

SPIRITUALITY AND JOB SATISFACTION: A CORRELATIONAL STUDY
AMONG NURSES

A Dissertation

Submitted to the
Faculty of Argosy University/Sarasota
in partial fulfillment of
the requirements for the degree of
Doctor of Business Administration

by

Rhonda S. Bell

Argosy University/Sarasota

Sarasota, Florida

August 2006

Dissertation Committee Approval:

Pete R. Simmons, Ph.D., Chair date

Cal Berkey, DBA, Member date

Kathleen Cornett, Ph.D., Reader date

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Chairperson: Dr. Pete Simmons
Member: Dr. Cal Berkey
Reader: Dr. Kathleen Cornett

Department: College of Business and Information Technology

The purpose of this study was to examine the relationship between spirituality and job satisfaction among registered nurses and licensed practical nurses.

Demographic characteristics such as age, educational levels, area of clinical practice and tenure were also examined as relates to spirituality and job satisfaction levels.

The study was conducted based on work (Ashmos & Duchon, 2002; Denton & Mitroff, 1999a) suggesting a direct relationship between meaningful work and spirituality and job satisfaction. Moreover, additional studies (Furino & Reineck, 2005; Tuttas, 2002) suggested that nurses feel more satisfied with the intrinsic factors of nursing when they feel that they are making a difference in the lives of others.

A convenience sample of approximately 500 nurses in a hospital setting in central Arkansas was originally surveyed for the study. The participants voluntarily

completed the questionnaires either in a conference room adjacent to the dining room of the hospital or at their work areas. A total of 259 responded to the request; however, only 240 completed surveys were used yielding a response rate of 49.5%. The three instruments used in this study were the Spirituality Assessment Scale (SAS) (Howden, 1992), the Minnesota Satisfaction Questionnaire (MSQ), Short-form (Weiss, Dawis, England, & Lofquist, 1967), and a demographic questionnaire.

Pearson correlation calculations, showed a moderate significant positive correlation ($r = .452$) between spirituality and general job satisfaction and a higher significant positive correlation ($r = .495$) between spirituality and intrinsic job satisfaction. Likewise, a less significant positive correlation ($r = .302$) was found between spirituality and extrinsic job satisfaction. These findings suggest that spirituality is intimately related to job satisfaction, and support the literature (Furino & Reineck, 2005; Tuttas, 2002); that nurses may be more satisfied with the intrinsic factors of job satisfaction when they are more spiritually oriented.

An analysis of variance was used to test for the differences in the level of spirituality and job satisfaction as relates to the demographic variables: Age, educational background, clinical practice, and job tenure. No differences were noted on the spirituality or general job satisfaction levels as relates to any of the demographic variables of this sample.

An interesting observation here was that the sample was not particularly well-educated, they were also somewhat older than expected and they were less experienced than one would imagine. These trends are a confirmation of the staffing problems in the nursing field. Additional research is needed to generalize the results

to other nurse populations. Research is also suggested regarding the relationship between spirituality and job satisfaction among nurses and the impact of these factors on patient satisfaction. Finally, practical personnel suggestions are outlined for hospital administrators and nurses regarding spirituality and job satisfaction.

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DEDICATION

This dissertation is dedicated to my two sons, Timothy A. Bell and Samuel K. Bell. These guys were thirteen and nine when I started this journey. Now at seventeen and thirteen they are seeing this journey of my life almost complete. Words cannot express the love I have for these two young men who have encouraged me immensely to focus and finish the task. The countless hours of “Mom” time that they have sacrificed will never be forgotten nor taken for granted. I could have never made this journey complete without their help with chores, supper, and the understanding that endurance and perseverance will always be rewarded. To these two special sons, I will always be grateful.

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CHAPTER ONE: THE PROBLEM

Introduction

The work environment in nearly every industry continues to be faced with numerous challenges that require constant change. Globalization, competition, technology, reengineering and downsizing are just a few factors that are creating a more complex work environment and ones requiring transformational changes initiated by leadership (Kotter, 1996). The healthcare industry is no different and sometimes brings even more challenges for management. The special concerns of health care, life and death, patient care, and a profitable bottom line, make this environment a particularly unique one. Over the last fifteen plus years, employees and management in these settings have been relying more on a new organizational culture, one that includes issues of spirituality in the workplace (Grant, 2004; Grant, O'Neil, & Stephens, 2004; Guillaume & McMillan, 2002; Schuster, 1997). It is almost as if this spirituality emphasis is fulfilling some unsettled needs for both management and employees. Spirituality may be more prevalent in the healthcare industry because of the past and present emphasis on holistic medicine which involves the physical, psychological, social, and spiritual dimensions of the patient (Nightingale, 1860; Burkhardt & Nagia-Jacobson, 1989). Spirituality in health care may also be a function of the life and death nature of many of the care-decisions that are made in these environments; many of which may leave the health care professional drained or depleted of emotional resources (Aiken, Clarke, Silber Sloane, & Sochalski, 2002; Carson, 1989; Furino & Reineck, 2005).

This increased interest in spirituality within organizations has inspired many professional health care organizations to include this topic during their annual events. During the 2003 annual Congress of the American College of Healthcare Executives five percent of the seminars were dominated by the topic of spirituality within the workplace, and additional seminars addressed the topics of corporate culture, patient and employee satisfaction, staff shortages, Magnet hospitals, change management, outsourcing, and information technology strategies (Bell, 2003). Clearly, due to work pressures or world-worries with 9/11 and/or the terrorist threats of today, spirituality concerns have risen in general (Blair, Kaldahl, Seo, & Torabi, 2004; Collins et al., 2001).

Problem Background

The term “spirituality” encompasses several definitions in the medical and business literature. Similarities in the definitions of spirituality include meaning and purpose in life, interconnectedness to a Higher Power, individuals, or community; transcendence, compassion, caring, and valuing mankind (Condemni, Ferguson, Milliman, & Trickett, 1999; Delbecq, 1999; Denton & Mitroff, 1999; Fairholm, 1996). One of the earliest definitions suggests spirituality in the realm of religion with one’s sense of and dependence on a Beyond that influences inner and outer experiences (Clark, 1958). Frankl (1959, 1969) suggests that the spiritual encompasses the mind and the spirit without the emphasis of religion. Additional authors and researchers (Ashmos & Duchon, 2000; Denton & Mitroff, 1999a; Rojas, 2002) have given much attention in trying to identify and measure spirituality as it relates to the workplace. Furthermore, the definitions of spirituality in healthcare

seem to center on meaning and purpose and understanding the person as a whole including the physical, psychological, social, and spiritual dimensions (Allen & Rowe, 2004; Burkhardt & Nagia-Jacobson, 1989; Chiu & Greasley, 2001; Nightingale, 1860).

The following question may be asked: Why is there a need for spirituality? Organizational spirituality concerns have been studied by classic organizational theorists (Follet, 1918; Greenleaf, 1980; Maslow, 1998) and even present day enthusiasts (Dehler & Welsh, 1994; Denton & Mitroff, 1999a; Condemi, Ferguson, Milliman, & Trickett, 1999; Giacalone & Jurkiewicz, 2003). According to these authors, organizational spirituality may even include job involvement, organizational integration, purposeful leadership, task significance, self actualization, and self-management. Some management experts (Condemi, Ferguson, Milliman, & Trickett, 1999; Denton & Mitroff, 1999a; Dhiman, King, & Marques, 2005; Garcia-Zamor, 2003; Quatro, 2002) suggest, even, that spirituality can have a considerable impact on profitability, organizational performance, motivation, organizational transformation, and job satisfaction. The inclusion of spirituality at work seems to be prompted by the worker's desire to find meaning and purpose in one's life, including the enormous part of ones life that is spent in the workplace (Biberman & Whitty, 1997; Cavanaugh, 1999; Denton & Mitroff, 1999b; Fairholm, 1996; Freshman, 1999; King & Nichol, 1999; Marcic, 2000).

Not only are workers searching for meaning and purpose in their lives at work, but they are often confronted with patients who are often relying on meaning and/or purpose issues in their lives to cope with their illnesses and/or diseases

(Albaugh, 2003; Brown, 2000; Chiu, Gartland, & Greasley, 2001; Allen & Rowe, 2004; Walton, 2002). Patients who endure the adversities during cardiac surgery, cancer treatments, psychological treatments, and other treatments for chronic diseases also seem to be relying on the meaning and purpose of life to cope with their illnesses (Albaugh, 2003; Brown, 2000; Chiu, Gartland, & Greasley, 2001; Allen & Rowe, 2004; Walton, 2002).

The roots of spirituality in health care can be traced back to the Greek gods and goddesses with their emphases on baths, fasting, medications, and prophecies to help with rejuvenation of the body and mind (Matthews, 1992). Florence Nightingale, a British leader in the nursing profession, even referred to her profession as a calling, believing that the body, mind, spirit, and environment were all factors that unified the whole person (Nightingale, 1860). Studies examining the role of spirituality and illness or disease, (Albaugh, 2003; Allen & Rowe, 2004; Bashmore, Crater, Green, & Koenig; Ganstrom, 1985; Walton, 1997) spirituality and health, (Arreloa, & Goodloe, 1992; Brown, 2000; Coyle, 2002; George, Koenig, & Titus, 2004;) and spiritual care (Chiu, Gartland, & Greasley, 2001; Davis, 2003; Felgen, 2004) all help provide a backdrop in understanding some of the purposes of spirituality for healthcare providers and their patients.

Clearly, healthcare work offers an environment that can be very rewarding; however, continued staff shortages (Coile, 2001; Donley, 2005), the demands to perform with fewer resources (Furino & Reineck, 2005), the struggle for a profitable bottom line (Hood, Smith, & Waldman, 2003), the error rate in medicine (Leape, 1994), and the strong pressures for quality patient care (Coile, 2001) can lead to a

work environment filled with many pressures and lots of dissatisfaction and stress (Donley, 2005). These issues have raised concerns for the health care provider (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Erlen, 2004; Donley, 2005; Mee & Robinson, 2003). The emotional stresses placed upon nurses to render the highest quality of care during times of staff shortages and administrative demands could be leading to the burnout of many nurses. In addition, the population of nurses is decreasing with fewer individuals entering the nursing profession and the approaching retirement age of the baby boomers (Mee & Robinson, 2003). The demands of the health care environment may have resulted in Jackson (2004) and O'Connor's (2002) call for nurses to find coping mechanisms to decrease the stresses of their work, and that they find meaning and purpose in their work. One has to wonder, however, how nurses perceive their work settings, are they as dissatisfied with their work settings as reported and one has to wonder if spirituality practices might help nurses deal with these pressures. The present study will examine the relationship between spirituality and job satisfaction among registered nurses and licensed practical nurses. The researcher hopes to gain an understanding of the relationship between the elements of spirituality (purpose and meaning in life, innerness or inner resources, unifying interconnectedness, and transcendence) and job satisfaction (general job satisfaction, intrinsic satisfaction, and extrinsic satisfaction) levels among nursing professionals.

Literature Review

The literature relevant to this study examines the history of spirituality as it relates to healthcare, including a brief history of nursing in general, spirituality and

how it is defined and relates to health care organizations, the holistic approach to healthcare and how it relates to spirituality, the practice of spirituality among nurses in general, the historical development of spirituality as relates to management practices in organizations, and the final part of the literature review will address the stress levels of nurses and how they relate to job satisfaction levels and spirituality as a coping mechanism.

The development of rendering care began as early as the patriarchal age (1950-1150 B.C.) with the mention of a nurse accompanying Rebekah in Genesis 24:59 (Genesis 24:59 New International Version). The development of healthcare progresses with the Greek gods and goddesses and the practice of nursing and spirituality with baths, fasting, medications, and prophecies (Matthews, 1992). The development of formal nursing care can be most likely traced to the British lady, Florence Nightingale (Barnum, 1996; Bullough & Bullough, 1964; Roberts, 1954). Early developments of nursing education consisted of one year of training and an examination to evaluate nursing skills and competencies (Roberts, 1954). Spirituality was a component of nursing care during these times with the approach to health encompassing the body, mind, and spirit.

The definitions of spirituality in healthcare seem to center on meaning and purpose, and understanding the person as a whole including the physical, psychological, social, and spiritual dimensions (Allen & Rowe, 2004; Burkhardt & Nagia-Jacobson, 1989; Chiu & Greasley, 2001; Nightingale, 1860). Research (Allen & Rowe, 2004; Deckro, Mandle, & Stuart, 1989; Nightingale, 1860; Walton, 1997) suggests that the benefits of spirituality as relates to health include health benefits in

terms of prevention, improved health status, recovery from illness, or enabling people to cope with illness and/or adversity. There has been an increased use of spirituality in the healing process among the older population with chronic diseases (George, Koenig, Titus, 2004).

The Joint Commission of Accreditation of Healthcare Organizations (JCAHO) requires healthcare institutions to accommodate the right to pastoral and other spiritual services if requested (Joint Commission, 2005). Physicians and nurses have a responsibility to perform a spiritual assessment to determine spiritual practices that may be important to the patient. Some research suggests that patients are not having their spiritual or religious needs met during acute hospitalization (Burton, Fitchett, Sivian, 1997). Research indicates that nurses do believe spirituality could have an influence and a positive outcome on the patients' health or meaning of their illness (Grant, 2004). This could mean that organizations need to consider a more holistic approach to healthcare.

A holistic approach to healthcare was evident very early with Florence Nightingale's (1860) philosophy of healing encompassing the connectedness of the body, mind, and spirit of the person. More recent literature (Anderson, Coulon, Krause, & Mok, 1996; Burkhardt, 1989; Richardson, 1994) supports the approach to healthcare as caring for the whole person, including the spiritual realm. The more recent practice of complementary and alternative medicine (CAM) has boosted the practice of holistic medicine (Esiemberg, 1998; Richardson, 2004).

Nurses continue to integrate spiritual care to gain a more holistic approach to healthcare (Albaugh, 2003; Brown, 2000; Chiu, Gartland, & Greasley, 2001; Walton,

2002). Spiritual care from a nurse can be as simple as a gentle touch, openness to listen, and the willingness to enter into a trusting relationship with the patient (Nussbaum, 2003). A spiritual assessment can help identify the spiritual needs of a patient, thus giving the nurse direction to rendering spiritual care to the patient (Tanyi, 2002). Prayer, a form of complimentary and alternative medicine and spiritual care, has been studied in cardiac patients (Abbott, Kennedy, & Rosenberg, 2002; Ai, Bolling, Peterson, & Koenig, 2002; Bryant, Desai, & Ng, 2002) with results being reduced adverse outcomes and lower complication rates. The role of spirituality is not only unique to healthcare organizations, but organizations across other industries have been taking notice and considering the role of the spirituality in organizations (Ashmos & Duchon, 2000; Denton & Mitroff, 1999b).

The increased awareness and concern for spirituality could be contributed to increased downsizing and layoffs, corporate greed in the 1980s and 1990s, the aging of the baby boomers, the influx of women in the workplace, and most recently the threats of terrorism (Ashmos & Duchon, 2000; Blair, Kaldahl, Seo, & Torabi, 2004; Dehler & Welsch, 1994; Dhiman, King, & Marques, 2005). Literature supports the idea that employee's are searching to find meaning and purpose in their work and in their life (Biberman & Whitty, 1997; Denton & Mitroff, 1999b; Curry, 2003). Organizational spirituality has been defined with themes of empowerment and job involvement (Condemni, Ferguson, Milliman, & Trickett, 1999; Giacalone & Jurkiewicz, 2003). Research suggests that organizational spirituality may; even have an impact on organizational performance (Condemni, et. al., 1999; Quatro, 2002).

Although a 1999 Gallup poll showed seventy-eight percent of Americans feel a need to experience spiritual growth, organizations will have to proceed with caution as they consider spirituality in their organizations. Religious discrimination and litigation expenses are present in today's workplace (Huang & Kleiner, 2001). Government and regulatory organizations (i.e. Joint Commission of Healthcare Organizations) have taken measures to protect and accommodate religious belief and practices in the workplace and in healthcare (Huang & Kleiner, 2001; Joint Commission, 2005). Regulations and accommodations sometimes take a toll on workers, especially in the healthcare industry.

Nurses in particular are expected to accommodate professional staff and patients, keep up with technology and research-based practices, and constantly being asked to do more with less (O'Connor, 2002). Higher levels of work dissatisfaction, job stress, low morale, and low employee retention rates are negatively impacting the motivation and job satisfaction of America's nurses (Aiken, Clarke, Sloan, Sochalski, Silber, 2002; Coile, 2001; Mee & Robinson, 2003). In addition, the structure of the nursing job may be influencing nurse satisfaction (United States Department of Health and Human Services, 2000). Research suggests that job stress and burnout among nurses (Menon, Narayanan, & Spector, 1996; Rub, 2003) are present and must be given serious consideration to protect the volume of nurses in the healthcare industry.

An active role of spirituality in healthcare organizations could be a key component to bring about meaning and purpose in the work of nurses and protect this valuable workforce. Literature suggests that nurses are faced with obstacles such as

the mechanics of nursing, emotional stress and burnout, and the lack of education regarding spiritual care that may hinder them from providing the necessary spiritual care (McEwan, 2004; Pesut, 2003). Jackson (2004) and O'Connor (2002) suggest in order for a nurse to understand and render spiritual care, the nurse will need to engage in stress coping resources to attempt to heal herself/himself from the obstacles that prohibit the necessary spiritual care.

Purpose of the Study

The purpose of this study will be to examine the relationships between spirituality and job satisfaction among nurses. The Spirituality Assessment Scale (SAS) (Howden, 1992) will be used to determine the spirituality scores and the level of spirituality among nurses. The Minnesota Satisfaction Questionnaire (MSQ), Short-form (Weiss, Dawis, England, & Lofquist, 1967) will be used to determine intrinsic satisfaction, extrinsic satisfaction, and general satisfaction. The general satisfaction and spirituality scores will be compared to determine if a relationship exists between job satisfaction and spirituality. Demographic variables will also be used to determine additional relationships between spirituality and job satisfaction among nurses.

Research Questions

Based on the literature review, spirituality seems to be a concern in the healthcare environment. Nurses who experience spirituality or meaning and purpose in their work may also experience greater job satisfaction levels (Dhiman, King, & Marques, 2005; Guillaume & McMillan, 2002; Lussier & Malloch, 2000). The following research questions have been developed for this study. Do nurses who

experience spirituality also experience general job satisfaction? Do nurses who experience spirituality also experience intrinsic job satisfaction? Are there differences in the level of spirituality and levels based on age? Are there differences in the level of spirituality based on educational background? Are there differences in the level of spirituality based on the area of clinical practice? Are there differences in the level of spirituality based on tenure of the nurse? Are there differences in the level of general job satisfaction and based on age? Are there differences in the level of general job satisfaction based on the educational background? Are there differences in the level of general job satisfaction and based on the area of clinical practice? Finally, are there differences in the level of general job satisfaction based on tenure of the nurse?

Research Hypotheses

The following null and alternative hypotheses have been developed based on the previous research questions.

H1_a: There is a statistically significant positive relationship between SAS scores and the general job satisfaction scores.

H1_o: There is no statistically significant positive relationship between SAS scores and the general job satisfaction scores.

H2_a: There is a statistically significant positive relationship between SAS scores and the intrinsic satisfaction scores.

H2_o: There is no statistically significant positive relationship between SAS scores and the intrinsic satisfaction scores.

H3_a: There is a statistically significant difference in the level of spirituality and age.

H3_o: There is no statistically significant difference in the level of spirituality based on age.

H4_a: There is a statistically significant difference in the level of spirituality and educational background.

H4_o: There is no statistically significant difference in the level of spirituality based on educational background.

H5_a: There is a statistically significant difference in the level of spirituality and the area of clinical practice.

H5_o: There is no statistically significant difference in the level of spirituality based on the area of clinical practice.

H6_a: There is a statistically significant difference in the level of spirituality and tenure of the nurse.

H6_o: There is no statistically significant difference in the level of spirituality based on the tenure of the nurse.

H7_a: There is a statistically significant difference in the level of general job satisfaction and age.

H7_o: There is no statistically significant difference in the level of general job satisfaction based on age.

H8_a: There is a statistically significant difference in the level of general job satisfaction and educational background.

H8_o: There is no statistically significant difference in the level of general job satisfaction based on educational background.

H9_a: There is a statistically significant difference in the level of general job satisfaction and the area of clinical practice.

H9_o: There is no statistically significant difference in the level of general job satisfaction based on the area of clinical practice.

H10_a: There is a statistically significant difference in the level of general job satisfaction and tenure of the nurse.

H10_o: There is no statistically significant difference in the level of general job satisfaction based on tenure of the nurse.

Limitations/Delimitations

The following limitations are to be considered in this study.

1. The study will be limited to a convenient random sample of Registered Nurses and Licensed Practical Nurses in the central Arkansas region. A threat of statistical validity problems may be present because of the sample being only from the state of Arkansas. In addition, a sampling bias may occur with the use of convenience sample of volunteers.
2. The population for this study is limited to participants that are licensed and currently practicing nursing.
3. The truthfulness of the participants may influence their self reports. This study also assumes that the responses are reflecting the actual behaviors of the respondents, which may or may not be the case here. These concerns could be a potential threat to the construct validity of the study.
4. The limited number of studies using the Spirituality Assessment Scale (SAS) (Howden, 1992) may leave some doubts about the validity of the results in general.

5. It is also realized here that multiple factors may affect job satisfaction scores, spirituality levels and/or the relationships between these variables. The findings here may not be examining all variables of influence as relates to these two factors; however, it is thought that job satisfaction and levels of spiritual concerns are in fact somewhat related.

Definitions

Below are the definitions of the key terms pertinent to this study.

Burnout-- a state of physical and emotional exhaustion (Maslach, 1982).

Extrinsic job satisfaction -- job satisfaction that includes the reinforcement factors working conditions, supervision, co-workers, and the company (Weiss, Dawis, England, & Lofquist, 1967).

General job satisfaction -- job satisfaction that includes both extrinsic and intrinsic reinforcement factors (Weiss, Dawis, England, & Lofquist, 1967).

Holistic health-- the health of a patient that includes the physical, psychological, social, and spiritual dimensions (Burkhardt & Nagai-Jacobson, 1989).

Innerness or Inner Resources-- is defined as the process of striving for or discovering wholeness, identity, and a sense of empowerment. Innerness or inner resources are manifested in feelings of strength in times of crisis, calmness or serenity in dealing with uncertainty in life, guidance in living, being at peace with one's self and the world, and feelings of ability (Howden, 1992).

Intrinsic job satisfaction-- job satisfaction that includes the reinforcement factors type of work, achievement, and ability utilization (Weiss, Dawis, England, & Lofquist, 1967).

Job satisfaction-- the pleasurable or positive emotional state as a result of the appraisal of one's job or job experiences (Locke, 1965).

Purpose and Meaning in Life-- is defined as the process of searching for or discovering events or relationships that provide a sense of worth, hope, and/or reason for living/existence (Howden, 1992).

Spirituality-- is defined as the dimension of one's being that is an integrating or unifying factor and that is manifested through unifying interconnectedness, purpose and meaning in life, innerness or inner resources and transcendence (Howden, 1992).

Spiritual care-- the acknowledgement of a person's sense of meaning and purpose in life which may or may not be expressed through formal religious beliefs and practices, and the quality of interpersonal care in expression of love, concern and kindness to the patient (Chiu, Gartland, & Greasley, 2001).

Spiritual well-being-- the measurement of one's spiritual health in general (Ellison, 1983).

Stress-- a term that is used to refer to stressors or demands, the stress response, eustress, and distress or strain (Hurrell, Nelson, Quick, & Quick, 1997).

Stressors-- the significant life-changing events that are either negative or positive, or minor events, or everyday hassles such as demands from all of the children's activities and home life to deadline at work (Fabricatore & Handal, 2000).

Transcendence-- is defined as the ability to reach or go beyond the limits of usual experience; the capacity, willingness, or experience of rising above or overcoming bodily or psychic conditions; or the capacity for achieving wellness (Howden, 1992).

Unifying Interconnectedness-- is defined as the feeling of relatedness or attachment to others, a sense of relationship to all of life, a feeling of harmony with self and others, and a feeling of oneness with the universe and/or a universal element or Universal Being (Howden, 1992).

Importance of the Study

There has been research conducted on the existence of spirituality among nurses (Dunajski, 1994; Davis, 2003; Hare, 1998; Vance, 2001); however, additional research is needed to determine where current levels of spirituality are among nurses and the nature of the relationship between spirituality and job satisfaction among nurses. Second, the stress and dissatisfaction levels among nurses seem to be causing excessive turnover and professional withdrawal in the field of nursing (Erlen, 2004). With the baby boomers approaching an age that will demand increased healthcare (Poduska, 2005) and baby boomer nurses exiting the field of healthcare (Mee & Robinson, 2003), healthcare leaders need to understand and identify the dissatisfaction levels of nurses and possible alternative solutions to these problems (Coile, 2001; Donley, 2005). Healthcare is a changing environment, one that depends on the ability of leaders to understand the healthcare issues and the needs of both the workers in such settings and the patients' needs. Ultimately, research is needed to help health care leaders in identifying the factors that may influence nurses in providing the best quality of care to their patients.

The remaining chapters will provide more details about spirituality in the healthcare industry. The literature review in chapter two will examine the history of spirituality as it relates to healthcare including a brief history of nursing, define

spirituality as it relates to organizations and healthcare, examine the past and renewed focus on the holistic approach to healthcare, the practice of spirituality among nurses, the historical development of spirituality and management practices, and explore the job satisfaction and stress levels of nurses. The third chapter will give the specific details of this study including the design of the study, a description of the participants, the instrumentation, the procedures of the study, and the data process and analysis steps, and the assumptions and limitation. Chapter four will provide the findings of the study and chapter five will discuss the conclusions and recommendations from the effort.

CHAPTER TWO: LITERATURE REVIEW

The ties between nursing care and the spiritual realm are deep. This review examines spirituality and health care from several different perspectives. The broad history of spirituality as relates to healthcare including a brief history of nursing care and what it involves will be the first aspect addressed. The defining of spirituality as it relates to business and healthcare will be included in this section. The past and renewed focus on the holistic approach to healthcare and the practice of spirituality among nurses in the healthcare industry will encompass the second part of the review. The third section of the literature review will examine the historical development of spirituality in management practices in general and the final part of the literature review will address the job satisfaction and stress levels among nurses.

The Historical Perspective of Spirituality in Healthcare

History of Nursing

The existence of healthcare in the form of care-giving can be traced back to Biblical times with women caring for members of the home and for children. Nurses are referred to in the Old Testament as wet nurses who provide breast milk to infants and nurses are caregivers for the sick. Exodus 2:7 states, "Shall I go and get one of the Hebrew women to nurse the baby for you?", and Genesis 24:59 it states, "So they sent their sister Rebekah on her way, along with her nurse and Abraham's servant and his men" (Exodus 2:7 and Genesis 24:59 New International Version). The development of healthcare progressed with advancement in medicine in Greeks times with nursing priests and attendants caring for the sick (Barnum, 1996; Bullough & Bullough, 1964). The Greeks also relied on Gods and Goddesses for healing the sick

in the temples with a procedure known as incubation. This would involve people going to the temples of Asclepius, of the God of healing, and sleeping or dwelling upon their illness until the God would appear in the sick person's dream and cure them or tell them how to be cured (Bullough & Bullough, 1964). This became one of the earliest forms of hospitalization. The Oracle at Delphi also played a role in nursing and spirituality with baths, fasting, medications and prophecies, all a part of Grecian healthcare (Matthews, 1992).

The Greek medical approach spread to Rome, with the greatest contribution to nursing coming in the Middle Ages with the Christian concept of charity (Bullough & Bullough, 1964). The Catholic and Anglican sisterhoods cared for the sick both nationally and internationally. Many members of the sisterhood also cared for soldiers in the American Civil War and in the British Crimean War (Roberts, 1954). These women were often not trained nurses by profession, but they were often there to offer words of encouragement, bandage wounds, clean barracks, and provide food for the wounded soldiers.

The first formal training of nurses can probably be credited to the British lady, Florence Nightingale (Barnum, 1996; Bullough & Bullough, 1964; Roberts, 1954). On July 9, 1860, Florence Nightingale started a nursing school at St. Thomas' Hospital in London (Bullough & Bullough, 1964). Candidates for the nursing school would train for one year and then take an examination to demonstrate competencies in the skills that were taught. Other countries followed suit and started schools using the Nightingale format. Isabel Adams Hampton, superintendent of nurses at Johns Hopkins Hospital, developed the first graded course for nurses in the United States at

the Illinois Training School for Nurses in Chicago in 1893. (Roberts, 1954). Miss Hampton's principles of nursing were founded on Nightingale's nursing criteria. These principles were communicated in her paper, "Sick Nursing and Health Nursing," (as cited in Roberts, 1954) and consisted of the following:

- A well organized hospital associated with a medical school, with a matron (superintendent of nurses) herself a trained nurse
- A special organization for the purpose of giving systematic technical training
- Provision for supervision and for records
- A well supervised student residence where the students are steadily "mothered"
- Ward sisters (head nurses) "not constantly changing-for they are the key to the whole situation" (pg. 23).

Miss Nightingale also pointed out the need for a holistic approach to health with an understanding of the human person as a unity where body, mind, spirit, and environment are all interrelated factors of the whole person. With this in mind, the spiritual dimension of an individual can be apparent in organizations with several meanings prevailing for the term "spirituality."

Defining Spirituality

The definitions of spirituality in the business literature have similarities with the definitions of spirituality in the medical literature. Some of the similarities in the definitions focus on meaning and purpose in life, interconnectedness to a Higher Power, individuals, or community; transcendence, compassion, caring, and valuing

mankind (Condemi, Ferguson, Milliman, & Trickett, 1999; Delbecq, 1999; Denton & Mitroff, 1999; Fairholm, 1996). One of the earliest definitions is devoted to the realm of religion that characterizes one's sense of and dependence of a Beyond that influences inner and outer experiences (Clark, 1958). The definition of spirituality according to Denton and Mitroff (1999b) focuses on the individual with interconnectedness, source of faith and determination, harmony and goodness with life, having meaning and purpose in life, and being guided by a supreme power that brings inner peace and calmness. The term Christian spirituality suggests a belonging to God and the reliance on His power to create spirit and direction for one's life, even in the workplace (Delbecq, 1999). Ashmos and Duchon (2000) suggest spirituality depends on a broader inner life and that meaningful work and the community of work influence that inner life. Freshman (1999) suggests that spirituality is unique and very individualized; with themes and applications to spirituality such as learning, awareness, spirit at work, connectedness, community, compassion, diversity, learning, and creativity. One unifying concept to these definitions appears to be early theories about meaning, the whole person, and self actualization (Frankl, 1959; Jung, 1933; Maslow, 1954).

The study of logotherapy by Frankl (1959, 1969) suggests a historical perspective of the meaning and purpose of life and the spiritual dimension of health. According to Frankl (1959) the word *logos* in Greek means not only "meaning" but also "spirit"(p. 103). Spiritual in this sense does not necessarily have a religious connotation but it refers to the dimensions of the mind and spirit. Consider the following statement by Frankl (1969):

...man is free to answer the questions he is asked by life. But this freedom must not be confounded with arbitrariness. It must be interpreted in terms of responsibility. Man is responsible for giving the *right* answer to a question, for finding the *true* meaning of a situation. And meaning is something to be found rather than to be given, discovered rather than invented (p. 62).

This statement suggests that even in the element (situation) of work, and in healthcare in particular, man must find true meaning. Denton and Mitroff (1999a) developed five models to help organizations implement spirituality in the organization for finding meaning and purpose through one's work. The models were developed after Denton and Mitroff (1999b) studied over 100 senior executives and managers over a span of two years. As a result, four orientations toward spirituality and religion were discovered. The first orientation discovered (representing 30% of those surveyed) had positive views of religion and spirituality; second, 60% had positive views of spirituality and negative views of religion; 2% had positive views of religion and negative views of spirituality, and 8% had negative views of both religion and spirituality. The respondents in this study were asked, "What meaning does spirituality have for you and you alone, even if no one else agrees with you?" Of the responses that were positive, the most common themes were interconnectedness, meaning, creative, creation, cosmic oneness, and a guiding plan. The study of spirituality continues to reveal similar themes and meanings.

The work of Rojas (2002) also explored the many concepts of spirituality as it relates to management theory and practice. Rojas (2002) developed the Independent

Spirituality Assessment Scale (iSAS) that is based on a relational-ideopraxis construct and is defined as the following:

This relational-ideopraxis construct is centered on a supernatural or spiritual presence (i.e. God, Ultimate Power, Great Spirit, etc.) and unifies, orients, and mobilizes all aspects of life, namely, the intrapersonal, suprapersonal, and interpersonal aspects. In essence, spirituality is defined as a relational-ideopraxis, centered on a spiritual presence that unifies, orients, and mobilizes all aspects of life (pg. 37).

The congruency of this instrument with other spirituality instruments (Beazley, 1997; Denton & Mitroff, 1999a; Ellison, 1983; Howden, 1992) has given management an additional avenue to measure spirituality in the workplace without the biases of religious preferences, but a focus on personal fulfillment and employee satisfaction.

Corporate America sends confusing signals when they question the practice of spirituality in the workplace, yet they want workers who are enthusiastic about their job and the organization in particular. A closer look at the definition of enthusiasm may explain the driving force that can produce a sense of meaning and purpose for work among the creative and enthusiastic employee. The word enthusiasm originates from two Latin roots, ens, meaning “within” and spiritus, meaning “god” or “spirit”- literally, the “god or spirit within”(Denton & Mitroff, 1999a, p. 6). Many aspects of a job require the whole person including the spirit. Organizations need to understand that the whole person consists of a mind and a spirit and that the development of each of these is equally important (Ashmos & Duchon, 2000). Likewise, the practice of holistic health recognizes that the spirituality of a patient is to be viewed as an

integral part in treating the whole person (Burkhardt & Nagai-Jacobson, 1989; Grant, 2004). Furthermore, nurses may have a positive influence on the outcomes of patient care by recognizing the meaning and purpose of their profession and relying on the mind, body, and spirit when rendering care (Bond, Callister, Mangum, & Matsumura, 2004; Jackson, 2004; Vance, 2001).

Carl Jung (1933) provides a psychological theory of wholeness and the general conceptions of a spiritual nature, elements that are indispensable parts of the psychic life. He also believed that there were spiritually conditioned processes of transformation in the psyche. The psyche can be explained as that part of the human being that cannot always be explained by the science of medicine, but rather manifests by instinct or intuition. The following statement by Jung (1933) suggests some congruency with the thoughts of Frankl (1959): “And it is only the meaningful that sets us free from the unexplained premises of nineteenth-century science.” (p. 259). In the discussion of a psycho-neurotic patient, Jung suggests that the patient is experiencing spiritual stagnation and psychic sterility. The patient lacks something to take possession of him and give meaning and form to the confusion of the neurotic mind.

These thoughts seem to be related to the need gratification theory of Maslow (1954). Maslow studied a hierarchy of values that were thought to be determined by satisfying physiological needs based on safety, love, and esteem. The hierarchy of needs start with physiological needs of food, shelter, rest, etc. The second level consists of safety needs, which motivate the person to achieve a sense of security. The third level is the need for belongingness and love, the need for being part of a group.

Next, the need for esteem requires the acceptance of others in the form of respect and assurance in order to feel worthwhile and competent. The fifth need is self-actualization which includes fulfilling all aspects of one's potential; becoming everything one is capable of becoming (Maslow, 1954, p. 80-92). The study by Denton and Mitroff (1999b) investigating religion and spirituality in organizations on the United States East and West coasts suggests that corporate managers and top executives of organizations are beginning to understand the whole person including the soul. The research also suggests that if the inner being can be nourished at work, then the employee's full potential may be reached. This research parallels Maslow's hierarchy of needs and self actualization theory in many ways. Whether an employee or a patient, the needs of individuals has been and will always be a part of who we are and how we function.

The Root of Spirituality in Healthcare

The root of spirituality has already been traced back to the Greeks with the gods and goddesses of healing. Florence Nightingale contributed to spirituality in healthcare with the concept of the whole person; believing that the environment greatly influenced the health and healing of a person. Nightingale (1860) left a legacy regarding how to nurse a sick person. Her concerns and suggestions for nursing were made clear with the following statement:

If a patient is cold, if a patient is feverish, if a patient is faint, if he is sick after taking food, if he has a bed-sore, it is generally not the fault of the disease, but of the nursing. I use the word nursing for want of a better. It has been limited to signify little more than the administration of medicines and the application

of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet-all at the least expense of vital power from the patient. ...The art of nursing, as now practiced, seems to be expressly constituted to unmake what God made disease to be, viz., a reparative process. (Introduction section, 5th, 6th, and 8th paragraphs).

Nightingale (1860) speaks of the reparative process involving the body, mind, and spirit of a person. In the "Light" section of the above work she speaks of the sunlight not only being a purifying element in the room, but also a healing element for the spirit of the patient. The mention of God and spirit throughout this entire work suggests that Nightingale was extremely supportive of the healing process involving the connectedness of the body, mind, and spirit. The nursing literature references Nightingale often (Bond, Callister, Mangum, & Mantsumura, 2004; Bullough & Bullough, 1964; Burkhardt & Nagai-Jacobson, 1989; Felgen, 2004; Jackson, 2004; Maddox, 2001; Ross, 1995; Sellman, 1997) and her appreciation for the different dimensions that unifies the whole person.

The literature suggests that the concept of spirituality in nursing centers on the spirit of the person that controls the body and mind and that is a vital force in influencing one's life, health, behavior, relationships, and meaning and purpose of life (Baldacchino & Draper, 2001; Burkhardt & Nagai-Jacobson, 1989; Deckro, Mandle, & Stuart, 1989; McEwan, 2004). Another dimension of spirituality suggests that the spirit or human psyche of a person extends to a power beyond to determine meaning and the purpose of life (Allen & Rowe, 2004, Ganstrom, 1985). O'Neill and

Kenny (1998) (as cited in Allen & Rowe, 2004) suggest that spirituality involves individuals using a higher power in connection with others, taking on more religious tones. With this concept in mind religion can be thought of as a motivating factor and spirituality emerging from religion.

Spirituality in nursing is typically characterized by a holistic approach to nursing with the physical, psychological, social, and spiritual dimensions of the patient (Anderson, Coulon, Krause, & Mok, 1996; Burkhardt & Nagai-Jacobson, 1989; Chiu & Greasley, 2001; Nightingale, 1860; Richardson, 2004; Ross, 1995). Although there is a long history of spiritual care, starting with the nurses of Nightingale's time period and the sisterhoods providing care, diagnosing and intervening with spiritual care may be difficult for some nurses. According to Granstrom (1985) there are five potential problems that nurses can encounter when initiating spiritual care in their routines:

1. lack of awareness of one's own spiritual quest, i.e., what gives meaning, purpose, direction, hope, and a sense of love to one's own life
2. fear of not being able to handle situations that may arise, intruding on the patient's privacy, or becoming confused or challenged in one's own beliefs
3. the pluralism of religions cause nurses and patients to embrace a wide variety of beliefs and creeds
4. confusion and uncertainty of the nurse's own religious and spiritual concepts

5. the nurse's basic attitudes relative to illness, aging, and suffering (pgs. 40-42).

These concepts become quite real, when one examines a study conducted by Chiu, Gartland, and Greasley (2001), in a mental healthcare facility with nurses and patients, revealed that nurses were reluctant to provide interpersonal care; which included spiritual care, because professionalism, the “mechanics of nursing,” evidence-based health, and quantifying outcomes of health have become the emphases in their jobs. Nurses cited that increased formality and the lack of interpersonal training have sometimes have created distances between nurses and patients, and removed the compassion, love and caring which have influenced the atmosphere of some wards. In this facility, neither the nurses nor the patients were satisfied with the quality of interpersonal care. Of the 400 patients surveyed, over half of them revealed that religious or spiritual beliefs played a part in their lives. The holistic approach to healthcare acknowledges all views of the patient by considering the body, mind, and spirit. The next section addresses the renewed focus on a holistic approach to healthcare and the spiritual dimensions of health and healing and how they relate to the stress associated with illness.

Holistic Approaches to Healthcare

Holistic Health Care

As has been mentioned, there is a growing emphasis on a holistic approach to health involving the physical, mental, spiritual and social (lifestyle) aspect of a person. The holistic approach to healthcare is caring for the whole person (Anderson, Coulon, Krause, & Mok, 1996; Burkhardt, 1989; Chiu & Greasley, 2001;

Nightingale, 1860; Richardson, 2004; Ross, 1995). As healthcare providers become increasingly consumed with profit margins, high-technology, and cost-effective care, the true treatment of a patient seems to be forgotten. Most patients are not only looking for a cure or improvement in their condition, but they are looking for hope, understanding, explanations, and advice (Richardson, 2004).

The avenue to this holistic approach to healthcare is often through the use of complimentary and alternative medicine (CAM) (Eisenberg, 1998; Richardson, 2004). An estimated \$27 billion was spent on CAM services and products during 1997 (Eisenberg, 1998). The research suggests that in 2002 one in three Americans participated in some form of complementary or alternative medicine, and sixty-two percent of adults used CAM therapy during a twelve month period if the definition of CAM includes prayer (Barnes, McFann, Nahin, & Powell, 2004). There are over fifty different types of complementary medicines with some of these including: chiropractic, bodywork and massage therapy, nutrition counseling, homeopathy, reiki, hypnotherapy, naturopathy, acupuncture, healing touch, meditation, prayer, shiatsu, yoga, tai chi, reflexology (Strasen, 1999).

Spirituality has been the core of the holistic movement to healthcare, with church leaders often leading the movement followed by secular leaders and researchers in health and medicine that observed healing in patients unexplained by scientific knowledge or medical intervention (Arreola & Goodloe, 1992; Burkhardt, 1989). Osman and Russell (1979) emphasizes this philosophy with the following statement, "...the time has come to accept the spiritual as an important aspect of individual and corporate life and a legitimate dimension of well-being" (p. 359). The

literature suggests that spiritual care should be a part of nursing in order to gain a more holistic approach to healthcare in general (Allen & Rowe, 2004; Burkhardt & Nagai-Jacobson, 1989; Nussbaum, 2003).

The Spiritual Dimension of Health and Healing

The spiritual dimension of health care refers to meaning, purpose and fulfillment in life, it contains elements of hope, belief and faith (Baldacchino & Draper, 2001; Burkhardt & Nagai-Jacobson, 1989; Cohen, Scott, & Wheeler, 2001; Coyle, 2002; Frankl, 1959; Johnson, 1998; Ross, 1995; Tanyi, 2002). Frankl (1959) even writes about a sense of meaning and purpose in life as relates to personal survival and the survival of other holocaust victims. Those who survived with minimal psychological damage seemed to be those who maintained a sense of purpose under these adverse conditions. In examining specific medical problems, patients of acute myocardial infarctions (heart attacks), chronic illnesses, cancer, and mental illnesses seem to be relying on the meaning and purpose of life to cope with their illnesses (Albaugh, 2003; Brown, 2000; Chiu, Gartland, & Greasley, 2001; Allen & Rowe, 2004; Walton, 2002).

Frankl (1959) speaks of the meaning of life as always changing, with three different ways to discover the meaning of life by (a) doing a deed, (b) by experiencing value, and (c) by suffering. He adds that even suffering ceases to be suffering at the moment meaning is discovered. This may explain the meaning that patients find during the suffering of their illnesses. A study by Walton (1997) of patients suffering from an acute myocardial infarction revealed five aspects of discovering meaning and purpose (a) facing mortality, (b) letting go of fear and

turmoil, (c) identifying and making lifestyle changes, (d) seeking Divine purpose, (e) making meaning in daily life.

Another element of the spiritual dimension seems to be transcendence. Ellison (1983) defines the need for transcendence as the sense of well-being that we experience when we find purposes to commit ourselves to, which involve ultimate meaning in life. Transcendence refers to a non-physical dimension of awareness and experience which can best be termed spiritual (Ellison, 1983). According to the National Interfaith Coalition on Aging (1975) (as cited by Ellison, 1983) the term spiritual well-being can be defined as “the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness” (p. 331). The transcendent approach in healthcare allows individuals to experience a heightened sense of physical well-being and the ability to transcend beyond the existence of their disease or illness (Baldacchino & Draper, 2001; Tanyi, 2002). In addition, the transpersonal transcendence allows knowledge to develop further through connectedness to God or a higher power (Coyle, 2002). Furthermore, Coyle (2002) proposes that with the transcendent approach, patients are thought to be able to enter a spiritual realm that provides a mental attitude that promotes health and healing. This approach suggests that patients can play a primary role in their personal healing and that their spiritual well-being plays an important role in this process. On the other hand, some individuals may be threatened by transcendent concepts because spirituality may bring to mind the meaning of death or the oblivion (Hahn, Koenig, Pargament, & Tarakeshwar, 2001). Coyle (2002) stresses that education and

knowledge can increase awareness and an understanding of the transcendent components of healing and their relationships to spiritual health.

McGee, Moore and Nagel (2003) report on a study designed to determine whether spiritual health can be increased by an educational intervention. Spirituality is thought to be flexible and a key factor in the spiritual health of the patient. Therefore, if the spirituality of the patient can be exercised and improved with a conscious effort through education, the spiritual health could be enhanced in the patient. Spiritual well-being is thought to be a measurement of one's spiritual health in general (Ellison, 1983). To assess whether spirituality can be used as a part of an educational program, Howden's Spirituality Assessment Scale (SAS) (1992) was used to assess the spiritual well-being of a group of university students in an educational setting. This scale focuses on four attributes that researchers and scholars deem critical to spiritual health: purpose and meaning in life, innerness and inner resources, unifying interconnectedness, and transcendence. A pre-test and post-test was given to several groups of students, with the treatment group receiving a semester of stress management curriculum with a component focused on spiritual health. The results from this procedure revealed that the post-test scores for the treatment group were significantly higher ($p < .05$) than the post-test scores for groups without the spiritual health component. The conclusions from the study were that spiritual health may be incorporated in a classroom setting, and that spiritual health can be enhanced through an educational intervention. The study gives support for teaching nurses, other healthcare providers, and even patients the possibility of increasing their spiritual health through education and instructional approaches.

The benefits of spirituality as relates to health have included health benefits in terms of prevention, improved health status, recovery from illness, or enabling people to cope with illness and/or adversity (Allen & Rowe, 2004; Ames & Klooserhouse, 2002; Brown, 2000; Deckro, Mandle, & Stuart, 1989; Grant, 2004; Nightingale, 1860; Post-White, 2003; Walton, 1997; Walton, 2002,). Similarly, a study by Allen and Rowe (2004) with chronically ill patients reported a positive correlation between spirituality and the ability to cope with the chronic illness. The chronic illnesses that were reported by the participants include diabetes (15.1%), cancer (14.9%), arthritis (9.9%) hypertension (8.9%), asthma (3.7%) and another group (36%) with various conditions such as epilepsy, heart disease, and migraine headaches. The results of this study also demonstrated a significant correlation between spirituality and age. The older population seems to include spirituality in the process of health and healing to a greater degree than the rest of the populations. A study at the Duke University Medical Center of 838 patients age 50 and older patients admitted for general medical service also concluded that religious activities, attitudes and spiritual experiences seemed to be quite prevalent in older hospitalized patients (George, Koenig, Titus, 2004). These patients also experienced greater social support, better psychological health, and to some extent better physical health in general.

These findings may be particularly relevant today with the first wave of baby boomers expected to enter the sixty-five plus years category in 2010. Spirituality could play an increased role in the area of healthcare in general for this group. The literature suggests that some Baby Boomers will need healthcare that facilitates chronic disease, while other baby boomers may need complementary and alternative

medicines and services (Blanchette & Valcour, 1998; Reinhardt, 2000; Setness, 2002). Some of these chronic diseases may even be better managed with the help of complementary and alternative medicines (Eisenberg, 1998; Drach, Tilden, & Tolle, 2004).

Muench (2003) conducted a study to test a causal model of the relationship between spirituality, hope, and psychological well-being among individuals who had been diagnosed with fibromyalgia syndrome (FMS) and chronic fatigue immune dysfunction syndromes (CFIDS). The best model noted that spirituality had a direct effect on the hope of a patient. According to Post-White (2003), hope tends to give strength, motivation, a will to live and a desire get through the journey; without hope there may be no healing.

Prayer is some patients' link to hope and healing and has been studied in various cardiac patients (Abbott, Kennedy, & Rosenberg, 2002; Ai, Bolling, Peterson, & Koenig, 2002; Bryant, Desai, & Ng, 2002). A study of cardiac patients undergoing a percutaneous coronary intervention (PCI) for unstable angina participated in noetic therapies (Bashmore, Crater, Green, Koenig, and et. al., 2001). The noetic therapies included stress relaxation, imagery, touch therapy, and distant intercessory prayer. The results were not statistically significant as compared to the control group of standard therapies; however, there was a 25-30% reduction in adverse outcomes with those treated with noetic therapies and the lowest complication rates were among those who received the intercessory prayer. These patients were allowed to experience complementary and alternative medicine as a part of this holistic approach.

The healthcare industry may need to continue in this direction and explore the alternative modalities that could impact the health of patients. The holistic approach to healing puts nurses in a critical role of influencing the hope and healing of their patients. This next section discusses nurses' attitudes and roles in providing spiritual care in healthcare settings.

Nurses and Spiritual Care

The role of spirituality and health continues to receive increased attention (Allen & Rowe, 2004; Arreloa & Goodloe, 1992; Clark, Drain, & Malone, 2003; Coyle, 2002; George, Koenig, & Titus, 2004; Grant, 2004; Kelly, 2004; Maddox, 2001; Ross, 1995; Walton, 1997). Nurses are at the forefront of providing the spiritual care to patients throughout many healthcare organizations including hospitals, ambulatory care centers, nursing homes, hospice and many other avenues. The Joint Commission of Accreditation of Healthcare Organizations (JCAHO) also acknowledges that the patients' psychosocial, spiritual, and cultural values affect how they respond to their care. Organizations accredited by JCAHO must comply with the Standards adopted by the organization. The Standard RI. 2.10 EP.4 even goes so far as to require organizations to accommodate the right to pastoral and other spiritual services if requested (Joint Commission, 2005). JCAHO suggests that a spiritual assessment should determine the patient's denomination, beliefs, and what spiritual practices may be important to the patient. Spirituality and its importance seem to be becoming an institutionalized phenomenon in the healthcare environment.

According to the 2001 Press Ganey National Inpatient Priority Index, (nationally recognized patient satisfaction instrument used by hospitals) the emotional

and spiritual needs of patients even ranked second (and have since 1998) with relative to importance to patients and their care (Clark, Drain, Malone, 2003). The data also suggested that emotional/spiritual needs were highly correlated ($r = .75$) with overall patient satisfaction. Patients seem to place a) a high value on emotional and spiritual needs while in the hospital, (b) there is a strong relationship between the care of emotional and spiritual needs and overall patient satisfaction, and (c) there is a significant opportunity for improvement in this realm with a mean score of 80.7 out of 100. Organizations should work toward obtaining a higher mean score to assure that the majority of their patients needs are being met.

Some research suggests that patients are not having their spiritual or religious needs met during acute hospitalization and in long term care settings. A study by Burton, Fitchett, and Sivan (1997) in a Chicago hospital indicated that 76% of medical/surgical and 88% of psychiatric patients had three or more religious/spiritual needs (i.e, the need to make sense of the illness, the need for spiritual beliefs to be acknowledged, respected and supported, the need to transcend the illness and the self, a need for purpose and meaning in the midst of illness) during hospitalization. When asked if there spiritual needs had been met, 80% of these patients reported never or rarely done. Koenig (2003) suggests that the widespread dissatisfaction of patients and healthcare providers may be related to the neglect of treating the whole person. The dissatisfaction may even be inhibiting patient recovery and increasing litigation against hospitals and providers. He reports that spiritual needs not being addressed could also lead to spiritual struggles or spiritual distress within the patient. Hahn, Koenig, Pargament, & Tarakeshwar (2001) report that spiritual struggles can be

defined as perceiving illness as a punishment, that faith is not a source of coping with illness, or that God is seen as distant or uncaring. A two-year longitudinal study by these authors even suggested an increased risk of death, poor mental health, and a low quality of life as consequences of spiritual struggles among patients after a hospital discharge. Again, healthcare providers may play critical roles in providing insights with such struggles.

To further emphasize some of these points, Davis (2003) designed a study to determine patients' expectations of nursing care and what constituted good and bad nursing care to them. Nursing presence was very important to the patient and nursing presence was seen as good nursing care. The study also revealed that the existential spiritual element of nursing presence was the most defining characteristic of good nursing care. However, patients often did not expect the existential spiritual care because they perceived nurses to be too busy and lacking the time to spend with the patient.

The literature suggests advances in medical science, new technologies, the reduction of staff to help recapture profits from lost reimbursement, improvement of patient care delivery systems, the mechanics of nursing, emotional stress and burnout, and a lack of education regarding spiritual care as being contributors to nurses being distracted from providing spiritual care (Chiu, Gartland, & Greasley, 2001; Kelly, 2004; McEwan, 2004; Nussbaum, 2003; Pesut, 2003). One author suggests that spiritual care can be as simple as the mere presence of the nurse: a gentle touch, openness to listen, and the willingness to enter into a trusting relationship with the patient (Nussbaum, 2003). The concept of presence implies self-giving by the health

care provider. Other authors suggest the simple caring philosophy, a consciousness of purpose, clarity in roles of providing spiritual care, and a more simple spirituality assessment tool may allow for more effective spiritual care (Tanyi, 2002; Vance, 2001; Felgen, 2004). The possibility does exist, however, that nurses may be intimidated by the term spiritual care. Confusion in nurses may arise over the difference of proselytizing and spiritual care. In addition, some nurses may assume or believe that spiritual care should be left to the chaplain. In spite of these concerns, ministering to patient's spiritual needs has been identified as a professional nursing role that could positively influence the health of a patient (Joint Commission, 2005; McEwan, 2004; Vance, 2001).

A study conducted by Grant (2004) in one of the largest university hospitals in the southwest reported almost every nurse believed that spirituality could give their patients inner peace, strength to cope, bring about physical relaxation and self awareness, and help them forgive, connect, and cooperate with others. The study also reported 75-90% of the nurses believed spirituality could reduce bodily pain, produce physical healing through the powers of the mind, provide an experience of God's forgiveness and the hope for eternal life, and help patients discover a deeper meaning of their illness. The meaning of the illness could be viewed as the process of finding out how the pieces of the puzzle (illness) come together to impact and influence every aspect of one's life. A smaller percentage of nurses (61-70%) thought spirituality could facilitate physical healing by the healing power of God, assist in a deeper meaning of one's pain, and produce an altered state of consciousness. The study also showed that 98% of the nurses surveyed thought that spiritual resources should be

made available to patients when they request them or are faced with serious and emotionally difficult situations. This institution, which was only identified in the article as one of the largest university hospitals in the southwest, was highly focused on the spiritual dimensions of care. The nursing and medical schools associated with the institution offered several courses in addressing the spiritual realm of medicine and the hospital sponsored an international conference on spirituality and healing (Grant, 2004). These efforts suggest that education may be a key component for nurses and other healthcare providers in improving spiritual care and increasing the awareness of spirituality among nurses could aid nurses in identifying when spiritual interventions may be appropriate.

As was mentioned, Florence Nightingale (1860) believed that creating a healing environment was the sole responsibility of the nurse caregiver. By removing obstructions to healing, the patient was in better shape to allow nature (innate healing abilities) to take place. Jackson (2004) and O'Conner (2002) suggest that first the nurse should heal herself/himself by implementing stress coping resources to buffer the affects of an erratic environment, and finding meaning and purpose in the profession of nursing as a healer. In addition, to be able to support the patients' spiritual needs the nurse may be a better resource if she or he is aware of their own religious and spiritual frame of reference (Bond, Callister, Mangum, & Matsumura, 2004). A study by Vance (2001) in a teaching hospital in a large Midwestern city was conducted to evaluate nurses' spirituality levels and the spiritual care they provide to their patients. These results showed a positive and significant ($p < .05$) relationship between the spirituality of the nurses and their spiritual care delivery. Those nurses

scoring higher on personal attitudes towards spirituality also scored higher in their spiritual care practices.

The most opportune time to teach nurses about spirituality and the holistic approach (mind, body, spirit) to healthcare may be through formal nursing education programs. Students could learn to perform holistic health assessments which include the values and beliefs of patients' spiritual needs, an awareness of the resources available to meet these spiritual needs, life transition problems, and the value of the relationship with a Higher Power (Bond et. al., 2004; Catanzaro, 2004; Maddox, 2001; Pesut, 2003). A study by Strang, Strang, and Ternestedt (2002) evaluating Swedish nurses and their understanding of spiritual needs reported that 59% of the nurses surveyed stated that education in spiritual dimensions was very important. Today's world may stress, however, that discussions of God in the classroom are inappropriate and unscientific, and may be better suited for theology rather than nursing education. However, the studies previously discussed in this review (Davis, 2003; Grant, 2004; Chi, Greasley, & Gartland, 2001; Vance, 2001; Walton, 1997) suggest that patients may have strong needs for the spiritual elements of life and that they may be a significant source for health and healing. For nursing educators to not address the spiritual dimensions of care may exclude a significant need for the population that nursing students care for; particularly in the time of high stress associated with illness. The concept and role of spirituality may be difficult for individual nurses to understand, but they may be even more difficult for organizations to grasp and understand.

Historical Perspective of Organizations and Spirituality

Spirituality has not only received additional attention in healthcare, but other industries and organizations have been exploring spirituality and its role and impact on employees and their organizations in general (Ashmos & Duchon, 2000; Biberman & Whitty, 1997; Dehler & Welsh, 1994; Denton & Mitroff, 1999b; Dhiman, King, & Marques, 2005; Garcia-Zamor, 2003; McCormick, 1994; Rojas, 2002). Several factors may be behind the increased awareness and concern for spirituality in organizations including increased downsizing and layoffs, corporate greed in the 1980s and 1990s, the aging of the baby boomers, and the influx of women into the workplace (Ashmos & Duchon, 2000; Dehler & Welsh, 1994; Dhiman et al., 2005). Some people are confused by the concept of spirituality in the workplace, while others consider spirituality a part of their life even at work. Spirituality seems to be an integral part of fulfilling the person's whole being; so what does this have to do with organizations in general? The literature (Biberman & Whitty, 1997; Cavanaugh, 1999; Denton & Mitroff, 1999b; Fairholm, 1996; Freshman, 1999; King & Nichol, 1999; Marcic, 2000) seems to support the idea that today's employees are searching and striving to find meaning and purpose in life and in the workplace. Many are dissatisfied with an intense workload, the lack of meaningful work, and the failure for fulfillment of their inner needs (Curry, 2003). Other literature (Bandsuch & Cavanaugh, 2002; Dhiman, King, & Marques, 2005; Garcia-Zamor, 2003; Trott, 1997) suggests that business people are considering spirituality as a means to organizational performance, profitability, motivation, integrity, organizational transformation, and job satisfaction.

A Harvard Business School study (as cited by Garcia-Zamor, 2003) examined 10 companies with strong corporate culture and 10 companies with weak corporate culture from a list of 207 leading corporations. These researchers found a strong correlation between the strength of a company's culture and profitability. In addition, the spirited companies or those with a strong corporate culture outperformed the others by 400-500 percent in terms of net earnings, return on investment, and shareholder value. A doctoral study with senior executives from 14% of the Fortune 500 companies by Quatro (2002) analyzed organizational spirituality and organizational performance. Organizational spirituality was defined by the contributions of the classic organizational theorists (Follet, 1918; Greenleaf, 1970; Maslow, 1998) and current literature (Dehler & Welsh, 1994; Denton & Mitroff, 1999a; Condemni, Ferguson, Milliman, & Trickett, 1999; Giacalone & Jurkiewicz, 2003) with the themes of empowerment, job involvement, organizational integration, purposeful leadership, task significance, self actualization, and self-management. The results from Quatro's (2002) study suggested that companies that demonstrated moderate to strong organizational spirituality achieved higher long-term rates of net income growth and return on investments. Healthcare organizations, particularly hospitals, are not exempt from the challenges of offering a culture that produces this idea of organizational spirituality with the hopes of increased profitability. The increased union activity, concerns of declining quality of care, and legislative mandates with nurse staffing ratios suggest dissatisfaction with current bureaucratic cultures of some hospitals (Bradley, 2000; Gifford, Goodman, Hill, & Zammuto, 2002).

Southwest Airlines is a company known for its spiritual-based values, as defined by Condemi, Ferguson, Millman, and Trickett (1999), and organizational performance and profitability. This organization exhibits a strong value for their employees by encouraging personal growth, developing one of the main characteristics of spirituality - a community of connectedness (Ashmos & Duchon, 2000; Freshman, 1999), teamwork, service to others and the freedom to make decisions to satisfy the customer even if it means going against company policy (Condemi, et al., 1999). The emphasis on values and strong work ethic, enthusiasm and humor, personal relationships and commitment to employees creates the spirit or life-force at work at Southwest Airlines. The presence of this aspect of spirituality – community, valuing mankind, connectedness, teamwork, learning, service to others, along with high quality service and low prices, has allowed SWA to have one of the lowest turnover rates in the airline industry, profitability every year except one since it began in 1971, and it being voted the best company to work for in 1998 (Levering & Moskowitz, 1998).

Another example of a company that strives to live by spiritual values, as defined by Ashmos and Duchon (2000) and Denton and Mitroff (1999b), is Tom's of Maine. Tom Chappell is the CEO and advocates the philosophy that when companies heed "the spirit" defined by the authors above, the bottom line will take care of itself (Cavanagh, 1999). Chappell has established a core belief and value system that emphasizes moral and social responsibility with the end result being a financially stable company. Likewise, Herman Miller Furniture under the leadership of CEO, Max DePree, was very financially successful and was voted as one of the best firms

in America to work for in 1984 (Bandsuch & Cavanagh, 2002). DePree's philosophy stems from a covenant with employees to make the work meaningful and fulfilling. His spirituality as defined by Ashmos and Duchon (2000), Denton and Mitroff (1999b), and Dehler & Welsh (1994), is confirmed in his policies and daily leadership to put people first. In relation to this philosophy, a doctoral study by Nur (2003) of 26 organizations compared Management-by-Virtue (MBV) firms, which are led by religious philosophies and values, with Traditional Management Principles (TMP), which are management philosophies based on secular principles and values. The study suggested that MBV firms create an organizational environment that is more conducive to higher organizational commitment, higher job satisfaction, and greater evidence of organizational citizenship behavior. These studies suggest that companies like SWA, Tom's of Maine, and Herman Miller Furniture are reaping benefits from their virtuous management practices that have been defined in literature discussing spirituality and organizations (Ashmos & Duchon 2000, Biberman & Whitty, 1997; Cavanaugh, 1999; Denton & Mitroff, 1999b; Fairholm, 1996, Freshman, 1999; King & Nichol, 1999; Marcic, 2000). Based on these ideas, spirituality in the workplace could mean practicing good moral habits and virtues (Bandsuch & Cavanaugh, 2002). Integrated in with good moral habits and virtues is a leadership style that seems to truly value employees and serves employees. Additional research is needed in this area to determine whether spirituality is the guiding force that creates this leadership style or whether the above components are just good management practices.

Leadership Styles and Spirituality

The leadership styles that are most likely to complement spirituality in the workplace would be spiritual leadership as defined by Fairholm (1996) and perhaps transformational leadership. A brief exploration of these two leadership styles will hopefully provide a connection between the influence of good management practices and the environment that is developed through these leadership styles.

Spiritual leadership was born out of the desires and needs of employees to fulfill whole-self needs at work (Fairholm, 1996). Spiritual leadership identifies and nurtures the core values among the followers. Senge (1990) suggests that before there can be purposeful participation, people must share values and ideas about their destiny in their jobs and in their lives. According to Fairholm (1996) the characteristics of spiritual leadership can be placed in three domains:

1. Moral leadership: building shared values, vision setting, sharing meaning, enabling, influence and power, intuition, risk taking, service and transformation
2. Stewardship: sharing the responsibility of everyone's work, becoming united as one, self-governance and self-direction, empowerment, partnership, personal ownership of organization, and teamwork
3. Community: group members and goals, continuous learning and development, unified vision, beliefs and values, and transformation of the organization (pgs. 4-7).

These three domains are representative of the characteristics that have been defined in the spirituality literature (Denton & Mitroff, 1999b; Ashmos & Duchon, 2000; Freshman, 1999). A spiritually based corporate culture has leaders who can identify

and nurture the core values of the followers (Denton & Mitroff, 1999a; Cavanagh, 1999; Czaplewski, Ferguson, & Milliman, 2003). Kouzes and Posner (1987) suggest that there is a need for change in traditional management, a change where leadership unleashes the creativity and aspirations of their employees. Their intense study of organizations and leaders around the United States led Kouzes and Posner (1987) to uncover five practices that suggest that leadership is a very active and personal process:

1. Challenge the process: effective leaders are always evaluating the processes knowing there is a better way of performing
2. Inspire a shared vision: effective leaders understand the importance of sharing a vision
3. Enable others to act: effective leaders know how to delegate and empower people
4. Model the way: effective leaders perform as they would want others to perform
5. Encourage the heart: effective leaders know that leadership is more than an intellectual endeavor; it involves encouraging people (pgs. 9-14).

These five characteristics mimic the characteristics of teamwork, connectedness, meaning and purpose in work, inner life that is encouraged and nourished by meaningful work, sense of community, compassion, caring, and valuing mankind that are found in the literature of spirituality and organizations (Ashmos & Duchon, 2000; Cavanagh, 1999; Dehler & Welsh, 1994; Denton & Mitroff, 1999b; Trott, 1996). A doctoral study by Strack (2001) of 384 healthcare managers

examining the relationship between spirituality, as defined by Beazley (1997), and leadership practices identified two dimensions of spirituality that seemed pertinent. The first dimension of spirituality represented a faith in the relationship with the Transcendent. The Transcendent, as defined by Beazley (1997), is a relationship with something beyond one's self ("God," "Creator," or "Transcendent Power") and the belief that the Transcendent influences the person's life – thoughts, actions, and feelings. The second dimension identified as spirituality represented honesty, humility, and service to others. The study was conducted utilizing the Kouzes and Posner Leadership Practices Inventory (1987) and Beazley's Spirituality Assessment Scale (1997). An ANOVA test revealed a statistically significant difference in three of the leadership practices by "more spiritual than non-spiritual" managers. The study suggested that leaders who identify and integrate the leadership practices of Kouzes and Posner (1987) are integrating their actualized spirituality with managerial and leadership skills. Although the concept of spirituality may be highly complex to some, it may be as simple as being the foundation for vision, courage, and compassion concepts that are consistent with the spirituality literature (Ashmos & Duchon, 2000; Denton & Mitroff, 1999a; Freshman, 1999). In order to challenge the process and transform an organization, leaders may want to consider examining the realm of spirituality.

Transformational leadership focuses on meeting individuals' needs and the organizations' visions (Goodwin & Wofford, 1998). Emotion and vision, two elements that may be related to more meaning in life (an element of spirituality), are the key components of transformational leadership (Dehler & Welsh, 1994).

Transformational leadership focuses on the consciousness of the followers and values such as liberty, justice, peace and equality (Santora & Sarros, 2001). The transformational leader seeks to motivate and influence followers to be in alignment with the leader's vision. In a study by Santora & Sarros (2001), four types of transformational leadership were seen as being used by 181 executives from the top 500 companies in Australia:

1. Individualized consideration: The leader is considerate of workers' needs and treats them as valuable contributors to the work place. In addition, the leader acts as a coach to encourage followers to develop appropriate work place behavior.
2. Inspirational motivation: The leader encourages followers to understand and be committed to the mission and vision of the organization. Understanding what motivates the follower and developing a culture that allows the follower to contribute to the success of the business.
3. Intellectual stimulation: The leader allows the follower to engage in creativity and problem solving techniques for reaching decisions. Organizational skills and character are developed through coaching and challenging the follower to think in creative and different ways.
4. Idealized influence: The leader is known as having charisma in this style of leadership. The creation of values is the focal point in hopes to inspire and provide meaning and purpose in people. The follower is encouraged to use the leader as a role model (p. 386-389).

The transformational leader, then, devotes time and energy to respecting the abilities and talents of their workers. These transformational leadership styles have the intent of encouraging employees to have a valued part in the organization. The leader's involvement with the employee while utilizing these leadership styles could aid the employee in finding meaning and purpose in their work and a connectedness to the organization which are common threads in the spirituality literature (Condemni, Ferguson, Milliman, & Trickett, 1999; Denton & Mitroff, 1999a; Freshman, 1999). Transformational leadership may be an avenue to expand the holistic perspective of organizations and make the shift from management to leadership (Trofino, 1995). The component of spirituality within any leadership style will need to be utilized with caution however. Religion has been viewed as intolerant and divisive; while spirituality is seen as more universal and broadly inclusive (Denton & Mitroff, 1999a). A brief discussion regarding concerns of "spiritualities" being used as a management tool will close the discussion of spirituality as it relates to organizations.

Cautions and Concerns of Spirituality in the Workplace

A Gallup Poll in 1999 asked Americans if they felt a need to experience spiritual growth. Seventy-eight percent of the respondents said yes, with an increase of 20% when asked the same question in 1994. Similarly, nearly half of these respondents said they had had occasion to talk about their faith in the workplace in the last 24 hours (Garcia-Zamor, 2003). Since the 1990s more than 300 titles of books and many journal articles have been written on workplace spirituality, suggesting that a spiritual awakening is occurring in America (Garcia-Zamor, 2003). According to Conlin (1999) Americans are spending approximately one month more per year on

the job suggesting increasing social interaction in the workplace. The workplace has become a support group for many; this may mean that discussing many topics including religion and spirituality are on the increase. In addition, America is becoming more religiously diverse with 239 officially recognized religious sectors and approximately 1,300 of what are considered unconventional groups (Brecheen & Kleiner, 1997).

The government agency that is responsible for monitoring and investigating claims for racial, sexual, and religious discrimination is the Equal Employment Opportunity Commission (EEOC). According to the EEOC, there was only an increase of 1.3% of religious discrimination complaints from 1990 to 1999; however, the number of cases awarded a settlement for religious discrimination over the same period increased 48% (Huang & Kleiner, 2001). The litigation expenses for religious discrimination could be reduced if organizations were in compliance with government guidelines.

Organizations need to comply with Title VII of the Civil Rights Act of 1964 which defines religious accommodations to include “all aspects of religious observance and practice, as well as beliefs, unless an employer demonstrates that he is unable to reasonably accommodate an employee’s or prospective employee’s religious observance or practices without undue hardships on the conduct of the employer’s business” (Cash, Gray, & Rood, 2000, p. 128). With this injunction, employees have the right to take time off from work to celebrate holidays, commemorate traditional events, attend Sabbath day services, and leaves of absences to attend spiritual missions or retreats (Cash et al., 2000; Montgomery, 2002).

Employees also have the right to express their religious experiences at work, wear religious jewelry or dress, and discuss faith at work (Atkinson, 2000). The Workplace Religious Freedom Act, which is still being considered by Congress, will attempt to simplify the terminology in Title VII and increase employers' responsibilities to the employee in regards to their religious rights (Huang & Kleiner, 2001; Montgomery, 2002). In contrast to employees' rights to religious beliefs and practices, employers must be careful not to impose their religious beliefs on employees resulting in religious harassment (Garcia-Zamor, 2003). Administrators and managers need to educate themselves regarding the history and diversity of religious beliefs within the United States and their individual states. The human resource departments of organizations need to keep abreast of current legislation and court decisions and implement any changes to policy and procedure manuals to be compliant with the law and avoid possible litigation. Employers will need to proceed with caution and go the extra mile in order to accommodate the various religious beliefs and spiritual practices. Likewise, the healthcare industry has been called by Joint Commission to facilitate the spiritual needs of patients (Joint Commission, 2005). Nurses should be aware of, and sensitive to, the impact that religious or spiritual beliefs have on the patient's perceptions of health and the patient's health behaviors.

Job Satisfaction and Stress in Healthcare

Occupations in healthcare can be a very rewarding experience. There are opportunities to see a child born, someone healed of a disease or rehabilitated from an accident, or someone recover from a psychological or substance abuse disorder. In any of these scenarios, the healthcare worker could be faced with events that test the

limits of human understanding however. The role of the nurse calls for a sound balance of personal involvement and sometimes a detachment from human life (Carson, 1989). In addition, nurses are expected to use critical thinking skills, communicate and collaborate with professionals and patients, focus on research-based practices with an emphasis on quality outcomes, and all the time being concerned with patient advocacy (O'Connor, 2002). With all of these job demands, a closer look at job satisfaction and stress among the nursing profession appears to be in order.

Job Satisfaction and Nursing

The majority of Americans spend a great deal of their lives at work. Being satisfied on the job should be an important element for consideration. The theoretical aspect of job satisfaction begins with the needs of individuals being met in the workplace (Herzberg, Mausner, & Snyderman, 1959). Job satisfaction could refer to the pleasurable or positive emotional state as a result of the appraisal of one's job or job experiences (Locke, 1965). The studies of Hoppock (1935) (as cited by Gruneberg, 1979) assumed that job satisfaction depends on the presence of a variable in a work situation and the absence of that variable leads to job dissatisfaction. Maslow's (1954) hierarchy of needs has been discussed earlier in the literature review with relevance to the meaning of life. With relation to the work environment, the lower needs of Maslow's model in this case, security and pay, will have to be met before the employee seeks satisfaction and achievement from the work itself.

The work of Herzberg, Mausner, and Snyderman (1959) revealed two classes of factors involved in job satisfaction. The first level factors or motivators include achievement, recognition, and the intrinsic interest of the work itself. These factors

correspond with Maslow's (1954) higher levels of self-autonomy and self-actualization. The motivators (first-level factors) if present in the working environment, lead to job satisfaction, but if absent do not lead to dissatisfaction. The second level factors, or hygiene factors, include pay, security, and physical working conditions. When the hygiene factors are inadequate, job dissatisfaction is likely; however, when adequate they do not necessarily lead to job satisfaction. The theories of Maslow (1954) and Herzberg et al. (1959) have been classified as being content theories of job satisfaction with interest in only identifying the factors which make for job satisfaction or dissatisfaction (Gruneberg, 1979). Process theories of job satisfaction address the interaction of needs, values and expectations that individuals have in relation to their jobs. One process theory based on expectation assumes the employee expects a pay raise of \$10 and if the raise is only \$5 the employee becomes dissatisfied. Both content and process theories have added to our understanding of the work environment and the satisfaction and dissatisfaction that exists among workers.

According to Weiss et al. (1967) there are individual differences in the vocational needs of people. People find different satisfactions in work and those satisfactions depend on the specific aspects of work and the work environment. Workers may express job satisfaction and contentment in their work for different reasons. An individual may be satisfied with their work because the intrinsic factors are being fulfilled, while another individual may be equally satisfied because the extrinsic factors are being fulfilled (Weiss et al., 1967). These authors identify intrinsic and extrinsic reinforcement factors as follows: "The intrinsic factors in this case can be identified as the reinforcement factors such as type of work, achievement,

and ability utilization; moreover, the extrinsic factors or environmental reinforcement factors such as working conditions, supervision, co-workers and the company” (Weiss et al., p. 12). The intrinsic characteristics of job satisfaction in nursing identified by Ellenbecker (2004) include autonomy and independence in patient relationships and profession, group cohesion with peers, physicians and the organizational culture; whereas, the extrinsic characteristics of job satisfaction may include stress, workload, autonomy and control of work hours and activities, salary and benefits, and the perception of real opportunities for jobs in other industries.

The job of a nurse is most fulfilled when they feel they are making a difference in the lives of others, when they are able to complete a job to the best of their ability, and when they are helping other people learn (Tuttas, 2002). Some literature suggests that problematic work environments, defined as higher levels of worker dissatisfaction, higher job stress, low morale, and low employee retention rates, are negatively impacting the motivation and job satisfaction levels among nurses (Aiken, Clarke, Silber, Sloane, Sochalski, 2002; Coile, 2001; Dendaas, 2004; Furino & Reineck, 2005; Mee & Robinson, 2003; Tuttas, 2002; West, 2004). The nursing shortage has been a cyclical problem; however, according to Mee and Robinson (2003) the present nursing shortage seems of be different for several reasons:

1. Approximately 50% of the workforce will be approaching retirement age in 15 years
2. Fewer people are entering the nursing profession because of opportunities in other professions

3. Nursing wages are usually capped early unless nurses advance to management
4. More patients with chronic diseases and surviving serious illnesses are being treated with fewer nurses to render care
5. Widespread dissatisfaction among today's nurses (p. 52)

Numerous factors seem to be responsible for the widespread dissatisfaction among nurses. A study of registered nurses by the United States Department of Health and Human Services (2000) reported that 61% of nursing home staff nurses and 66% of staff nurses in hospitals were satisfied with their jobs. This compares with satisfaction rates between 72% and 82% for non-staff nurse positions. Non-staff nurses such as nurse managers or clinical nurse specialists who spend more than 50% of their time in direct patient care reported higher job satisfaction levels. This study suggests that the structure of the job, rather than the composition of the work, may be influencing nurse satisfaction. The difference in satisfaction between the non-staff and staff nurses may be explained by the increased flexibility of nursing roles and increased opportunity to influence decisions regarding patient's treatment that are more prevalent with the nurse manager or clinical nurse specialist positions.

American Nurses Credentialing Center, the credentialing branch of the American Nursing Association, began a program in 1994, Magnet Recognition Program®, to help hospitals design a new work environment to render the best possible nursing care and to foster a professional nursing environment (Making Nursing Attractive, 2001). Hospitals that are credentialed as "magnet facilities" are committed to improving work conditions with supportive and effective leadership

with autonomy and accountability, increasing teamwork with participatory management and nursing staff involvement in decision making, and commitment to professional nurse qualities by lowering the nurse-to-patient ratio and ultimately increasing patient satisfaction (Coile, 2001). Nurses in “magnet facilities” have been found to have a greater level of job satisfaction and an increased level of empowerment. In addition, these hospitals are reporting small to zero vacancy rates (Berkowitz & Ward, 2002). In order to combat and prevent the nursing shortage from becoming a national or worldwide crisis, the practices of magnet facilities need to be given top consideration by hospitals experiencing nursing job dissatisfaction (Coile, 2001; Dendaas, 2004).

A study of registered nurses in the state of Texas by Furino and Reineck (2005) reported that nurses are most satisfied with the intrinsic rewards of nursing. Intrinsic rewards are internal motivators such as accountability, professional confidence, knowledge and confidence, personal achievement, satisfaction, or growth. The most frustrating and exhausting aspects reported by these nurses were the work environments, with decreased staffing, increased paperwork, the increased severity of illnesses, RN turnover, and voluntary overtime not mandatory, but necessary and fulfilled out of a desire to provide adequate patient care on a shift that is short staffed. Relationships between physicians and nurses and administration and nurses were also considered a major strain for nurses in this study. The overall health of the nurses was also a concern in this study with 66% reporting very good to excellent health and 44% reporting chronic health conditions. Stress and exhaustion were specific health concerns with 57% participants reporting stress concerns in four

categories: the sources of stress, influence of pay to offset stress, outcomes of stress, and calls for help.

Registered nurses in this study indicated a need for ways to help reduce stress. Employer programs could help reduce the emotional stresses that often lead to burnout (Maslach, 1982). Employers are not the only party that needs to educate and train for stress and burnout. Nursing schools should provide education and training regarding the conflict between the real and the ideal in nursing. The ideal is: believing that caring matters, helping people heal, and providing care with all the needed resources. The real is: hospitals are caring for more patients with fewer resources, physicians and administration may not be so kind and caring, and patients may not be healed (Dendaas, 2004; Furino & Reineck, 2005; Mee & Robinson, 2003). The clash between “what was taught,” “what is believed,” and “what really is” tends to be a contributing factor to the stress and burnout experienced by nurses (Maslach, 1982). This stress and burnout could possibly be the most damaging and prominent deterrents for entrance to or longevity in the nursing profession.

Stress and Nursing

The term stress has become more common in everyday conversations over the last several decades. There is not a universal, scientific term for the word stress; instead, the term often is used to refer to stressors or demands, the stress response, eustress, and distress or strain (Hurrell, Nelson, Quick, & Quick, 1997). Stressors can be defined as significant life-changing events that are either negative or positive, or minor events, or everyday hassles such as demands from all of the children’s activities and home life to deadlines at work (Fabricatore & Handal, 2000). Stress can

originate from nearly every angle of one's life; however, organizational/job stress has been given increased attention due to the many changes in the workforce, and the resultant effects on people, over the last four decades. Organizational/job stress has been studied since 1958 with a classic study by Friedman, Rosenman, and Carrol revealing accountants' serum cholesterol level rising during tax season and then leveling back to normal after the busy period (Ganster & Schaubroeck, 1991). Research continues in an attempt to aid organizations in determining and understanding the relationship between stress and well-being; and stress and occupational health and job components (Cooper, Faragher, & Sparks, 2001; Fabricatore & Handal, 2000; Menon, Narayanan, & Spector, 1996). Some of the factors influencing occupational health and employee well-being seem to be job security (Cooper, Faragher, & Sparks, 2001), work hours (Cooper, Fried, Shriom, & Sparks, 1997), control at work (Bunce & West, 1996; Menon, Narayanan, & Spector, 1996), and managerial styles used (Bass, Numeroff, & Seltzer, 1989; Cooper, Faragher, & Sparks, 2001). The taxing work environment of the healthcare industry is no different than many other work settings, however the staff shortages, patients with more severe and chronic illnesses, increased technology demands, and strained relationships between nursing staff and senior management may result in some special types of job demands.

Consequently, the healthcare industry may be a breeding ground for stress. Among the issues discussed in the previous section (improved nurse to patient ratios, time constraints to render quality care, nurse involvement in the decision making process, the desire for increased salaries, and the return of dignity to the nursing

profession) nurses struggle with the daily care of patients and human suffering. The challenge for nurses may be to find a balance between reality and compassion before the outcome is human exhaustion (Furino & Reineck, 2005). A study by Menon, Narayanan, and Spector (1996) reported on perceived stressors for both nurses and physicians. The stressors of situational constraints and work load were perceived to be significantly higher for nurses than physicians. The study also examined constraints and meeting deadlines that may result in stress and anxiety among nurses. This research suggested that nurses are concerned with the work situations interfering with their work progress and the increased workloads within their environment, while doctors are concerned with interpersonal conflict. A doctoral study by Rub (2003) also analyzed the effect of job-related stress on job performance in hospital nurses. Additional analysis was also performed on the effects of social support from coworkers and supervisors on the stress-performance relationship. These researchers reported that increased levels of social support from peers and supervisors increased job performance and decreased job stress. This study suggests that even though job stress may be present in the workplace, fostering an environment that allows relationships to develop between all levels of employees could reduce the amount of job stress. Nursing staff and management need to be aware of the stressors experienced in their workplaces and find resources and strategies to manage this stress. Spirituality may be the missing component in our hospitals and organizations in order to cultivate a more holistic and caring attitude. Our hospital and organizations need to be fully alive, working not only together, but for each other to bring about meaning and purpose to work and life.

Conceptual Integration

Bedside nursing is an important and valuable aspect of healthcare. The compassion, care, and touch of a nurse have been a part of society since Biblical times. Fewer nurses are entering the nursing profession and by 2010, 40% of the registered nurses in America will be age 50 or older (Mee & Robinson, 2003) which means those nurses will reach retirement age during the time baby boomers are predicted to be demanding increased amounts of healthcare. With the fastest growing patient population age being 85 and older and the population of those 65 years of age and older expected to double by 2030 to approximately 70 million, the healthcare industry faces many challenges in the future (Setness, 2002). Short- and long-term solutions to these problems are being considered by nursing educators, nurses, nurse leaders, and hospital administrators to bring an end to the daunting nursing shortage (Tuttas, 2002; Lanser, 2001; Laschinger & Finegan, 2005). In addition, stress and job dissatisfaction levels among this group of employees have caused excessive turnover and professional withdrawal to become a very serious issue (Hood, Smith, & Waldon, 2003).

One has to wonder, however, if the moral distress and dissatisfaction felt by nurses has reached such an extreme, that the lack of purposeful focus cannot be recaptured. Can the caring and healing environment that was so prominent in the time of Florence Nightingale (1860) be rediscovered to bring dignity and value back to the profession of nursing? As the works of Frankl (1959) suggest, could the suffering and stress that has been felt by so many nurses provide the meaning that is needed to

persevere and provide the caring, compassion, and faithfulness that are so important for patients today?

The literature suggests that the holistic approach to healthcare; encompassing the body, mind, and spirit can be a positive influence and vital force during times of illness (Baldacchino & Draper, 2001; Burkhardt & Nagia-Jacobson, 1989; Deckro, Mandle, & Stuart, 1989; McEwan, 2004). The holistic approach to health brings forth a spiritual dimension that refers to meaning, purpose and fulfillment in life, hope, belief and faith (Baldacchino & Draper, 2001; Burkhardt & Nagia-Jacobson, 1989; Cohen, Scott, & Wheeler, 2001; Coyle, 2002; Frankl, 1959; Johnson, 1998; Ross, 1995; Tanyi, 2002). One important element of this holistic approach seems to be the spiritual dimension. An important element of the spiritual dimension seems to be the transcendence that allows individuals to experience a heightened sense of physical well-being and the ability to transcend beyond their disease or illness in search for meaning and purpose and ultimately hope (Baldacchino & Draper, 2001; Tanyi, 2002). The transcendence approach also allows individuals to develop a connectedness to God or others, entering a spiritual realm that provides a mental attitude to provide personal healing and spiritual well-being (Coyle, 2002). A great deal of research has been conducted suggesting that spiritual health has a positive influence on those suffering from illnesses or disease (George, Koeing, Titus, 2004; McGee, Moore, & Nagel, 2003; Muench, 2003).

The spiritual health of an individual can be enhanced by the spiritual care that is provided by the nurse (Grant, 2004). The Joint Commission of Accreditation of Healthcare Organizations acknowledges and is supportive of the patients' spiritual

values and requires organizations to try to accommodate spiritual services for patients (Joint Commission, 2005). The research also suggests that the spirituality of the nurse can play a positive role in the outcome of the patient's health (Vance, 2001; Strang, Strang, & Ternestedt, 2002). Spirituality in this context means that the nurse is aware of the meaning and purpose of her job and the care that she renders does have value to the patient, mankind and to the nurse themselves. Several authors suggest the importance of the nurse being aware of her own religious and spiritual frame of reference to provide an environment that is healing (Jackson, 2004; O'Connor, 2002; Bond, Callister, Mangum, & Matsumura, 2004). Not only does the spirituality of the nurse need to be evaluated and fulfilled, but there are other needs that will need to be met for the spectrum of caring to be fully engaged.

Maslow's (1954) ideas regarding need fulfillment also seem to have relevance for the nursing profession today. The need for improved compensation for nurses may need to be addressed before the higher needs of self-actualization can be fulfilled (Furino & Reineck, 2005; Tuttas, 2002). The achievement, recognition, and intrinsic rewards of nursing are essential for job satisfaction (Ellenbecker, 2004; Erlen, 2004; Finegan & Laschinger, 2005; Herzberg, Mausner, & Snyderman, 1959; Furino & Reineck, 2005; Weiss, et al., 1967). Redesigning the work environment for nurses may also be necessary in order for nurses to be able to provide quality care for their patients (Aiken, Clarke, Sloane, Sochalski, Silber, 2002; Coile, 2001; Dendaas, 2004; Hackman & Oldman, 1980; Furino & Reineck; Mee & Robinson, 2003; Tuttas, 2002; Weiss, et al., 1967; West, 2004). A true consciousness of purpose, a desire for management and nurses to work together, and a commitment to touching the lives of

patients and their families could provide the healing element to restore the nursing profession. The following statement by Tuttas (2002, p. 40) speaks volumes about the need for a change in the healthcare industry: “It would seem that the whole health care system, including nursing, may be in need of a defibrillatory shock, so to speak, thereby creating an opportunity for recovery to an organized, controlled rhythm.” The time may have come, then, for health care organizations to focus on encouraging a better sense of purpose for nurses, so that better patient care, and greater job satisfaction may result. There appears to be a relationship between nurses experiencing meaning and purpose in their work and their levels of job satisfaction. The present study will focus on these issues by exploring nursing spirituality beliefs and practices and how they relate to job satisfaction levels in the health care environment.

CHAPTER THREE: METHODOLOGY

The purpose of this study will be to examine the relationship between spirituality and job satisfaction among registered nurses and licensed practical nurses. The researcher hopes to gain an understanding of the levels of spirituality (purpose and meaning in life, innerness or inner resources, unifying interconnectedness, and transcendence) among nurses and how they relate to general job satisfaction, intrinsic job satisfaction, and extrinsic job satisfaction. In addition, certain demographic characteristics such as age, educational background, area of clinical practice, and tenure will be examined as they relate to spirituality and job satisfaction levels.

Research Design

A descriptive, quantitative, and primarily a correlational study will be conducted to evaluate the spirituality and job satisfaction of registered nurses and licensed practical nurses. The Spirituality Assessment Scale (SAS) (Howden, 1992) will be used to measure spirituality. The SAS (Howden, 1992) was found to have high internal consistency with overall Alpha coefficients ranging from 0.71 to 0.91 for the four subscales that were used in the instrument. Based on the original study (Howden, 1992), the instrument was found to be a reliable and valid measurement of spirituality. The Minnesota Satisfaction Questionnaire, Short-form (Weiss et al., 1967) will be used to measure general job satisfaction, intrinsic satisfaction, and extrinsic satisfaction. The reliability coefficients for the MSQ, Short-form (Weiss et al.) were high ranging from 0.80 to 0.86 for the three subscales of the instrument. Evidence for validity of the MSQ, Short-form (Weiss et al.) was based on the theory of work adjustments and the construct validation studies of the MSQ, Long-form

(Weiss et al.). The combination of these tools will allow the researcher to perform a thorough correlational analysis of these critical issues for nurses.

In addition, a general questionnaire will be used to obtain the demographical information on gender and age of the participants, the educational background, tenure, and the area of clinical practice. This information will allow for a description of the relationships between these demographic factors and spirituality and the job satisfaction levels.

This study is threefold in nature and the following dependent and independent variables will be discussed here. First, the dependent variable is spirituality with the independent variables being gender, age, educational background, tenure, and area of clinical practice. Second, the dependent variable will be job satisfaction with the independent variables being gender, age, educational background and area of clinical practice. Thirdly, the dependent variable in this study is job satisfaction with the independent variable being spirituality.

Selection of the Study Participants

Registered nurses and licensed practical nurses who are currently practicing nursing will be the population used in this study. A hospital in central Arkansas employing approximately 500 nurses will be used to develop the sample size of approximately 300 nurses. There is one additional hospital in central Arkansas that is also willing to participate in the research if an adequate sample is not obtained in the first institution. Overall, the sample will be a convenience sample, with those participating being strictly voluntary. The participants and the organization(s) will remain anonymous in all cases (assurances will be guaranteed here; see Appendix C).

The hospital chief executive officers have agreed to have the survey performed in their institutions in a conference room that is convenient for the nursing staff.

Instrumentation

The instruments to be used in this study are the Spirituality Assessment Scale (SAS) (Howden, 1992) and the Minnesota Satisfaction Questionnaire (MSQ), Short-form (Weiss et al., 1967). The Spirituality Assessment Scale (SAS) has been used in limited studies to evaluate individual spirituality in general (Briggs, 2001; McGee, 1998; Rojas, 2002) and the spirituality of nurses in particular (Hare, 1998). The Minnesota Satisfaction Questionnaire (MSQ), Short-form (Weiss et al.) has been used more extensively (Kinnoin, 2005; Lukowski, 2004) in evaluating general satisfaction and also general job satisfaction among nurses (Mitchell, 1994; Onuorah, 2001).

The Spirituality Assessment Scale (SAS) by Howden (1992) was developed with a desire to create an instrument that would measure spirituality among individuals with the hope of understanding how spirituality may influence an individual's health or response to illness, death and dying. Howden's (1992) study revealed four attributes of spirituality: Purpose and Meaning in life, Innerness or Inner Resources, Unifying Interconnectedness, and Transcendence. The instrument was originally developed with 44 items. A careful evaluation of the questionnaire was conducted for construct and content validity by five doctorally prepared nurses and one nurse in the dissertation stage of doctoral work that were geographically dispersed including the northeast, south, north, north central and southwest regions of the United States. These content experts had written and/or conducted research in the area of spirituality. After evaluation and pilot data analysis the instrument was

reduced to 36 items. The 36-item instrument was administered to a convenience, non-random sample recruited from a variety of civic, social, and recreations settings of 189 adults between the ages of 40 and 60 years residing in a large southwestern metroplex and 50 mile radius area. After reliability and factor analysis, the instrument was further reduced 32 items. Principal component factor analysis and varimax rotation resulted in the final version of the instrument consisting of 28 items that are measured with a 6-point Likert scale, with a format ranging from “1” Strongly Disagree to “6” Strongly Agree with no neutral option. The Spirituality Assessment Scale (SAS) (Howden, 1992) produces an overall score for assessing an individual’s spirituality levels based on the attributes listed above. The score is then evaluated with interpretations of strong spirituality with a score of 113-168, moderate spirituality 57-112, and low evidence of spirituality 28-56.

The instrument was found to have high internal consistency with an overall Alpha coefficient of 0.91; with the Alpha coefficients for the final four subscales ranging from 0.91 for the Purpose and Meaning in Life scale (4 items), 0.79 for the Innerness or Inner Resources scale (9 items), 0.80 for the Unifying Interconnectedness scale (9 items), 0.71 for the Transcendence scale (6 items). By using this instrument, the researcher hopes to add additional information regarding the validity of this instrument for nurses. In the original study, (Howden, 1992) the entire instrument in the final form was found to be a valid and reliable measure of spirituality. Permission to use the Spirituality Assessment Scale (SAS) has been granted by Dr. Judy Howden. A formal permission letter to use the Spirituality

Assessment Scale (SAS) can be found in Appendix D. The Spirituality Assessment Scale (SAS) can be found in Appendix E.

Studies to develop the Minnesota Satisfaction Questionnaire (MSQ) (Weiss et al., 1967) began in 1957. The framework surrounding the work was based on the Theory of Work Adjustment which states that work adjustment is predicted by the individual's abilities relating to the ability requirements in work, and how well those abilities and needs relate to the reinforcers available in the work environment. In 1977, The Minnesota Satisfaction Questionnaire (MSQ), Short-form (Weiss et al.) was designed from the Minnesota Satisfaction Questionnaire (MSQ) Long-form (Weiss et al.). The MSQ Long-form was developed with twenty scales; whereas, the MSQ Short-form was developed with only three scales: general satisfaction, intrinsic satisfaction, and extrinsic satisfaction. Both questionnaires measure satisfaction with respect to several aspects of work and the work environment. The questionnaires were designed to measure satisfaction, gain an understanding of the different satisfactions in work and work environments, and aid individuals in vocational planning.

According to Weiss et al. (1967) the MSQ, Long-form was developed from the Hoppock Job Satisfaction Blank (short form) and the Employee Attitude Scale. The instrument was developed to measure both extrinsic reinforcement factors (e.g. working conditions, supervision, co-workers, company) and intrinsic reinforcement factors (e.g. type of work, achievement, and ability utilization). The MSQ, Long-form (Weiss et al.) consisted of 100 items with 20 scale titles and 5 items appearing under each scale title. A 5-point Likert scale was used as follows: "1" very dissatisfied, "2"

dissatisfied, “3” neither (dissatisfied nor satisfied), “4” satisfied, “5” very satisfied. The raw scores are converted to percentile scores. A ceiling effect was obvious on many of the scale scores. The rating categories of the scales were modified to range from “not satisfied” to “extremely satisfied” with the following 5-point Likert scale: “1” not satisfied, “2” only slightly satisfied, “3” satisfied, “4” very satisfied, “5” extremely satisfied. A group of 200 individuals were surveyed and the desired objectives were achieved with the ceiling affect being eliminated with no changes in scale reliabilities or intercorrelations. A percentile score of 75 yields a high degree of satisfaction, 26 to 74 would indicate average satisfaction and 25 or lower would represent a low level of satisfaction. The average percentile score should be 50 or better for the group to be considered satisfied. The MSQ, Long-form (Weiss et al.) questionnaire was utilized for a group of 1,793 individuals.

A short version of the MSQ (Weiss et al., 1967) was developed utilizing the highest correlated item from each of the 20 scales represented in the long version of the MSQ. The short form was administered to a heterogeneous group of 1,460 employed men and the data was factor analyzed. Two factors resulted intrinsic and extrinsic satisfaction resulting in a three scale instrument with general satisfaction being the third scale. The internal reliability and consistency of the MSQ, short-form (Weiss et al.) was assessed by using Hoyt’s analysis of variance method. The reliability of coefficients were high with a median reliability coefficient of 0.86 for the intrinsic satisfaction scale, 0.80 for the extrinsic satisfaction scale, and 0.90 for the general satisfaction scale. The evidence for validity was confirmed with studies of occupational group differences and from construct validation studies based on the

theory of work adjustment (Weiss et al.). Permission to use the Minnesota Satisfaction Questionnaire, Short-form (MSQ), (Weiss et al.) has been granted by Dr. David J. Weiss. A formal permission letter to use the MSQ, Short-form can be found in Appendix F. Permission to publish the MSQ in the dissertation is usually not granted; therefore, a copy of the MSQ will not be in the appendices of this dissertation (Weiss et al.).

Assumptions or Limitations

This study assumes that the determinants of spirituality, as defined and measured by the Spirituality Assessment Scale (SAS) (Howden (1992) will be revealed in the registered nurses and licensed practical nurses in the institution(s) examined. Also, the limited number of studies using the SAS may leave some doubt about the validity of the results in general. The study also assumes that some degree of dissatisfaction has been measured among nurses employed in the hospital industry. It is assumed that nurses are searching for meaning and purpose in their lives and jobs and that a relationship exists between these elements, for these subjects, from an organizational perspective.

The study is assuming that previous research and information regarding job satisfaction are accurate. The study is assuming that the determinants of job satisfaction as defined by Weiss et al. (1967) and measured by the Minnesota Satisfaction Questionnaire (MSQ), Short-form will be revealed in registered nurses and licensed practical nurses in the institution(s) examined.

The truthfulness of individuals as relates to self-reports, and the assumption that the responses actually reflect behaviors on the jobs may be limitations in the

present study. The results, of course, can only be generalized to nurses in central Arkansas and the convenience nature of the sample used here also limits the generalizability of the results to other populations. In addition, there is a realization that multiple factors may affect job satisfaction scores, spirituality levels and/or the relationship between these variables. The findings may not be examining all the variables that influence these two factors; however, the literature review suggests that job satisfaction and levels of spirituality concerns are somewhat related.

Procedures

Institutional permission was obtained by contacting the chief executive officer of the hospital to be used as the research site. A letter explaining the purpose of the research, the hypotheses of the study, and copies of the assessment tools were given to the chief executive officer. Further conversations followed and a letter of informed consent was obtained before any research was conducted. The same information has been communicated to the chief executive officer of another hospital that could be used as a back-up location if the sample size of the one hospital is not sufficient. The permission letters from the CEOs are placed in the Appendix section (A and B). The researcher has met with all the nurse managers to explain the study and to develop a sense of commitment to the study.

Survey packets containing the Spirituality Assessment Scale (SAS) (Howden, 1992), the Minnesota Satisfaction Questionnaire, Short-form (MSQ) (Weiss, Dawis, England, & Lofquist, 1967), and a demographic assessment tool (see Appendix G) will be supplied to each participant. A letter of informed consent will be included in each packet with the understanding that by taking the survey, consent is granted and

understood. The confidentiality of the information and specific assurances here will be contained in the intro materials also (see Appendix C). Specific instructions regarding the informed consent letter and importance of completing the entire questionnaire will be included in each packet, and the researcher will be available for questions specifically to scale questions in any of the questionnaires. The participants will not be asked to sign or return the consent letter. Confidentiality is most important, so the participants will be asked not to identify themselves anywhere on the materials. Personal information regarding spirituality of a person and their perceptions of the job are being exposed by completing the questionnaires. Therefore, strict confidence needs to be communicated and upheld in order to allow the participant to be truthful in the self reporting of the information being requested. The researcher will conduct the research on site in a conference room centrally located in the hospital for all nurses and away from administration offices. The nurses are to take the survey at their convenience, either on a break, before or after their shift in the room provided. They will be asked to return the surveys to the researcher upon completion. The paper and pencil survey should take approximately 25-30 minutes to complete.

Each survey packet will be coded for statistical purposes only. The participants will not be given their individual scores on the assessment tools, but they will have access to the compiled results of the study. The letter of informed consent will explain the procedure for receiving the general results and a copy of the findings. All of the research information will be kept in a secure location at all times.

Data Processing and Analysis

In order to perform a statistical analysis of the data, the software package SPSS, 14.0 will be used. Descriptive statistical analysis will be used to classify, summarize, and describe the sample in terms of age, educational background, areas of clinical practice, and tenure. Frequency distributions, measures of central tendency, and measures of variability could be used to calculate the sample, analysis of variance could be used to examine differences, and a correlation coefficient could be used to examine relationships of the variables.

Research question one, is there a relationship between SAS scores and nurses who are generally satisfied with their jobs?

H1_a: There is a statistically significant positive relationship between SAS scores and MSQ general satisfaction scores. The Pearson Product Correlation was used to evaluate the relationship between these variables.

H1_o: There is no statistically significant positive relationship between SAS scores and the MSQ general satisfaction scores. This was determined by using a .05 level of significance. Based on literature, it is thought that nurses that have a high level of spirituality would also have a high level of general satisfaction. Nurses are most satisfied when they feel like they are making a difference in the lives of others (Tuttas, 2002). Spirituality depends on a broader inner life and that meaningful work and the community of work influences that inner life (Ashmos & Duchon, 2000) thus giving relevance for a relationship between spirituality and job satisfaction.

Research question two, is there a relationship between SAS scores and nurses who are intrinsically satisfied with their jobs?

H2_a: There is a statistically significant positive relationship between SAS scores and MSQ intrinsic satisfaction scores. The Pearson Product Correlation was used to evaluate the relationship between these variables.

H2_o: There is no statistically significant positive relationship between SAS scores and the MSQ intrinsic satisfaction scores. This was determined by using a .05 level of significance. Based on literature, it is thought that nurses that have a higher level of spirituality would also have a higher level of intrinsic satisfaction. Intrinsic satisfaction includes achievement and ability utilization (Weiss et al., 1967) which could be in direct correlation with meaningful work influencing spirituality and job satisfaction as suggested by Ashmos and Duchon (2000) and Denton and Mitroff (1999a). Additionally, according to research by Furino and Reineck (2005), nurses are most satisfied with the intrinsic rewards of nursing.

Research question three, is there a difference between SAS scores and age?

H3_a: There is a statistically significant difference in the level of spirituality and age. A one-way analysis of variance was used to determine the differences in these variables.

H3_o: There is no statistically significant difference in the level of spirituality based on age. This was determined by using a .05 level of significance. Intuitively, nurses with higher spirituality scores would also be of an increased age. Age allows individuals to experience many aspects of life, thus allowing spirituality to be a presence that unifies, orients, and mobilizes all aspects of life (Rojas, 2002).

Research question four, is there a difference between SAS scores and educational background?

H4_a: There is a statistically significant difference in the level of spirituality and educational background. A one-way analysis of variance was used to determine the differences in these variables.

H4_o: There is no statistically significant difference in the level of spirituality based on educational background. This was determined by using a .05 level of significance.

Intuitively, nurses with higher spirituality scores would also have an increased level of education.

Research question five, is there a difference between SAS scores and the area of clinical practice?

H5_a: There is a statistically significant difference in the level of spirituality and the area of clinical practice. A one-way analysis of variance was used to determine the differences in these variables.

H5_o: There is no statistically significant difference in the level of spirituality based on the area of clinical practice. This was determined by using a .05 level of significance.

Based on literature, spirituality scores will vary in clinical practices. Patients with acute myocardial infarctions (Walton, 2002) chronic illness (Allen & Rowe, 2004), cancer (Alaugh, 2003), and mental illnesses (Chiu, Gartland, & Greasley, 2001) seem to rely on the meaning and purpose of life to cope with their illnesses. Therefore, higher spirituality scores may be present in nurses in the clinical practices that render care to the above patients.

Research question six, is there a difference between SAS scores and tenure of the nurse?

H6_a: There is a statistically significant difference in the level of spirituality and the tenure of the nurse. A one-way analysis of variance was used to determine the differences in these variables.

H6_o: There is no statistically significant difference in the level of spirituality based on the tenure of the nurse. This was determined by using a .05 level of significance.

Intuitively and based on literature, higher spirituality scores may be present in nurses with increased tenure due to increased, possible exposure to meaning and purpose in life through their work and the connectedness to work (Ashmos & Duchon, 2000).

Research question seven, is there a difference between the MSQ general satisfaction scores and age?

H7_a: There is a statistically significant difference in the level of general job satisfaction and age. A one-way analysis of variance was used to determine the differences in these variables.

H7_o: There is no statistically significant difference in the level of general job satisfaction based on age. This was determined by using a .05 level of significance.

Based on literature, lower levels of general job satisfaction may be present in nurses of an increased age. Nurses that have been in nursing for an extended number of years would also be of a maturing age. Stress and burnout could be prominent deterrents for longevity in nursing profession (Maslach, 1982; Dendaas, 2004).

Research question eight, is there a difference between the MSQ general satisfaction scores and educational background?

H8_a: There is a statistically significant difference in the level of general job satisfaction and educational background. A one-way analysis of variance was used to determine the differences in these variables.

H8_o: There is no statistically significant difference in the level of general job satisfaction based on educational background. This was determined by using a .05 level of significance. Intuitively, higher general job satisfaction scores may be present in nurses with higher levels of education. These nurses may be more adequately prepared to perform their jobs thus leading to greater satisfaction with the work.

Research question nine, is there a difference between the MSQ general satisfaction scores and the area of clinical practice?

H9_a: There is a statistically significant difference in the level of general job satisfaction and the area of clinical practice. A one-way analysis of variance was used to determine the differences in these variables.

H9_o: There is no statistically significant difference in the level of general job satisfaction based on the area of clinical practice. This was determined by using a .05 level of significance. Intuitively, general satisfaction scores will vary in clinical practices. Stress levels increase and the need for advanced nursing skills tend to be present in areas of trauma, critical care, and terminal illnesses which could result in lower general satisfaction of the nurse.

Research question ten, is there a difference between the MSQ general satisfaction scores and the tenure of the nurse?

H10_a: There is a statistically significant difference in the level of general job satisfaction and the tenure of the nurse. A one-way analysis of variance was used to determine the differences in these variables.

H10_o: There is no statistically significant difference in the level of general job satisfaction based on the tenure of the nurse. This was determined by using a .05 level of significance. Based on literature, lower general satisfaction scores may be present in nurses with increased tenure due to nurses caring for more patients with fewer resources, ongoing conflicts with physicians and administration, and the extended exposure to patients that may not be healed (Dendaas, 2004; Furino & Reineck, 2005; Mee & Robinson, 2003).

Chapter four will present the descriptive results of this study. Similarly, the statistical analyses of these results of the tests of the hypotheses will be presented in this chapter.

CHAPTER FOUR: FINDINGS

Introduction

This chapter provides a restatement of the purpose, and the results of the descriptive and demographic data. In addition, the statistical analysis and results of the hypotheses will be presented as outlined in Chapter Three. And finally, a summary of the findings is offered.

Restatement of the Purpose

The purpose of this study was to examine the relationship between spirituality and job satisfaction among registered nurses and licensed practical nurses. It was hoped that some level of understanding could be gained regarding spirituality (purpose and meaning in life, innerness or inner resources, unifying interconnectedness, and transcendence) and the levels of job satisfaction (general, intrinsic and extrinsic) among this population. Demographic characteristics such as age, educational background, area of clinical practice, and tenure were also examined as relates to the main variables of spirituality and job satisfaction levels.

The study was based on ideas suggested by Ashmos and Duchon (2002) and Denton and Mitroff (1999a). These authors noted a direct correlation between levels of meaningful work, spirituality and levels of job satisfaction. In addition, research from Furino and Reineck (2005) and Tuttas (2002) suggested that nurses are most satisfied with the intrinsic rewards of nursing and when they feel they are making a difference in the lives of others. Two instruments were used, the Spirituality Assessment Scale (SAS) (Howden, 1992) and the Minnesota Satisfaction Questionnaire, Short-form (Weiss, Dawis, England, & Lofquist, 1967), along with

demographic items. Correlations between the spirituality assessment scores and job satisfaction scores were examined as relates to age, educational level, tenure and areas of clinical practice.

Survey Sample and Response Rates

The sample for this study was drawn from a population of nurses who work in a hospital setting in central Arkansas. The total potential population for this study was 484 with 343 registered nurses and 141 licensed practical nurses. A total of 300 survey packets were made available to the nurses by the researcher in a designated area located by the cafeteria or distributed by the researcher to the nurses at their work stations. Approximately 100 of the potential population were only available as pool nurses, working only 1-5 shifts per month, decreasing the availability for those nurses to be surveyed. With this reduction of availability of nurses being at the hospital during the time of surveying, the researcher anticipated that approximately 300 survey packets could be completed. The survey packets contained a letter of consent explaining the purpose of the study and the confidentiality rules to be followed, along with the Spirituality Assessment Scale (SAS) (Howden, 1992), the Minnesota Satisfaction Questionnaire (MSQ), Short-form (Weiss, Dawis, England, & Lofquist, 1967), and a demographic questionnaire. The participants either completed the survey packets in a conference room adjacent to the dining room of the hospital or they completed them in their work area. Nurses who did not have time to remain in the conference room and complete the survey away from their work stations chose to take the survey packet with them and complete them during a short break. The researcher was available for questions in the group setting and by cell phone for those

choosing to complete the survey at their work stations. The survey packets filled out in the conference room and at each nurse station were collected by the researcher in order to insure the confidentiality of the data afterwards. During the second week of data collection, the researcher visited each nurse's station several times in an attempt to encourage participation from those who had not returned their forms or those who had not had an opportunity to participate in the survey. A total of 259 responded to the study request; however, due to incomplete questionnaire responses, only 240 completed survey packets were used. This represented an overall response rate of 49.5% from the entire 484 considered in the initial sampling pool.

Descriptive Statistics and Frequency Distributions

One-hundred and forty-six were registered nurses (60.8%) and ninety-four were licensed practical nurses (39.2%). Of the useable forms, 223 (92.9%) were female and 17 (7.1%) were male. Most of the participants 232 (96.7%), were Caucasian, six (2.5%) were African-Americans, one was (.4%) Hispanic, and one (.4%) was of Asian descent.

Age of the Participants

The age of the nurses completing the scale correctly approximated a normal distribution with 18 (7.5%) between 20-24 years of age, 33 (13.8%) between 25-29 years of age, 38 (15.8%) between 30-34 years of age, 20 (8.3%) between 35-39 years of age, 38 (15.8%) between 40-44 years of age, 28 (11.7%) between 45-49 years of age, 27 (11.3%) between 50-54 years of age, and 15 (6.3%) 60 years of age or older. Over half of the nurses (54.7%) were between the ages of 40 to 60+ years old. See Table 1 below.

Table 1

Age of Nurse Participants

Age	Frequency	Percent
20-24 years	18	7.5
25-29 years	33	13.8
30-34 years	38	15.8
35-39 years	20	8.3
40-44 years	38	15.8
45-49 years	28	11.7
50-54 years	27	11.3
55-59 years	23	9.6
> 60 years	15	6.3
Total	240	100

Educational Level of Nurses

Seventy-five (31.3%) of the nurses had a licensed practical nurse technical certificate, 19 (7.0%) possessed a licensed practical nurse diploma, 74 (30.8%) had an associate degree in nursing, 64 (26.7%) held a bachelor of science in nursing degree, and 8 (3.3%) had a masters of science in nursing degree. See Table 2 below.

According to a national sample survey of registered nurses by the United States Department of Health and Human Services (2000), the number of registered nurses in the state of Arkansas was 23,291. The nurses in Arkansas predominantly held lower levels of degrees with 22% diploma degrees, 48% associate degrees, 24% bachelor degrees, and 6% masters and doctorate degrees. The largest group of nurses in the present study possessed a licensed practical nursing technical certificate, followed closely by an associate degree in nursing.

Table 2

Education Level of the Nursing Population

Education	Frequency	Percent
LPN (technical certificate)	75	31.3
LPN Diploma	19	7.9
Associate (ADN)	74	30.8
Bachelor (BSN)	64	26.7
Masters (MSN)	8	3.3
Total	240	100

Area of Clinical Practice

The majority of the nursing participants 105 (43.8%) worked on medical/surgical wards, 21 (8.8%) in the critical care unit, 17 (7.1%) in obstetrics/gynecology, 16 (6.7%) in emergency, 13 (5.4%) in cardiovascular, 11 (4.5%) in the operating room, 7 (2.9%) in rehabilitation, 6 (2.5%) in pediatrics, 6 (2.5%) in outpatient care, and 38 (15.8%) worked in other departments. See Table 3 below for this information. The single largest percentage (43.8%) of nurses in this population worked within a medical/surgical ward.

Table 3

Area of Clinical Practice

<i>Area of Clinical Practice</i>	<i>Frequency</i>	<i>Percent</i>
Medical/Surgical	105	43.8
Emergency	16	6.7
OR	11	4.6
Critical Care	21	8.8
Cardiovascular	13	5.4
Pediatrics	6	2.5
OB/GYN	17	7.1
Outpatient	6	2.5
Rehab	7	2.9
Other	38	15.8
Total	240	100

Tenure

The number of years the nurse participants had practiced nursing varied with 69 (28.8%) practicing 1-5 years, 32 (13.3%) 6-10 years, 39 (16.3%) 11-15 years, 26 (10.8%) 16-20 years, 25 (10.4%) 21-25 years, 23 (9.6%) 26-30 years, and 26 (10.8%) practicing 30 or more years. See Table 4 below. Nearly one third (28.8%) of the nurses in this population were relatively new to the nursing field.

Table 4

Tenure of Nurse

<u>Number of years Practicing</u>	<u>Frequency</u>	<u>Percent</u>
1-5 years	69	28.8
6-10 years	32	13.3
11-15 years	39	16.3
16-20 years	26	10.8
21-25 years	25	10.4
26-30 years	23	9.6
> 30 years	26	10.8
Total	240	100

Research Questions and Hypotheses

The following research questions were tested in this study. Do nurses who report more spirituality also experience higher levels of general job satisfaction? Do nurses who report more spirituality also experience more intrinsic job satisfaction? Are there differences in the level of spirituality reported based on age? Are there differences in the level of spirituality reported based on educational background? Are there differences in the level of spirituality reported based on the area of clinical practice? Are there differences in the level of spirituality based on the tenure levels of the nurse? Are there differences in the levels of general job satisfaction reported based on age? Are there differences in the level of general job satisfaction reported based on their educational backgrounds? Are there differences in the level of general job satisfaction reported based on the area of clinical practice performed? Finally, are there differences in the level of general job satisfaction reported based on the tenure of the nurses?

In order to examine these research questions the following specific hypotheses were developed and explored.

H1_a: There is a statistically significant positive relationship between SAS scores and the general job satisfaction scores.

H1_o: There is no statistically significant positive relationship between SAS scores and the general job satisfaction scores.

H2_a: There is a statistically significant positive relationship between SAS scores and the intrinsic satisfaction scores.

H2_o: There is no statistically significant positive relationship between SAS scores and the intrinsic satisfaction scores.

H3_a: There is a statistically significant difference in the level of spirituality and age.

H3_o: There is no statistically significant difference in the level of spirituality based on age.

H4_a: There is a statistically significant difference in the level of spirituality and educational background.

H4_o: There is no statistically significant difference in the level of spirituality among educational background categories.

H5_a: There is a statistically significant difference in the level of spirituality and the area of clinical practice.

H5_o: There is no statistically significant difference in the level of spirituality based on the area of clinical practice.

H6_a: There is a statistically significant difference in the level of spirituality and tenure of the nurse.

H6_o: There is no statistically significant difference in the level of spirituality based on the tenure of the nurse.

H7_a: There is a statistically significant difference in the level of general job satisfaction and age.

H7_o: There is no statistically significant difference in the level of general job satisfaction based on age.

H8_a: There is a statistically significant difference in the level of general job satisfaction and educational background categories.

H8_o: There is no statistically significant difference in the level of general job satisfaction based on educational background.

H9_a: There is a statistically significant difference in the level of general job satisfaction and the area of clinical practice.

H9_o: There is no statistically significant difference in the level of general job satisfaction based on the area of clinical practice.

H10_a: There is a statistically significant difference in the level of general job satisfaction and tenure of the nurse.

H10_o: There is no statistically significant difference in the level of general job satisfaction based on tenure of the nurse.

Analysis and Findings

Alternative Hypothesis One

H1_a: There is a statistically significant positive relationship between SAS scores and the general job satisfaction scores. A Pearson correlation coefficient was calculated to test relationship between SAS scores and MSQ general job satisfaction scores. A significant moderate positive correlation was found here ($r(238) = .452, p = .000$) between spirituality and general job satisfaction (See Table 5). Therefore, the null hypothesis was rejected. The SAS instrument measures meaning and purpose in life, innerness, interconnectedness; thus, the findings support the literature review suggesting that nurses are more satisfied when they feel that they have a sense of connectedness and purpose in life (Tuttas, 2002). A broader inner life (innerness), meaningful work (meaning and purpose) and a sense of community

(interconnectedness) seem to be associated with greater general job satisfaction levels (Ashmos & Duchon, 2000).

Table 5 Correlations between Spirituality and General Job Satisfaction

		MSQ general job satisfaction	SAS Spirituality
MSQ general job satisfaction	Pearson Correlation	1	.452(**)
	Sig. (1-tailed)		.000
	N	239	239
SAS Spirituality	Pearson Correlation	.452(**)	1
	Sig. (1-tailed)	.000	
	N	239	240

** Correlation is significant at the 0.01 level (1-tailed).

Alternative Hypothesis Two

H2_a: There is a statistically significant positive relationship between SAS scores and the intrinsic satisfaction scores. A Pearson correlation coefficient was calculated to test the relationship between SAS scores and the MSQ intrinsic satisfaction scores. A significant moderate positive correlation was found here ($r(238) = .495, p = .000$) indicating a moderate significant relationship between spirituality and intrinsic job satisfaction (See Table 6). Therefore null hypothesis two was rejected. Once again, the SAS instrument measures meaning and purpose in life, innerness, interconnectedness and the MSQ intrinsic scale also measures the intrinsic reinforcement factors (type of work, achievement, and ability utilization) associated with one's work; thus, the findings seem to support the literature review. The nurses experience more meaning and purpose in their lives when they are able to complete the job to the best of their ability (ability utilization), and when they feel they are helping other people (achievement/interconnectedness) (Tuttas, 2002).

Table 6 Correlations between Spirituality and Intrinsic Job Satisfaction

		MSQ Intrinsic job satisfaction	SAS Spirituality
MSQ Intrinsic job satisfaction	Pearson Correlation	1	.495(**)
	Sig. (1-tailed)		.000
	N	239	239
SAS Spirituality	Pearson Correlation	.495(**)	1
	Sig. (1-tailed)	.000	
	N	239	240

** Correlation is significant at the 0.01 level (1-tailed).

Supplemental Analysis – Extrinsic Job Satisfaction

Although there was not an explicit hypothesis stated regarding the relationship between the SAS scores and the MSQ extrinsic satisfaction, the researcher thought it would be interesting to report the findings of this relationship. A moderate significant positive correlation was found here ($r(238) = .302, p = .000$) between spirituality and extrinsic job satisfaction (see Table 7). Even though there was an indication of a moderate relationship between spirituality and extrinsic job satisfaction, when compared to spirituality and intrinsic job satisfaction ($r(238) = .495, p = .000$) the relationship was clearly weaker than the latter comparison. This finding may be an indication that the intrinsic job satisfaction elements (type of work, achievement, and ability utilization) of the job go hand and hand with the spiritual perspectives of the nurses (meaning and purpose in life, innerness, interconnectedness, and transcendence); more so than the external factors of the job (working conditions, supervision, co-workers, company). This finding seems to support the literature review ideas (Furino & Reineck, 2005) that the meaning elements of the work are important as relates to the personal fulfillment components. This finding makes intuitive sense as well.

Table 7 Correlations between Spirituality and Extrinsic Job Satisfaction

		MSQ Extrinsic job satisfaction	SAS spirituality
MSQ	Pearson Correlation	1	.302(**)
Extrinsic job satisfaction	Sig. (1-tailed) N	239	.000 239
SAS	Pearson Correlation	.302(**)	1
Spirituality	Sig. (1-tailed) N	.000 239	240

** Correlation is significant at the 0.01 level (1-tailed).

Alternative Hypothesis Three

H3_a: There is a statistically significant difference in the level of spirituality and age. The results of the Analysis of Variance comparing SAS (spirituality) scores as the dependent variable and the age categories (20-24 years of age, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, >60 years) as the independent variable showed no significant differences ($F(8,230) = .736, p = .660$) (See Table 8). Therefore, the null hypothesis was accepted. The findings did not support the notion that older nurses would be more spiritual.

Table 8 ANOVA: Spirituality (DV) and Age (IV)

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1435.179	8	179.397	.736	.660
Within Groups	56073.349	230	243.797		
Total	57508.527	238			

Alternative Hypothesis Four

H4_a: There is a statistically significant difference in the level of spirituality and educational background. The results of the Analysis of Variance, comparing SAS (spirituality) scores as the dependent variable and the educational background categories (LPN technical certificate, LPN diploma, Associate (ADN), Bachelor (BSN), Masters (MSN)) as the independent variable showed no significant differences ($F(4,234) = 1.093, p = .361$) (See Table 9). Therefore, the null hypothesis was accepted. The finding did not support the original idea that the more educated people would have higher spirituality scores.

Table 9 ANOVA: Spirituality (DV) and Education Level (IV)

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1054.804	4	263.701	1.093	.361
Within Groups	56453.723	234	241.255		
Total	57508.527	238			

Alternative Hypothesis Five

H5_a: There is a statistically significant difference in the level of spirituality and the area of clinical practice. The results of the Analysis of Variance comparing SAS (spirituality) scores as the dependent variable and area of clinical practice (medical/surgical, emergency, OR, critical care, cardiovascular, pediatrics, OB/GYN, outpatient, rehab, and other) as the independent variable also showed no significant differences ($F(9,229) = .837, p = .583$) (See Table 10). Therefore, the null hypothesis was accepted. The findings did not support the assumption that nurses' spirituality scores would be higher in areas of clinical practice where the nurses have to rely on a great deal of meaning and purpose to cope with serious illnesses such as cancer (Alaugh, 2003), mental illnesses (Chiu, Gartland, & Greasley, 2001) myocardial infarctions (Walton, 2002), and/or more chronic illnesses (Allen & Rowe, 2004).

Table 10 ANOVA: Spirituality (DV) and Area of Clinical Practice (IV)

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1830.493	9	203.388	.837	.583
Within Groups	55678.034	229	243.136		
Total	57508.527	238			

Alternative Hypothesis Six

H_{6a}: There is a statistically significant difference in the level of spirituality and the tenure of the nurses. The results of the Analysis of Variance comparing SAS (spirituality) scores as the dependent variable and the tenure of the nurse (1-5 years, 6-10, 11-15, 16-20, 21-25, 26-30, >30 years) as the independent variable showed no significant differences ($F(6,232) = 1.742, p = .112$) (See Table 11). Therefore, the null hypothesis was accepted. The finding did not support the idea that high spirituality scores would be present in nurses with higher tenure; having been exposed to more meaning and purpose issues in their work (Ashmos & Duchon, 2000).

Table 11 ANOVA: Spirituality (DV) and Tenure of Nurses (IV)

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	2479.522	6	413.254	1.742	.112
Within Groups	55029.005	232	237.194		
Total	57508.527	238			

Alternative Hypothesis Seven

H7_a: There is a statistically significant difference in the level of general job satisfaction and age. The results of the Analysis of Variance comparing MSQ (general job satisfaction) scores as the dependent variable and age (20-24 years of age, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, >60 years) as the independent variable showed no significant differences either ($F(8,231) = 1.250, p = .271$) (See Table 12). Therefore, the null hypothesis was accepted. The findings did not seem to support previous studies (Spector & White, 1987) suggesting older workers are more generally satisfied with their job because of the different preferences and perceptions in a job (income and advancement opportunities) from that of younger workers. Additional studies (Al-Ajmi, 2001; Rhodes, 1983) suggest increased job satisfaction in older workers may stem from increased contentment, increased advancement opportunities, decreased employment changes, and a greater sense of work locus of control. Spector (1997) suggests that greater general job satisfaction in older employees may be influenced by the acceptance of authority, less expectations from a job, the advancement to better jobs, and the increased experience and skill sets. However, a study by Clark, Oswald, and Warr (1996) suggested lesser general job satisfaction in women than men due to the increased likeliness for promotions, and the decrease of leaving unsatisfying jobs as age increases in men. The previous studies suggesting older workers have a higher level of general job satisfaction may not be exemplified in nursing. One reason may be due to the nursing employment population being primarily female and two, previous studies in nursing literature suggest that older workers tend to have lesser general job satisfaction due to more

stress and burnout (Maslach, 1982, Dendaas, 2004), lower job satisfaction levels (Mee & Robinson, 2003), and have a tendency to hasten retirement and turnover decisions (Furino & Reineck, 2005).

Table 12 ANOVA: General Job Satisfaction (DV) and Age (IV)

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1100.352	8	137.544	1.250	.271
Within Groups	25418.832	231	110.038		
Total	26519.183	239			

Alternative Hypothesis Eight

H8_a: There is a statistically significant difference in the level of general job satisfaction and educational background categories. The results of the Analysis of Variance comparing MSQ (general job satisfaction) scores as the dependent variable and educational background categories (LPN technical certificate, LPN diploma, Associate (ADN), Bachelor (BSN), Masters (MSN)) as the independent variable showed no significant differences either ($F(4,235) = 1.588, p = .178$) (See Table 13). Therefore, the null hypothesis was accepted. The findings did not seem to support the idea that nurses with higher levels of education would be better trained to perform their jobs, consequently leading to greater job satisfaction levels.

Table 13 ANOVA: General Job Satisfaction (DV) and Education Level (IV)

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	697.905	4	174.476	1.588	.178
Within Groups	25821.279	235	109.878		
Total	26519.183	239			

Alternative Hypothesis Nine

H9_a: There is a statistically significant difference in the level of general job satisfaction and the area of clinical practice. The results of the Analysis of Variance comparing MSQ (general job satisfaction) scores as the dependent variable and area of clinical practice (medical/surgical, emergency, OR, critical care, cardiovascular, pediatrics, OB/GYN, outpatient, rehab, and other) as the independent variable showed no significant differences ($F(9,230) = 1.173, p = .313$) (See Table 14). Therefore, the null hypothesis was accepted. The findings did not support the idea that general job satisfaction levels decreased if someone worked in areas of high pressure (Dendaas, 2004; Furino & Reineck, 2005).

Table 14 ANOVA: General Job Satisfaction (DV) and Area of Clinical Practice (IV)

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1163.738	9	129.304	1.173	.313
Within Groups	25355.445	230	110.241		
Total	26519.183	239			

Alternative Hypothesis Ten

H10_a: There is a statistically significant difference in the level of general job satisfaction and the tenure of the nurses. The results of the Analysis of Variance comparing MSQ (general job satisfaction) scores as the dependent variable and tenure (1-5 years, 6-10, 11-15, 16-20, 21-25, 26-30, >30 years) of the nurses as the independent variable showed no significant differences ($F(6,233) = 1.948, p = .074$) (See Table 15). Therefore, the null hypothesis was accepted. The findings did not seem to support the previous findings indicating lower general satisfaction scores among nurses with increased tenure because of nurses caring for more patients with fewer resources, ongoing conflicts with physicians and administration, and extended exposure to patients with chronic diseases that bring about death (Dendaas, 2004; Furino & Reineck, 2005; Mee & Robinson, 2003).

Table 15 ANOVA: General Job Satisfaction (DV) and Tenure of Nurses (IV)

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1266.538	6	211.090	1.948	.074
Within Groups	25252.645	233	108.380		
Total	26519.183	239			

Summary

This chapter presented the descriptive results of the demographical data. In addition, the results of the specific hypotheses were reported.

The survey was conducted as proposed with survey packets available either in a conference room adjacent to the cafeteria or distributed by the researcher to the work stations of registered nurses and licensed practical nurses in a hospital setting in Central Arkansas. Participation in the survey was strictly voluntarily, and the researcher personally collected the completed survey packets to ensure confidentiality.

Of the usable responses, 240 out of 300 surveys made available, one-hundred forty-six were from registered nurses (60.8%) and ninety-four were from licensed practical nurses (39.2%). The gender data, 223 (92.9%) female and 17 (7.1%) male, was similar to data reported in The National Sample Survey of Registered Nurses by the United States Department of Health and Human Services (2000), with 94% of registered nurses being female and 6% being male. The racial diversity of the present group was not particularly mixed with 232 (96.7%) being Caucasian. The age of the nurses in the present study were somewhat older, with a cumulative (five out of nine age categories) percentage of 54.7% of the nurses being ages 40 to 60+. This compares with the cumulative percentages of 61% of nurses being ages 40 to 60+ as reported in The National Sample Survey of Registered Nurses by the United States Department of Health and Human Services (2000). In addition, a study of registered nurses in the state of Florida by Tjong (2000) yielded similar cumulative results, with (59.4%) of the nurses being ages 40 to 60+. In contrast to the older nurses in the field,

the younger nurses in the present study ranging in age from 20-29 yielded a cumulative percentage of 21.3%, as compared to a national average of only 9.1% for the age category of 20-29 (United States Department of Health and Human Services, 2000).

The cumulative educational level of nurses in this study was lower than expected; 31.3% of the nurses had a licensed practical nurse technical certificate and 30.8% had an associate degree in nursing. The state of Arkansas also reported, however, a cumulative lower educational level percentage (69.5%) of nurses possessing a diploma or associate degrees (United States Department of Health and Human Services, 2000). The majority of the nursing participants 105 (43.8%) worked on medical surgical wards, with the next largest segment 38 (15.8%) working in other departments. The tenure level of the nurses in the present study also reflected a large cumulative percentage (42.1%) of the nurses practicing less than 10 years, 69 (28.8%) practicing 1-5 years, and 32 (13.3%) practicing 6-10 years. The study by Tjiong (2000) revealed similar results with respect to tenure, 30 (24.4%) practicing 1-5 years, and 16 (13%) 6-10 years.

It was interesting to note, then, that at least demographically the sample was not particularly well-educated. They were also somewhat older than expected and they were less experienced than one would imagine.

In computing Pearson correlation coefficients, a moderate significant positive correlation was found ($r = .452$) between spirituality and general job satisfaction. Likewise, a higher significant positive correlation was found ($r = .495$) between spirituality and intrinsic job satisfaction and a supplemental analysis revealed a lower,

but still significant, positive correlation ($r = .302$) relationship between spirituality and extrinsic job satisfaction. These findings seemed to confirm the idea that spirituality is intimately related to general job satisfaction levels for nurses and that it seems to be more closely related to the intrinsic job satisfaction components (the meaning elements) than it is to the more formal aspects of nursing work (the working conditions, etc.); although the latter component was also found to be significantly related to spirituality levels.

An analysis of variance approach was used to test for differences in the levels of spirituality and levels of general job satisfaction on age, educational background, areas of clinical practice, and/or the job tenure of the nurses. No significant differences were noted on the spirituality measure and/or on the general job satisfaction scale on any of the demographic aspects of this sample.

Chapter Five will present a summary of the entire study, and discuss the conclusions of the study. It will also outline some future practical recommendations and future research ideas relating to spirituality and job satisfaction levels among nurses.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This final chapter includes a brief statement of the problem, the literature review, the methodology, and the findings. The conclusions from the findings, the implications of the results on future practices in the field of healthcare particularly nursing, and a discussion of recommendations for future research will also be included.

Summary

The purpose of this study was twofold; one, to examine the relationships between spirituality (purpose and meaning in life, innerness or inner resources, unifying interconnectedness, and transcendence) and the various components of job satisfaction among nurses, and two, to obtain a greater understanding of the importance of spirituality as relates to various demographic characteristics of this work group. As stated in Chapter One, over the last fifteen plus years, management and leaders in varied organizational settings have embraced spirituality as a core element of new organizational cultures (Grant, 2004; Grant, O'Neil, & Stephens, 2004; Guillaume & McMillan, 2002; Schuster, 1997). Organizations across industries are taking notice of spirituality and considering its importance in organizations (Ashmos & Duchon, 2000; Denton & Mitroff, 1999b). The healthcare industry is no different than many of these other settings. In fact, it may be more prevalent in healthcare because of the past and present emphasis on holistic medical ideas and the intensity of dealing with serious patient concerns (Nightingale, 1860; Burkhardt & Nagia-Jacobson, 1989). Employees, in general, are searching for meaning and

purpose in their lives, and in healthcare these issues are often amplified by patients who are relying on meaning and/or purpose issues in dealing with their illnesses and/or diseases (Albaugh, 2003; Brown, 2000; Chiu, Gartland, & Greasley, 2001; Allen & Rowe, 2004; Walton, 2002). Working within the healthcare environment can be very rewarding; however, continued staff shortages (Coile, 2001; Donley, 2005), the demands to perform with fewer resources (Furino & Reineck, 2005), the struggle for a profitable bottom line (Hood, Smith, & Waldman, 2003), the error rate in medicine (Leape, 1994) and the strong pressures for quality patient care (Coile, 2001) can lead to a work environment filled with many pressures, stressors, and dissatisfaction (Donley, 2005). These demands and pressures may have resulted in Jackson (2004) and O'Connor's (2002) calls for nurses to find coping mechanisms to decrease the stress levels and ways to find meaning and purpose in their sometimes frustrating lives. One has to wonder even if job stress, burnout, and dissatisfaction are a threat to the supply of nurses in the healthcare industry? One also has to wonder if spirituality can play an active role in helping nurses to find meaning and purpose in their work and consequently buffering the negative effects of this stressful environment.

The intent of this study was, then, to examine the relationships between spirituality and general, intrinsic, and extrinsic job satisfaction among nurses. Furthermore, the dynamics between spirituality and general job satisfaction and the independent variables of gender, the age of the nurses, the educational background levels, tenure and areas of clinical practice were also considered.

Spirituality was defined here as the dimension of one's being that is an integrating or unifying component, manifested through the unifying components of interconnectedness, purpose and meaning in life, innerness or inner resources and transcendence (Howden, 1992). It is an element of life, then, that gives purpose to one's existence and life activities. Spirituality was measured by using the Spirituality Assessment Scale (SAS), developed by Howden (1992). General job satisfaction involves perceptions of the job that include both extrinsic and intrinsic reinforcement factors (Weiss, Dawis, England, & Lofquist, 1967). Extrinsic job satisfaction includes feelings about the working conditions, supervision, co-workers, and the company (Weiss, Dawis, England, & Lofquist, 1967). Intrinsic job satisfaction includes feelings about the type of the type of work performed, the achievements associated with the job, and ability utilization (Weiss, Dawis, England, & Lofquist, 1967). General job satisfaction, extrinsic job satisfaction, and intrinsic job satisfaction were measured by using the Minnesota Satisfaction Questionnaire (MSQ), Short Form developed by Weiss, Dawis, England, & Lofquist (1967). Some additional questionnaire items were also used to capture what were thought to be various pertinent demographic characteristics (gender, the age of the nurses, the educational background levels, tenure and areas of clinical practice) that might be tied to the satisfaction and spirituality measures.

A hospital in central Arkansas employing approximately 500 nurses was used as a convenience sample to collect approximately 300 nurse responses. As stated in chapter three, approximately 100 of the nurses were considered as pool nurses meaning that the availability for these nurses to be present to participate in the study

was greatly reduced. Also, a seventy-five to one hundred percent response rate was not likely based on the response rates of former studies. The nurses were asked to voluntarily complete the Spirituality Assessment Scale (SAS) (Howden, 1992), the Minnesota Satisfaction Questionnaire (MSQ), Short Form (Weiss, Dawis, England, & Lofquist, 1967), and the demographic questionnaire. Two hundred and forty completed surveys were received, representing a 49.5% response rate from the entire 484 considered the initial sampling pool. Although a higher response rate would have been desirable, the sensitive nature of the subject material and the unpredictable down time of a nurse's schedule may have contributed to a less than perfect response rate. However, the response rate was considered to be acceptable.

As can be noted in Table 16, the Pearson correlation coefficient was used to test the correlation between spirituality and general, intrinsic, and extrinsic job satisfaction. As was noted, moderate significant positive correlations were found between spirituality and general job satisfaction and intrinsic job satisfaction levels; therefore, the first and second hypotheses were rejected. A supplemental analysis between spirituality and extrinsic job satisfaction revealed a lesser positive, but significant, correlation between the two variables. Also as was mentioned, Analyses of Variance tests were used to examine the differences between the dependent variables (spirituality and general job satisfaction) and the independent demographic variables (age, educational background, area of clinical practice, and tenure) in hypotheses three through ten. The results of these analyses did not show any significant differences; therefore, null hypotheses three through ten were accepted.

Table 16 Summary of Results

<u>Hypothesis</u>	<u>Value</u>	<u>Results</u>
H1 _a : There is a statistically significant positive relationship between SAS scores and the general job satisfaction scores.	r = .452	
H1 _o : There is no statistically significant positive relationship between SAS scores and the general job satisfaction scores.		Rejected
H2 _a : There is a statistically significant positive relationship between SAS scores and the intrinsic satisfaction scores.	r = .495	
H2 _o : There is no statistically significant positive relationship between SAS scores and the intrinsic satisfaction scores.		Rejected
H3 _a : There is a statistically significant difference in the level of spirituality and age.	p = .660	
H3 _o : There is no statistically significant difference in the level of spirituality based on age.		Accepted
H4 _a : There is a statistically significant difference in the level	p = .361	

of spirituality and educational background.

H4_o: There is no statistically significant difference in the level of spirituality among educational background categories. Accepted

H5_a: There is a statistically significant difference in the level of spirituality and the area of clinical practice. p = .583

H5_o: There is no statistically significant difference in the level of spirituality based on the area of clinical practice. Accepted

H6_a: There is a statistically significant difference in the level of spirituality and tenure of the nurse. p = .112

H6_o: There is no statistically significant difference in the level of spirituality based on the tenure of the nurse. Accepted

H7_a: There is a statistically significant difference in the level of general job satisfaction and age. p = .271

H7_o: There is no statistically significant difference in the level of general job satisfaction based on age. Accepted

H8_a: There is a statistically significant difference in the level of general job satisfaction and educational background. p = .178

categories.

Accepted

H8_o: There is no statistically significant difference in the level of general job satisfaction based on educational background.

H9_a: There is a statistically significant difference in the level of general job satisfaction and the area of clinical practice. $p = .313$

Accepted

H9_o: There is no statistically significant difference in the level of general job satisfaction based on the area of clinical practice.

H10_a: There is a statistically significant difference in the level of general job satisfaction and tenure of the nurse. $p = .074$

H10_o: There is no statistically significant difference in the level of general job satisfaction based on tenure of the nurse.

Accepted

Conclusions

The moderate positive correlation between spirituality and general job satisfaction seems to support the literature findings that nurses are more satisfied when they feel like they are making a difference in the lives of others (Tuttas, 2002). It is thought that nurses feel they are making a difference in the lives of their patients by helping to provide insights into the meaning and purpose of illness/disease. In return, the nurse is thought to experience greater job satisfaction by perceiving the work as being more meaningful and by developing greater interconnectedness through the community influence of their work (Ashmos & Duchon, 2000). The moderate positive relationship between spirituality and intrinsic job satisfaction supports the research of Furino and Reineck (2005); suggesting that nurses are more satisfied with the intrinsic characteristics of nursing. This also seems to support the research of Weiss, Dawis, England, and Lofquist (1967); that some individuals are very in-tune with the internal aspects of their (the type of work, the achievement components, and ability utilization issues).

The supplemental analysis revealing a lesser relationship between spirituality and extrinsic job satisfaction provides increased support for the relationship between spirituality and the intrinsic components of job satisfaction. According to Ellenbecker (2004), the extrinsic characteristics of job satisfaction in nursing include stress, workload, autonomy and control of work hours and activities, salary and benefits, and the perception of real opportunities for jobs in other industries. This present findings may drive home the importance of things like purpose and meaning and interconnectedness in this particular work, as compared to the extrinsic factors. If this

is the case, management needs to be aware of the importance nurses place on the spiritual dimensions of themselves, and the potential benefits that may accrue for their patients. If nurses are able to render spiritual care to their patients and if they experience a sense of purpose in the job, perhaps the end results will be increased job satisfaction, increased patient satisfaction, and increased quality of care. These relationships may be circular in nature. The research does suggest that the spirituality of the nursing staff can play a positive role in the outcome of the patient's health (Vance, 2001; Strang, Strang, & Ternstedt, 2002).

The spirituality descriptive statistics for this group may also lend a further explanation to the relationship between spirituality and the job satisfaction components of this group. The mean spirituality score for this group was $m = 140.81$, with an $sd = 15.54$, suggesting a strong level of spirituality. The normed information for the SAS instrument are a strong spirituality score at 113-168, a moderate spirituality score ranging from 57-112, and a low evidence of spirituality ranging from 28-56 (Howden, 1992). In addition, the mean score of general job satisfaction for this group was $m = 78.10$, with an $sd = 10.53$. This raw score converts to a percentile score of 65, suggesting that the nurses observed in this group are on the high end of average on the satisfaction measure. The norms for job satisfaction with the MSQ instrument suggest high job satisfaction percentile scores at 75 or higher, average satisfaction scores at the 26-74 percentile scores, and low level of satisfaction at the 25th percentile or below (Weiss, Dawis, England, & Lofquist, 1967). Research by Weiss, Dawis, England, and Lofquist (1967) with full-time nurses yielded only mean percentile scores of 50. Research by the United States Department of Health

and Human Services (2000) with registered nurses also showed that only 48 percent of nurses in the United States were even moderately satisfied. The group of nurses in the present study appears to be considerably more satisfied than the other nurses previously studied.

These two observations bring up the issue of which variable might be driving the other. Are the participants in this study more satisfied with their jobs because of the higher degree of sense of purpose and meaning in life, innerness or inner resources, unifying interconnectedness, and transcendence (spirituality) or is the higher satisfaction with their jobs providing the higher degree of spirituality? A qualitative study focusing on group or individual interviews with the nurses might lend a clearer picture of which variable is the driving, or primary, force in the present study.

With the high degree of spirituality orientation in this sample, an evaluation of patient satisfaction, especially as relates to spiritual needs being met, may provide information regarding the spiritual care delivery skills of the nurses in this study. A study by Vance (2001), for instance, showed a positive and significant ($p < .05$) relationship between the spirituality of nurses and their spiritual care delivery approaches. Those nurses scoring higher on personal attitudes towards spirituality also scored higher in their spiritual care practices. The Joint Commission of Accreditation of Healthcare Organizations acknowledges and is supportive of the patient spiritual needs and values and requires organizations to try to accommodate those needs (Joint Commission, 2005). Organizations that may be struggling with meeting the spiritual needs of their patients, may want to consider intentional

instruction regarding caring philosophies, clarity in providing a sense of conscious purpose, clarity in the role of providing spiritual care, and a simple spirituality assessment tool that might aid in determining the spiritual needs of patients so that their spiritual needs can be better met (Tanyi, 2002; Vance 2001; Felgen, 2004). Assessing the levels of potential spirituality among prospective nursing employees may be another avenue to take. Even though this approach might be somewhat controversial, if this selection criteria can be used in a nondiscriminatory manner it may drive home the importance of this characteristic for nursing personnel. The positive impact on the patients may be significant also.

Although there appears to be a high degree of spirituality influencing the general or intrinsic, or both job satisfaction components, observed in this group, the job satisfaction levels may be attributed to general life satisfaction scores and attitudes. Research has suggested that general life satisfaction (satisfaction with broader life domains, such as work, health, family, etc.) are clearly related to job satisfaction scores (Kinicki & Kreitner, 2004). Therefore, future research may want to include a measurement of general life satisfaction in order to more clearly understand the total constellation of patterns among the satisfaction domain. It may be for instance, that those who are happier in general, tend to be more satisfied with their jobs and that they are also more appreciative of a sense of purpose in their lives, they are more interconnected with other forces or people and that they see more relatedness in the world around them, etc. They may, consequently, have a more positive outlook toward many aspects of their lives

The demographic data observed in this study, particularly age, tenure and the education levels, do raise some concerns for the future supply of nurses in the industry. As reported in Chapter Four, the ages of the nurses in the present study were older with a cumulative percentage of 54.7% of the nurses being between the ages of 40 to 60+. Similar results (61% in the United States and 59% in Florida) were observed in two additional studies that were noted in the summary section of Chapter Four. In addition, younger nurses in the present study age 20-29 yielded a cumulative percentage of 21.3% and a national average of only 9.1% for age 20-29 (United States Department of Health and Human Services, 2000). These age observations raise two concerns. One, with the lower percentage of younger nurses this could be an indication that fewer young people are entering the field of nursing. Two, there is a large percentage of older nurses who within fifteen and continuing to twenty-five years will be entering retirement and exiting the nursing field. With the baby boomers fast approaching the need for major healthcare, this observation does bring serious concerns for the general population

The tenure information also observed in this group reflected a large percentage (42.1%) of the nurses practicing less than 10 years here, with 69 (28.8%) practicing 1-5 years, 32 (13.3%) practicing 6-10 years. This observation, again, suggests major shortfalls in the number of nurses in the near future. Even more shocking, according to a study by the United States Department of Health and Human Services (2000), nearly 20% (18.3%) of registered nurses are no longer employed in nursing occupations. Research is needed, then, to determine the reason(s) why registered nurses are no longer either entering the field or practicing as nurses.

Similarly, one has to wonder why the education levels of this group were so low. Are advanced nursing degrees being sacrificed in order to fill nurse vacancies more quickly? This raises a concern regarding the preparedness of the nurse to render the best quality of care to patients. Effective strategies of recruitment and retention need to be developed to attract, retain and educate this valuable professional group.

Recruitment of prospective nurses may need to even start at a younger age, perhaps in grade school and middle school in order to help with these shortages. And those in the profession need to be encouraged to increase their educational levels. Mentoring and shadowing programs may also be necessary to teach the value and importance of nursing care in general. Strong measures may be necessary here if these trends are to be rectified.

Recommendations

The literature review and the findings from this study suggest that job satisfaction and spirituality levels are related. This research has added a degree of understanding regarding spirituality and job satisfaction among nurses. There is very limited research in the area of spirituality and job satisfaction in the nursing industry and additional research is clearly needed. This work should also include the effects that greater levels of spirituality have on patient care and satisfaction. The research has also added valuable information regarding the large percentage of this sample being 40 to 60+ years of age practicing nursing, and the lower tenure and educational levels of this sample. This information may be a wake up call for those in the healthcare industry regarding the future challenges of providing care to the general population in the near future and beyond.

The generalizability of the results of this study are, of course, limited to central Arkansas. This particular area is considered to be in the Bible belt region of the United States. Additional research is needed in other regions of the country in order to compare not only the spirituality levels among nurses, but also the relationship between spirituality and job satisfaction in this occupational group. Similarly, larger sample sizes are needed. A similar study comparing the spirituality and job satisfaction scores of nurses in different types of hospitals (for profit, not for profit, teaching institutions, and Veteran hospitals) may prove to be fruitful as well.

A more in-depth study evaluating intentional instruction regarding spiritual care may be useful. The literature suggests that the spiritual health of an individual can be enhanced by the spiritual care provided by the nurse (Grant, 2004). Determining which types of educational programs prove to be most beneficial for the nurses themselves and for the patients are a must.

As mentioned in the conclusion section of this chapter, adding a qualitative research component to the original study may provide more specific information regarding job satisfaction and spirituality among nurses, as well as providing valuable information to management as relates to the recruitment, retention and education of nurses. With fewer people entering the nursing profession, the widespread dissatisfaction among today's nurses, and more patients with chronic illnesses surviving serious illnesses with fewer nurses (Mee & Robinson, 2003), nursing management must seek to better understand these issues and to identify strategies to overcome these challenges.

Additional research also needs to be conducted in evaluating spirituality scores and satisfaction levels among nurses possessing higher degrees of education. There was not an indication in the present study that a higher degree of education yields increased spirituality and satisfaction among nurses; however, those who are encouraged to continue lifelong learning and to increase their levels of education may show greater levels of satisfaction and spirituality. This would be another interesting area for future research.

The nursing profession was inspired by a nurse who understood the whole person (body, mind, and spirit) and how each of those elements can be a part of the healing process. Florence Nightingale viewed the healing environment as the sole responsibility of the nurse caregiver (Nightingale, 1860). Florence Nightingale believed in the holistic aspect of healthcare. The nursing field has been inspired by the example of Florence Nightingale and her desire to provide care to the entire person (Bond, Callister, Mangum, & Mantsumura, 2004; Bullough & Bullough, 1964; Burkhardt & Nagia-Jacobson, 1989; Felgen, 2004; Jackson, 2004; Maddox, 2001; Ross, 1995; Sellman, 1997). This research project may not inspire all nurses or healthcare providers to value and care for the whole person during a time of illness or disease. However, this research project has hopefully provided the nurse or healthcare provider with a flashing light to care for patients from a more holistic perspective and hopefully it has inspired them to provide care with a nobler sense of purpose. The benefits of emphasizing such a model may be profound.

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Appendix A

Permission Letter from Organization to Conduct Research

Appendix B
Informed Consent Letter

LETTER OF INFORMED CONSENT

Dear Participant:

I am a doctoral candidate at Argosy University. The purpose of this study is to determine whether a relationship exists between spirituality and job satisfaction in registered nurses and licensed practical nurses. As a participant nurse in this study, you will be asked to complete a short demographic questionnaire, a spirituality assessment questionnaire, and a job satisfaction questionnaire. The Spirituality Assessment Scale will measure four attributes: purpose and meaning in life, innerness or inner resources, unify interconnectedness, and transcendence.

Your participation in this survey will be approximately thirty minutes. Participation in this research is strictly voluntary. You may refuse to participate, or choose to stop your participation at any point in the research without any penalty or negative consequences of any kind. There are no known risks involved in this study all is needed from you is to simply complete the questionnaires. The return of the completed questionnaires will indicate your consent to participate in the study.

The information you will provide will be treated confidentially, and all raw data will be kept in a secured file by the researcher. Individual scores will not be available to you or anyone else. Results of the research will be reported as aggregate summary data only, and no individually identifiable information will be presented. The questionnaire will be coded for the purpose of statistical analysis only.

You also have the right to review the results of the research if you wish to do so. A copy of the results may be obtained by contacting the researcher at the address below: Rhonda S. Bell, 108 Oak Valley Circle, Searcy, AR 72143 or rsbell@cablelynx.com.

There will be no direct or immediate benefit to you from this study. However, the results of the research may contribute information to help understand (1) the nursing industry and the characteristics that are present in nurses; and (2) the satisfaction with the work and/or the work environment of a nurse. Your help is greatly needed to help understand this valuable profession and prepare for the increased nursing care that will be needed in the future.

I admire those who work in the nursing profession and appreciate the countless hours you spend dedicated to caring for others. Thank you for your assistance in participating in this study. If you have any questions regarding the study, please contact me.

Sincerely,

Rhonda S. Bell

Appendix C

Permission Letter to use Spirituality Assessment Scale (SAS)

REQUEST FORM

I request permission to copy the Spirituality Assessment Scale (SAS) for use in my research entitled

Spirituality and Job Satisfaction: A correlational study among nurses.

In exchange for this permission, I agree to submit to Judy W. Howden a copy of the following:

1. An abstract of my study purpose and findings (or a copy of article if published), which includes the correlations between the SAS scale scores and any other measures used in my study. (This will be used by Judy W. Howden to assess construct validity).
2. The reliability coefficient as computed on the total instrument and identified subscales from my sample (Cronbach's alpha).
3. Data (anonymous) of each subjects score on the instrument.

Any other information or findings that could be helpful in assessing the reliability or validity of the instrument would be greatly appreciated (e.g.: problems with items, comments from subjects, other findings).

This data will be used to establish a normative data base for clinical populations. No other use will be made of the data submitted. Credit will be given in reports of normative statistics that make use of the data submitted for pooled analyses.

Signature _____

Date _____

Position and Full Address: _____

Permission is hereby granted to copy the SAS for use in the research described above.

Judy W. Howden Date

Judy W. Howden

1108 Lou Ann, Corsicana, TX 75110

fax (903) 874-0328

Appendix D
Spirituality Assessment Scale (SAS)

SPIRITUALITY ASSESSMENT SCALE

DIRECTIONS: Please indicate your response by circling the appropriate letters indicating how you respond to the statement.

MARK:

“SA” if you STRONGLY AGREE

“ A ” if you AGREE

“AM” if you AGREE MORE than DISAGREE

“DM” if you DISAGREE MORE than AGREE

“ D ” if you DISAGREE

“SD” if you STRONGLY DISAGREE

There is no “right” or “wrong” answer. Please respond to what you think or how you feel at this point in time.

- | | | |
|----|--|-----------------|
| 1. | I have a general sense of belonging. | SA A AM DM D SD |
| 2. | I am able to forgive people who have done wrong to me. | SA A AM DM D SD |
| 3. | I have the ability to rise above or go beyond a physical or psychological condition. | SA A AM DM D SD |
| 4. | I am concerned about destruction of the environment. | SA A AM DM D SD |
| 5. | I have experienced moments of peace in a devastating event. | SA A AM DM D SD |
| 6. | I feel a kinship to other people. | SA A AM DM D SD |

- | | | | | | | | |
|-----|---|----|---|----|----|---|----|
| 7. | I feel a connection to all of life. | SA | A | AM | DM | D | SD |
| 8. | I rely on an inner strength in hard times. | SA | A | AM | DM | D | SD |
| 9. | I enjoy being of service to others. | SA | A | AM | DM | D | SD |
| 10. | I can go to a spiritual dimension within myself for guidance. | SA | A | AM | DM | D | SD |
| 11. | I have the ability to rise above or go beyond a body change or body loss. | SA | A | AM | DM | D | SD |
| 12. | I have a sense of harmony or inner peace. | SA | A | AM | DM | D | SD |
| 13. | I have the ability for self-healing. | SA | A | AM | DM | D | SD |
| 14. | I have an inner strength. | SA | A | AM | DM | D | SD |
| 15. | The boundaries of my universe extend beyond usual ideas of what space and time are thought to be. | SA | A | AM | DM | D | SD |
| 16. | I feel good about myself. | SA | A | AM | DM | D | SD |
| 17. | I have a sense of balance in my life. | SA | A | AM | DM | D | SD |
| 18. | There is fulfillment in my life. | SA | A | AM | DM | D | SD |
| 19. | I feel a responsibility to preserve the planet. | SA | A | AM | DM | D | SD |

- | | | | | | | | |
|-----|--|----|---|----|----|---|----|
| 20. | The meaning I have found for my life provides a sense of peace. | SA | A | AM | DM | D | SD |
| 21. | Even when I feel discouraged, I trust that life is good. | SA | A | AM | DM | D | SD |
| 22. | My life has meaning and purpose. | SA | A | AM | DM | D | SD |
| 23. | My innerness or an inner resource helps me deal with uncertainty in life. | SA | A | AM | DM | D | SD |
| 24. | I have discovered my own strength in time of struggle. | SA | A | AM | DM | D | SD |
| 25. | Reconciling relationships is important to me. | SA | A | AM | DM | D | SD |
| 26. | I feel a part of the community in which I live. | SA | A | AM | DM | D | SD |
| 27. | My inner strength is related to a belief in a Higher Power or Supreme Being. | SA | A | AM | DM | D | SD |
| 28. | I have goals and aims for my life. | SA | A | AM | DM | D | SD |

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Appendix E
Permission Letter to Use the Minnesota Satisfaction Questionnaire

Appendix F
Demographic Questionnaire

Demographic Questionnaire

Please provide the following demographic information to be used in the statistical analysis.

Gender:

Male
 Female

Age:

20-24
 25-29
 30-34
 35-39
 40-44
 45-49
 50-54
 55-59
 > 60

Race:

Caucasian
 Afro-American
 Hispanic
 Native American
 Asian
 Other

Years in Nursing Practice:

1-5
 6-10
 11-15
 16-20
 21-25
 26-30
 > 30

Education:

- LPN (technical certificate)
- LVN (technical certificate)
- Diploma
- Associate (ADN)
- Bachelor (BSN)
- Masters (MSN)
- Masters (MBA)
- Other _____

Area of nursing practice/specialty:

- Medical/Surgical
- Emergency
- OR
- Critical Care
- Cardiovascular
- Pediatrics
- OB/GYN
- Outpatient
- Rehab
- Physician Clinic
- Other _____

Current Position:

- Staff nurse
- Charge nurse/team leader
- Manager
- Shift Supervisor
- Administration
- Other _____

Has most of your nursing experience been with a:

- for-profit healthcare organization
- not-for profit healthcare organization
- Veterans or state healthcare organization
- Other _____

Religious Affiliation:

- Protestant
- Catholic
- Jewish
- Other _____

Do you consider yourself to be a religious person?

- _____ Not at all
- _____ Not very religious
- _____ Moderately religious
- _____ Very religious
- _____ Other _____

Do you consider yourself to be a spiritual person?

- _____ Not at all
- _____ Not very spiritual
- _____ Moderately spiritual
- _____ Very spiritual
- _____ Other _____