing organizational performance. San Francisco: Jossey-Bass Publishers.

Lind, B., Sendelbach, S., & Steen, S. (2011). Effects of a spirituality training program for nurses on patients in a progressive care unit. *Critical Care Nurse, 31(3*), 87-90.

Lucchetti, G., Bassi, R., & Lucchetti, A. (2013). Taking a spiritual history in clinical practice: A systematic review of instruments. *Journal of Science and Healing*. 9(3), 159-170.

Marin Health and Human Services. (2017). Older Adults and Aging in Marin. Retrieved from http://www.healthymarin.org/index.php?module=indicators&controller=index&action=dashboard&alias=olderadults.

Marin Health and Human Services. (2015). Marin County Homeless Point-in Time Census & Survey: Comprehensive Report. Retrieved from https://www.marinhhs.org/sites/default/files/ files/servicepages/2015_06/marincounty_homelessreport_2015_final-6.23review.pdf

Maugans, T. (1996). The SPIRITual history. *Archives of Family Medicine*, 5(1), 11-16.

McCauley, J., Jenckes, M., Tarpley, M., Koenig, H., Yanek, L., & Becker, D. (2005). Spiritual beliefs and barriers among managed care practitioners. *Journal of Religion and Health*, 44(2), 137-146.

Metraux, S., Eng, N., Bainbridge, J., & Culhane, D. (2011). The impact of shelter use and housing placement on mortality hazard for unaccompanied adults and adults in family households entering New York City shelters. *Journal of Urban Health*, 88(6), 1091-1104.

National Association of Social Work. (2010). High caseloads: How do they impact delivery of

health and human services? *Social Work Policy Institute*. Retrieved from http://www.socialworkpolicy.org/wp-content/uploads/2010/02/r2p-cw-caseload-swpi-1-10.pdf.

National Organization of Nurse Practitioner Faculties. (2017). *Nurse Practitioner Core Competencies with Curriculum Content*. Retrieved from http://www.nonpf.org/?page=14.

Noble, A. & Jones, C. (2010) Getting it right: Oncology nurses' understanding of spirituality. International journal of Palliative Nursing, 16(11), 565-569.

Pargament, K.I., Koenig, H.G., Tarakeshwar, N., & Hahn, J. (2004). Religious coping methods as predictors of psychological, physical, and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study. *Journal of Health Psychology, 9,* 713-730.

Pearce, M.J., Coan, A.D., Herndon, J.E., Koenig, H.G., & Abernathy, A.P. (2012). Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients. *Supportive Care in Cancer, 20,* 2269-2276.

Periyakoil, V. (2016). A randomized clinical feasibility trial comparing the letter project advance directive to traditional advance directive. Journal of Pain and Symptom Management, 53(2), 419.

Periyakoil, V. S., Neri, E., & Kraemer, H. (2014). Do unto others: Doctors' personal end-of-life resuscitation 402 preferences and their attitudes toward advance directives. PLoS ONE, 9(5), e98246. https://doi.org/10.403 1372/journal.pone.0098246.

Plante, T. (2016). Principles of incorporating spirituality into professional clinical practice. *Practice Innovations, 1(4),* 276-281.

Puchalski, C. (2001). Reconnecting the science and art of medicine. *Academic Medicine*,

76(12), 1224-1225.

Puchalski, C. (2012). Spirituality as an essential domain of palliative care: Caring for the whole person. Progress in Palliative Care, 20(2), 63-65.

Puchalski, C., Ferrell, B., Virani, R., Otis-Green, S., Baird, P., Bull, J., & Chochinov, G. (2009). Improving the quality of spiritual care as a dimension of palliative care: The report of the consensus conference. *Journal of Palliative Medicine, 12(10),* 885-904.

Puchalski, C., Lunsford, B., Harris, M. H., & Miller, T. (2006). Interdisciplinary spiritual care for seriously ill and dying patients: A collaborative model. *The Cancer Journal, 12(5),* 398-416.

Puchalski, C. & Romer, A. L. (2000). Taking a spiritual history allows physicians to understand patients more. *Journal of Palliative Medicine, 3(1),* 129-137.

Puchalski, C., Vitillo, R., Hull, S., & Reller, N. (2014). Improving the spiritual dimension of whole person care: Reaching national and international consensus.

Robinson, M., Thiel, M., Shirkey, K., Zuraskowski, D., & Meyer, E. (2016). Efficacy of training interprofessional spiritual care generalists. *Journal of Palliative Care, 19(8),* 814-821.

Rushton, L. (2014). What are the barriers to spiritual care in the hospital setting? *British Journal of Nursing,* 23(7), 370-374.

Scott, L.O., Law, J.M., Brodeur, D.P., Salerno, C.A., Thomas, A., & McMillan, S.C. (2014). Relationship with God, loneliness, anger, and symptom distress in patients with cancer who are near the end of life. *Journal of Hospice & Palliative Nursing, 16(8),* 482-488.

Stephenson, P.M. & Berry, D.M. (2014). Spirituality and uncertainty at the end of life. Oncology Nursing Forum, *41(1),* 33-39.

Sudore, R., Le, G. M., McMhan, R., Feuz, M., Katen, M., & Barnes, D. (2015). The advance care planning PREPARE study among older veterans with serious and chronic illness: Study protocol for a randomized control trial. *Trials, 16(57).* Doi 10.1186/s13063-015-1055-9.

Sudore, R. L., Stewart, A. L., Knight, S. J., McMahan, R. D., Feuz, M., Miao, Y., & Barnes, E., E. (2013). Development and validation of a questionnaire to detect behavior change in multiple advance care planning behaviors. PLoS ONE 8(9): e72465. Doi: 10.1371/journal.pone.0072454.

Sulmasy, D. (2009). Spirituality, religion, and clinical care. *Chest, 135(6),* 1634-1642.

Sulmasy, D.P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist, 42,* 24-33.

Sulmasy, D. (1999). Is medicine a spiritual practice? *Academic Medicine, 74(9),* 1002-1005.

Tarzian, A., Neal, M., & O'Neil, A. (2005). Attitudes, experiences, and beliefs affecting end-of-life decision-making among homeless. *Journal of Palliative Medicine,* 8(1), 36-48.

Todres, D., Catlin, E., & Thiel, M. (2005). The intensivist in a spiritual care training program adapted for clinicians. *Critical Care Medicine, 33(12*), 2733-2736.

Veterans Health Administration Office of Patient Centered Care and Cultural Transformation. (2017). Whole Health: Epistemology and health clinical tool. Retrieved from http://projects.hsl.wisc.edu/SERVICE/modules/11/M11_How_Do_You_Know_That_Epistemology_and_Health.pdf.

Veterans Health Administration Office of Patient Centered Care and Cultural Transformation. (2017). Whole Health: Spirit and soul. Retrieved from http://projects.hsl.wisc.edu/ SERVICE / modules/11/M11_EO_Spirit_and_Soul.pdf.

Vlasblom, J., van der Steen, J., Knol, D., & Jochemsen, H. (2010). Effects of a spiritual care training for nurses. *Nurse Education Today, 31,* 790-796.

Wasner, M., Longaker, C., Fegg, M., & Borasio, G. (2005). Effects of spiritual care training for palliative care professionals. *Palliative Medicine, 19,* 99-104.

Yang, G., Tan, Y., Cheung, Y., Lye, W., Lim, S., Ng, W., & Neo, P. (2017). Effect of a spiritual care training program for staff on patient outcomes. *Palliative and Supportive Care, 15*, 434-443.

Yong, J., Kim, J., Park., J., Seo, I., & Swinton, J. (2010). Effects of a spirituality training program on the spiritual well-being of hospital middle manager nurses in Korea. *Journal of Continuing Education in Nursing, 42(6),* 280-288.

Zollfrank, A., Trevino, K., Cadge, W., Balboni, M., Thiel, M., & Fitchett, G. (2015). Teaching health care providers to provide spiritual care: A pilot study. *Journal of Palliative Care 18(5),* 408-414.

Zukav, G. (1989). *The Seat of the Soul.* New York: Simon & Schuster Paperbacks.

Appendix A

Definitions

Advance care planning: An individual process of making decisions about future medical care, if the individual were incapacitated and unable to participate in medical decision-making. Ideally, advance care planning includes a life review and identification of life goals not yet met, contemplation of values and wishes, and evaluation of treatment options as they related to life goals and values. Further, advance care planning requires communication of these discoveries to a surrogate, or an individual who will speak for the individual if incapacitated, and a primary healthcare provider. The process is summed up with completion of appropriate legal documentation. Advance care planning is dynamic and should be revisited at intervals throughout the healthcare continuum (Sudore, 2008)

Religion: A specific set of beliefs about the transcendent (the divine however conceived), usually in association with a particular language used to describe spiritual experiences, and a community sharing key beliefs, as well as certain practices, texts, rituals, and teachings (Sulmasy, 1999).

Spirituality: An aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred (U.S. National Consensus Project, 2014).

Self-reflection: A deliberate, metacognitive process involving self-observation of thoughts, feelings, attitudes, and behaviors. Self-reflection is most productive as a planned component of one's personal and professional life (Knapp, Gottlieb, Handelsman, 2017).

Appendix B

Statement of Determination

UNIVERSITY OF SAN FRANCISCO | School of Nursing and Health Professions

DNP Statement of Non-Research Determination Form

Student Name: Katie Lutz

Title of Project: Spirituality in Clinical Practice: Recognizing the Importance of Personal Values and Beliefs in Medical-Decision Making

Brief Description of Project:

A) Aim Statement: To conduct three training seminars for public health professionals on developing one's spiritual practice and how to use spiritual assessment tools. The aim is to increase healthcare professional spiritual attitude and behavior and increase healthcare professional wellbeing. Participants will engage in thoughtful self – reflection in the context of spirituality.

B) Description of Intervention:

The setting for the intervention is a community health agency for aging and adult services.

Three seminars will be conducted. Each seminar will focus on a self-reflection exercise and skill building. The first seminar will introduce the purpose and intent of the intervention. A PowerPoint presentation will outline for participants the background and evidence for the intervention. After which, the focus will shift to intervention content. Participants will engage in three self-reflection assessments from the Multidimensional Measurement of Religiousness/Spirituality for Health Use workbook. Total assessment time will be 30 minutes. At the completion of the assessments, a discussion will be held to explore the experience of completing the assessments and insights learned. This segment of the seminar represents the "Know Thyself" portion of the seminar, otherwise being the opportunity for participants to explore their own spiritual beliefs, values, and spiritual practices. The second half of the first seminar will explore the topic of gratitude. A Veterans Health Administration toolkit will be used to review content and practice exercises. The first seminar will conclude with a meditation.

The second seminar will begin with a discussion on spiritual concepts, spiritual distress and healing. The lecture and shared discussion will be 30 minutes in duration. The discussion on spiritual distress will segue into spiritual assessment. Spiritual assessment is the evaluation of a patient's faith beliefs and values, practices, community and medical decision making. Introduction videos and demonstrations of spiritual assessments will be viewed from George Washington's Institute of

Spirituality's. Christina Puchalski, geriatrician and founder of the Institute created these resources. Puchalski's validated spiritual assessment tool, the FICA (faith, importance, community, and address in care will be carefully reviewed for appropriateness and comfort level of use at the setting. As follow up, an online spirituality and clinical practice module will be assigned to participants as prework. The self-paced module can be completed in 45 minutes. The second seminar will conclude with a brief Qigong exercise.

The third seminar will open with a brief lecture and 20-minute complimentary and alternative medicine (CAM) exercise, such Taichi or Qigong. The exercise is to demonstrate the benefits to health and wellbeing. The second half of the third seminar will include the viewing of four vignettes offered through a digital platform for advance care planning. The selections will represent the viewpoints of a contemporary philosopher, theologian, and artist on spirituality, health, and death. Selections will be chosen based on their potential to provoke thought, challenge patterned beliefs, and generate conversation so that participants will share to learn from each other.

Each seminar will include a light snack or meal. This is representative of the idea that sharing a meal is symbolic of the ties we share with each other and the sacred, as Churchill tells us (2014). He goes on to say the work of spirituality helps an individual decipher his life's journey as a pilgrimage, mission, or calling. Spirituality helps with feelings of abandonment and isolation, and conversely reconciliation and comfort (Churchill, 2014). Teaching healthcare professionals to provide spiritual care has shown positive results in several studies (Isaac, Hay, & Lubetkin, 2016; Koenig, Perno, & Hamilton, 2017; Zollfrank, Trevino, Cadge, Balboni, Thiel, & Fitchett, 2015).

C) How will this intervention change practice

Change of practice will be the development or enhancement of healthcare professional's own self-reflection on their spiritual health and professional wellbeing. Also, change of practice will be reflected in healthcare professional confidence using spiritual assessment tools for assessing the spirituals needs of clients.

D) Outcome measurements:
Healthcare professional outcomes to be measured will be sense of meaning and purpose in work, increased sense of wellbeing, decreased compassion fatigue, and decreased burnout (Puchalski, Vitillo, Hull, & Reller, 2014).

UNIVERSITY OF SAN FRANCISCO | School of Nursing and Health Professions

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: (http://answers.hhs.gov/ohrp/categories/1569)

x This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐ This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	x	
The specific aim is to improve performance on a specific service or program and is		

UNIVERSITY OF SAN FRANCISCO | School of Nursing and Health Professions

a part of usual care. ALL participants will receive standard of care.	x	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	x	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	x	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	x	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	x	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	x	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	x	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	x	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print):
__Katie Lutz_____8/1/2017_____
Signature of Student:
_____DATE_____

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print):
_____Jodie Sandhu_____
Signature of Supervising Faculty Member (Chair):
_____DATE_____

Appendix C

Evaluation of Evidence

Citation	Design Method	Sample/ Setting	Variables Studied	Study Findings	Limitation Strength	Level (L) Quality (Q)	Conclusion
Balboni, Paulk, Balboni, Phelps, Loggers, Wright, …& Prigerson, 2010	Quasi-experiment-al	Seven outpatient sites N=343 EOL patients Female: 46% Age, years, mean: 58 White: 63%.	DV: Patient quality of life with receipt of early hospice care IV: Spiritual care delivery.	DV: Spiritual support associated with better QOL. OR 3.53 [95%CI, 1.53 to 8.12], P=0.003 v. 0.46 [95%CI, 0.15 to 1.36], P=0.16	Limitation: No control group, Cannot generalize to non-terminal, non-cancer patients. Spiritual care was not standardized Strengths: Prospective, longitudinal, multi-site study.	L: II Q: A	Statistically significant association between spiritual care and increased QOL, earlier hospice care, and increased religious coping.
Koenig, Perno, & Hamilton (2017)	Quasi-experimental	220 outpatient practices in south-eastern & mid-western states. N: 520 MD: 427 MLP: 93 Female: 45.6% Age, years, mean: 44.8 Christian: 78.7%	DV: Increased comfort providing spiritual care DV: Increase frequency of prayer with patients IV: Training in spirituality and clinical practice.	DV: No significant change DV: 11.3% increase in behavior change towards praying with patients.	Limitation: No control group, voluntary recruitment Attrition: 16.2%. Strength: Baseline, one month, and 12-month follow up.	L: II Q: C	No significant change in comfort. Appeared to slightly increase frequency of clinician integrating spirituality into practice.

		White: 60.5%					
Lind, Sendelback, & Steen (2011)	Quasi-experimental	Abbott-Northwestern Hospital, Minneapolis, MN N: 37 Nurses: 37	DV: Patient satisfaction score for spiritual needs met during hospital stay. Baseline hospital score 62-69%. IV: Spiritual care training. Introduced spiritual assessment tool.	DV: Post- study quarterly patient satisfaction scores 9% (74%) and 6% (71%) above the hospital average score for single-item question.	Limitation: Convenience sample, volunteer participants Strengths: Evidence-based.	L: II Q: C	Sustained two-month increase in patient satisfaction Anecdotal nurse feedback of increased comfort with addressing patient spiritual needs. Increase in pastoral care consults from 16 to 27 per month.
Robinson, Thiel, Shirkey, Zurakowski, & Meyer (2016)	Quasi-experimental	Boston Children's Hospital N: 115 MD: 12% RN: 50% SW: 17% Female: 88% Age, years, mean: 49 White: 94%.	DV: Improvement in self-reported ability to deliver spiritual care. IV: Spiritual care training in 15 spiritual generalist skills for clinical practice.	DV: Minimum 10-point increase in 15 spiritual generalist skills immediate post workshop ($p<0.001$) and at three-month follow up ($p<0.001$).	Limitation: Volunteer participants Attrition 32%. No control. Strengths: Well-powered, significant size sample. Evidence based, use of validated spiritual assessment tool.	L: II Q: A	Sustained results three-month post workshop. 98.6% of participants would recommend the training.
Todres, Catlin, & Thiel (2005)	Program description and analysis	Massachusetts General Hospital	Description of a five-month clinical	Program focus is to enhance the relationship	Themes: Enhanced ability to recognize	L: III Q: B	Emphasis on integration of medicine

		N: 2	pastoral education program adapted for healthcare professionals. Fifty-three healthcare professional graduates in six years	between healthcare profession-al, patient, and family within the scope of spiritual needs.	spiritual distress. Increased spiritual care delivery to patients and families. Personal healthcare profession-al spiritual growth.		and chaplaincy for delivery of spiritual care.
Vlasblom, van der Steen, Knol, & Jochemsen (2011)	Quasi-experimental	Non-academic, urban hospital, Christian affiliation. N: 51 nurses Female: 91% Age, years: 66% 30-49.	DV: Increase nurses' competence and job satisfaction Increase in frequency of chaplain referrals. IV: Spiritual care training and clinical practice.	DV: Comfort discussing spiritual care rose 23%. No change in job satisfaction 19.0, SD 2.9 from average baseline score of 18.4, SD 3.1. No clear change in frequency of chaplain referrals.	Limitation: Selection bias due to Christian hospital. Small sample size. Non- U.S. setting, challenging generalizability to U.S. population. Strengths: Control group. Single blind study.	L: II Q: B	Nurses inquired more frequently of patient's spiritual needs during hospitalization. Nurses indicated more comfort discussing personal spirituality with patients after training.
Wasner, Longaker, Fegg, & Borasio (2005)	Quasi-experimental	Munich, Germany. N=59 Female: 91% Age, years, median: 49 Christian: 71%	DV: Effect on attitudes, spiritual wellbeing, lower levels of work-related stress. IV:	DV: Overall numeric scores for singular attitudinal change (100 points possible). Baseline 71.8, +/-	Limitation: Results not sustained over six-month post implement-ation. Strengths: Evidence-based.	L: II Q: A	77% of participants felt training had improved communication, managing spiritual distress in family

			Spiritual care training program for palliative care professionals.	10.6 points. Six-month follow-up: 76.0, +/-9.1 points.			members, and improved personal emotional health and uncertainty around death.
Yang, Tan, Cheung, Lye, Lim, Ng, …& Hui Neo (2017)	Cluster-controlled study	Singapore, Malaysia. N: 253 patients. Intervention group: Female: 49.6% Age, years, mean: 58.1 Control Group: Female: 44.5% Age, years, mean: 62.3	DV: Advanced cancer patient's self-perceived spiritual wellbeing and quality of life. IV: Spiritual training program for palliative care professionals.	DV: FACIT-Sp: Significant result that when adjusted for baseline characteristics lost power. FACT-G: Significant 4-point improvement in quality of life scores.	Limitation: Training was given in one 30-minute session. Not powered to effect. Strengths: Hetero-genous groups.	L: I Q: C	Studied patient effects of spiritual training program. Results were suggestive of positive effect on spiritual wellbeing.
Yong, Kim, Park, Seo, & Swinton (2011)	Experimental	Seoul, Korea. N: 24 Female: 100% Age, years, mean: 34.8 Control: 27 Female: 100% Age, years, mean: 34.7	DV: Improved spiritual development and psycho-social wellbeing. IV: Spiritual training program for nursing managers.	Intervention group with significant findings: spiritual wellbeing: F = 6.03, p = 0.018. Spiritual integrity: F = 5.56, p = 0.023. Leadership practice: F = 5.56, p = 0.023. Lower	Limitation: Small, convenience sample. Strengths: Use of 5 validated instruments.	L: II Q: A	Training showed beneficial effect for nurse managers.

				burnout: F = 20.57, p = 0.00.			
Zollfrank, Trevino, Cadge, Balboni, Thiel, Fitchett,… & Balboni (2015)	Quasi-experimental	Boston, MA. N: 50 Female: 82% Age, years, mean: 47.1 RN: 58% MD: 22% SW: 8% Christian: 60%	DV: Self-report of provision and confidence in religious/ spiritual care, comfort using religious/ spiritual language. IV: Spiritual care training program (Clinical Pastoral Education for Healthcare Providers)	Mean, SD. Provision of care: 3.14 (0.59) baseline, 4.19 (0.33) post program. Confidence in language: 3.21 (0.92) baseline, 4.14 (0.55) post program. Frequency of care: 1.57 (1.30) baseline, 2.74 (0.77) post program.	Limitation: Self report measures. Participants self-selected for program and study.	L: II Q: B	Spiritual training program increased provision and confidence in delivering spiritual care.

Note: RCT = randomized controlled trial; DV = dependent variable; IV = independent variable. MD = Medical Doctor. MLP = Mid-level Practitioner. RN = Registered Nurse. SW = Social worker. FACIT-Sp = Functional Assessment of Chronic Illness Therapy-Spiritual Well-being. FACT-G = Functional Assessment of Cancer Therapy- General. Evidence evaluated with John Hopkins Nursing Evidence Based Practice Research Evidence Appraisal Tool & John Hopkins Nursing Evidence Based Practice Non-Research Evidence Appraisal Tool (The John Hopkins University).

Appendix D

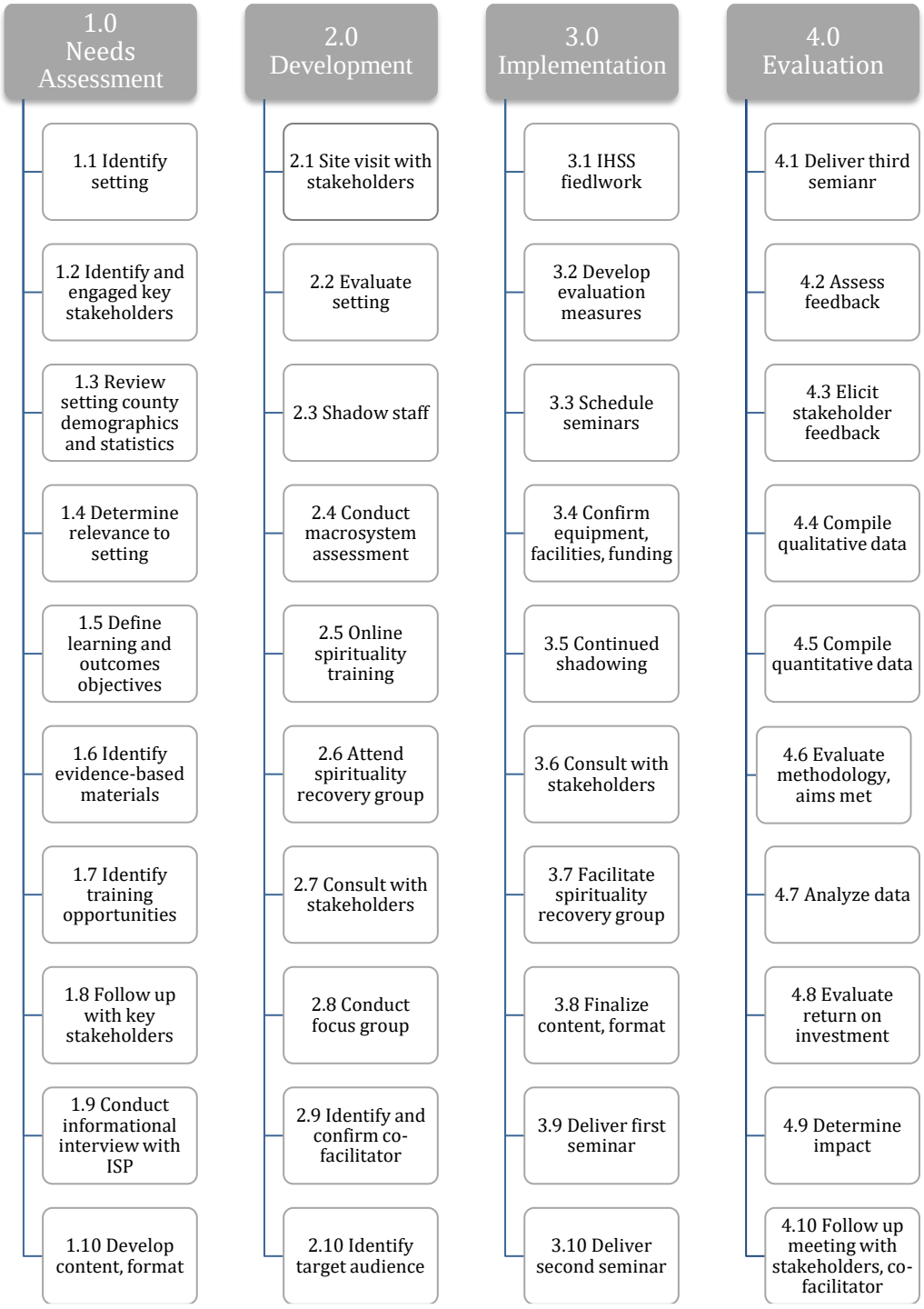
Gap Analysis

Best Practice	Evidence-Based Strategy	Current State	Barriers	Future State
	Healthcare Professional: Identify core beliefs, values, and practices. Connect with colleagues in meaningful way to prevent compassion fatigue. Build practice of wellbeing.*	Not established	Grassroots effort Institutional endorsement	Integrate use of MMRS, FACIT-sp, or SRA for identification of beliefs and practices. Create program for continued spiritual development and training
Spirituality and Clinical Practice Competence	Create method and comfort guiding patient towards identified beliefs, values, and practices. Foster discussions between patient and family that identify life goals, quality of life, and spiritual development.*	Not established	Professional comfort, knowledge of ethical imperative. Institutional guidance	Integrate use of MMRS, FACIT-sp, SRA for identification of beliefs and practices. Integrate spiritual assessment tool, such as the FICA.
	Develop method and comfort around death and dying discussions, facilitate advance care planning.**	Utilizing evidence-based health literate advance care planning packet. Rate of completion unknown.	Knowledge, time, comfort.	Integrate platforms such as Death over Dinner to normalize end of life discussions and aid advance care planning.

Note. *Puchalski, Vitillo, Hull, & Reller, 2014. **Churchill, 2014.

Appendix E

Work Breakdown Structure



Appendix F

GANTT

1.0 Development	Month # 1: August 2017																													
Name of Activity	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
1.1 Identify setting																															
1.2 Identify and engage key stakeholders																															
1.3 Review setting county demographics, statistics																															
1.4 Determine relevance to setting																															
1.5 Define learning & outcomes objectives																															
1.6 Identify evidence-based materials																															
1.7 Identify training opportunities																															
1.8 Follow up with key stakeholder																															
1.9 Conduct informational interview with ISP																															
1.10 Develop content, format																															

2.0 Need Assessment	Month # 2: September 2017																														
Name of Activity	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
2.1 Site visit with stakeholders																															
2.2 Evaluate setting																															
2.3 Shadow staff																															
2.4 Conduct macrosystem assessment																															
2.5 Online spirituality training																															
2.6 Attend spirituality recovery group																															
2.7 Consult with key stakeholders																															
2.8 Conduct focus group																															
2.9 Identify and confirm co-facilitator																															
2.10 Identify target audience																															

3.0 Implementation 3.0	Month # 3: October 2017																												
Name of Activity	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
3.1 IHSS fieldwork																															
3.2 Develop evaluation measures																															
3.3 Schdeule seminars																															
3.4 Confirm equipment, facillities, funding																															
3.5 Shadow staff																															
3.6 Consult with key stakeholders																															
3.7 Facilitate spirituality recovery group																															
3.8 Finalize content, format																															
3.9 Deliver first semianr																															
3.10 Assess feedback																															

4.0 Evaluation	Month # 4: November 2017																														
Name of Activity	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
4.1 Deliver second seminar																															
4.2 Assess feedback																															
4.3 Deliver third semianr																															
4.4 Compile quantitative data																															
4.5 Compile qualitative data																															
4.6 Evaluate methodology, aims met																															
4.7 Analyze and compile data																															
4.8 Evaluate return on investment																															
4.9 Determine impact																															
4.10 Follow up meeting with stakeholders, co-																															

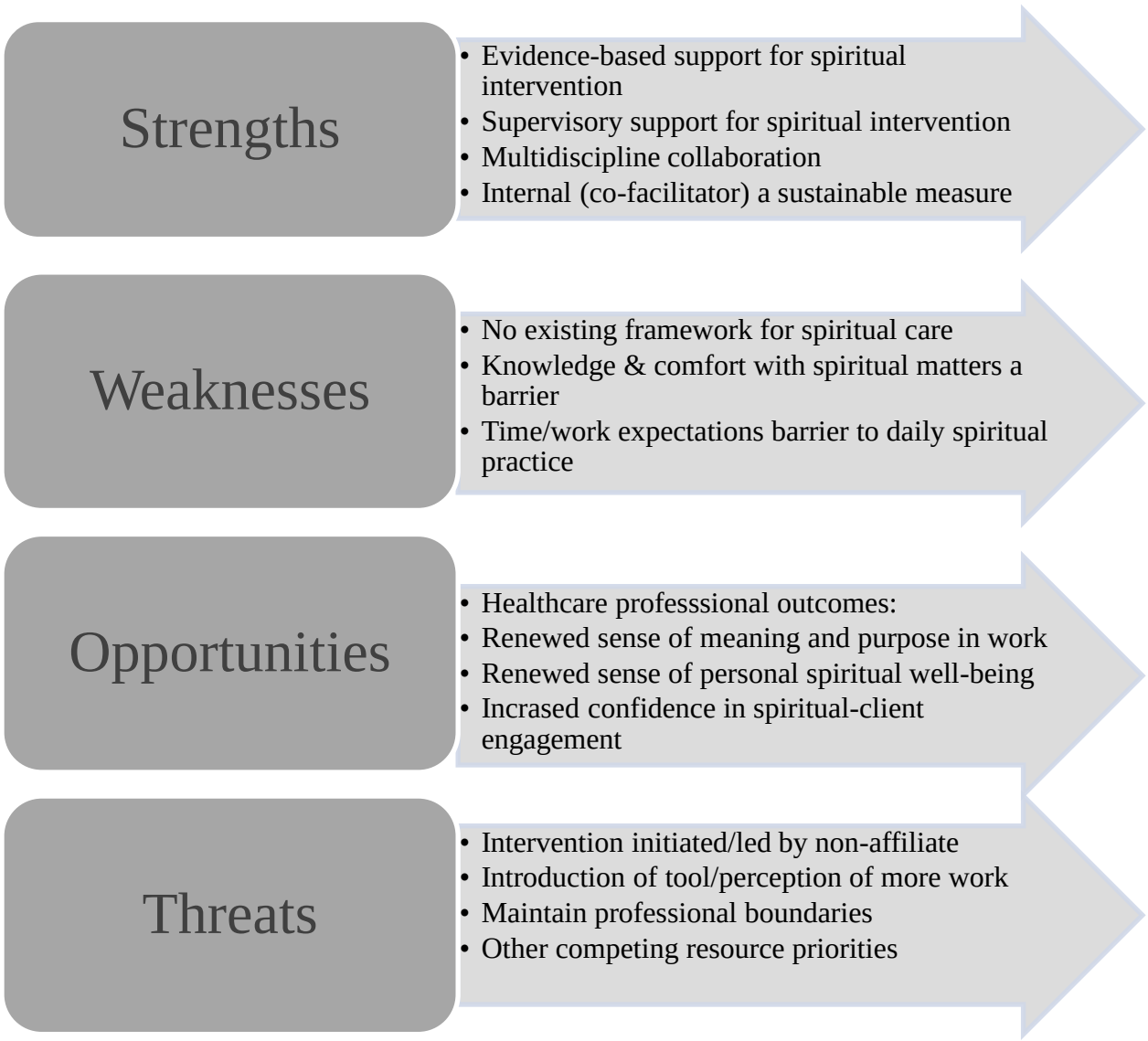
Appendix G

Communication Matrix

COMMUNICATIONS MATRIX								
Project Name:		Spirituality & Clinical Practice						
National Center:		Marin County Aging and Adult Services						
Project Manager Name:		Katie Lutz						
Project Description:		Evidence-based intervention for testing the applicability of spiritual care in a public health setting						
ID	**Communication Vehicle**	**Target Audience**	**Description/Purpose**	**Frequency**	**Owner**	**Distribution Vehicle**	**Internal / External**	**Comments**
1	Feasibility	Stakeholder #1	Determine competing interests, resource availability, interest	Once	Chair	Email or phone	External	August -Chair presented initial concept to stakeholder. Interst generated.
2	Feasibility	Stakeholder #1	Present concept, determine conflict with policy or regulation	Once	DNP student	In person	External	September early -DNP presented definitive concept which was accepted as appropriate to site.
3	Macrosystem assessment/ fieldwork	Stakeholder #1 and Stakeholder #2	Coordinate site visits, informational interviews, macrosystem assessment	Weekly	DNP student	Email or phone	External	October month long -On site assessments conducted.
4	Marketing	Staff	Flyer of interest with learning	Once	DNP student	Electronic	External	October - Generate staff interest.
	Logistics	Stakeholder #2	Determine intended audience, coordinate scheduling, conference space and technology availability	Weekly	DNP student	Email or phone	External	October -Three dates, two classes were re-scheduled due to conflicts. Last day of intervention November 7th.
5	Status report	Chair	Communicate updated project	Weekly	DNP Student	Email or phone	Internal	October and first two weeks of November- Maintain goals,

Appendix H

SWOT Analysis



Appendix I

Budget

Personnel	Time (hours)	Sub-total
Stakeholder (s)	5	5
Staff	3	3
Co-facillitator	5	5
Program Manager (DNP student)	150	150
Total		163

Personnel	Value (dollars)	Sub-total
Stakeholder (s)	$ 50.00	$ 250.00
Staff	$ 35.00	$ 105.00
Co-facillitator	$ 35.00	$ 175.00
Program Manager (DNP student)	$ 50.00	$ 7,500.00
Total	$ 170.00	$ 8,030.00

Out-of-pocket	Value (dollars)	Sub-total
Direct costs		
Spirituality training	$ 10.00	$ 10.00
Folders, printer paper	$ 50.00	$ 50.00
Food	$ 60.00	$ 60.00
Total		$ 120.00
Indirect costs (In-kind contribution)		
Facility, equipment	$ 100.00	$ 100.00
Personnel costs	$ 8,030.00	$ 8,030.00
Total		$ 8,130.00
Total Expenses		$ 8,250.00

Appendix J

Budget and Return on Investment Proforma

Cost-Benefit Analysis, Spirituality and Clinical Practice Program, Bimonthly Seminar

Table A-1

Budget for Spirituality and Clinical Practice Program

Item	Cost per Class (6)	Cost per Attendee (10)	Annual Cost
Fixed Costs:			
Staff @ $35/hr for 60 min (instruction)	$350	$210	$2,100
DNP student @ 50/hr for 60 min (instruction) x3 cl	$50	$15	$150
Training Materials (print outs, folders)	$50	$30	$300
Food (snacks, coffee, tea, supplies)	$25	$15	$150
Program Development @ $50 (50hrs)	$417	$250	$2,500
Variable Costs:			
Education Materials (assessments, exercises, advance care planning documents)	N/A	N/A	$200
Total:	$892	$520	$5,400

Table A-2

Summary of Participation, Bimonthly

	1st 6 months	2nd 6 months
Average Attendance/Class	10	10
Number of Classes	3	3

Table A-3

Cost Savings Estimates for Spirituality Program-Marin County

	Current State	Future State	Adjustment
Inpatient Days per Decedent Last 6 Months@ $400	7	6	$4000/client
Estimated Deaths in Medical Facilities	46%	41%	5%
Aging and Adult Services Caseload (clients)	2100	N/A	105
Aging and Adult Services Total Staff	20	N/A	N/A
Estimated Staff Turnover/National Average	20%	15%	5%
Estimated Cost of Separation, Replacement, Trainin	$27,500	N/A	N/A
Inpatient Days Cost Savings Net Benefit:	4000(105)		$420,000
Staff Retention Cost Savings Net Benefit:	27500(1)		$27,500
Total Net Benefit:			$447,500

Table A-4

Cost-Benefit Analysis, Spirituality and Clinical Practice Program

	Estimated per Class	Estimated per Attendee	Estimated Annual
Program Costs:	$892	$520	$5,400
Inpatient Days Cost Savings Net Benefit:	$70,000	$42,000	$420,000
Staff Retention Cost Savings Net Benefits:	$4,600	$2,750	$27,500
CBA:			
Total Inpatient Care Net Benefit:	$69,108	$41,480	$414,600
Total Staff Retention Net Benefit:	$3,708	$2,230	$22,100
Total Inpatient Benefit/Cost Ratio	78.0	81.0	78.0
Total Retention Benefit/Cost Ratio	5.0	5.0	5.0

Appendix K

Continuous Quality Improvement Model

Appendix L

Implementation Content

If we are to heal patients as whole persons, we ourselves must first seriously engage the transcendent questions... –Hershel

SPIRITUALITY IN CLINICAL PRACTICE

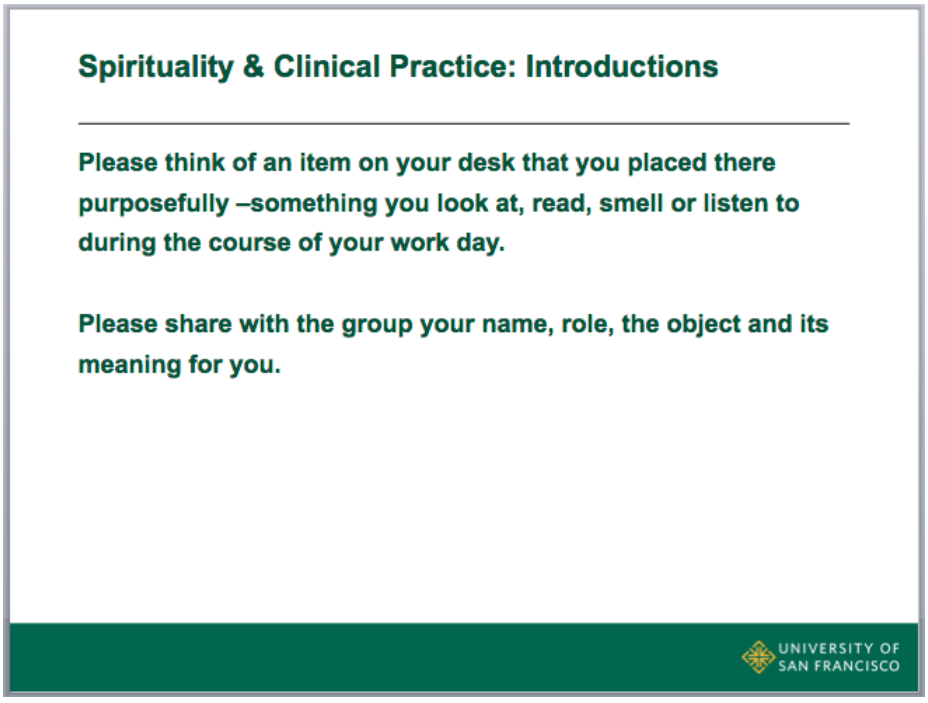
THREE SESSIONS

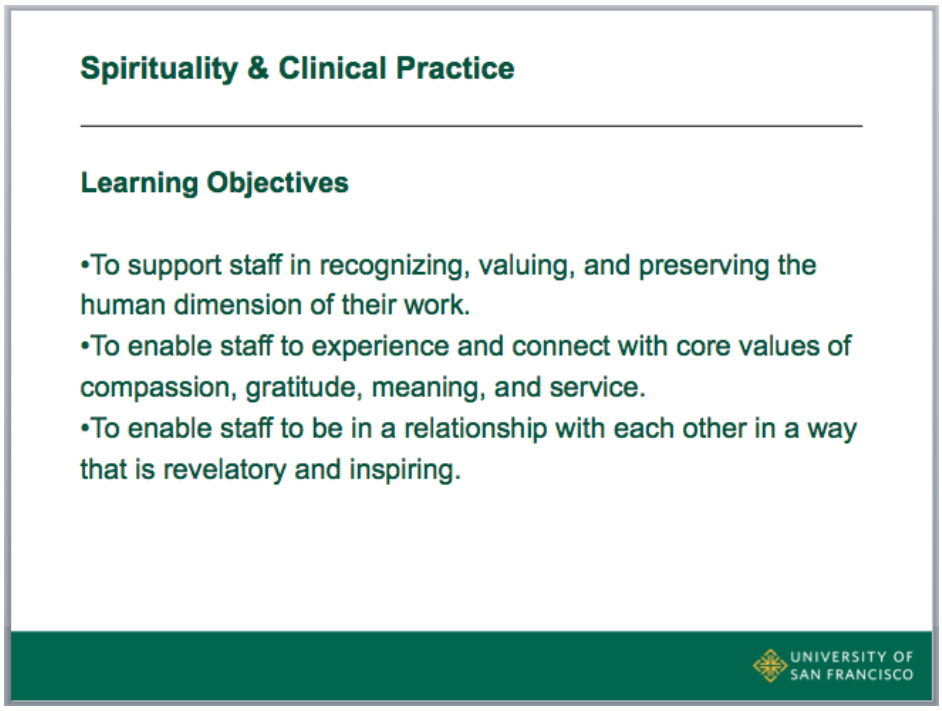
A collaboration between Marin County Aging & Adult Services leadership and a University of San Francisco Graduate Student

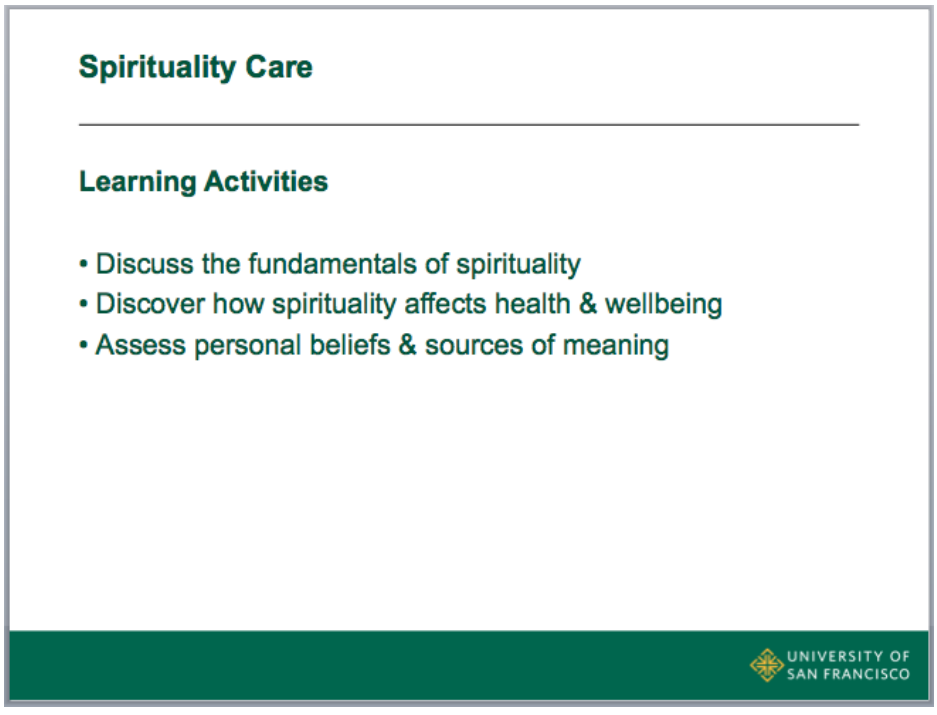
THEMES

- Self reflection on clinician values, beliefs, and meaning
- Treating the soul in clinical practice
- How to develop a clinical practice of spiritual care
- Reflections on death and dying


UNIVERSITY OF SAN FRANCISCO
CHANGE THE WORLD FROM HERE
Spirituality & Clinical Practice:
'Secure your mask first, then help the other person…"
Katie Lutz, RN
University of San Francisco
Rachel Gila, RN
HOPE Program & Senior Peer Counseling
Marin County Aging & Adult Services/
Marin Center for Independent Living
10/30/2017


Spirituality & Clinical Practice: Introductions
Please think of an item on your desk that you placed there purposefully –something you look at, read, smell or listen to during the course of your work day.
Please share with the group your name, role, the object and its meaning for you.
UNIVERSITY OF SAN FRANCISCO


Spirituality & Clinical Practice
Learning Objectives
•To support staff in recognizing, valuing, and preserving the human dimension of their work.
•To enable staff to experience and connect with core values of compassion, gratitude, meaning, and service.
•To enable staff to be in a relationship with each other in a way that is revelatory and inspiring.
UNIVERSITY OF SAN FRANCISCO


Spirituality Care
Learning Activities
• Discuss the fundamentals of spirituality
• Discover how spirituality affects health & wellbeing
• Assess personal beliefs & sources of meaning
UNIVERSITY OF SAN FRANCISCO

Spirituality Care

Ground Rules

- Success depends on participation – share ideas, ask questions, draw from each other
- Treat everything you hear as an opportunity to learn and grow
- Articulate hidden assumptions
- Be brief and meaningful when voicing your opinion
- Whatever is said in the room stays in the room
- Have fun!

UNIVERSITY OF SAN FRANCISCO

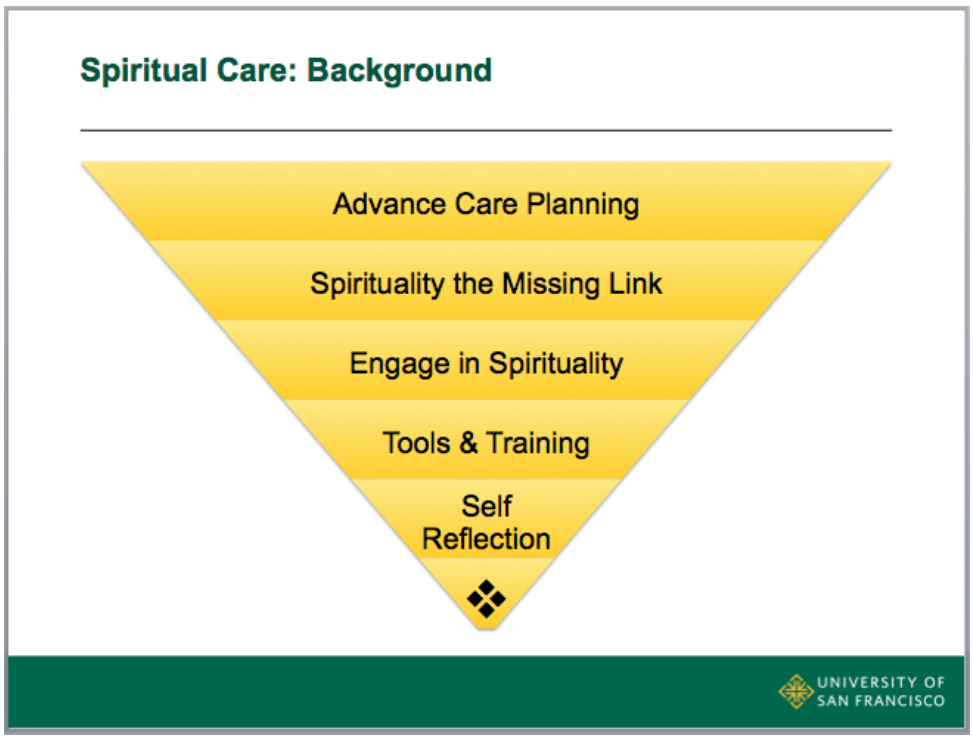
Spirituality Care

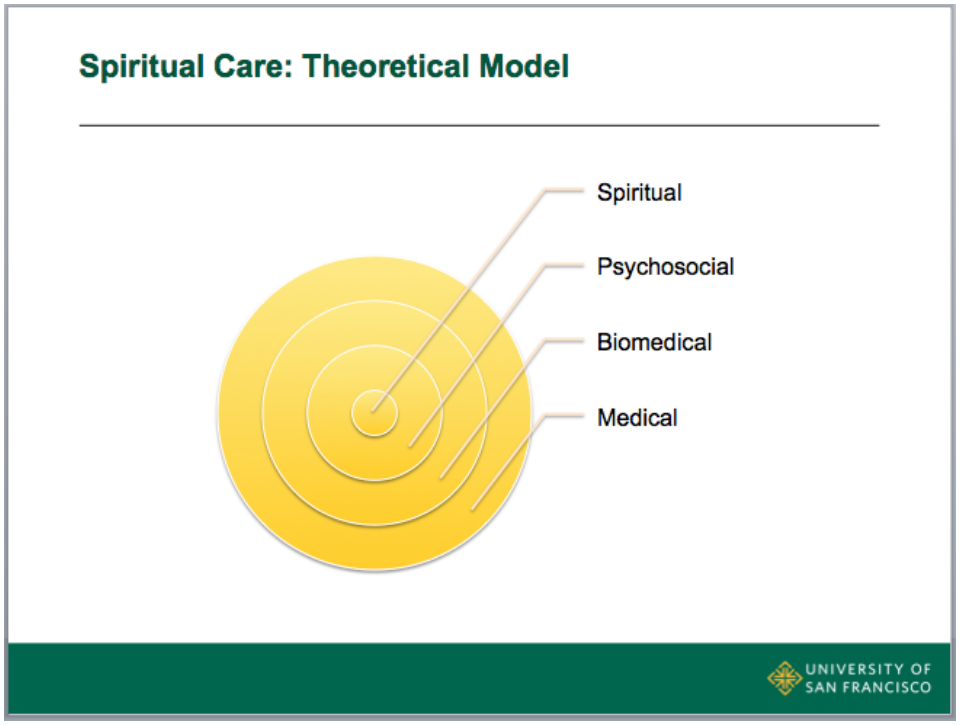
'Silver Tsunami'

- 65 year olds make up 13% of today's population
- In 2030, this number will be 18%
- Octogenarians make up 1%
- In 2050, this number will be 4%
- Birth rates fell since 1960s (~4 children), since the 1980s (~2 children).

- U.S Census Bureau, 2012

UNIVERSITY OF SAN FRANCISCO


Spiritual Care: Background
Advance Care Planning
Spirituality the Missing Link
Engage in Spirituality
Tools & Training
Self Reflection
UNIVERSITY OF SAN FRANCISCO


Spiritual Care: Theoretical Model
Spiritual
Psychosocial
Biomedical
Medical
UNIVERSITY OF SAN FRANCISCO

Spiritual Care: Key Terms

Religion

A specific set of beliefs about the transcendent, usually in association with a particular language used to describe spiritual experiences, and a community sharing key beliefs, as well as certain practices, texts, rituals, and teachings.

-Sulmasy, 1999

UNIVERSITY OF SAN FRANCISCO

Spiritual Care: Key Terms

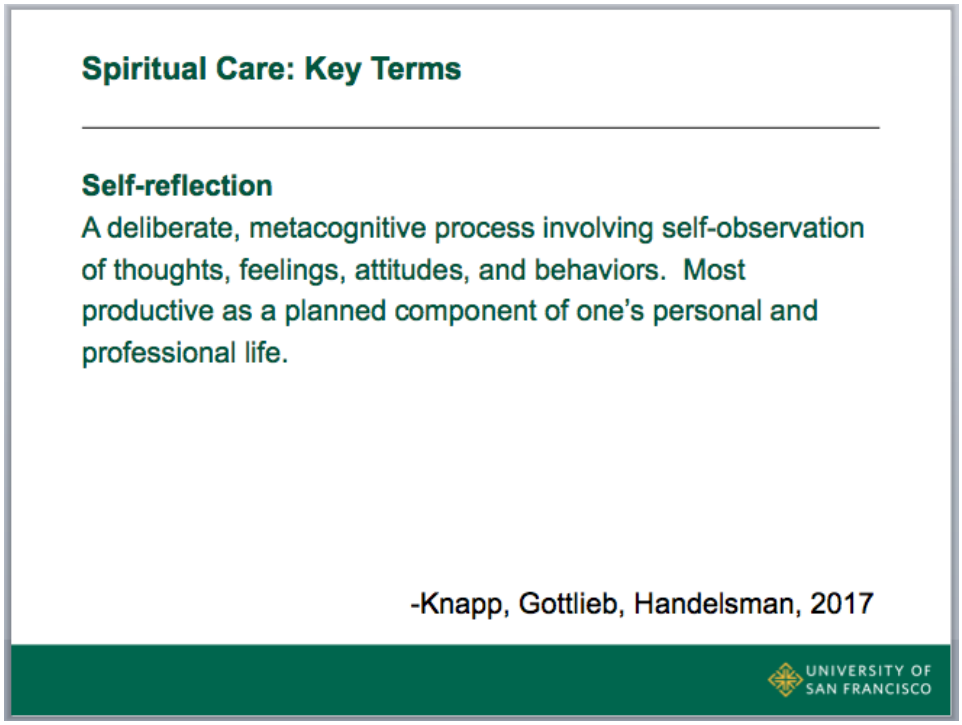
Spirituality

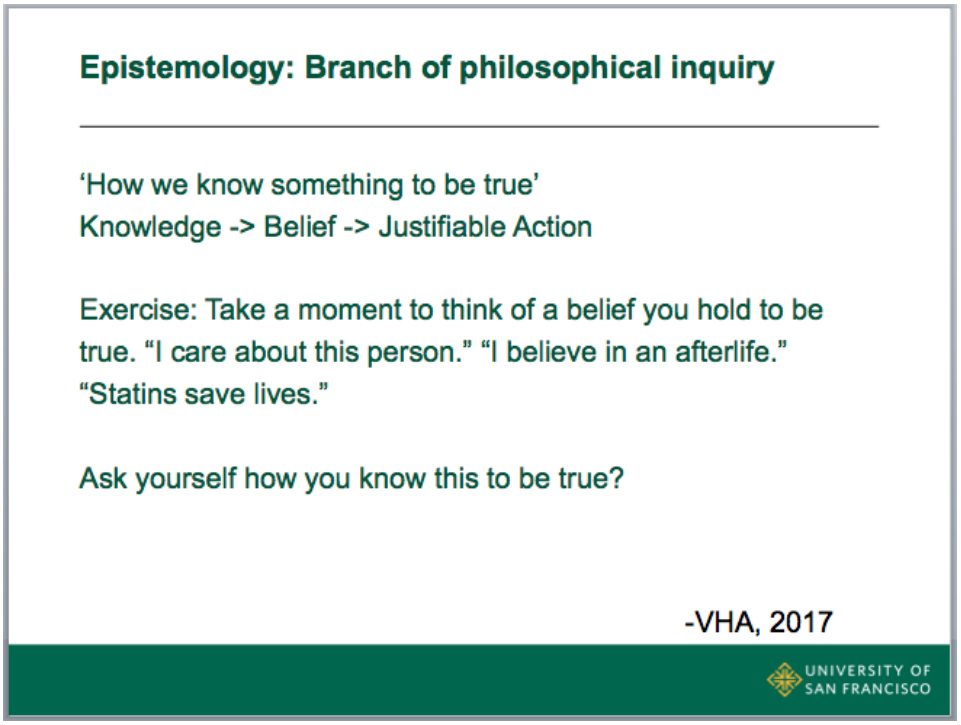
Aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.

- Religious: fostering closeness to a Higher Power
- Humanistic: involving feelings of love, reflection, altruism
- Nature: connecting to the environment
- Experiential: involving personal narrative
- Cosmos: contemplating the universe
- Mystery: allowing for the unknowable

-U.S. National Consensus Project, 2014

UNIVERSITY OF SAN FRANCISCO


Spiritual Care: Key Terms
Self-reflection
A deliberate, metacognitive process involving self-observation of thoughts, feelings, attitudes, and behaviors. Most productive as a planned component of one's personal and professional life.
-Knapp, Gottlieb, Handelsman, 2017
UNIVERSITY OF SAN FRANCISCO


Epistemology: Branch of philosophical inquiry
'How we know something to be true'
Knowledge -> Belief -> Justifiable Action
Exercise: Take a moment to think of a belief you hold to be true. "I care about this person." "I believe in an afterlife." "Statins save lives."
Ask yourself how you know this to be true?
-VHA, 2017
UNIVERSITY OF SAN FRANCISCO

Epistemology Types

Biomedical-psychosocial	Spiritual
Statistics (Facts, figures)	Humanism (Arts, narrative)
Expert Opinion (Trusted source)	Collective Consciousness (Shared inspiration)
Enculturation (Social training)	Contemplation, reflection (Mindful awareness)
Empiricism (Observation)	Intuition (Inspiration)
Heuristics (Hands on)	Subconscious, Supraconscious (Dreaming)
Instinct (Personality)	Serendipity (Chance)

-VHA, 2017

UNIVERSITY OF SAN FRANCISCO

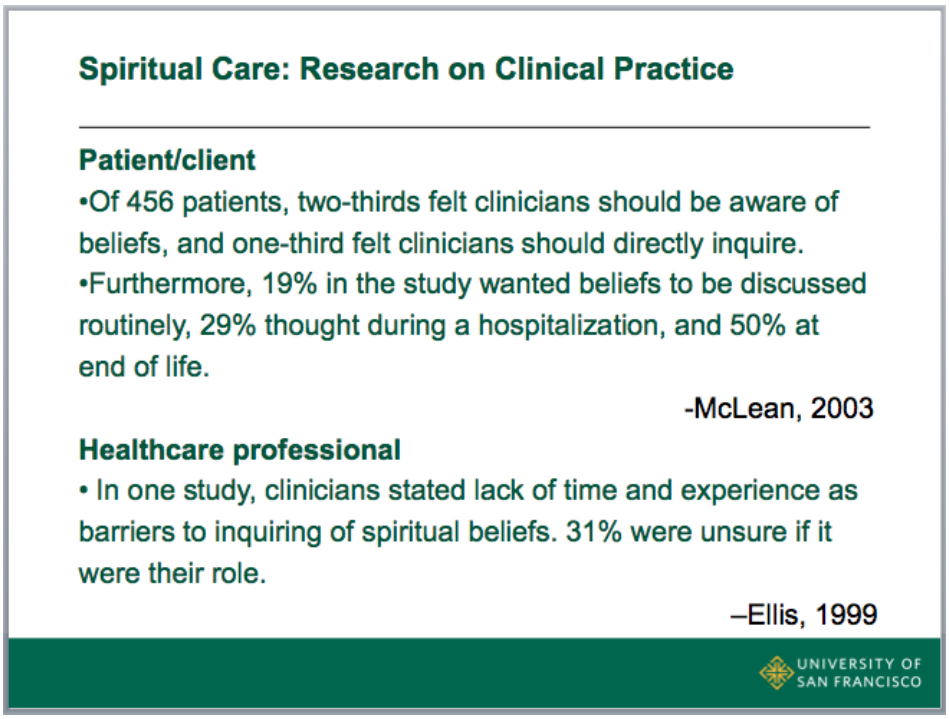
Epistemology "Know thyself"

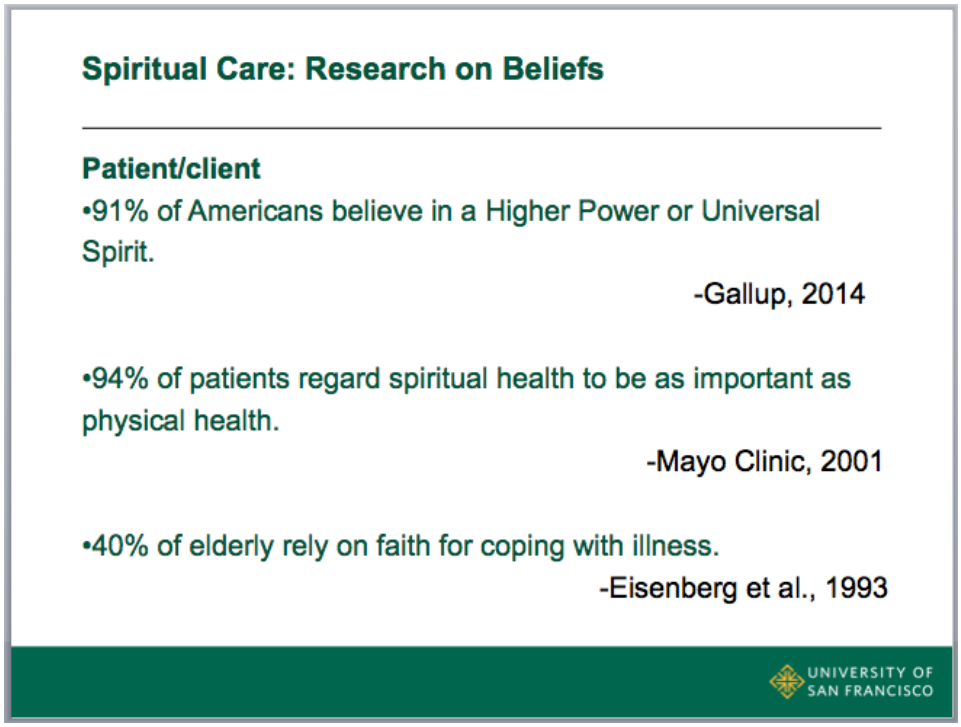
A [healthcare professional] needs to understand his or her own spiritual beliefs, values, and biases in order to remain patient-centered:

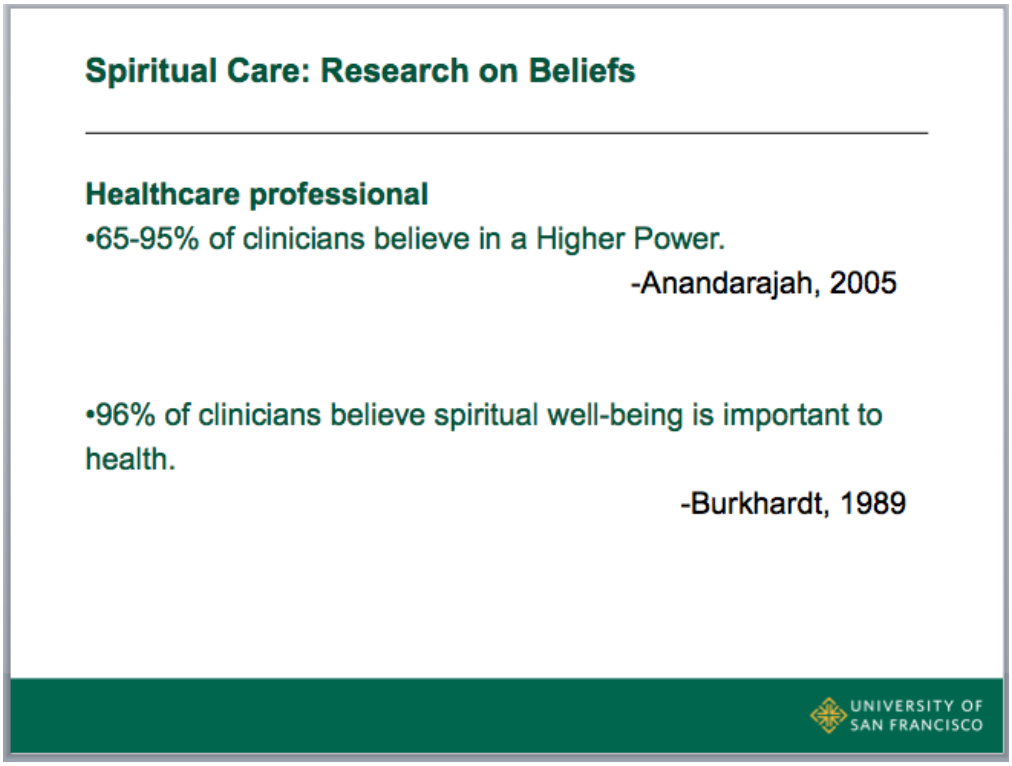
- Personal faith, tradition, beliefs and practices
- Belief in Higher Self or Higher Power
- Belief in prayer, energy work
- Perspectives on sin and punishment, guilt, forgiveness, gratitude, compassion and relevance to the healthcare setting
- Comfort discussing these ideas
- Belief and comfort around dying and death

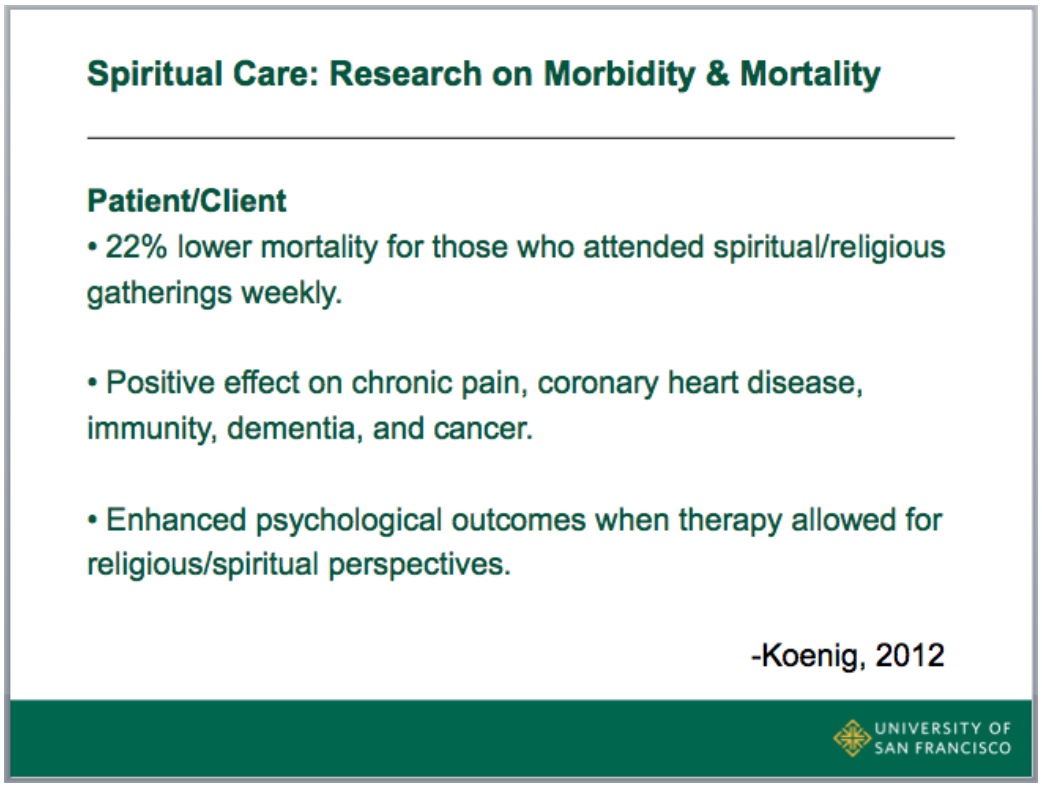
-Sulmasy, 1999; VHA, 2017

UNIVERSITY OF SAN FRANCISCO


Spiritual Care: Research on Clinical Practice
Patient/client
•Of 456 patients, two-thirds felt clinicians should be aware of beliefs, and one-third felt clinicians should directly inquire.
•Furthermore, 19% in the study wanted beliefs to be discussed routinely, 29% thought during a hospitalization, and 50% at end of life.
-McLean, 2003
Healthcare professional
• In one study, clinicians stated lack of time and experience as barriers to inquiring of spiritual beliefs. 31% were unsure if it were their role.
–Ellis, 1999
UNIVERSITY OF SAN FRANCISCO


Spiritual Care: Research on Beliefs
Patient/client
•91% of Americans believe in a Higher Power or Universal Spirit.
-Gallup, 2014
•94% of patients regard spiritual health to be as important as physical health.
-Mayo Clinic, 2001
•40% of elderly rely on faith for coping with illness.
-Eisenberg et al., 1993
UNIVERSITY OF SAN FRANCISCO


Spiritual Care: Research on Beliefs
Healthcare professional
•65-95% of clinicians believe in a Higher Power.
-Anandarajah, 2005
•96% of clinicians believe spiritual well-being is important to health.
-Burkhardt, 1989
UNIVERSITY OF SAN FRANCISCO

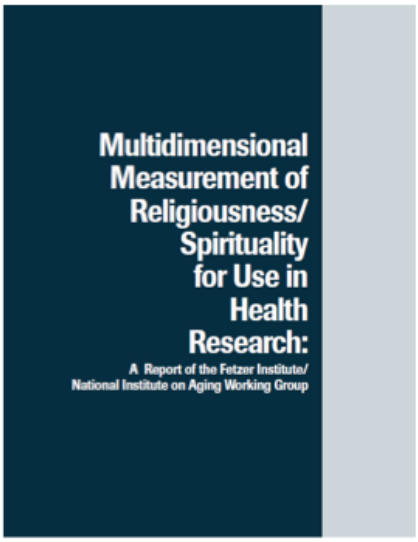

Spiritual Care: Research on Morbidity & Mortality
Patient/Client
• 22% lower mortality for those who attended spiritual/religious gatherings weekly.
• Positive effect on chronic pain, coronary heart disease, immunity, dementia, and cancer.
• Enhanced psychological outcomes when therapy allowed for religious/spiritual perspectives.
-Koenig, 2012
UNIVERSITY OF SAN FRANCISCO

Spiritual Care: Know Thyself

Fetzer Institute/NIA/NIH (2003)

- Values
- Meaning
- Daily Spiritual Experiences

•Clarification: The surveys include items you may or may not experience. Consider if and how often you have these experiences, and try to disregard whether you feel you should or should not have them. In addition, a number of items use the word "God." If this word does not speak to your belief, please substitute another idea that calls to mind the divine or transcendent for you.



UNIVERSITY OF SAN FRANCISCO

Spiritual Care: Heal Thyself

Gratitude

- Recognition that one has obtained a positive outcome and that there is an external source for the positive outcome.
- External source: personal, impersonal (nature) or nonhuman sources (e.g., God, animals, the cosmos).
- Increase in life satisfaction, physical well-being, social connection, and resilience.

-Emmons & , 2003

UNIVERSITY OF SAN FRANCISCO

Spiritual Care: Assessment Tools

Spiritual History

A set of exploratory questions designed to invite patients to share their beliefs to identify spiritual issues. It is patient centered and guided to the extent the patient chooses to disclose his or her spiritual needs.

-Borneman, et al., 2010

- FICA
- HOPE
- SPIRIT
- IAMSECURE

UNIVERSITY OF SAN FRANCISCO

Spiritual Care

Advance Care Planning

- Peter Safar –father of critical care & Nobel peace prize recipient
- Paul Kutner –human rights lawyer & proponent of living will
- PSDA Act- result of Quinlan & Cruzan cases
- Research findings: provider comfort, reimbursement, time, institutional support; patient comfort, health literacy, culture, surrogate burden
- Dartmouth Atlas: ~$30k EOL costs
- AD completion rate over time: steady at 20-30%

UNIVERSITY OF SAN FRANCISCO

Spiritual Care

Advance Care Planning

- Ellen Goodman and the Conversation Project (2010)
- Rebecca Sudore and PREPARE (2016)
- Vyjeyanthi Periyakoil "What matters most" letter (2015)
- Angelo Volandes and ACP Decisions (2010)
- Michael Hebb Deathoverdinner platform (2012)

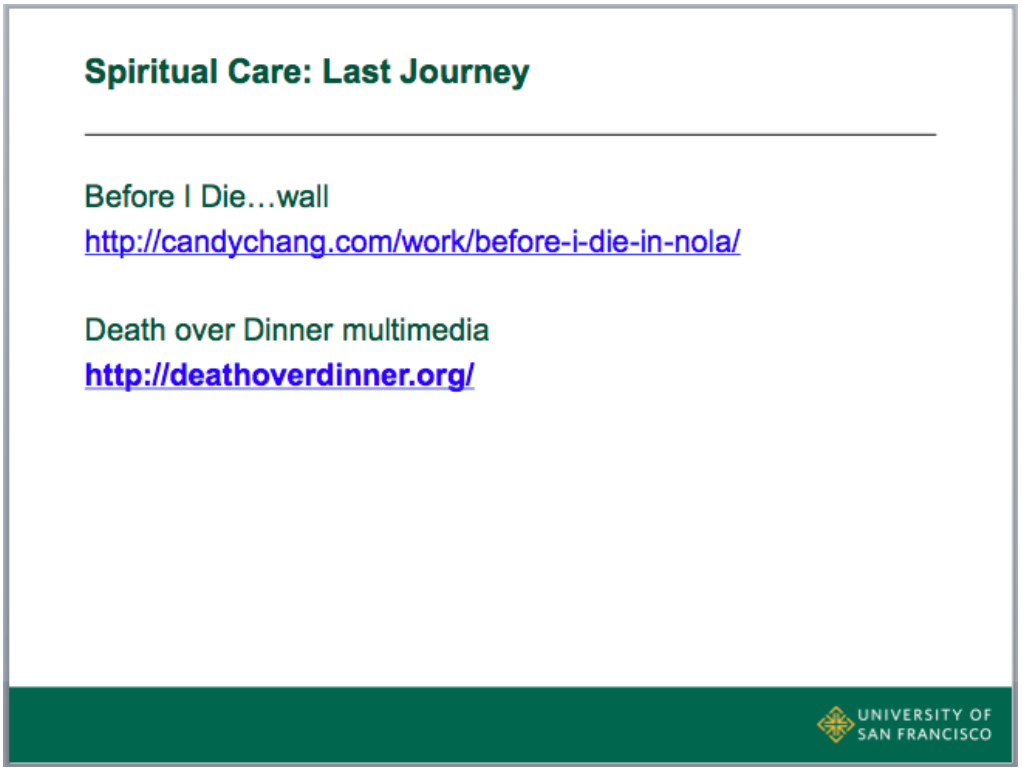
UNIVERSITY OF SAN FRANCISCO

Spiritual Care

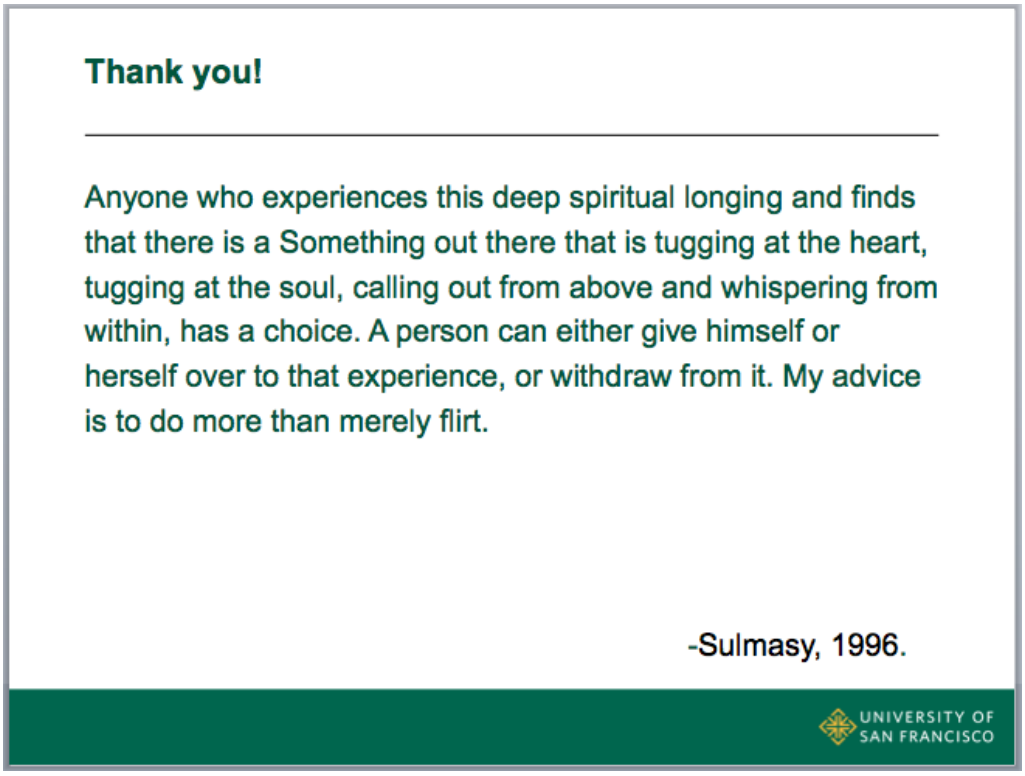
Reflections on Death & Dying

- https://www.smithsonianmag.com/videos/category/arts-culture/the-coffin-maker/
- https://www.ted.com/talks/steve_jobs_how_to_live_before_you_die
- http://www.npr.org/programs/death/readings/stories/ebwhite.html
- https://www.thisamericanlife.org/radio-archives/episode/476/what-doesnt-kill-you?act=1

UNIVERSITY OF SAN FRANCISCO


Spiritual Care: Last Journey
Before I Die…wall
http://candychang.com/work/before-i-die-in-nola/
Death over Dinner multimedia
http://deathoverdinner.org/
UNIVERSITY OF SAN FRANCISCO


Future Directions
Continued Practice
• Thank God, it's Spirituality Friday!
• Balint group
• Spiritual assessment of clients
• Ignatian spiritual practice (ISP) for clients
UNIVERSITY OF SAN FRANCISCO


Thank you!
Anyone who experiences this deep spiritual longing and finds that there is a Something out there that is tugging at the heart, tugging at the soul, calling out from above and whispering from within, has a choice. A person can either give himself or herself over to that experience, or withdraw from it. My advice is to do more than merely flirt.
-Sulmasy, 1996.
UNIVERSITY OF SAN FRANCISCO

Daily Spiritual Experiences

Lynn G. Underwood, PhD
Vice President-Health Research
Fetzer Institute
Kalamazoo, Michigan

Domain of Measurement

This domain is intended to measure the individual's perception of the transcendent (God, the divine) in daily life and the perception of interaction with, or involvement of, the transcendent in life. The items attempt to measure experience rather than cognitive constructions. Although a variety of the domains in the more complete Brief Multidimensional Measure of Religiousness/Spirituality: 1999 address spirituality, this domain makes spirituality its central focus and can be used effectively across many religious boundaries.

Description of Measures

This domain attempts to capture those aspects of life that represent day-to-day spiritual experience particularly well. The domain was designed to be a more direct measure of the impact of religion and spirituality on daily life. The items assess aspects of day-to-day spiritual experience for an ordinary person, and should not be confused with measures of extraordinary experiences (such as near-death or out-of-body experiences), which may tap something quite different and have a different relationship to health outcomes. The experiences reflected in this domain may be evoked by a religious context or by daily life. They may also reflect the individual's religious history and/or religious or spiritual beliefs.

Cognitive interviews conducted with this instrument across a variety of cultural, religious, and educational groups have encouraged the use of the word "God" to describe the transcendent. Even the few people for whom the word "God" is not the usual descriptor of the transcendent seem capable of connecting the term with their experience. Although this instrument assumes a predominantly Judeo-Christian research population, the items have shown promise in preliminary evaluations for use with other groups and may require only minor modifications for such application.

This complete domain has not been separately addressed in any published, tested instrument. In developing this instrument, the author drew on in-depth interviews and focus groups conducted over a number of years, exploring in an open-ended way the experiences of a wide variety of individuals from many religious perspectives. These reports of individual experience, plus a review of features of the spiritual life as highlighted in theological, spiritual and religious writings (Buber 1937, van Kaam 1991, Merton 1969, Hanh 1994, Underhill 1927, De Wit 1991), were used to develop this instrument. A review of current scales that attempt to measure some aspect of spiritual experience was also conducted (Hood 1975, Elkins et al 1988, Idler and Kasl 1992). Some of the most helpful insights came from reading works by those who have a deep understanding of the spiritual as an integral aspect of life, and seeing many similar issues emerge in the open-ended interviews. Cognitive interviews on earlier drafts of the instrument led to further refinements, and efforts were repeatedly made to ground the questions in daily experience.

The interviews revealed that connection was an important concept. Western spirituality emphasizes a more personal connection with God and other people, while Eastern spirituality places more emphasis on connection with all of life, and connection in unity. Many people have frequent interaction with the transcendent on a daily basis, looking to God for strength, asking for help, and feeling guidance in specific circumstances. Emotional support from the transcendent is manifested in feelings of being loved and comforted. A concept that emerges frequently in the spiritual literature of both Eastern and Western traditions is the concept of spiritual integration, with a resulting sense of inner harmony or wholeness.

Another concept that emerged was the sense that one can have an existence that does not solely depend on physical or mental aspects of self or social definitions: that one is connected to something beyond self or deeper within self. The ability to transcend the limits of one's present situation frequently comes from a spiritual and religious context. van Kamm (1986) suggests that awe is the central quality of the spiritual life and all other aspects flow from that. Awe comes from a realization that one is not the center of the universe, and from a sense of wonder or mystery that the universe itself speaks of the transcendent and can frame one's approach. David Steindal-Rast (1984) describes how gratefulness can provide a resting place for much of the rest of spiritual life. An attitude of gratefulness suggests that life is a gift rather than a right.

Compassion is a central component to many spiritual traditions (Smith 1991) and its capacity to benefit the one who is compassionate might be profitably explored in the setting of health. Forgiveness, while developed as its own domain in the larger instrument, is linked with the concept of mercy, which is employed in this scale. Giving others the benefit of the doubt, dealing with others' faults in light of one's own, and being generous are possible ways in which the spiritual is evident in everyday life.

In developing this instrument, the notion that one might not have a connection with the transcendent, but that one might long for such a connection was discussed. Longing for connections with God, or the divine, is an aspect of the spiritual life that crops up in the mystical literature of many traditions and can easily be considered an element of daily spiritual experience of ordinary people. Such yearning is also manifested in a sense of wanting to be closer to God, or to merge with the divine.

In developing this domain, 9 key dimensions were identified: connection with the transcendent, sense of support from the transcendent, wholeness, transcendent sense of self, awe, gratitude, compassion, mercy, and longing for the transcendent. The response categories, except for question 16, relate to frequency, and make use of the following scale: many times a day, every day, most days, some days, once in a while, never or almost never.

Connection with the Transcendent

1. I feel God's presence.
2. I experience a connection to all of life.

As in our relationships with each other, this quality of intimacy can be very important. These questions were developed to address both people whose experience of relationship with the transcendent is one of personal intimacy and those who describe a more general sense of unity as their connection with the transcendent.

Sense of Support from the Transcendent

A sense of support is expressed in 3 ways: strength and comfort, perceived love, and inspiration/discernment.

Strength and Comfort

4. I find strength in my religion or spirituality.
5. I find comfort in my religion or spirituality.

This dimension has been described as "social support from God." The Index of Religiosity measure—"I obtain strength and comfort

from my religion" (Idler and Kasl 1992)—was broken into 2 parts, based on cognitive interviews that revealed a perception that strength and comfort were distinct. The items intend to measure a direct sense of support and comfort from the transcendent. They may prove highly correlated and may be combined as this instrument undergoes further testing.

Perceived Love

9. I feel God's love for me directly.
10. I feel God's love for me through others.

Individuals can believe that God is loving without feeling loved themselves. The emotional support of feeling loved may prove important in the relationship of religious/spiritual issues to health outcomes. The quality of love imputed to God has potential differences from the love humans give each other, and there is a kind of love from others which many attribute to God. God's love can be experienced as affirming, and can contribute to self-confidence and a sense of self-worth independent of actions.

Inspiration/Discernment

7. I ask for God's help in the midst of daily activities.
8. I feel guided by God in the midst of daily activities.

These items address the expectation of divine intervention or inspiration and a sense that a divine force has intervened or inspired. The "guidance" item was most often deemed similar to a "nudge" from God and more rarely as a more dramatic action.

Sense of Wholeness, Internal Integration

6. I feel deep inner peace or harmony.

This item attempts to move beyond mere psychological well-being. In the cognitive interviews, individuals were asked repeatedly whether a person could experience a sense of wholeness while feeling overwhelmed, stressed, or depressed. Those interviewed generally felt that a sense of wholeness would be harder to experience under adverse circumstances, but that such internal integration was still possible. The word "deep" allows people to consider factors other than psychological ease.

Transcendent Sense of Self

3. During worship, or at other times when connecting with God, I feel intense joy which lifts me out of my daily concerns.

This item attempts to identify the experience of a lively worship service where one's day-to-day concerns can dissolve in the midst of worship. Transcending the difficulties of present physical ills or psychological situations may also be possible through an awareness that life consists of more than the physical and psychological. For further exploration of this concept, see Underwood 1998. This was a particularly difficult dimension to translate from metaphysical terms into more practical lay language.

Sense of Awe

11. I am spiritually touched by the beauty of creation.

This dimension attempts to capture the ways in which people experience the transcendent. A sense of awe can be provoked by exposure to nature, human beings, or the night sky, and has an ability to elicit experience of the spiritual that crosses religious boundaries and affects people with no religious connections (van Kaam 1986).

Sense of Gratitude

12. I feel thankful for my blessings.

This aspect of spirituality is considered central by many people and has potential connection to psychologically positive ways of viewing life. Because of the potential connections between gratitude and circumstances of life, external stressors may modify a respondent's feelings of thankfulness. It is important to note, however, that some people find blessings even in the most dire circumstances.

Sense of Compassion
13. I feel a selfless caring for others.

This item was preferred to "I care for others without expecting anything in return," which can reflect negative connotations about expectations of others. "Selfless caring," a seemingly unwieldy term, was easily understood by diverse individuals. Compassion is valued in Buddhist, Christian, and Jewish traditions, and may be a useful measure beyond these traditions.

Sense of Mercy
14. I accept others even when they do things I think are wrong.

This item addresses the felt sense of mercy, rather than the mere cognitive awareness that mercy is a good quality. As demonstrated in the cognitive interviews, this measure was successful in presenting mercy as a neutral, easily understood concept. Mercy, as presented in this item, is closely linked to forgiveness, yet is a deeper experience than isolated acts of forgiveness.

Longing for the Transcendent
15. I desire to be closer to God or in union with Him.

This item should always be paired with question 16 to fully evaluate the concept of longing. There are 2 opposed ways of responding to this item: some people feel they are so close to God that it is not possible to get closer; others have no desire to become closer. To clarify a respondent's view, item 16 has been added.

16. In general, how close to God do you feel?

Item 15 was included to evaluate experiences of being drawn to the spiritual, to assess desire or longing. Question 16 assesses the individual's current degree of intimacy or connection with God.

These dimensions form a starting point and will likely be expanded as this work progresses. We hope that a number of the dimensions will be strongly correlated. The wide variety of items seeks to elucidate a few common elements.

Previous Psychometric Work

The instrument has been incorporated into 3 large studies of physical health outcomes, including the Chicago site of a multicenter menopause study, an Ohio University pain study, and a study at Loyola University of Chicago. In addition, the instrument has been incorporated into 3 ongoing health studies as well as a qualitative and quantitative evaluation on a non-Judeo-Christian Asian population at the University of California, San Francisco.

Reliability and exploratory factor analysis from the different samples support the use of the instrument to measure daily spiritual experiences. The scale is highly internally consistent, with alphas ranging from .91 to .95 across samples. Preliminary construct validity was established by examination of the mean scale scores across sociodemographic subgroups, and preliminary exploratory factor analyses support a unidimensional set. The analysis has been included in an article submitted for publication (Underwood and Teresi 1999).

A shortened version of the instrument was embedded in the 1997-1998 wave of the General Social Survey. A summary of that psychometric data is included in Appendix A of this report.

Association with Health

While existing scales for mystical or spiritual experience attempt to capture aspects of this domain associated with psychological well-being, little empirical work links the spiritual experiences of daily life with health outcomes. However, one of the items most strongly predictive of positive health outcome in the Oxman study of cardiovascular disease (Oxman et al 1995) was incorporated into this scale: "I obtain strength and comfort from my religion."

The emotional and physical feelings described by these items may buffer individuals from psychological stress, which has been extensively linked to health through specific physiologic effects (Cohen et al 1995). Positive emotional experiences have also been connected with positive effects on the immune system, independent of the negative effects of stress (Stone 1994). Likewise, positive expectations for outcomes have been linked to positive immune effects (Flood et al 1993, Roberts et al 1995). There may also be overlap between endorsing a "sense of deep peace" and the condition that leads to or emanates from direct neurologic and endocrine effects similar to those identified during meditation (Benson 1975).

The inclusion of this domain in health studies has great potential for establishing a pathway by which religiousness and spirituality might influence health, providing a possible link between certain religious/spiritual practices and/or cognition and health outcomes. This domain also provides an opportunity to assess direct effects of daily spiritual experiences on physical and mental health.

Estimated Completion Time

Less than 2 min.

Other Considerations

We are hoping to tap into a trait. However, since this domain measures perceptions and feelings, scores may vary according to external stressors and emotional state. Ideally, psychosocial variables (such as emotional states, traits, and levels of stressors) would be addressed in concurrently administered measures, allowing researchers to account for confounding by these factors.

Please note: When introducing the Daily Spiritual Experience items to subjects, please inform them, *"The list that follows includes items you may or may not experience. Please consider if and how often you have these experiences, and try to disregard whether you feel you should or should not have them. In addition, a number of items use the word 'God.' If this word is not a comfortable one, please substitute another idea that calls to mind the divine or holy for you."*

Proposed Items

DAILY SPIRITUAL EXPERIENCES–LONG FORM

You may experience the following in your daily life. If so, how often?

1. I feel God's presence.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

2. I experience a connection to all of life.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

3. During worship, or at other times when connecting with God, I feel joy which lifts me out of my daily concerns.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

4. I find strength in my religion or spirituality.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

5. I find comfort in my religion or spirituality.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

6. I feel deep inner peace or harmony.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

7. I ask for God's help in the midst of daily activities.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

8. I feel guided by God in the midst of daily activities.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

9. I feel God's love for me, directly.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

10. I feel God's love for me, through others.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

11. I am spiritually touched by the beauty of creation.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

12. I feel thankful for my blessings.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

13. I feel a selfless caring for others.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

14. I accept others even when they do things I think are wrong.
   1 - Many times a day
   2 - Every day
   3 - Most days
   4 - Some days
   5 - Once in a while
   6 - Never or almost never

The following 2 items are scored differently.

15. I desire to be closer to God or in union with Him.
   1 - Not at all close
   2 - Somewhat close
   3 - Very close
   4 - As close as possible

16. In general, how close do you feel to God?
   1 - Not at all close
   2 - Somewhat close
   3 - Very close
   4 - As close as possible

DAILY SPIRITUAL EXPERIENCES-SHORT FORM

None provided.

Additional Information regarding DSES Survey:

The Daily Spiritual Experience Scale (DSES) has been included in a number of research studies, including the alcohol studies mentioned in the preface as well as projects funded from the Fetzer Institute request for proposals, Scientific Research on Altruistic Love and Compassionate Love. We found that many investigators without current self-report measures directly addressing compassionate love included two items from the DSES in their study as a measure of compassion and mercy. These items are DSES #13, "I feel a selfless caring for others," and DSES #14, "I accept others even when they do things I think are wrong."

These same two items were also placed in the latest 2002 wave of the General Social Survey in a National Study of Altruism, (National Opinion Research Center/University of Chicago). The results are as follows:

	I feel a selfless caring for others	I accept others even when they do things I think are wrong
Many times a day	9.8	9.4
Every day	13.2	15.5
Most days	20.3	32.4
Some days	24.0	23.0
Once in a while	22.3	14.8
Never or almost never	10.4	4.9

Including the DSES as measurement of a spiritual component along with more organizational religious measures may present an important method to examine religiousness/spirituality in health studies.

A copy of the article, "The Daily Spiritual Experience Scale: Development, Theoretical Description, Reliability, Exploratory Factor Analysis, and Preliminary Construct Validity Using Health-Related Data" by Underwood and Teresi, *Annals of Behavioral Medicine* 2002, 24(1): 22-33, can be found at www.fetzer.org or by contacting info@fetzer.org.

Bibliography

Benson H. *The Relaxation Response.* New York, NY: Avon; 1975.

Buber M. *I and Thou.* New York, NY: Charles Scribners & Sons; 1970.

Cohen S, Kessler R, Underwood-Gordon L. *Measuring Stress: A Guide for Health and Social Scientists.* New York, NY: Oxford Press; 1995.

De Wit HF. *Contemplative Psychology.* Pittsburgh, Penn: Duquesne Press; 1991.

Elkins DN, Hedstrom LJ, Hughes LL, Leaf JA, Saunders C. Toward a humanistic-phenomenological spirituality: definition, description, and measurement. *J Humanistic Psychol.* 1988;28(4):5-18.

Flood AB, Lorence DP, Ding J, et al. The role of expectations in patients' reports of post-operative outcomes and improvement following therapy. *Med Care.* 1993;31(11):1043-1056.

Hanh TN. *A Joyful Path: Community, Transformation and Peace.* Berkeley, Calif: Parallax Press; 1994.

Hood R. The construction and preliminary validation of a measure of reported mystical experience. *J Sci Study Religion.* 1975;22:353-365.

Howden J. *Development and Psychometric Characteristics of the Spirituality Assessment Scale* [dissertation]. Texas Women's University; 1992.

Idler EL. Religiousness involvement and health of the elderly: some hypotheses and an initial test. *Soc Forces.* 1987;66:226-238.

Idler EL, Kasl S. Religion, disability, depression and the timing of death. *Am J Sociol.* 1992;97(4):1052-1079.

Koenig HG, Smiley M, Gonzales J. *Religion, Health, and Aging.* Westport, Conn: Greenwood Press; 1988.

Merton, T. *Life & Holiness.* New York, NY: Doubleday; 1969.

Oxman TE, Freeman DH, Manheimer ED. Lack of social participation or religious strength and comfort as risk factors for death after cardiac surgery in the elderly. *Psychosom Med.* 1995;57:5-15.

Roberts AH, Kewman DG, et al. The power of nonspecific effects in healing: implications for psychosocial and biological treatments. *Clin Psychol Rev.* 1995;13:375-391.

Smith H. *The World's Religions: Our Great Wisdom Traditions.* Rev ed. San Francisco, Calif: Harper; 1991.

Steindal-Rast D. *Gratefulness, the Heart of Prayer: An Approach to Life in Fullness.* New York, NY: Paulist Press; 1984.

Stone AA, Bovbjerg DH. Stress and humoral immunity: a review of the human studies. *Adv Neuroimmunol.* 1994;4:49-56.

Underhill E. *Practical Mysticism.* United Kingdom: Shaw Publications; 1927.

Underwood LG. A working model of health: spirituality and religiousness as resources: applications to persons with disability. *J Religion Disability Rehabil.* In press.

Underwood L., Teresi J. Development, theoretical description, reliability and exploratory factor of the daily spiritual experience (DSE) scale. In press.

van Kaam A. *Formation of the Human Heart.* In: *Formative Spirituality Series.* Vol 3. New York, NY: Crossroads; 1991.

van Kaam A. *Fundamental Formation.* In: *Formative Spirituality Series.* Vol 1. New York, NY: Crossroads; 1986.

Meaning

Kenneth I. Pargament, PhD
Bowling Green State University
Department of Psychology
Bowling Green, Ohio

Domain of Measurement

Constructing meaning from life's events is an essentially human endeavor. Less clear is the means for measuring a person's search for meaning (the process) and the success or failure of that search (the outcome). Although many items pertaining to meaning are present in a variety of scales, none could be called definitive.

Description of Measures

Attempts to measure the construct of meaning grow largely out of the theoretical work of Viktor Frankl, who asserted that the "will to meaning" is an essential human characteristic, one that can lead to physical and mental symptomatology if blocked or unfulfilled (Frankl 1963). Others have also spoken of the importance of meaning or purpose in life as part of a sense of coherence (Antonovsky 1979), an essential function of coping with major life stresses (Park and Folkman in press), or an element of psychological well-being (Ryff 1989).

The search for meaning has also been defined as one of the critical functions of religion. Frankl himself viewed meaning in religious terms. Meaning as he saw it was something to be "discovered rather than created," that is, every individual was said to have a unique, externally given purpose in life. Other theorists have also defined religion as that individual and social force concerned with existential questions and their solutions (Batson, Schoenrade, and Ventis 1993; Geertz 1966).

In support of the "religion-meaning" connection, several studies have demonstrated significant relationships between measures of religiousness (particularly conservative religiousness) and a sense of purpose in life (Dufton and Perlman 1986, Paloutzian 1981).

Previous Psychometric Work

Current Scales for Assessing Meaning: Several scales have been developed to measure aspects of meaning or purpose in life. These include:

- The Purpose-in-Life scale (PIL), which assesses the degree to which the individual experiences a sense of meaning or purpose (Crumbaugh 1968);
- The Seeking of Noetic Goals scale (SONG), which measures the strength of motivation to find meaning in life (Crumbaugh 1977);
- The Life Regard Index (LRI), which assesses whether the individual has a framework from which meaning can be derived and the degree to which these life goals are being fulfilled (Battista and Almond 1973);
- The Life Attitude Profile (LAP), which contains items from the PIL and SONG, as well as other items (Reker 1992);
- The Sense of Coherence scale (SOC), which assesses the degree to which the world and life events are perceived as comprehensible, manageable, and meaningful (Antonovsky 1979, 1987); and
- Ryff's Purpose-in-Life subscale, which assesses the degree to which the individual has goals in life, holds beliefs that give life purpose, and perceives meaning in the present and past (Ryff and Keyes 1995).

Measures of meaning have been criticized. First, the scales appear to be multidimensional. For example, factor analyses of the PIL test (one of the most heavily used meaning measures) reveal several factors which vary from study to study (Dufton and Perlman 1986, Chamberlain and Zika 1988). Dufton and Perlman (1986) in working with college students created a two-factor solution (life satisfaction and life purpose) and another set of items that did not use either of these factors. Chamberlain and Zika (1988), working with a sample of community women, found a four-factor solution (meaning in life through goal commitment, contentedness with life, being in control, enthusiasm with life). They did, however, find a higher order general factor. Other rationally derived meaning scales include a number of subscales that seem to be related, tangentially at best, to the core construct of meaning. For example, an early form of the LAP consisted of 7 subscales: goal seeking, future meaning, existential vacuum, death acceptance, life purpose, life control, and will to meaning (Reker and Peacock 1981). The PIL subscale by Ryff (1989) appears to measure an active goal orientation ("I enjoy making plans for the future and working to make them a reality"), as well as the sense of meaning and purpose.

Criticisms can also be made of the confounding of meaning with other health-related constructs, such as depression. The PIL scale, for instance, correlates -.65 with the Minnesota Multiphasic Personality Inventory depression scale and -.58 with the Beck Depression Inventory (Dyck 1987). The correlation is understandable; several items on the PIL include responses about suicidal ideation, emptiness and despair, and painful and boring experiences.

It would be useful to distinguish the search for meaning (a process) from the success or failure of the search (the outcome). In fact, some of the factor-analytic results suggest this split (Dufton and Perlman 1986). The scales seem to do a better job of measuring the outcome than the process. Stated another way, more measures evaluate whether the individual has found meaning than whether the individual is searching for meaning. The outcome-oriented approach to measurement is apparently more vulnerable to confounding; the attainment of a sense of meaning and purpose in life seems difficult to separate from life satisfaction or low levels of depression. The process-oriented approach seems to be less vulnerable to confounding; whether people who are engaged in a search for meaning are more likely to report better health status is an interesting question. In this vein, Emmons has conducted a number of studies that indicate significant relationships between various personal strivings (efforts to attain a variety of goals in daily life) and indices of mental and physical health (Emmons 1986, Emmons in press).

The Religious Aspects of Meaning:

A key question for researchers is whether meaning is inherently religious or spiritual. This question cuts to the heart of what it means to be religious. From the functional tradition of religious definition, the search for meaning could be (and has been) defined as inherently religious (Pargament 1997). Anyone who searches for answers to questions of meaning from this point of view would be defined as religious, regardless of the nature of that search. The person who seeks meaning through science, drugs, power, etc., would be considered as religious as the person who seeks meaning through transcendental means. From the substantive tradition of religious definition, the search for meaning becomes religious only when it involves some connection with the sacred.

Meaning has traditionally been measured from the functional tradition. Most items on meaning scales do not explicitly reference God, higher powers, or spiritual matters. To assess meaning from the perspective of this tradition, researchers could select the PIL test by Crumbaugh (the most widely used instrument), the Purpose and Coherence subscales from the LAP by Reker (conceptually

sharper), or the PIL subscale from Ryff (linked to a larger theory of psychological well-being). It is also important to note that these scales generally focus more on the attainment of meaning (the outcome) than the search for meaning (the process). Reker's subscales, however, do recognize this distinction.

No scales measure meaning from a substantive religious perspective. The development of a more explicit religious and/or spiritual meaning scale would be a useful addition to the literature. Because religious/spiritual meaning lies at the core of meaning itself, according to some theorists, an explicitly religious/spiritual meaning may add power to the study of meaning (for example, a spiritual meaning measure may predict health above and beyond the effects of traditional meaning measures). An explicitly theistic meaning scale would consist of items such as: "The events in my life unfold according to a divine plan"; and "Without God, my life would be meaningless." A spiritual meaning scale would consist of items such as: "My spirituality gives meaning to my life's joys and sorrows"; and "What gives meaning to my life is the knowledge that I am a part of something larger than myself." These illustrative items are also better indicators of the attainment of religious/spiritual meaning (the outcome) than the search for religious/spiritual meaning (the process).

Studies of the search for religious/spiritual meaning are also needed. Batson's "quest" scale provides 1 useful tool for assessing the degree to which the individual is engaged in efforts to answer fundamental existential questions (Batson, Schoenrade, and Ventis 1993). Emmons' research on personal strivings could also be extended to include studies of religious and spiritual strivings, or the degree to which personal strivings are sanctified (Emmons in press).

Association with Health

A number of studies have found significant relationships between the sense of meaning in life and indices of health, particularly mental health (Crumbaugh 1968, Zika and Chamberlain 1987, Padelford 1974, Ryff 1989).

Proposed Items

MEANING–LONG FORM

Instructions: Please circle how much you agree or disagree with the following statements on the scale below.

1 - Strongly disagree
2 - Disagree
3 - Neutral
4 - Agree
5 - Strongly agree

1. My spiritual beliefs give meaning to my life's joys and sorrows.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

2. The goals of my life grow out of my understanding of God.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

3. Without a sense of spirituality, my daily life would be meaningless.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

4. The meaning in my life comes from feeling connected to other living things.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

5. My religious beliefs help me find a purpose in even the most painful and confusing events in my life.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

6. When I lose touch with God, I have a harder time feeling that there is purpose and meaning in life.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

7. My spiritual beliefs give my life a sense of significance and purpose.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

8. My mission in life is guided/shaped by my faith in God.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

9. When I am disconnected from the spiritual dimension of my life, I lose my sense of purpose.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

10. My relationship with God helps me find meaning in the ups and downs of life.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

11. My life is significant because I am part of God's plan.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

12. What I try to do in my day-to-day life is important to me from a spiritual point of view.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

13. I am trying to fulfill my God-given purpose in life.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

14. Knowing that I am a part of something greater than myself gives meaning to my life.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

15. Looking at the most troubling or confusing events from a spiritual perspective adds meaning to my life.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

16. My purpose in life reflects what I believe God wants for me.
   1 - Strongly disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
   5 - Strongly agree

17. Without my religious foundation, my life would be meaningless.
    1 - Strongly disagree
    2 - Disagree
    3 - Neutral
    4 - Agree
    5 - Strongly agree

18. My feelings of spirituality add meaning to the events in my life.
    1 - Strongly disagree
    2 - Disagree
    3 - Neutral
    4 - Agree
    5 - Strongly agree

19. God plays a role in how I choose my path in life.
    1 - Strongly disagree
    2 - Disagree
    3 - Neutral
    4 - Agree
    5 - Strongly agree

20. My spirituality helps define the goals I set for myself.
    1 - Strongly disagree
    2 - Disagree
    3 - Neutral
    4 - Agree
    5 - Strongly agree

MEANING–SHORT FORM

None provided. See Brief Multidimensional Measure of Religiousness/Spirituality: 1999, Appendix.

Bibliography

Antonovsky A. *Health, Stress, and Coping.* San Francisco, Calif: Jossey-Bass; 1979.

Antonovsky A. *Unraveling the Mystery of Health.* San Francisco, Calif: Jossey-Bass; 1987.

Batson CD, Schoenrade P, Ventis WL. *Religion and the Individual: A Social-Psychological Perspective.* New York, NY: Oxford; 1993.

Battista J, Almond R. The development of meaning in life. *Psychiatry.* 1973;36:409-427.

Chamberlain K, Zika S. Measuring meaning in life: an examination of three scales. *Pers Individual Differences.* 1988;9:589-596.

Crumbaugh JC. Cross-validation of Purpose in Life Test based on Frankl's concepts. *J Individual Psychol.* 1968;24:74-81.

Crumbaugh JC. The Seeking of Noetic Goals Test (SONG): a complementary scale to the Purpose in Life Test (PIL). *J Clin Psychol.* 1977;33:900-907.

Dufton BD, Perlman D. The association between religiosity and the Purpose-in-Life test: does it reflect purpose or satisfaction. *J Psychol Theology.* 1986;14:42-48.

Dyck MJ. Assessing logotherapeutic constructs: conceptual and psychometric status of the Purpose in Life and Seeking of Noetic Goals tests. *Clin Psychol Rev.* 1987;7:439-447.

Emmons RE. Assessing spirituality through personal goals: implications for research on religion and subjective well-being. *Soc Indicators Res.* In press.

Emmons RE. Personal strivings: an approach to personality and subjective well-being. *J Pers Soc Psychol.* 1986;51:1058-1068.

Frankl V. *Man's Search for Meaning.* New York, NY: Washington Square Press; 1963.

Geertz C. Religion as a cultural system. In: Banton M, ed. *Anthropological Approaches to the Study of Religion.* London: Tavistock; 1966:1-46.

Padelford BL. Relationship between drug involvement and purpose in life. *J Clin Psychol.* 1974;30:303-305.

Paloutzian RF. Purpose in life and value changes following conversion. *J Pers Soc Psychol.* 1981;41:1153-1160.

Pargament KI. *The Psychology of Religion and Coping: Theory, Research, Practice.* New York, NY: Guilford Publications; 1997.

Pargament KI, Mahoney AM. *Sacred Purpose: Exploring the Implications of Spiritual Meaning for Physical and Mental Health.* Unpublished manuscript.
Park CL, Folkman S. Meaning in the context of stress and coping. *Gen Psychol Rev.* In press.
Reker GT. *The Life Attitude Profile-Revised (LAP-R).* Peterborough, Ont: Student Psychologists Press; 1992.
Reker GT, Peacock EJ. The Life Attitude Profile (LAP): a multidimensional instrument for assessing attitudes toward life. *Can J Behav Sci.* 1981;13:264-273.
Ryff CD. Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *J Pers Soc Psychol.* 1989;57:1069-1081.
Ryff CD, Keyes CLM. The structure of psychological well-being revisited. *J Pers Soc Psychol.* 1995;69:719-727.
Zika S, Chamberlain K. Relation of hassles and personality to subjective well-being. *J Pers Soc Psychol.* 1987;53:155-162.

Values

Ellen Idler, PhD
Rutgers University
Department of Sociology
Institute for Health, Health Care Policy, and Aging Research
New Brunswick, New Jersey

Domain of Measurement

This domain is intended to measure dimensions distinct from the value the individual places on religion itself ("How important is religion in your life?"), which is currently covered under the domain entitled "Commitment." This domain is not about the sheer presence or absence of values per se; presumably everybody values something. Instead, this domain is based on the approach of Merton (1968), who described values as goals, and norms as the means to those goals. Other theorists viewed values as criteria people use to select and justify actions (Williams 1968, Kluckhohn 1951). This domain attempts to assess the extent to which an individual's behavior reflects a normative expression of his/her faith or religion as the ultimate value.

Description of Measures

The Short Form for this domain directly assesses the influence of faith on everyday life. Three items have been proposed, 1 from Benson (1988) and 2 from the Intrinsic/Extrinsic (I/E) Revised Scale (Gorsuch and McPherson, 1989). One of the 3 items is phrased negatively and 1 includes a moral dimension.

The Long Form assesses the importance of a wide range of possible values, placing religious values in a more general context of competing values. The advantage of this approach is that it minimizes the known social desirability problems of the I/E Scale (Leak and Fish 1989). The best known work in the comprehensive measurement of values is that of Rokeach (1973). His Value Survey asks respondents to rank 18 terminal (goal) values and 18 instrumental (process) values. Rokeach's research reflects a strong interest in the relationship between values and religiousness (Rokeach 1969a, 1969b) and reveals some differences between American Christians and American Jews. It also demonstrates differences by religiousness: the values of salvation and forgiving are more salient for those who attend church/synagogue more often and say religion is more important to them. An important feature of the Rokeach scale is that respondents are asked to rank their values, necessitating that some be placed ahead of others.

More recently, Schwartz (Schwartz and Bilsky 1987, Schwartz 1992, Schwartz and Huismans 1995) has developed and tested an expanded and modified version of the Rokeach scale. Respondents are asked to rate each of 56 values in terms of their importance as guiding principles in their life on a scale varying from "opposed to my principles" (-1) through "not important" (0) to "of supreme importance" (7). Schwartz's original work used the same ranking technique as Rokeach, but the later work added more values and shifted to a rated scoring system. The ranking tasks can be time-consuming. Schwartz's work demonstrated that the 56 values can be categorized into a smaller number of domains, and that results from a survey organized in this manner can be replicated across populations as diverse as German students, Israeli teachers, Greek Orthodox, Dutch Protestants, and Spanish Catholics. He also found that religiousness among respondents correlates

negatively with the "individualist" value domains of hedonism, stimulation, achievement, and self-direction, and positively with the "collectivist" domains of tradition, conformity, benevolence, and security. Some value domains, such as power and universalism, show little association with religion.

According to Schwartz and Huismans:

> Theological analyses suggest that most and possibly all major contemporary religions promote transcendence of material concerns. Religions encourage people to seek meaning beyond everyday existence, linking themselves to a "ground of being" through belief and worship. Most foster attitudes of awe, respect, and humility by emphasizing the place of the human being in a vast, unfathomable universe, and exhort people to pursue causes greater than their personal desires. The opposed orientation, self-indulgent materialism, seeks happiness in the pursuit and consumption of material goods. In this view, the primary function of religion is to temper self-indulgent tendencies and to foster transcendental concerns and beliefs. Religions seek to do this by promulgating religious creeds, moral prescriptions, and ritual requirements. If greater religiosity signifies acceptance of these priorities, we would expect religiosity to correlate positively with values that emphasize reaching toward and submitting to forces beyond the self and negatively with values that emphasize gratification of material desires. (1995:91).

Other researchers have also identified the prosocial orientation of religious respondents. Ellison (1992), Pollner (1989), and others argue along these lines: modeling human relationships after divine ones provides "godlike" models for behavior; there are direct teachings in many faiths on the subject of love and concern for others; feelings of divine protection may encourage feelings of security and friendliness to strangers. Ellison found that religious people were generally kind, as judged by the interviewers for the National Survey of Black Americans (1992).

Previous Psychometric Work

For the Short Form, the I/E Scale is the single most frequently used measure in the social scientific study of religion (Allport and Ross 1967). One of the items from the I/E Scale was determined to be the highest loading item on the I/E Scale, and Gorsuch and MacPherson (1989) suggest it can be used as a single item if the survey sample is large enough.

The Long Form comes from Schwartz, who has tested his instrument for reliability and validity in numerous international samples (Schwartz 1992, Schwartz and Bilsky 1987, Schwartz and Huismans 1995).

Association with Health

There is no obvious, direct connection between values and health, and virtually no research has been done in this area. The link would have to be through behaviors that are promoted by the value or criteria of faith. Schwartz and Huismans (1995) found that religious people consistently show a more collectivist orientation and place less value on self-indulgence or sensation-seeking.

A collectivist orientation that places little value on self-stimulation, pleasure, and excitement might cause a person to avoid risky behaviors, such as heavy drinking, fast driving, and/or promiscuous sex. Such a collectivist orientation may also be reflected in larger or more supportive social networks. Ellison and George (1994) and Bradley (1995) found that religiously active people report larger social networks, especially of friends, which would provide another link to health.

Another effect of the value of concern for others, especially those less fortunate than oneself, may be the facilitation of social comparisons. In health research, "downward comparisons," or the tendency of people to compare themselves with others who are worse off, is commonly shown to enhance feelings of well-being and reduce depression (Wood, Taylor, and Lichtman 1985; Gibbons 1986; Affleck and Tennen 1991). Volunteering time to others in the community is said to produce an altruistic "helper's high" (Luks 1993). If religiously motivated values cause people to expose themselves to the physical or social needs of others, and perhaps to help others in some way, feelings of relative well-being may be an unintentional but nevertheless real benefit.

Suggested Administration

The Short Form items are easily self-administered or administered by phone or in-person. The Long Form items must be self-administered.

Time Referent

Both scales refer to the present only.

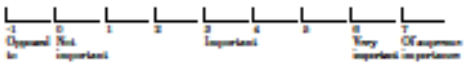
Estimated Completion Time

Short Form: 15-20 sec.
Long Form: approximately 10 min.

Proposed Items

VALUES-LONG FORM

Instructions: Please rate the following values "AS A GUIDING PRINCIPLE IN MY LIFE." Begin by reading the first column (1-30). Then, from that column only, choose and rate the most important value and the least important value. Next read the second column (31-56), and select the most important value and the least important value in that column. Finally, rate each value in both columns using the following scale.



First Column

1. ___ Equality (equal opportunity for all)
2. ___ Inner harmony (at peace with myself)
3. ___ Social power (control over others, dominance)
4. ___ Pleasure (gratification of desires)
5. ___ Freedom (freedom of action and thought)
6. ___ A spiritual life (emphasis on spiritual not material matters)
7. ___ Sense of belonging (feeling that others care about me)
8. ___ Social order (stability of society)
9. ___ An exciting life (stimulating experiences)
10. ___ Meaning in life (a purpose in life)
11. ___ Politeness (courtesy, good manners)
12. ___ Wealth (material possessions, money)
13. ___ National security (protection of my nation from enemies)
14. ___ Self-respect (belief in one's own worth)
15. ___ Reciprocation of favors (avoidance of indebtedness)
16. ___ Creativity (uniqueness, imagination)
17. ___ A world at peace (free of war and conflict)
18. ___ Respect for tradition (preservation of time-honored customs)
19. ___ Mature love (deep emotional and spiritual intimacy)
20. ___ Self-discipline (self-restraint, resistance to temptation)
21. ___ Detachment (from worldly concerns)
22. ___ Family security (safety for loved ones)
23. ___ Social recognition (respect, approval by others)
24. ___ Unity with nature (fitting into nature)
25. ___ A varied life (filled with challenge, novelty, and change)
26. ___ Wisdom (a mature understanding of life)
27. ___ Authority (the right to lead or command)
28. ___ True friendship (close, supportive friends)
29. ___ A world of beauty (beauty of nature and the arts)
30. ___ Social justice (correcting injustice, care for the weak)

Second Column

31. ___ Independent (self-reliant, self-sufficient)
32. ___ Moderate (avoiding extremes of feeling and action)
33. ___ Loyal (faithful to my friends, group)
34. ___ Ambitious (hardworking, aspiring)
35. ___ Broad-minded (tolerant of different ideas and beliefs)
36. ___ Humble (modest, self-effacing)
37. ___ Daring (seeking adventure, risk)
38. ___ Protecting the environment (preserving nature)
39. ___ Influential (having an impact on people and events)
40. ___ Honoring of parents and elders (showing respect)
41. ___ Choosing own goals (selecting own purposes)
42. ___ Healthy (not being sick physically or mentally)
43. ___ Capable (competent, effective, efficient)
44. ___ Accepting my portion in life (submitting to life's circumstances)
45. ___ Honest (genuine, sincere)
46. ___ Preserving my public image (protecting my "face")
47. ___ Obedient (dutiful, meeting obligations)
48. ___ Intelligent (logical, thinking)
49. ___ Helpful (working for the welfare of others)
50. ___ Enjoying life (enjoying food, sex, leisure, etc.)
51. ___ Devout (holding to religious faith and belief)
52. ___ Responsible (dependable, reliable)
53. ___ Curious (interested in everything, exploring)
54. ___ Forgiving (willing to pardon others)
55. ___ Successful (achieving goals)
56. ___ Clean (neat, tidy)

VALUES-SHORT FORM

1. My whole approach to life is based on my religion. (I/E Scale)
   1 - Strongly agree
   2 - Agree
   3 - Not sure
   4 - Disagree
   5 - Strongly disagree

2. Although I believe in my religion, many other things are more important in life. (I/E Scale)
   1 - Strongly agree
   2 - Agree
   3 - Not sure
   4 - Disagree
   5 - Strongly disagree

3. My faith helps me know right from wrong. (Benson)
   1 - Strongly agree
   2 - Agree
   3 - Not sure
   4 - Disagree
   5 - Strongly disagree

Schwartz SH. *Adv Exp Soc Psychol.* 1992;25:60-62.

Bibliography

Affleck G, Tennen H. Social comparison and coping with major medical problems. In: Suls J, Wills T, eds. *Social Comparison: Contemporary Theory and Research.* Hillsdale, NJ: Lawrence Erlbaum; 1991:369-393.

Allport G, Ross J. Personal religious orientation and prejudice. *J Pers Soc Psychol.* 1967;5:432-443.

Benson P. *Effective Christian Education: A National Study of Protestant Congregations.* Minneapolis, Minn: Search Institute; 1988.

Bradley DE. Religious involvement and social resources: evidence from the data set "Americans' Changing Lives." *J Sci Study Religion.* 1995;34:259-267.

Ellison CG. Are religious people nice people? Evidence from the National Survey of Black Americans. *Soc Forces.* 1992;71:411-430.

Ellison CG, George L. Religious involvement, social ties, and social support in a southeastern community. *J Sci Study Religion.* 1994;33:46-61.

Gibbons F. Social comparison and depression: company's effect on misery. *J Pers Soc Psychol.* 1986;51:140-148.

Gorsuch RL, McPherson SE. Intrinsic/extrinsic measurement: I/E-revised and single-item scales. *J Sci Study Religion.* 1989;28:348-354.

Kluckhohn C. Values and value-orientations in the theory of action: an exploration in definition and classification. In: Parsons T, Shils E, eds. *Toward a General Theory of Action.* Cambridge, Mass: Harvard University Press; 1951:388-433.

Leak GK, Fish S. Religious orientation, impression management, and self-deception: toward a clarification of the link between religiosity and social desirability. *J Sci Study Religion.* 1989;28:355-359.

Luks A. *The Healing Power of Doing Good.* New York, NY: Ballantine; 1993.

Merton RK. *Social Theory and Social Structure.* New York, NY: Free Press; 1968.

Pollner M. Divine relations, social relations, and well-being. *J Health Soc Behav.* 1989;30:92-104.

Rokeach M. Religious values and social compassion. *Rev of Religious Res.* 1969a;11:24-39.

Rokeach M. *The Nature of Human Values.* New York, NY: Free Press; 1973.

Rokeach M. Value systems in religion. *Rev of Religious Res.* 1969b;11:3-23.

Schwartz SH. Universals in the content and structure of values: theoretical advances and empirical tests in 20 countries. *Adv Exp Soc Psychol.* 1992;25:1-65.

Schwartz SH, Bilsky W. Toward a universal psychological structure of human values. *J Pers Soc Psychol.* 1987;53:550-562.

Schwartz SH, Huismans S. Value priorities and religiosity in four western religions. *Soc Psychol Q.* 1995;58:88-107.

Williams RM. Values. In: Shils E, ed. *International Encyclopedia of the Social Sciences.* New York, NY: Macmillan; 1968.

Wood J, Taylor S, Lichtman R. Social comparison in adjustment to breast cancer. *J Pers Soc Psychol.* 1985;49:1169-1183.

WHOLE HEALTH: CHANGE THE CONVERSATION

Advancing Skills in the Delivery of
Personalized, Proactive, Patient-Driven Care

Creating a Gratitude Practice
Clinical Tool

This document has been written for clinicians. The content was developed by the Integrative Medicine Program, Department of Family Medicine, University of Wisconsin-Madison School of Medicine and Public Health in cooperation with Pacific Institute for Research and Evaluation, under contract to the Office of Patient Centered Care and Cultural Transformation, Veterans Health Administration.

Information is organized according to the diagram above, the *Components of Proactive Health and Well-Being*. While conventional treatments may be covered to some degree, the focus is on other areas of Whole Health that are less likely to be covered elsewhere and may be less familiar to most readers. There is no intention to dismiss what conventional care has to offer. Rather, you are encouraged to learn more about other approaches and how they may be used to complement conventional care. The ultimate decision to use a given approach should be based on many factors, including patient preferences, clinician comfort level, efficacy data, safety, and accessibility. No one approach is right for everyone; personalizing care is of fundamental importance.

WHOLE HEALTH: CHANGE THE CONVERSATION
Creating a Gratitude Practice
Clinical Tool

If the only prayer you said in your whole life was "thank you" that would suffice.
—Meister Eckert

The Importance of Gratitude

One of the greatest contributing factors to overall happiness and well-being is the amount of gratitude that a person experiences. Gratitude involves noticing and appreciating the positives in life. Gratitude is both (1) an attitude and (2) a practice.

Gratitude is universal and found across all cultures and all people.[1] It is considered a virtue and is different from optimism, hope, and trust. Emmons and McCullough state that the root of the word gratitude is the Latin root *gratia*, which means "grace, graciousness, or gratefulness . . . all derivatives from this Latin root having to do with kindness, generousness, gifts, the beauty of giving and receiving, or getting something for nothing."[2]

What Does the Research Tell Us?

An increasing range of empirical research has found that gratitude can improve a sense of personal well-being in two ways:[2]

- As a direct cause of well-being and
- Indirectly, as a means of buffering against negative states and emotions, and making us more resilient to stress.

A number of researchers have proposed a theoretical relationship between gratitude and well-being. Experiencing gratitude, thankfulness, and appreciation tends to foster positive feelings, which in turn contribute to one's overall sense of well-being.[3]

Gratitude has been linked to a host of psychological, physical, and social benefits, such as:

- More feelings of happiness, pride, and hope[4]
- A greater sense of social connection among many others and cooperation—feeling less lonely and isolated[5]
- A reduction in risk for depression, anxiety, and substance abuse disorders[6]
- Improvement in body image[7]
- Spurring acts of kindness, generosity, and cooperation[8,9]
- Resilience in the face of trauma-induced stress, recovering more quickly from illness, and enjoying more robust physical health[10]
- Improvement in sleep and energy [11]

WHOLE HEALTH: CHANGE THE CONVERSATION
Clinical Tool: Creating a Gratitude Practice

Cultivating an Attitude of Gratitude

Grateful Contemplation Exercise 1, adapted from Ryan and colleagues[12]
Take a few minutes right now to reflect on a happy moment in your own life that stands out for you—a memory that is still strong and has remained with you, even if it happened 10, 20, or 40 years ago. Re-experience it. Visualize the scene, hear the sounds that were around you, feel the sensations in your body. What was it about that experience that stays with you? Was gratitude part of it? What was happening that allowed you to feel grateful? Write down your reflections in the space below:

_____
_____
_____
_____
_____
_____

Grateful Contemplation Exercise 2
We cannot change what life presents. We can, however, choose our attitude in any given circumstance. You can practice consciously choosing to cultivate gratitude with this daily practice:

Practice stopping and having an attitude of gratitude throughout the day. You might incorporate a cue, like sitting down for a meal, hearing an alarm go off, or commuting home, to turn your mind to gratitude. Acknowledge and savor the positive experiences of your day.

List a few cues you can use to remind you to stop and practice an attitude of gratitude:

_____
_____
_____
_____
_____

Benefits of a Written Gratitude Practice

Another way to foster gratitude is to create daily lists of things for which to be grateful. Research has shown health benefits to this written gratitude practice. For example, people who kept gratitude journals on a weekly basis exercised more regularly, reported fewer physical symptoms, felt better about their lives as a whole, and were more optimistic about the upcoming week compared with those who recorded neutral life events or hassles.[2] A daily gratitude journal has been associated with higher positive states of alertness, enthusiasm, determination, attentiveness, and energy. Those who journaled daily about gratitude were also more likely to report helping someone with a personal problem or offering emotional support to another person. Wood and colleagues found that a daily

WHOLE HEALTH: CHANGE THE CONVERSATION
Clinical Tool: Creating a Gratitude Practice

gratitude practice was associated better sleep, more energy, fewer symptoms of illness, and more happiness.[11] Seligman and colleagues discovered that writing about three good things that happened each day and why they happened made people happier and less depressed up to 6 months later.[13]

How to begin a daily gratitude journal practice

At the end of each day, find a regular time to reflect on the day's events and write down five things that you are grateful for. As you write them down, spend a few moments to reflect on their value to you. This makes it more likely for this practice to boost your mood. Research shows that writing down these things has advantage over just thinking about them.

It is recommended that you get a special journal to record your gratitude list. Some people prefer to use a jar where they store pieces of paper that each have something they are grateful for listed on them. Other people use social media, such as Facebook, to record their daily list. There are also several apps that allow you to record your gratitude-inspiring events, if you would prefer. Your list could include simple everyday things, people in your life, personal strengths or talents, moments of natural beauty, or gestures of kindness from others. Consider reviewing your list once a month or once a year to remind you of the good things in your life.

How often is it optimal to journal?

It is recommended to start by journaling daily, but after a while research shows that *just once a week* is enough to lead to significant changes. Make certain not to overdo it. Writing once or twice a week is more beneficial than daily journaling long-term about gratitude. One study showed that writing once a week for 6 weeks boosted happiness; writing three times a week did not.[14]

Expressing Gratitude to Others

We all have had people who have influenced our lives. The mere act of expressing gratitude has been shown to boost happiness and make us less depressed.

Research on its effectiveness

Seligman and colleagues studied the impact of a gratitude intervention where participants completed a "gratitude visit" where they wrote and then delivered a letter of gratitude in person to someone who had been especially kind to them but had never been properly thanked.[13] Participants, 1 week after doing the assignment, experienced significantly increased happiness and decreased depression for up to 1 month after they delivered their letters.

Action steps

Consider doing that exercise yourself. Think about expressing gratitude to someone who has made a difference in your life that you may not have thanked. You might tell them in person, write them a letter, or send them an e-mail where you describe in detail what they did for you, how it affected your life, and how you often remember their efforts. Be specific

WHOLE HEALTH: CHANGE THE CONVERSATION
Clinical Tool: Creating a Gratitude Practice

about what you are grateful for. It makes the expression of gratitude feel more authentic, for it reveals that you were paying attention to what they did.

Informal practice
If you find your gratitude practice is getting stale, switch to another format and mix it up a bit make it work for you. Some other ways to practice gratitude include:

- Pick one co-worker each day and express thanks for what he or she is doing for the organization.
- Go around the dinner table and share one thing each person is grateful for that happened that day.
- Express appreciation about what your partner, child, or friend does and who they are as a person.
- Go for a walk with a friend and talk about what you are most grateful for.
- Do an art project that focuses on your blessings.
- Write a thank you letter to yourself.
- Give thanks for your body.
- Pause to experience wonder about some of the ordinary moments of your life.
- Imagine your life without the good things in it, so as not to take things for granted.

Whole Health: Change the Conversation Website
Interested in learning more about Whole Health? Browse our website for information on personal and professional care. http://projects.hsl.wisc.edu/SERVICE/index.php

This clinical tool was written by Shilagh A. Mirgain, PhD, Senior Psychologist, and Clinical Assistant Professor, Department of Orthopedics and Rehabilitation, University of Wisconsin-Madison School of Medicine and Public Health, and by Janice Singles, PsyD, Distinguished Psychologist, and Clinical Assistant Professor, Department of Orthopedics and Rehabilitation, University of Wisconsin-Madison School of Medicine and Public Health.

References

1. Emmons RA, Stern R. Gratitude as a psychotherapeutic intervention. *J Clin Psychol.* 2013;69(8):846-855.
2. Emmons RA, McCullough ME. Counting blessings versus burdens: an experimental investigation of gratitude and subjective well-being in daily life. *J Pers Soc Psychol.* 2003;84(2):377.
3. Bono G, Emmons RA, McCullough ME. Gratitude in practice and the practice of gratitude. *Positive psychology in practice.* 2004:464-481.

4. Overwalle FV, Mervielde I, Schuyter JD. Structural modelling of the relationships between attributional dimensions, emotions, and performance of college freshmen. *Cognition Emotion.* 1995;9(1):59-85.
5. Algoe SB, Haidt J, Gable SL. Beyond reciprocity: gratitude and relationships in everyday life. *Emotion.* 2008;8(3):425.
6. Kendler KS, Liu X-Q, Gardner CO, McCullough ME, Larson D, Prescott CA. Dimensions of religiosity and their relationship to lifetime psychiatric and substance use disorders. *Am J Psychiatry.* 2003;160(3):496-503.
7. Geraghty AW, Wood AM, Hyland ME. Attrition from self-directed interventions: Investigating the relationship between psychological predictors, intervention content and dropout from a body dissatisfaction intervention. *Soc Sci Med.* 2010;71(1):30-37.
8. Tsang J-A. BRIEF REPORT Gratitude and prosocial behaviour: An experimental test of gratitude. *Cognition Emotion.* 2006;20(1):138-148.
9. Weiner B, Graham S. Understanding the motivational role of affect: Life-span research from an attributional perspective. *Cognition Emotion.* 1989;3(4):401-419.
10. Kashdan TB, Uswatte G, Julian T. Gratitude and hedonic and eudaimonic well-being in Vietnam war veterans. *Behav Res Ther.* 2006;44(2):177-199.
11. Wood AM, Joseph S, Lloyd J, Atkins S. Gratitude influences sleep through the mechanism of pre-sleep cognitions. *J Psychosom Res.* 2009;66(1):43-48.
12. Ryan M. *Attitudes of Gratitude: How to Give and Receive Joy Everyday of Your Life.* San Francisco, CA: Conari Press; 1999.
13. Seligman ME, Steen TA, Park N, Peterson C. Positive psychology progress: empirical validation of interventions. *Am Psychol.* 2005;60(5):410.
14. Lyubomirsky S, Dickerhoof R, Boehm JK, Sheldon KM. Becoming happier takes both a will and a proper way: an experimental longitudinal intervention to boost well-being. *Emotion.* 2011;11(2):391.

Spiritual Assessment Tool

An acronym that can be used to remember what is asked in a spiritual history is:

F: Faith or Beliefs
I: Importance and influence
C: Community
A: Address

Some specific questions you can use to discuss these issues are:

F: What is your faith or belief?
Do you consider yourself spiritual or religious?
What things do you believe in that give meaning to your life?

I: Is it important in your life?
What influence does it have on how you take care of yourself?
How have your beliefs influenced your behavior during this illness?
What role do your beliefs play in regaining your health?

C: Are you part of a spiritual or religious community?
Is this of support to you and how?
Is there a person or group of people you really love or who are really important to you?

A: How would you like me, your healthcare provider, to address these issues in your healthcare?

© 1999 Christina Puchalski, M.D. reprinted with permission from Christina Puchalski, M.D.

CME 2008

Tuning In to Spiritual Themes

Patient's Words	Spiritual Themes Revealed
"I don't know why this is happening to me." "My life is pretty worthless right now." "I find no value in life." "I don't want to take the meds anymore." "I don't have any reason to get well." "I don't feel like living."	Lack of meaning and purpose
"Why me?" "Why am I suffering?" "I don't know why this is happening to me."	Existential crisis
"It's not going to get better, is it?" "I'm just going to die, so why bother doing anything more?"	Hopelessness (or Realism)
"I can't take this anymore!" "Let me die!" "There is nothing left for me."	Despair
"I must have done something to deserve this." "This illness is a punishment (or curse)."	Guilt/Shame

© 2008 The George Washington University. All rights reserved.

"I prayed, went to church, did all the right things, now this. It's not fair!" "If God is all-loving, why is this happening to me?"	Anger at God
"It's my husband's fault. He worked such long hours. He was never there. The stress was too much for me." "If the doctor had diagnosed this correctly, I wouldn't be sick like this now."	Anger at others
"You come into the world alone, you go out alone." "I'm in this by myself. There is no one that really cares."	Feeling abandoned by God or others
"My children will just move on with their lives without me." "No one will be grateful for what I did." "I'll never have a chance to finish this [book, project, etc.]." "My two-year-old won't remember who her mother was."	Not being remembered
"I can't share this with my faith community or with loved ones." "I don't believe I can trust anyone with my feelings." "I've been hurt before. I don't want to get hurt again." "I don't want to go there. Leave me alone."	Lack of trust
"I've done some pretty bad things in the past. I need to deal with that."	Reconciliation/forgiveness

© 2008 The George Washington University. All rights reserved.

Hello All,

This might be the most unusual dinner invitation I have ever sent, but bear with me. I think we are in for a remarkable experience.

I recently stumbled upon the work of a group of healthcare and wellness leaders who are committed to breaking the taboo regarding conversations about end of life.

Their project "Let's Have Dinner and Talk About Death" aims to inspire an ever-growing community of people to talk about an often-not-discussed topic—death and dying. As the opening statement on their website notes "How we want to die represents the most important and costly conversation America isn't having."

I would be honored if you would take the time to join me for a light snack and engage in this conversation. This is not meant to be a morbid conversation, but instead a very human one where we consider what we want, both in life and during its closure. Through sharing our thoughts and feelings on this subject, we can more readily move through our fears, shed inhibitions, and forge deeper understanding and connection with our loved ones. To learn more about this unique project, visit http://deathoverdinner.org/.

Details
Date: November 6
Time: 430pm
Location: Building 20, John Muir Conference Room

So that we can have starting places for our shared conversations, I have selected a few "homework" assignments for all of us to watch and listen to before we gather at the table. They are very short but are quite engaging, informative, and inspiring.

Watch: The Coffinmaker

Every year, Americans bury enough metal in the ground to rebuild the Golden Gate Bridge, says Vashon Island coffin maker Marcus Daly. His simple, handcrafted wooden coffins are an environmentally friendly burial alternative. But Daly believes a coffin's most important feature is that it can be carried.

Listen: What Doesn't Kill You

Tig was diagnosed with cancer. A week later she went on stage in Los Angeles and did a now-legendary set about her string of misfortunes. Please listen from 3:04 - 15:35.

Watch: Before I die I want to...

In her New Orleans neighborhood, artist Candy Chang turned an abandoned house into a giant chalkboard asking a fill-in-the-blank question: 'Before I die I want to ___.' Her neighbors' answers -- surprising, poignant, funny -- became an unexpected mirror for the community.

Watch: Steve Jobs: How to live before you die.

At a Stanford University commencement speech, Steve Jobs, urges us to pursue our dreams and see the opportunities in life's setbacks -- including death itself.

I'm looking forward to sharing this special gathering with you.

Sincerely,

Katie

QIGONG

HEALTH BENEFITS

Promotes overall physical health

Aid for stress reduction

Improves concentration

Strengthens consciousness

Creates emotional balance and fosters mental well-being

Aids sleep

It is a spiritual practice

It improves physical stamina

It can help the individual cultivate a positive attitude to life

It is claimed that regular practice can slow down the aging process

This practice can help to increase body strength

It can strengthen the cardiovascular system

It increases body suppleness and flexibility

It boosts the immune system

Increases sexual vitality

This practice can help to reduce or eliminate chronic pain

These techniques cause feelings or warmth within the body

Qigong can help eliminate negative emotions such as anger and pessimism

Qigong may be particularly useful practice for those recovering from addiction, finding it helps stabilize mood and develops emotional sobriety, and mental clarity.

Appendix M

Data Collection Instruments

Marin County Department of Aging and Adult Services Seminar 1

SPIRITUALITY & CLINICAL PRACTICE POST-TEST

Initials & year of your first car:

Informed Consent: Thank you for participating in this effort. This is a quality improvement project that evaluates spirituality and practice in support of whole health for healthcare professionals and their clients. Your input is valuable. I do not anticipate that taking this survey or participating will pose any risk or inconvenience to you. Your participation is strictly voluntary and you may withdraw your participation at any time. All information collected is confidential. There will be no financial cost or reimbursement to you. Once the study is completed, I will share the results with you if you desire. If you have any questions, please contact me: Katie Lutz.
Contact info kelutz@dons.usfca.edu

For each item identified below, circle the number to the right that best fits your judgment of its quality.	Scale				
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I feel confident in my ability to express my personally held values (i.e. justice, harmony).	1	2	3	4	5
2. I am able to express how my definition of spirituality gives my life meaning (i.e. life is significant because I am part of a plan).	1	2	3	4	5
3. I engage in spiritual experiences and practices on a daily basis.	1	2	3	4	5
4. I am comfortable engaging in a gratitude practice.	1	2	3	4	5
5. There is a place for spirituality in my work.	1	2	3	4	5
6. Spirituality likely plays a role in most individual lives whether they are aware of it or not.	1	2	3	4	5
7. I discovered something new about one of my colleagues.	1	2	3	4	5
8. Research shows spirituality is beneficial to clients/patient wellbeing.	1	2	3	4	5
9. The content and discussion increased my knowledge of spirituality.	1	2	3	4	5
10. I am interested in learning more about spirituality & clinical practice.	1	2	3	4	5

Marin County Department of Aging and Adult Services Seminar 2

SPIRITUALITY & CLINICAL PRACTICE POST-TEST

Initials & year of your first car:

Informed Consent: Thank you for participating in this effort. This is a quality improvement project that evaluates spirituality and practice in support of whole health for healthcare professionals and their clients. Your input is valuable. I do not anticipate that taking this survey or participating will pose any risk or inconvenience to you. Your participation is strictly voluntary and you may withdraw your participation at any time. All information collected is confidential. There will be no financial cost or reimbursement to you. Once the study is completed, I will share the results with you if you desire. If you have any questions, please ask or contact me: Katie Lutz.
Contact info kelutz@dons.usfca.edu

For each item identified below, circle the number to the right that best fits your judgment of its quality.	Scale				
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I have a clear understanding of what spirituality means.	1	2	3	4	5
2. I am interested in taking a client spiritual history.	1	2	3	4	5
3. I am able to recognize spiritual distress in myself and others.	1	2	3	4	5
4. Maintaining professionalism is a significant barrier to spiritual discussion.	1	2	3	4	5
5. Knowledge and understanding of spiritual matters is a barrier to discussion.	1	2	3	4	5
6. Today's session with friends and colleagues has inspired me to be more active in my own spirituality.	1	2	3	4	5
7. Today's session has encouraged me to ask a spiritual question of a client if it might help him/her gain insight.	1	2	3	4	5
8. Today's session has encouraged me to ask a spiritual question of a colleague if it might help him/her gain insight.	1	2	3	4	5
9. I enjoy discussing this topic with my colleagues.	1	2	3	4	5
10. I would be interested in learning more about qi gong and its philosophy.	1	2	3	4	5

What did you enjoy most about today's session?

Comments?

Marin County Department of Aging and Adult Services Seminar 3

SPIRITUALITY & CLINICAL PRACTICE SURVEY

Initials & year of your first car:

Informed Consent: Thank you for participating in this effort. This is a quality improvement project that evaluates spirituality and practice in support of whole health for healthcare professionals and their clients. Your input is valuable. I do not anticipate that taking this survey or participating will pose any risk or inconvenience to you. Your participation is strictly voluntary and you may withdraw your participation at any time. All information collected is confidential. There will be no financial cost or reimbursement to you. Once the study is completed, I will share the results with you if you desire. If you have any questions, please ask or contact me: Katie Lutz.
Contact info kelutz@dons.usfca.edu

For each item identified below, circle the number to the right that best fits your judgment of its quality.	Scale				
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The death over dinner series is an innovative way to conduct end of life discussions that is creative and engaging.	1	2	3	4	5
2. From the video clips and post discussion, I see there is a way to address individual's fear of the death & dying that is easier than previously thought	1	2	3	4	5
3. The more I discuss spirituality and death & dying the more comfortable I am with the topic	1	2	3	4	5
4. Advance care planning might benefit from the inclusion of spiritual discussion	1	2	3	4	5
5. Spirituality helps with managing compassion fatigue.	1	2	3	4	5
6. I feel the classes have helped me recognize the meaning and purpose in my professional work	1	2	3	4	5
7. At any one time during the classes, I experienced a sense of spiritual peace	1	2	3	4	5
8. I plan to experiment with the spiritual class material in my clinical work	1	2	3	4	5
9. It was worthwhile to attend the presentations	1	2	3	4	5
10. I would be interested in continuing a series on spirituality & clinical practice among my colleagues	1	2	3	4	5

What do you think could be done to further advance care planning in the U.S.?

Is spirituality a part of whole health?

Additional comments regarding benefits of this class:

Appendix N

Quantitative Data

Table 1

Marin County Department of Aging & Adult Services Pre-test and Post-test Raw Scores Knowledge Day 1

	Knowledge Items									
	Item 1		**Item 2**		**Item 3**		**Item 4**		**Item 5**	
Participant	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
1	4	4	5	5	5	5	5	5	5	5
2	5	5	5	5	5	5	5	5	5	5
3	4	4	3	4	4	4	4	4	5	5
4	4	5	4	5	5	5	5	5	4	5
5	4	5	5	5	5	5	5	5	3	5
6	3	5	4	4	4	4	5	5	3	3
Mean	4.00	4.67	4.33	4.67	4.67	4.67	4.83	4.83	4.17	4.67

Note. 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree

Table 2

Marin County Department of Aging & Adult Services Post-test Percentage Distribution Knowledge Day 1

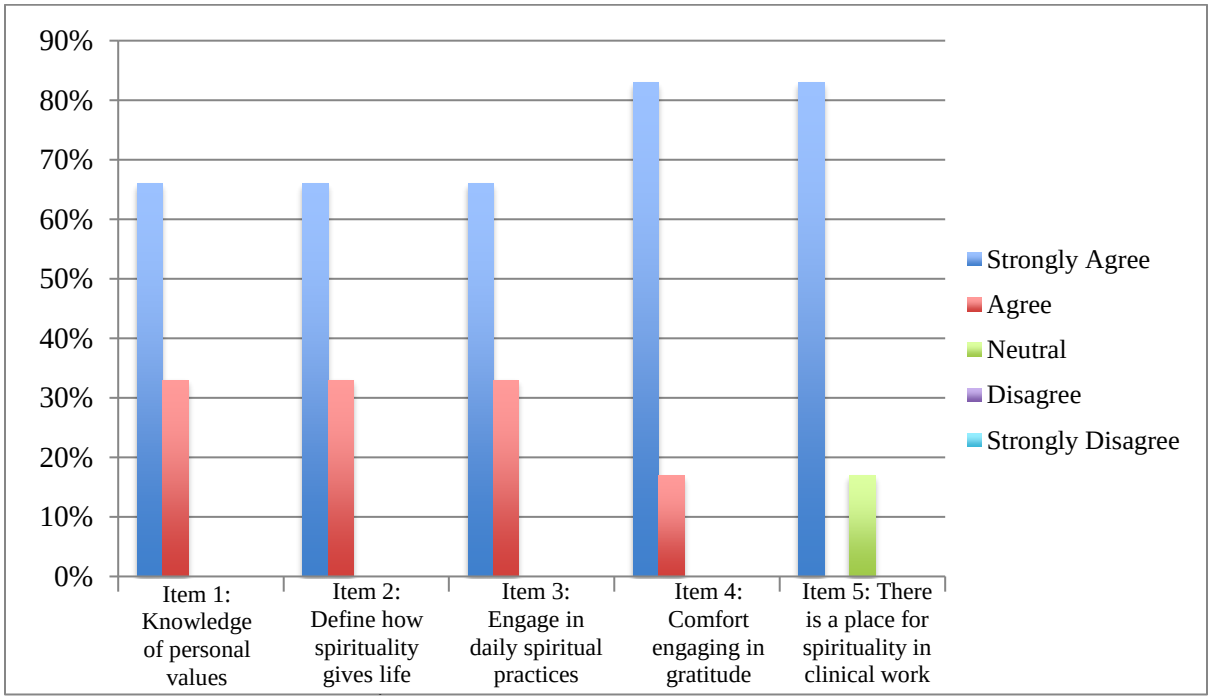


Table 3

Marin County Department of Aging & Adult Services Post-test Raw Scores Experience Day 1

	Experience items				
Participant	**Item 6**	**Item 7**	**Item 8**	**Item 9**	**Item 10**
1	5	5	5	4	5
2	4	5	5	5	5
3	5	5	5	4	4
4	5	5	5	3	5
5	5	4	5	4	5
6	5	5	4	4	4
Mean	4.83	4.83	4.83	4.00	4.66

Note. 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree

Table 4

Marin County Department of Aging & Adult Services Post-test Chart of Experience Items Day 1

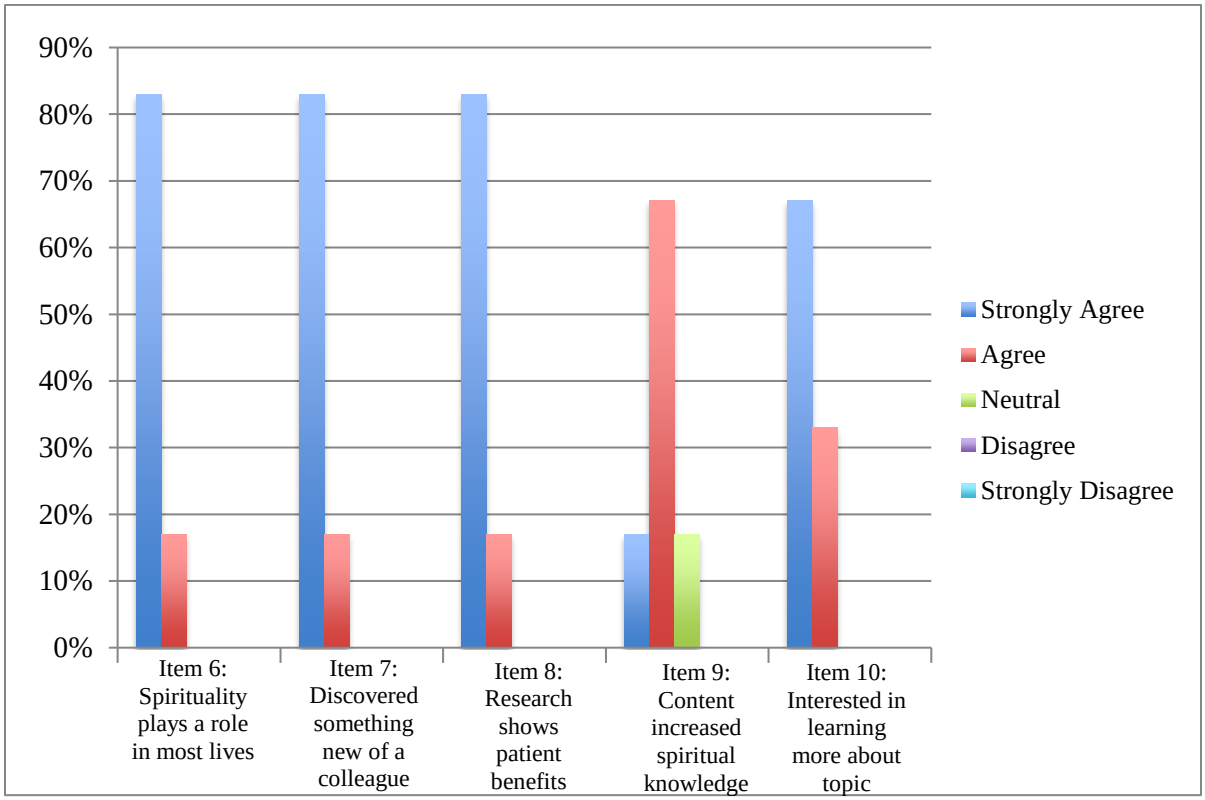


Table 5

Marin County Department of Aging & Adult Services Post-test Positive Change for Knowledge Post-test Day 1, N=6

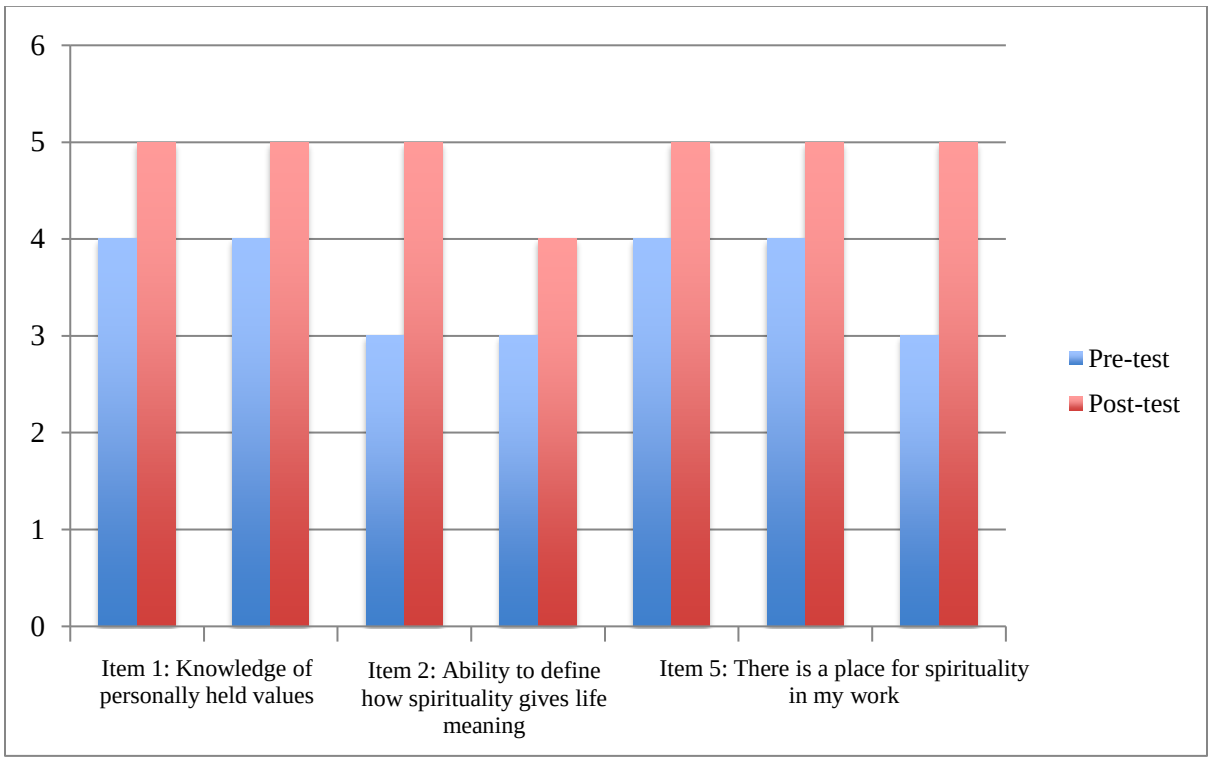


Table 6

Marin County Department of Aging & Adult Services Pre-test Raw Scores Knowledge Day 2

	Knowledge Items									
	Item 1		**Item 2**		**Item 3**		**Item 4**		**Item 5**	
Participant	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
1	4	4	3	4	4	4	3	4	2	1
2	4	4	5	5	3	3	2	4	1	1
3	4	4	3	3	3	4	3	3	3	2
4	5	5	5	5	5	5	5	5	5	3
5	5	4	3	3	3	4	5	4	2	1
Mean	4.40	4.20	3.80	4.00	3.60	4.00	3.60	4.00	2.60	1.60

Note. 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree

Table 7

Marin County Department of Aging & Adult Services Post-test Percentage Distribution Knowledge Day 2

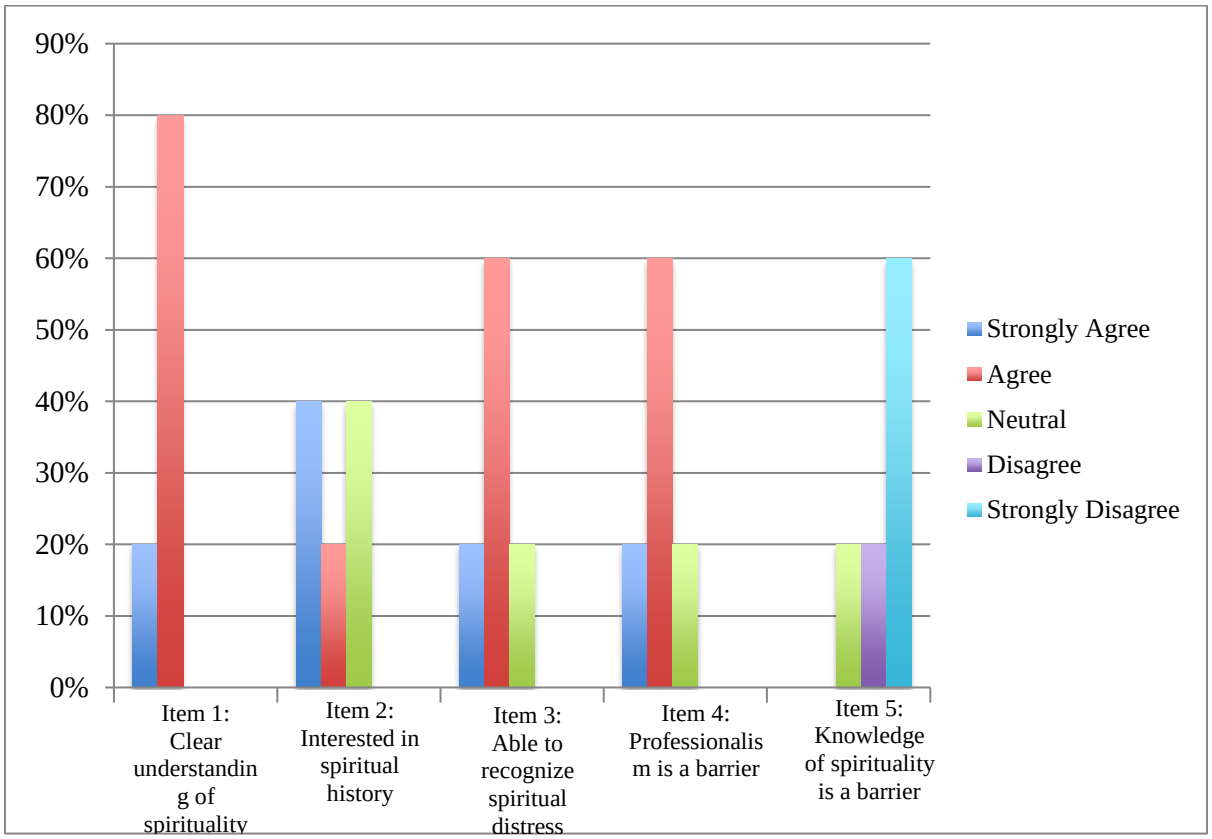


Table 8

Marin County Department of Aging & Adult Services Post-test Raw Scores Experience Day 2

	Experience items				
Participant	**Item 6**	**Item 7**	**Item 8**	**Item 9**	**Item 10**
1	4	4	5	5	5
2	5	5	5	5	5
3	3	3	3	5	3
4	5	4	3	5	5
5	4	3	3	4	5
Mean	4.20	3.80	3.80	4.80	4.60

Note. 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree

Table 9

Marin County Department of Aging & Adult Services Post-test Chart of Experience Items Day 2

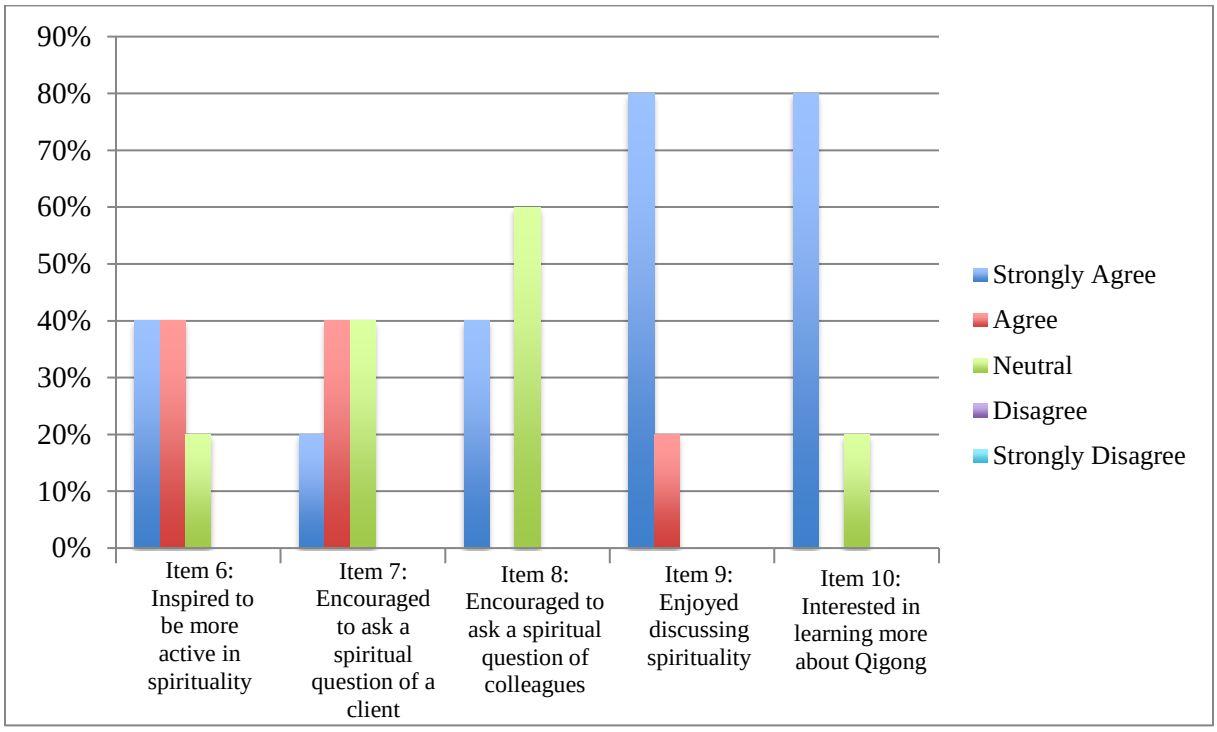


Table 10

Marin County Department of Aging & Adult Services Post-test Positive Change for Knowledge Day 2

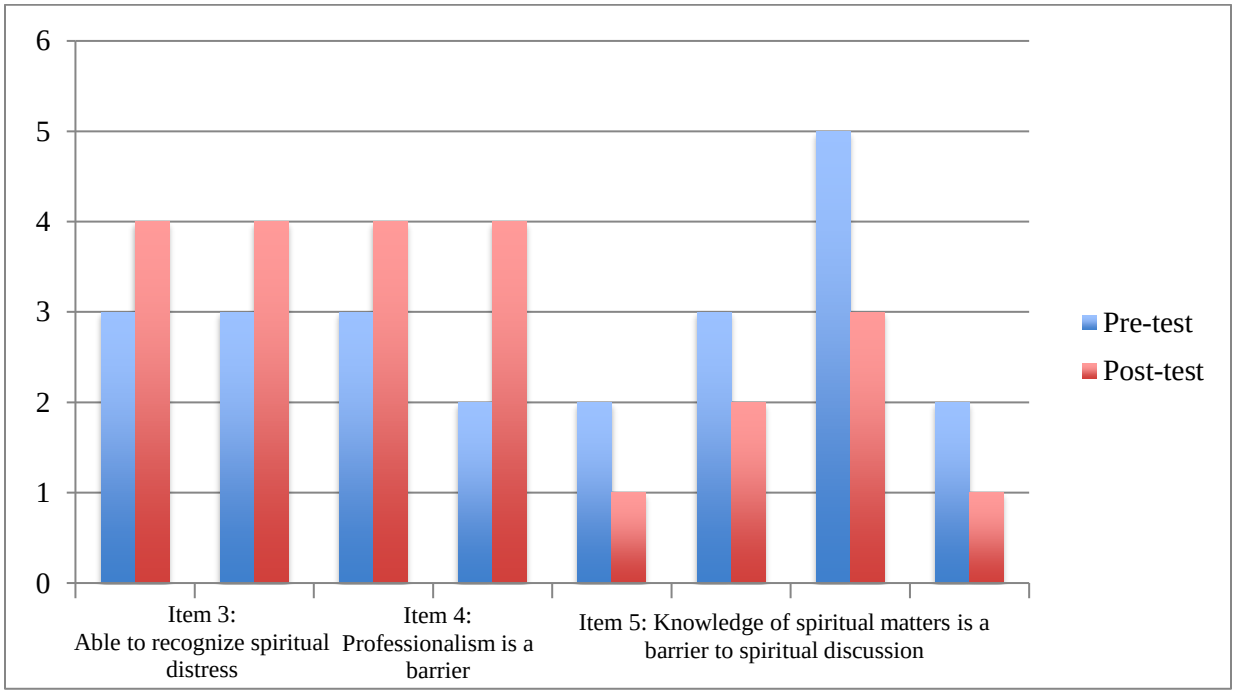


Table 11

Marin County Department of Aging & Adult Services Pre-test Raw Scores Knowledge Day 3

	Knowledge items									
	Item 1		**Item 2**		**Item 3**		**Item 4**		**Item 5**	
Participant	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
1	2	4	3	3	2	5	4	3	4	5
2	x	x	5	5	5	5	5	5	5	5
3	1	3	2	4	2	4	4	4	4	4
4	5	4	3	3	3	4	5	4	2	1
Mean	2.67	3.67	3.25	3.75	3.00	4.50	4.50	4.00	3.75	3.75

Note. 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree

Table 12

Marin County Department of Aging & Adult Services Post-test Percentage Distribution Knowledge Day 3

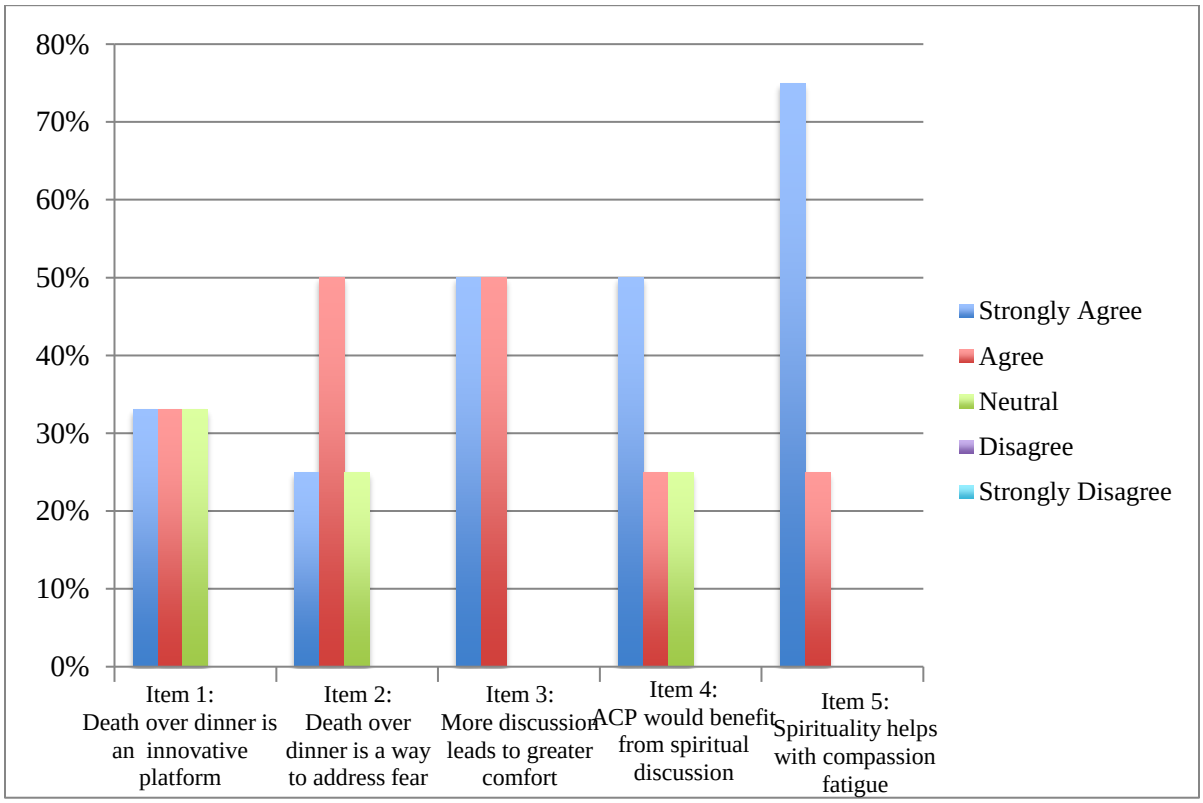


Table 13

Marin County Department of Aging & Adult Services Post-test Raw Scores Experience Day 3

	Experience items				
Participant	**Item 6**	**Item 7**	**Item 8**	**Item 9**	**Item 10**
1	3	4	4	4	4
2	5	5	5	5	5
3	4	4	3	5	3
4	4	5	4	5	4
Mean	4.00	4.50	4.00	4.75	4.00

Note. 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree

Table 14

Marin County Department of Aging & Adult Services Post-test Chart of Experience Items Day 3

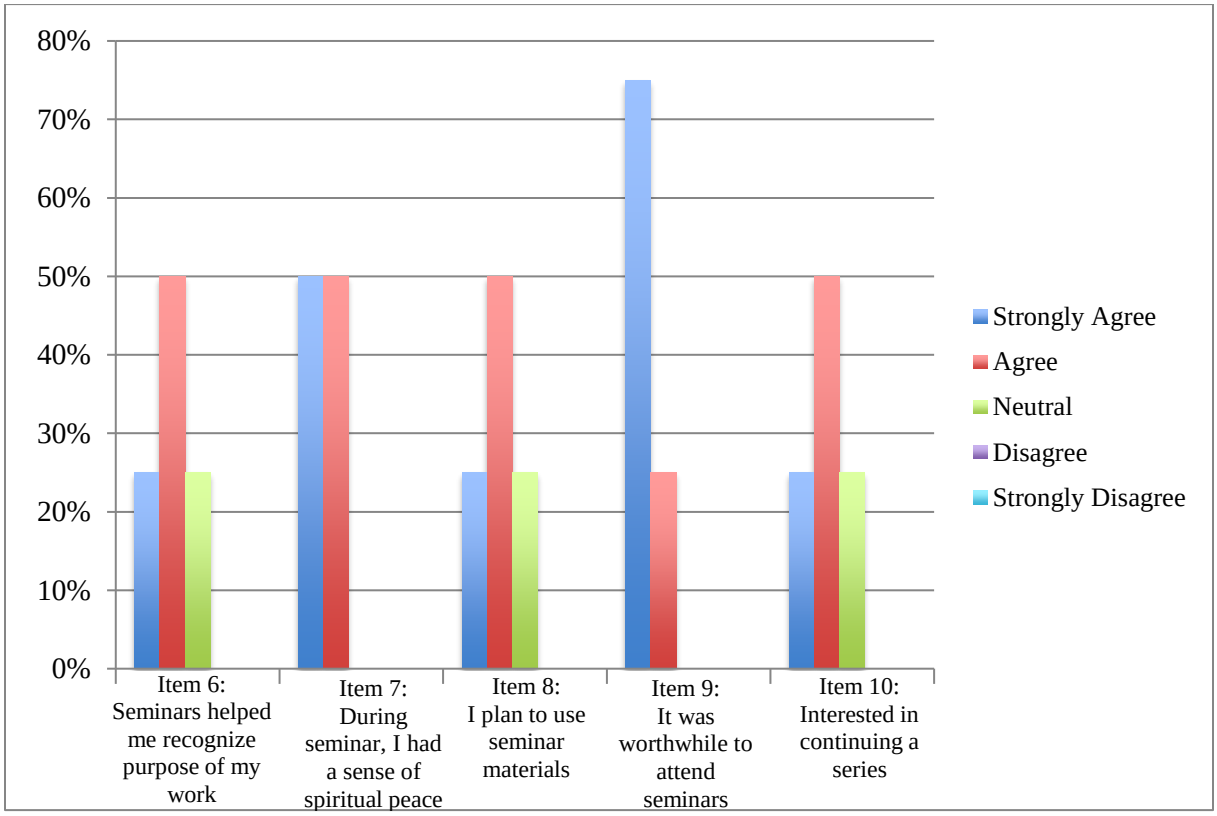
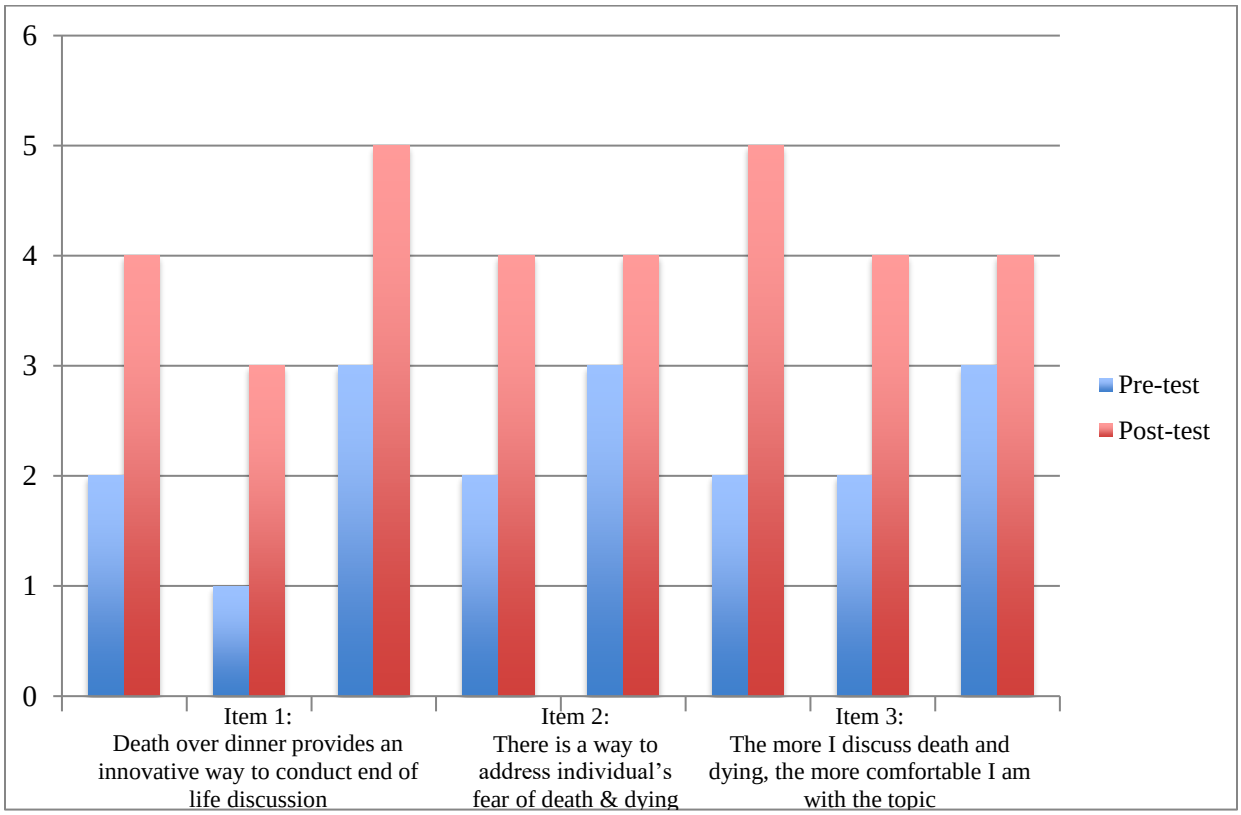


Table 15

Marin County Department of Aging & Adult Services Post-test Positive Change Knowledge Items Day 3



Appendix O

Qualitative Data

Table 1

Marin County Department of Aging & Adult Services Post-test Responses Day 2

Post-test item: What did you enjoy most about today's session?

"Sharing-your "soul map" of spirituality. [Co-facilitator's] exercises."

"Everyone seemed more relaxed and open. Subject matter was very interesting and we could talk for hours!"

"Discussing what it means to be spiritual."

"Participant's sharing what is really meaningful to them in their lives"

Post-test item: Comments?

"Awesome"

"Wonderful discussion. Thank you."

"I feel spiritual discussions are important to assist people in finding meaning and purpose in their personal and professional lives"

Table 2

Marin County Department of Aging & Adult Services Post-test Responses Day 3

Post-test item: What do you think could be done to further advance care planning in the U.S.?

"Talk about it. Normalize it."

"More teaching and education on this topic."

"More of these classes. Thank you!"

Post-test item: Is spirituality a part of whole health?

"Yes"

"Yes definitely"

"Absolutely"

Post-test item: Additional comments regarding benefits of this class.

"Thanks for your time and teaching."

"So grateful…BSN students and I wish to recommend advancing this within the SONHP"

"You did a wonderful job in organizing, presenting, re-grouping, and providing excellent materials, which included delightful, healthy treats."

APPENDIX P

Project Evaluation

Table 1

REACH Public Health Model

Measure	Definition	Data Source	Goal
Reach	Minimum 25% staff attendance.	Attendance	Seminar 1: 46% Seminar 2: 38% Seminar 3: 31%
Effectiveness	Intended participant outcomes: a) Identify spiritual beliefs, values, practices. b) Renewed sense of meaning in professional work.	Pre-test Post-test	Post-test grouped positive change distribution scores: a) 66% strongly agreed, 33% agreed. b) 25% strongly agreed, 50% agreed, 25% neutral.
Adoption	Identify ideal setting for intervention with appropriate site permissions.	Project summary	Positive site evaluation of spiritual-based intervention.
Implementation	Plan an intervention with consistent, and repeated iterations.	Project timeline	Three seminars delivered.
Maintenance	Develop a long-term plan for sustainable results.	Continued communications	Development of a participant-driven, spiritual and clinical practice effort.

APPENDIX Q

Project Summary

SPIRITUALITY & CLINICAL PRACTICE
KATIE LUTZ, RN
DNP/Candidate University of San Francisco
School of Nursing and Health Professions
Practicum: Fall Semester 2017

SUMMARY REPORT
January 19, 2018

It was my pleasure to facilitate a link to clinical practice for Katie Lutz, RN and the Marin County HHS, Division of Aging/Adult Services. Katie is a dedicated and talented nurse clinician and candidate for her Doctorate in the domain of Nurse Practitioner. While engaged in her compelling practicum, Katie distinguished herself as a field leader by her keen intellect, dedication to the art and science of nursing and her deep compassion for the vulnerable population that will benefit greatly from her important work.

Katie has developed a tool that assesses death and dying from a spiritual perspective which allows patients the respect and decision making time and resources needed to incorporate their wishes into a directive.

Her learning objectives:

1. To support staff in recognizing, valuing and preserving the human dimension of their work,
2. To enable staff to experience and connect with the core values of compassion, gratitude, meaning and service,
3. To enable staff to be in a relationship with each other in a way thetis revelatory and inspiring.

To meet her goals, Katie engaged with social workers, public health nurses in the Division of Aging/Adult Services and BSN student nurses in USF's School of Nursing and Health Professions. She set up three training sessions in which she discussed Advance Care Planning, suggested that spirituality is the missing link, presented tools, training and self-reflection necessary to help staff and clients engage in spirituality. Staff, at first, expressed skepticism about the professional and cultural acceptability of such a dimension in their work. Is spirituality a "taboo" in the secular workplace? Katie's razor-sharp reasoning together with the scholarly research supporting her hypothesis, demonstrated to students and staff

that, not only is such a focus acceptable, but it is actually essential to the work which nurtures and heals the human condition. She skillfully demonstrated, in a compelling way, that spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose. It is the way they experience their connectedness to the moment, to self, to others, to nature, and the the significant or sacred.

The outcome of her practicum will, I predict, have far reaching effects as staff and students alike recognized the fact that they are actually engaged, in an undefined way, in their client's spirituality! They already "get it" and affirm their client's spiritual dimension and related needs through compassionate motivational interviewing that can be brought to a more meaningful and productive level by skillfully applying the tools Katie demonstrated. In one study (McLean, 2003), of 456 patients surveyed, two-thirds felt clinicians should be aware of belief, and one third felt clinicians should inquire....19% wanted beliefs to be discussed routinely. In a Mayo Clinic study done in 2001, 94% of patients stated that they regard spiritual health to be as important as physical health.

It is important to note that one staff member, Rachel Gila, RN of the HOPE Program and Senior Peer Counseling was so moved by the importance of Katie's work that she co-presented with her in the aforementioned trainings adding her insights through her practice of Qi Gong.

Students from the USF BSN program enthusiastically responded to Katie's work by requesting that Dean Maggie Baker consider incorporating this learning model into their curriculum.

I am ever grateful to Katie's instructor, Dr. Jodie Sanhhu,DNP for connecting us, and to Katie for her amazing and important work.

In Gratitude,

Rita Widergren, RN, PHN
Program Director
Opportunity Village Marin