Factors Influencing Hospice Workers Use of Religion and Spirituality in Patient Care

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Abstract

Research demonstrates the importance of a meaningful link between religion/spirituality (R/S) and the well-being of older adults (Whitehead and Bergeman., 2020; Malone and Dadswell, 2018). There are numerous additional studies that emphasize the benefit of R/S in end-of-life care (Abbas, et al., 2011; Cipriano-Steffens et al., 2021; Richardson, 2014). Selman, et al., (2014) conducted an online international study that surveyed 971 participants from 87 different countries and examined from the practitioner's perspective what is needed in the field of palliative care and found that research on the integration of R/S was needed. Yet, according to a study by Oxhandler, et al., (2015) only 13% of Licensed Clinical Social Workers (LCSW) had taken a course in R/S. There is a gap in our knowledge relative to factors that influence the use of R/S within the helping professions (Oxhandler and Giardina, 2017). Therefore, the purpose of this research is to try to identify the extent to which Hospice workers integrate R/S in patient care and what factors influence the use of R/S in patient care. An online survey was used to collect the data (Monkey Survey software). Univariate and bivariate analysis was conducted to analyze the findings. The findings of this study show a majority of respondents are white, female, Christians with a college degree, professional licensure, and are predominately nurses. Even though a majority of the respondents are nurses and nurses tend to follow more of a medical model rather than a social work model which is client self-determination, interestingly, nearly 70% of respondents gather religious and spiritual history from their patients. However, less than 50% of the respondents indicated they were adequately trained to integrate religion/spirituality into patient care. Most of the respondents were religious and their religious attendance was low. Most of the other independent variables were not significantly related to the dependent variables. The only correlations that were significant were the following: use of training was positively correlated with referring patients to other R/S resources were years of experience in hospice care ($r = .33$, $p > .05$); frequency of attendance in R/S services is

negatively correlated with having confidence in integrating R/S in their work ($r = -.34$, $p > .05$); years of experience in hospice care had a moderate correlation with the use of training in practice. The higher number of years of experience in hospice care leads one to be more likely to use their training in R/S when providing care to patients ($r = .34$, $p > .05$).

Key Words: hospice, hospice care worker, end of life, religion, spirituality, training

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Background Literature

The National Consensus Project and *National Quality Forum* stated that spiritual care is an essential component of palliative care (Puchalski, et al., 2009). "Palliative care objective is to provide the best quality of life (QoL) for people who have a serious illness and endeavors to support the whole-person (physical, psychological, social, and spiritual) and their family (National Coalition for Hospice and Palliative Care (NCHPC), 2018). The National Consensus Project's *Clinical Guidelines for Palliative Care (CGPC)*, 4th edition was written to illustrate and promote high quality palliative care for all people in any setting. Of the eight domains listed in the CGPC, the following aspects of care, physical, psychological, and psychiatric, social, and spiritual, religious, and existential, are domain two through domain five (NCHPC, 2018). The Whole-person model of care is also known as Biopsychosocial-spiritual care model (Sulmasy, 2002). Salmasy (2002) notes that the Biopsychosocial-spiritual model does not divide the person into a body and a soul, but rather, notes that the biological, psychological, social, and spiritual dimensions that make up the whole person cannot be separated from the whole person. Yet, each of these aspects of the person can be impacted differently. Furthermore, Salmasy (2002) elaborates that being human is to be relational; as humans we have extra personal relationships (body and mind) and intrapersonal relationships (environment and transcendent). Especially, when caring for the dying addressing the whole person utilizes a Biopsychosocial-spiritual model of care is appropriate (Salmasy, 2002). Spirituality is a basic component of being human (Juškienė, 2016). Juškienė (2016) states that spiritual wellbeing is relational whether evaluated through a secular or sacred perspective, and according to the research it manifest, "through relations with oneself, others, the environment and God". Having a transcendental relationship with God is a significant component of spiritual wellbeing, positively impacting a person's ability to deal with adverse

circumstances (Juškienė, 2016). The World Health Organization supports a Biopsychosocial-spiritual approach to palliative care (2023).

> "Hospice is a specific type of palliative care provided to individuals with a life expectancy measured in months, not years. Hospice teams provide patients and families with expert medical care, emotional, and spiritual support, focusing on improving patient and family quality of life." (NCHPC, 2018).

Hospice Workers Integration of Religion and Spirituality

According to Ferrell, et al., (2020), "even though palliative care workers are perhaps more prepared to deal with spiritual issues, COVID-19 "exposed the fault lines exposing the need to improve spiritual care delivery" (p.e8). Authors assert that the palliative care community should reinvest in addressing the religious and spiritual aspect of helping the client as much as everyone is giving importance to wearing personal protective gear during COVID. When supporting a person-centered care, one must address the religious and/or spiritual needs of the patients for the holistic approach of serving to take place. The proposed study which explores the extent to which hospice workers and volunteers integrate religion and spirituality into the care of hospice patients and assesses factors influencing the use of religion and/or spirituality in the care will add knowledge to existing literature on EoL care. It is anticipated that the results from this study will be useful in designing training, practice approaches, and policy in care of patients in hospice care. In addition, integration of S/R by the healthcare and nonhealthcare professionals' will improve the responsiveness to psychological needs of patients across cultures during the most critical and vulnerable phase in their life. Overall, the goal is to improve the quality of care provided during EoL care. Limitations of these studies are that no studies compared social workers and nurses integration of R/S in hospice care, nor did they look at determinates related to the integration of R/S.

Religion and Spirituality Defined

Religion and spirituality are defined in numerous ways. For the purpose of this study a widely used definition of religion and spirituality will be utilized. Religion is defined as "a personal set or institutionalized system of religious attitudes, beliefs, and practices; in the service and worship of God or the supernatural" (Merriam-Webster, n.d.). Spirituality: Spirituality, on the other hand, connotes an experience of connection to something larger than you; living everyday life in a reverent and sacred manner (Koenig, et al., 2001).

Research Review

Selman, et al., (2014) conducted an online international study that surveyed 971 Participants from 87 different countries and examined from the practitioner's perspective what is needed in the field of palliative care and found that research on the integration of R/S was needed. The top three areas noted by clinicians and researchers for further research were, "1) the evaluation of screening tools used to identify patients with spiritual needs 2) the development and evaluation of conversation models for spiritual conversations with patients, 3) evaluation of the effectiveness of spiritual care" (Selman, et al., 2014, p.521). Addressing the religious and spiritual (R/S) component of a person at end-of-life (EoL) is important as R/S often are a significant consideration of the patient in EoL decisions (Richardson, 2014). Richardson, further notes " The assessment of and attention to spiritual needs have been identified as important factors in promoting QoL, yet these needs often go unrecognized or unaddressed" (2014, p. 156).

Christine Longaker, the second author of the study Effects of Spiritual Care Training for Palliative Care Workers designed a course titled *Wisdom and Compassion in Care for the Dying*. This course was presented to professionals in palliative care (n=63) over three and half day (Wasner et al., 2005). The participants completed a questionnaire at three points during the study (Wasner et al.2005) to assess the impact of the training. Instruments utilized in this study included *Functional Assessment of*

Chronic Illness Therapy -Spiritual Well-being (FACIT-Sp), *Self-Transcendence Scale* (STS), and *Idler Index of Religiosity* (IIR), both these scales used numeric ratings on items of the scales (Wasner et al., 2005). The results indicate spiritual care training had a positive influence on the participating palliative care professionals which was preserved over a six-month period (Wasner et al., 2005). Wasner and associates (2005) stress the need to educate medical care workers of their role in implementing patient centered spiritual care in EoL and the importance of integrating pastoral care into multi-disciplinary teams, as a way of improving the quality of care for patients.

Rather than collecting data at three points, researchers Dane and Moore, (2006) employed a single study design to survey 610 social workers using two sample groups.to study if there was a relationship between the social workers personal spiritual practices and the social workers recommendation of spiritual practices, based on client needs (Dane and Moore, 2006). The study also examined why spiritual practices may not have been implemented when there was an indication of client need (Dane and Moore, 2006). Sample 1 consisted of 283 social workers who belonged to the New York State Association of Clinical Social Workers (NYACSW) and sample 2 was comprised from 327 Palliative Care End of Life (PCEOL) list serve social workers (Dane, & Moore, 2006). The sample used was mostly made up of social workers from the northeastern part of the United States, with a high proportion from New York due to self-selection of participants. One recommendation from this study is that "a fundamental focus for planning should include the role of spirituality in coping" (Dane, & Moore, 2006, p. 79).

A later study by Balboni, et al., (2009), examined if spiritual care from the medical team impacted medical care and quality of life (QoL) at end of life (EoL) and to look at these relationships according to patient religious coping. The *Coping with Cancer Study* was conducted across multiple institutions and demonstrated the significance of providing spiritual care to cancer patients during the EoL (Balboni, et al., 2009). The study noted that advanced cancer patients who had their spiritual needs

met by the medical team had three-time greater odds of receiving hospice care at EoL than those who did not receive support (Balboni, et al., 2009). Cancer patients with high religious coping capacity receiving support for their spiritual needs had five times greater odds of receiving hospice care and five-fold decreased odds of receiving aggressive EoL care compared with those who did not receive spiritual care (Balboni, et al., 2009). It was noted that there is a need to educate medical caregivers regarding their role in providing patient centered-spiritual care and the importance of integrating pastoral care into the multi-disciplinary team (Balboni et al., 2009).

Religion and spirituality, while defined in various ways, are a universal construct. A qualitative pilot study conducted in the United Kingdom (UK) using focus groups to elicit greater depth of discussion among the healthcare professionals working in an in-patient hospice unit n=15 found that the following themes that emerged were related to the healthcare professionals issues toward spirituality, a lack of confidence, not enough time, and a lack of training (Abbas, et al., 2011). The authors noted spirituality as a component of care is an increasingly recognized part of palliative care. Therefore, it is important to evaluate staff's skills and provide needed training (Abbas, et al., 2011).

Adding to the evidence showing the benefits of religion and spirituality at EoL, a study conducted in Soweto, South Africa, examined the spiritual needs, and religious and spiritual care (R/S) of palliative care cancer patients. This study was a longitudinal observational study and included participants who were diagnosed with cancer. A sample of physicians were asked to assess the level of R/S integration in their curative treatment with patients who are likely to live past six months (Ratshikana-Moloko, M., et al., 2020). Results show that of the 598 patients approached, only 235 were enrolled in EoL care and all received R/S care with the exception of two patients. Consistent with many other studies the study by Ratshikana-Moloko et al., found that patients who receive R/S care reported less pain, and used less of morphine (40.2% compared to 55.6% ; P = 0.026). Those who received R/S care were more often able

to die at home than the participants who did not receive R/S (Ratshikana-Moloko, M., et al., 2020). It seems R/S is provided more often when the preferred place of death is at home rather than in an institution.

Another cross-sectional study of patients in palliative care with a sample size of 206 participants found that spiritual well-being and meaning in life (MIL) appears to be factors that protect from end-of-life despair. Bernard, et al., (2017). These researchers conducted face-to-face interviews with participants from Switzerland and used the following scales [*Schedule for Meaning in Life*, (SMILE), *The Functional Assessment of Chronic Illness Therapy Spiritual Well-Being Scale* (FACIT-Sp), *The Idler Index of Religiosity* (IIR*), The Hospital Anxiety and Depression Scale* (HADS), *The Schedule of Attitudes toward Hastened Death (SAHD), and The Single-Item Quality of Life Scale (*SQOLS)] to determine "the relationship between spirituality and MIL with the wish to hasten death (WTHD) and psychological distress in palliative patients, the extent to which these nonphysical determinants can be considered as significant predictors of subjectively perceived QOL in palliative care patients, and, whether differences occur in three geographically and linguistic diverse regions of Switzerland" (Bernard et al., 2017, p. 515). Study found spirituality and meaning in life enhanced QOL and reduced psychological distress (Bernard, et al., 2017). Authors stated that there is a need for " meaning-oriented and spiritual care interventions tailored to the fragility of palliative patients" (Bernard, et al., 2017, p. 514)

Cipriano-Steffens et al., (2021) administered two surveys one at baseline and another at 3-4 months with a sampling of 42 stage IV cancer patients, with a life expectancy of less than 12 months to assess the extent to which Spiritual Care Advocates (SCA) provided R/S care to the patients. Findings from this research suggest that SCA intervention increases perceived spiritual support by the patient and lends to decreased aggressive EoL care. Limitations noted by was authors was this study was developed

to manage the spiritual issues of predominantly Black Christian population and did not address concerns of patients who did not express a desire for spiritual care (Cipriano-Steffens et al., 2021).

Many studies have noted the importance of R/S in caring for people during EoL. Abbas, et al., (2011) documented the importance of R/S in palliative care yet professionals find it difficult to discuss R/S needs; Cipriano-Steffens et al., (2021) found that spiritual care was associated with improved EoL care patients QoL and spiritual well-being; Ferrell et al., (2020) posit that palliative care practitioners need to advocate for quality R/S care for all people; Richardson (2014) concludes that lack of attention to R/S needs of clients can adversely affect QoL and EoL care; Selman et al., (2017) asserts that the integration of R/S care needs should guide future research, clinical and educational programs; Wasner et al., (2005. states that comprehensive palliative care should not only address patients' physical distress but should also address the patients' spiritual needs and concerns. A study using an online Qualtrics survey tool, collected data from 437 social work practitioners on use of R/S competencies in EOL care and grief (Pomeroy et al., 2021). Social worker practitioners from a variety of practice fields participated in this study and most of these social workers have a master's degree. These researchers found that "a majority reported encountering end of life (EOL) and grief issues in their practice (very often, 39.6%; sometimes, 42.86%" (Pomeroy et al., 2021, 268). These practitioners were asked, "how competent do you feel to address the spiritual issues of their grieving and dying clients" and more than 20% considered themselves incompetent, 17.26% somewhat incompetent, and 6.15% stated being very incompetent. In this study spirituality was defined as human quality to search for meanings, well-being, and profundity through connections with oneself, others, and the universe (Pomeroy et al., 2021). Further, it was defined as "an institutionalized system of beliefs, values and practices that are oriented toward spiritual concerns and transmitted over time by a community" (Pomeroy et al., (2021, 270). When asked how competent the social workers felt in addressing the religious needs of their grieving and dying clients, thirty percent

stated they were incompetent, 23.7%. somewhat competent, and 8.53% very incompetent. More than a third of the participants reported that their personal spirituality and religion pose a problem when their patients have a different S/R belief (34.07%). These researchers recommend the need for continuing research to further our understanding of best practices for integrating R/S in grief and loss services in practice, and with clients across cultures and belief systems (Pomeroy et al., 2021). Social work is one of the many professions that make up the interdisciplinary teams in hospice care settings, therefore including other professionals in such studies will be beneficial.

Selman, et al. (2017) used focus groups across nine countries and four continents to explore spiritual care needs of patients' and caregivers', their experiences, preferences, and research priorities in an international sample of patients with life-limiting disease. Separate patient and caregiver focus groups were conducted at 11 sites (South Africa, Kenya, South Korea, the United States, Canada, the United Kingdom, Belgium, Finland, and Poland). This study was a first for providing an illustration from an international sample regarding patients' and caregivers' spiritual concerns, spiritual care experiences and their priorities for spiritual care research (Selman, et al., 2017). The findings suggest spirituality is a principal component of care, though often, a neglected component according to patients' and caregivers' in the nine countries where the study took place (Selman, et al., 2017). Furthermore, participants emphasized the need for spiritual competency across disciplines (Selman, et al., 2017).

Purpose of Study

This study is to fill in gaps in knowledge, specifically to learn how social workers use R/S compared to other health professionals. Also, factors influencing the use of R/S in the care provided by the hospice workers and volunteers were analyzed. An online survey was used to collect information from the staff and volunteers of a large Central Ohio hospice organization. Statistical analyses of the data gathered was used to see if there is a relationship between the use of religion and spirituality and

factors such as support of staff time by agency, level of training, personal beliefs, religion or spirituality and select demographics. Additionally, a comparison of the social workers' use of religion and/or spirituality to other hospice worker's use of religion and/or spirituality was examined. This study differs from other studies, as the focus of this study was on the experiences of healthcare professionals and nonhealthcare professionals' integration of religion and spirituality rather than exclusively on healthcare professionals and clergy experiences of S/R. The implication of this research is to recommend appropriate development and promotion of skills and practice approaches among professionals and paraprofessionals who work in hospice care settings.

Methods

Study Design

The proposed study used a cross-sectional research design, collecting data at one-point in time from the respondents (Rubin and Babbie, 2017) which allowed for quick data collection. A quantitative approach enabled data to be collected from a larger sample than most qualitative studies (Ponto, 2015), and allowed for generalizability, less subjectivity through the use of standardized measures, results can be duplicated, and respondents were confidential. The weakness of this design is that research results can be skewed if an instrument did not have validity and reliability, answer validity can be an issue, as respondents self-reported and may answer according to their most recent scenario rather than based on their usual pattern of behavior, since respondents are confidential there was no way to seek clarification if an answer was not clear (Rubin and Babb, 2017).

The data collected was used to conduct statistical analysis to examine the extent to which hospice workers and volunteers integrated R/S when caring for hospice patients. An online survey was used to collect information from the staff and volunteers of a large Central Ohio hospice organization. Statistical analyses were used to examine the relationship between the use of religion and spirituality by

hospice care workers and volunteers, and adequacy of time spent with patients, level of training, and support received from the employers .

Sampling

Respondents were selected from among staff and volunteers who work at a large Central Ohio hospice organization. The potential participants for this study were all the employees and volunteers who work for this large Central Ohio hospice organization. There are approximately 170 employees and volunteers at this hospice organization. This was a convenience sample, and people who responded were self-selected.

The population from which the sample was derived is hospice workers and volunteers affiliated with a large Central Ohio hospice organization. The people who responded to the survey were the sample. The survey was distributed to hospice workers and volunteers from a large Central Ohio hospice organization. Based on the data there are approximately 170 employees and volunteers who work in this hospice care organization. Of these staff and volunteers, it was anticipated that at least 30% of the employees and volunteers would respond to the survey, given the relevancy of the content of this survey. This size of sample helped to ensure that there was less sampling error. The sample was a non-probability sample. There was a total of fifty-six respondents; of these fifty-six respondents thirteen cases did not meet the inclusion criteria of having direct patient contact and completing all of the survey. Therefore, the sample was N=43.

Data Collection Procedure

An online survey was generated using the survey software program, Survey Monkey (See Appendix D) . The survey included information on the background of the participant, training, and application of knowledge. Background information included demographics such as age, race, gender, years of experience, length of practice in hospice, and educational background. Age, years of

experience, and length of practice in hospice are continuous variables. Respondents were asked to list their age and number of years of experience and length of practice in hospice care.

The remainder of the demographic variables were categorical. There was a list of categorical variables with a list of options for the participant to check what religious and/or spiritual practices they have. Application of knowledge included a measure of religiosity. Measure of religiosity included religious affiliation, attendance of religious institution, and religious /spiritual practices and to what extent do they apply this knowledge? Section one of the survey included two questions modified from the DUREL (Koenig and Büssing 2010). Section two-part a, b, and c utilized a modified version of Oxhandler' s RSIPAS instrument (Oxhandler, 2019).

The researcher formulated a letter requesting participants from a large Central Ohio hospice organization (See Appendix A). This letter requested the professionals and volunteers to participate in the survey study, by using an online link. This letter requesting their participation was forwarded by the manager to all the affiliated agencies and disseminated to the employees of the large Central Ohio hospice organization. The participant used the online link to complete the survey. A second follow-up letter with the embedded link to the survey was sent two weeks later. The second letter included a statement requesting the staff and volunteers to complete the survey if they had not already done so (See Appendix B). A thank you letter was disseminated to the agency following the survey thanking them for participating. The e-survey was uploaded by the researcher. Respondents could either choose to volunteer to participate or choose to decline to participate in the e-survey. Clicking on the survey was considered as consent to participate. Consent was acquired through the participant voluntarily clicking on the e-survey, direct consent was obtained using an embedded consent form (See Appendix C).

Data was collected using an online survey from professionals and volunteers who work in hospice care. There was no need to retain the respondents past the completion of the survey, as this

study was not a longitudinal study. Participants were confidential and voluntary. Only ID numbers were assigned to the respondents. No personal identification information was collected on anyone who participated in this study. According to Rubin and Babbie (2017) reimbursement of participants should consider the time and effort a participant is expected to contribute to the research project. Respondents were not reimbursed for their time. Therefore, it should not be seen as "undue inducement to participate" (NASW, National Association Social Workers, 2021) in this study.

Measurement

This study used quantitative data to explore the extent to which hospice workers and volunteers utilize R/S in the care of hospice patients and what factors influence the hospice workers use of R/S in patient care. There are two major set of variables that were used in this study: 1) A scale that includes statements (items) to measures general spirituality, use of R/S in practice with patients in hospice care, use of training in practice and support by agency to use S/R in practice. These were considered as the dependent variables of this study. 2) Demographics and background information like age, gender, years of experience, education level, discipline, and religious affiliation were considered as the independent variables of this study.

Existing scales were used to measure use of R/S by the healthcare and nonhealthcare professionals', and the level of integration of religion rather than healthcare professionals and clergy response (Oxhandler and Parrish, 2016;). This study limited the concept of spirituality to the dimension of general spirituality as proposed by Monod et al., (2011). Monod et al., gave us the conceptual framework for spirituality, measuring spirituality with four dimensions, "general spirituality, spiritual well-being, spiritual support or coping, and spiritual needs" with each of the categories being operationalized through "cognitive expression, behavioral expression, and affective expression" (2011, p. 1347), These researchers conducted a systematic review of instruments that were developed to assess

religiousness and spirituality in clinical research. Three major citations were given by Monod et al., (2011), that relates to measuring S/R in the United States (Fetzer Institute National Institute on Aging, 1999; Idler et al., 2003; Stewart and Koeske, 2006).

The Multidimensional Measurement of Religiousness / Spirituality was validated in a large sample (N=1,445) of participants from the United States (Monod, et al., 2011). Stewart and Koeske, (2006) and Oxhandler (2019) reevaluated the use of the Religious/ Spiritual Integrated Practice Assessment Scale (RSIPAS) with clinical psychologists, social workers, marriage and family therapists, professional counselors, and nurses. The findings suggest that the RSIPAS can be used to assess professionals working in different disciplines. The scale includes measures of overall orientation toward integrating clients R/S in practice, their self-efficacy, attitudes, perceived feasibility, and behaviors with regard to practice (Oxhandler, 2019). Koenig and Büssing (2010), also created a measure of S/R in practice called the Duke University Religion Index (DUREL) which measures three dimensions of religion. For the proposed study research will use measures of R/S and related training from both the RSIPAS and the DUREL instruments with some modifications. From the RSIPAS scale 24 items were selected to measure R/S, training, support from agency, and integration of practice of R/S with patients. Two items measuring frequency of religious service attendance and extent to which respondents consider themselves religious were used from the DUREL for this study.

The items that measure R/S reflect the definition of the scale (RSIPAS) developed by (Oxhandler, 2019). The validity of the RSIPAS scale as well as reliability was undertaken by the authors. The reliability of the scale was strong, alpha = .95 (Oxhandler and Parrish, 2016). After collecting data from the respondents, a reliability test was performed.

A modified scale was used in this study which is composed of 24 items. The scale has three sections: a) knowledge R/S of the patients/clients which is measured with 12 items; b) extent to which

one integrates R/S in practice measured by 6 items; and c) use of training in practice is measured by 6. Each of these items in part a and b are statements and the responses to the statement are measured by the extent to which one agrees or disagrees. Response categories for part a and b of the scale are 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree. Part c of the scale is statements and the response to these statements is measured by the frequency of use. Response categories for part c of the scale are 1 = never, 2 = rarely, 3 = some of the time, 4 = often, 5 = very often.

A reliability analysis of the twenty-four items was generated. The six items that measured the use of training in practice was not correlated to the items of the two sub-scales [a) knowledge R/S of the patients/clients which is measured with 12 items; b) extent to which one integrates R/S in practice measured by 6 items]. Out of the twelve-item scale one item was excluded because there was no variability in the response. Therefore, the scale of the use of training in practice was excluded from the reliability analysis and was treated as a separate subscale. The twenty-three-item scale that included the three subscales added together had a Cronbach reliability that was lower than the original scale (alpha = .78). The scores ranged from 23 to 115 (mean score = 48.73, SD = 5.80).

However, when the alpha level for the three subscales were created independently, the reliability ranged from moderate to moderately high (alpha = .42, .57, and alpha = .81). For example, the reliability of the subscale on use of training with six items had an alpha level of .81. The scores ranged from 6 to 18 (mean score = 13.14, SD = 3.34). For the purposes of the analysis of the relationship between the independent variables and dependent variables, each of the subscales were used independently to better understand the predictive factors as conceptualized in the purpose of this study.

The background information of the respondents was measured as follows: 1) age – respondent reported their actual age (continuous variable); 2) race – respondent selected one of the 7 categorical-nominal variable (1 = American Indian, 2 = Alaskan Native, 3 = Asian, 4 = Black or African American,

5 = Native Hawaiian or other Pacific Islander, 6 = White, 7 = Other); 3) sex is a categorical-nominal variable, 1 = female, 2 = male, 3 = self-identify; 4) professional background is categorical-nominal, respondents will be asked to select their background from the following, 1 = Social Worker, 2 = Nurse Practitioner, 3 = Nurse, 4 = Health Aid, 5= Chaplain/Rabbi/Priest, 6 = Other; 5) highest level of education is a categorical-nominal variable, respondents will be asked to list their highest level of education; 6) years of experience will be measured as a continuous variable and respondent with asked to provide actual years and months of experience; 7) length of practice in hospice, will be measured as a continuous variable, respondents will be asked to list actual years and months of hospice practice; 8) religious affiliation is a categorical-nominal variable, respondents will be asked to select their religious affiliation, 1 = Christian, 2 = Jewish, 3 = Buddhist, 4 = Hinduism, 5 = Other; 9) frequency of attendance at religious services is a categorical-ordinal variable and respondents will be asked to select one answer on a 5 point Likert scale 1 = never, 2 = once or twice per year, 3 = several times per year, 4 = once a week, 5 = more than once per week; 10) extent to which the respondent considers themselves a religious person is categorical-ordinal variable the respondents will be asked to select one answer on a 5 point Likert scale, 1 = not religious at all, 2 = somewhat religious, 3 = neither religious or nonreligious, 4 = religious, 5 = very religious. The independent variables for this study include age, sex, race, religion, level of training, educational background, professional background, employed or volunteer, years of experience, frequency of attendance at religious services, and religiosity. The major dependent variable is knowledge and awareness R/S, integration of R/S, and level of support from employer for use of R/S in practice.

Analyses

For describing the population univariate analysis such as frequency, percentage, mean, mode, and median will be used. Bivariate analysis (correlation and t-test) will be used to assess the association

between the independent and dependent variable and the relationship among independent variables. Prior to doing t-test to see differences between scores on extent of knowledge and level of application on use of R/S in hospice care by demographics (age, gender, race/ethnic identity, years of job experience, type of occupation and whether subjects received training in use of R/S, overall scores on the three subscales will be calculated to create a continuous measure. If an adequate number of samples is obtained, a reliability test will be computed on the three sub-scales and reported in the findings.

Univariate analysis was performed on all the independent variables (frequency, percentage, mean, and standard deviation). Reliability test was performed on the scales and subscales prior to doing the bivariate analysis. Bivariate analysis was undertaken to assess the relationship between the independent variables and the three dependent variables, training in R/S, influence on R/S integration, and how R/S is integrated in practice, using crosstabulations and correlation statistics. SPSS statistical software was used to conduct the analysis.

Results and Findings

Univariate

The results of the demographics shows that a majority of the participants of the survey were white (95.3%), female (86%), and Christians (86%) and a small percentage of them belonged to other religious groups. Interestingly, the participants tended to be over the age of 50 (44.2). A majority of the survey participants had an associate or bachelor's degree (54%), followed by master's degree (35%). More than three-fourths of the participant stated they had professional licensure (76.7%), and a majority of them were healthcare professionals, which requires holding licensure. A large percentage of participants have been in the workforce for over fifteen years (48.8%) and over one third of the participants had five to fifteen years of work experience (34%). Half of the participants had sixteen years of work experience (mean = 16.34, SD = 9.87, range = 2 years - 45 years). With respect to having

experience in hospice care services, more than half of the participants had 7.5 years of experience (mean = 9.84, SD = 10.0, range = 1year – 53 years). Overall, these participants had extensive work experience and in hospice care (see Table 1).

Table 1 Demographics

Characteristics of the Sample (I.Vs.)		
Characteristics	**N**	**%**
Race		
White	41	95.3
Hispanic/Latino	2	4.7
Gender		
Female	37	86.0
Male	6	14.0
Age in Years		
≥26 to < 40	10	23.3
≥40 to < 50	14	32.5
≥ 50	19	44.2
Education Level		
HS/Some College	5	11.6
Associate/Bachelor's	23	53.5
Master's	15	34.9
Additional Licensure		
Yes	33	76.7
No	10	23.3
Professional Background		
Nurse/Nurse Practitioner	28	65.1
Social Worker	9	20.9
Other	6	14.0
Years Experience Professional Practice		
≤ 5	7	17.1
> 5 to ≤ 15	20	34.1
> 15	14	48.8
Years Experience Hospice Care		
≤ 5	15	34.9
> 5 to ≤ 15	20	46.5
> 15	8	18.6
Religious Affiliation		
Christian	37	86.0
Spiritual	1	2.3
Paganism	2	4.7
Non-religious	3	7.0

Characteristics of the Sample (I.Vs.)		
Characteristics	**N**	**%**
Religious Attendance		
Never	8	18.6
Yearly	19	44.2
Weekly	16	37.2
Consider Oneself Religious		
Not Religious	6	14.0
Somewhat Religious	12	27.9
Religious/Very religious	25	58.1

When the participants were asked whether they considered themselves religious more than half of them considered themselves religious or very religious (58%) and almost thirty percent identified as somewhat religious (28%). However, the response to how often they attend organized religious service there was not much difference between those that attend weekly services (37%) versus. those that attend yearly(44%).

Bivariate

Before conducting the bivariate analysis between the independent variables and dependent variables a correlation among the three subscales was conducted. The results show the use of training was correlated with the extent to which the participants integrate the use of R/S in their practice ($r = .34$, $p = .03$). The findings also shows that those whose stated having higher levels of knowledge had a moderately high correlation with the level of confidence they have in integrating R/S in practice ($r = .61$, $p < .001$). The results further show the greater the confidence in integration of R/S in practice the more likely the participants are to refer patients to needed R/S resources. The greater the confidence in integration of R/S in practice the more likely participants tend to refer patient to resources ($r = .55$, $p > .01$) (See Appendix E).

An analysis was conducted to assess the relationship between select independent variables (one considers themselves religious or not, frequency of attendance in R/S services, years of experience in

hospice care, and overall length of time in professional practice) the three major dependent variables. Some of the independent variables were excluded from the analysis because these did not have any variability in their values. Majority of the participants were white (95.3%), female (86%), Christians, (86%), and nurses (65.1%). Most of the independent variables were nominal level variables and the dependent variables were ordinal level. Therefore, a bivariate analysis was limited to doing correlation and chi square.

Findings from the bivariate analysis show that only three independent variables were significantly correlation with the three dependent variables in the study, namely:

1. Use of training was positively correlated with referring patients to other R/S resources ($r = .33$, $p > .05$). If one has more training in R/S they are more likely to use their training to link patients to resources, conduct a R/S assessment, help the patient to consider the R/S meaning and purpose of their life situation from the patient's R/S perspective, assist patient in evaluating how their current R/S support system could help them, engage patient in deciding if their R/S beliefs should be integrated into their care plan, and to seek consultation on how best to address the patient's R/S issues in the patient's care.
2. Frequency of attendance in R/S services is negatively correlated with having confidence in integrating R/S in their work. In other words, data suggests that one's attendance at R/S services may not be a critical factor in their confidence in the of use of R/S in practice. There is a strong negative correlation between level of attendance and having confidence in use of R/S in in their practice ($r = -.34$, $p > .05$).
3. Years of experience in hospice care had a moderate correlation with the use of training in practice. The higher number of years of experience in hospice care leads one to be more likely to use their training in R/S when providing care to patients ($r = .34$, $p > .05$).
4. There was no relationship between years of experience in professional practice and the three dependent variables $r= .21$, $r = .28$, $r = .01$).
5. Whether one considered themselves religious was also not correlated to any of dependent variables ($r = -.16$, $r = .06$, and $r = -.04$).

There was no correlation between the participant considering oneself religious and the three dependent variables.

Crosstab Analysis

To further assess some of the independent variables of interest that did not show any significance in influencing the dependent variable several crosstabs were conducted to understand the association between specific independent variables and the dependent variables. Given that the number of respondents was low, more than 15% of the cells had less than 5 responses. Therefore, a decision was made to do crosstabs rather than chi squares. The following tables present the results of the analysis (Table 2 – Table 11).

Table 2: Professional Background by Gather R/S History from Patients

The results show that most of the social workers (89%) and nurses (64%) gather a R/S history from their patients. Regardless of the professional background participants those that work in hospice care tend to be conscious of gathering R/S history from their patients. See Table 2 below.

Table 2: Professional Background by Gather R/S History from Patients

Professional Background		Gather R/S History		
		SA/A	SD/D	Total
Nurse	Count	18	10	28
	%	64.3	35.7	100
Social Worker	Count	8	1	9
	%	88.9	11.1	100
Other	Count	3	3	6
	%	50.0	50.0	100
Total	Count	29	14	43
	%	67.4	32.6	100

Table 3 Education Level by Recognize Patient's R/S Struggle

Those with a higher level of education (Associate/bachelor's 87%, Master's 93%) strongly agree/agree that they recognize patient's R/S struggle. Interestingly, even those with lower education like high school and some college stated that they were able to recognize patient's struggle with R/S (60%) See Table 3, below).

Table 3: Education Level by Recognize Patient's R/S Struggle				
Education Level	Recognize Patient's R/S Struggle			
		SA/A	SD/D	Total
Master's	Count	14	1	15
	%	93.3	6.7	100.0
Associate/Bachelor's	Count	20	3	23
	%	87.0	13.0	100.0
HS/Some College	Count	3	2	5
	%	60.0	40.0	100.0
Total	Count	37	6	43
	%	86.0	6.7	100.0

Table 4 Education Level by Gather R/S History from Patients

Educational level did not matter much whether the participants gathered data on R/S of the patients. Results show that people with higher education strongly agree/agree to collecting R/S data from the patients (master's degree, 73%, associates, bachelor's 70%) gather a R/S history from their patients. While those with a high school/some college (29%) strongly agree/agree that they gather a religious and spiritual history from their patients. See Table 4.

Table 4: Education Level by Gather R/S History from Patients				
Education Level	Gather R/S			
		SA/A	SD/D	Total
Master's	Count	11	4	15
	%	73.3	26.7	100.0
Associate/Bachelor's	Count	16	7	23
	%	69.6	30.4	100.0
HS/Some College	Count	2	3	5
	%	40.0	60.0	100.0
Total	Count	29	14	43
	%	67.4	32.6	100.0

Table 5 Years Experience of Professional Practice by Recognize Patient's R/S Struggle

The greater the number of years of experience in professional practice the more likely the participant was to recognize a patient's R/S struggle. Those with 15 years and above (90%) and five to fifteen years of professional practice experience, (86%) are more likely to strongly agree/agree that they recognize patient's struggle with R/S compared to those five years or under. See Table 5 below.

Table 5: Years Experience in Professional Practice by Recognize Patient's R/S Struggle				
Years Experience in Professional Practice		Gather R/S		
		SA/A	SD/D	Total
<=5	Count	5	2	7
	%	71.4	28.6	100.0
5<=15	Count	12	2	14
	%	85.7	14.3	100.0
>15	Count	18	2	20
	%	90.0	10.0	100.0
Total	Count	35	6	41
	%	85.4	14.6	100.0

Table 6 Consider Oneself Religious by recognize Patient's R/S Struggle

Almost all the respondents to some degree consider themselves to be majority of the respondents that considered themselves religious/very religious or somewhat religious (76.7%) and they likely strongly agree/agree that they are able to recognize the patient's R/S struggle. A third of the participants who indicated not being religious also stated that they are unable to recognize a patient's R/S struggle (33%). See Table 6 below.

Table 6: Consider Oneself Religious by Recognize Patient's R/S Struggle				
Consider Oneself Religious		Rec. R/S Struggle		
		SA/A	SD/D	Total
Religious/Very Religious	Count	22	3	25
	%	88.0	12.0	100.0
Somewhat Religious	Count	11	1	12
	%	91.7	8.3	100.0
Not Religious	Count	4	2	6
	%	66.7	33.3	100.0
Total	Count	37	6	43
	%	86.0	14.0	100.0

Table 7 Adequate Training in R/S by Gather R/S History from Patients

In order to better understand the role of training for hospice care workers respondents were asked to indicate whether they have received adequate training in R/S and the extent to which they gather a R/S history from their patient's. While a majority of the participants indicated not having adequate training (53.5%), and of those participants who indicated not having adequate training in R/S close to half of them stated that they strongly agree/ agree (52.2%) that they gather a R/S history from their patients. However, about the same percentage of the participants stated that they do not gather information about R/S history from their patients (47.8%). See Table 7 below.

Table 7: Adequate Training R/S by Gather R/S History from Patients				
Adequate Training R/S		Gather R/S		
		SA/A	SD/D	Total
SA/A	Count	17	3	20
	%	85.0	15.0	100.0
SD/D	Count	12	11	23
	%	52.2	47.8	100.0
Total	Count	29	14	43
	%	67.4	32.6	100.0

Table 8 Years Experience in Hospice Care by Gather R/S History from Patients

Table 8 shows that about the same percentage of those with less than five years' of experience in hospice care stated either gathering (57.1%) or not gathering (42.9%) a R/S data from the patients. There

is discrepancy in agreeing (70%) or disagreeing (30%) whether they gather a R/S history from their patients. In the group with over 15 years' of experience in hospice care a good percentage of them do not gather a R/S history from their patients (35.7%). See Table 8 below.

Table 8: Years Experience in Hospice Care by Gather R/S History

Years Experience Hospice Care		Gather R/S		
		SA/A	SD/D	Total
<=5	Count	4	3	7
	%	57.1	42.9	100.0
>5<=15	Count	14	6	20
	%	70	30	100.0
>15	Count	9	5	14
	%	64.3	35.7	100.0
Total	Count	27	14	41
	%	65.9	34.1	100.0

Table 9 Adequate Training in R/S by Confidence Integrating Patient's R/S Beliefs

Table 9 shows a good percentage of the participants did not state that either receiving training or not receiving training in R/S (39.5%). Of these respondents a majority of them agree that they have confidence in integrating R/S in practice (64.7%). Similarly, participants who strongly agree/agree that they have been adequately trained strongly agree/agree that they are confident to integrate a patients' R/S in practice (75%). Of those who have stated that they did not receive adequate training in R/S, half of the participants stated that they have confidence to integrate R/S and the other half stated not having confidence. See Table 9 below.

Table 9: Adequate Training in R/S by Confidence Integrating Patient's R/S Beliefs				
Adequate Training in R/S	Confidence Integrating R/S			
		SA/A	SD/D	Total
SA/A	Count	15	5	20
	%	75.0	25.0	100.0
Neutral	Count	11	6	17
	%	64.7	35.3	100.0
SD/D	Count	3	3	6
	%	50.0	50.0	100.0
Total	Count	29	14	43
	%	67.4	32.6	100.0

Table 10 Consider Oneself Religious by Gather R/S History from Patient

Table 10 shows that only a small percentage of them do not consider themselves religious (14%). Of those who consider themselves to be very religious or somewhat religious (86%) and of these participants a third of them indicated that they do not gather a R/S history from their patients (32.4%) and (67.6%) do gather a R/S data from their patients. Interestingly, whether one considers themselves to be religious/very religious, somewhat religious, or not religious the respondents that strongly agree/agree (67.4%) that they gather a R/S history.

Table 10: Consider Oneself Religious by Gather R/S History from Patients				
Consider Oneself Religious	Gather R/S			
		SA/A	SD/D	Total
Religious/ Very Religious	Count	17	8	25
	%	68.0	32.0	100.0
Somewhat Religious	Count	8	4	12
	%	66.7	33.3	100.0
Not Religious	Count	4	2	6
	%	66.7	33.3	100.0
Total	Count	29	14	43
	%	67.4	32.6	100.0

Table 11 Years Experience in Professional Practice by Gather R/S History from Patients

Table 11, below, indicates a moderate relationship between years of experience in professional practice and having ability to gather R/S history from their patients. However, regardless of number of

years of experience more than a third of the participants do not gather R/S history with exception to those that have fifteen plus years of experience. Of the participants with greater than 15 years of experience in practice the majority of them strongly agree/agree that they gather a R/S history from the patients (70%). The participants between five years to fifteen years of experience in professional practice strongly agree/agree that they gather a R/S history from the patients (64%). The participants with less than five years of experience in professional practice strongly agree/agree that they gather a R/S history from the patients (57%).

Table 11: Years Experience in Professional Practice by Gather R/S History from Patients

Years Experience Professional Practice		Gather R/S History		
		SA/A	SD/D	Total
<=5	Count	4	3	7
	%	57.1	42.9	100.0
>5<=15	Count	9	5	14
	%	64.3	35.7	100.0
>15	Count	14	6	20
	%	70.0	30.0	100.0
Total	Count	27	14	41
	%	65.9	34.1	100.0

Conclusions and Suggestions

This study notes that those who have a higher level of knowledge in R/S are more likely to integrate R/S in patient care. Inversely, a study by Abbas, et al.,(2011), found that lack of training was a barrier to the implementation of R/S in patient care. Addressing how professionals in the healthcare field (which includes social workers) are trained in R/S is in need of attention as those who are trained in R/S are more likely to integrate R/S in practice, and R/S are a component of quality palliative care. Therefore, assuring that healthcare professionals receive R/S training is warranted. The respondents highlighted the need for education in R/S when asked, “Do you have any suggestions on how to integrate religion and/or spirituality in hospice care, and to improve care for patients overall?” Participants in this study stated, “Knowledge is empowering- perhaps education on how to ingrate

spirituality into our daily practice would give caregivers the confidence to do so", "Education of caregivers and patients about spirituality at the end of life and how it can relate to anxiety and pain management". "Education for all new staff on these topics and more Hospice Chaplains being able to provide education and experience to new staff ". Findings of this research show that a majority of the participants did not strongly agree/agree that they were adequately trained to integrate R/S in patient care (<50%). Given the importance of addressing a patient's R/S in palliative care and that more training appears to be needed in R/S, especially for those that are new to hospice care. It is recommended that additional training in R/S be implemented for all newcomer's to palliative care. Another recommendation is that apart from gathering R/S data at intake, the agency should also monitor the extent to which this information is collected and is integrated into the patient's care. The R/S assessment provides valuable information about the patient's R/S beliefs which helps the hospice worker in understanding how to best integrate the patient's R/S into their care. Implementing the training of hospice care workers so that they may more fully assist the patient by incorporating the patient's R/S into their care is congruent with Ferrell, et al., (2020) that asserted there is a need for the palliative community to reinvest in addressing the R/S needs of the patient. Furthermore, continued research on a larger scale is suggested, related to the training of hospice care professionals in R/S and factors influencing the integration of R/S in patient care.

Limitations

Limitations of this research are self-selection bias, the respondents self-selected. Therefore, only people who are committed or interested in this research completed the survey; others were less likely to complete the survey. Also, no incentive was given for participation; This convenience sampling led to an over representation nurse and less representation of social workers and others within the population. Additionally, the use of religion and spirituality in hospice patient care was self-reported, participant bias may skew the results. Another potential limitation is that the respondents may not be reflective of the larger population of hospice workers. Generalizability is limited to the population who work at this particular hospice care. The experience of professionals will differ based on whether it is a non-denominational or religious based program. This study employed a cross-sectional design and findings are limited to the experiences of the participants at the time when the data was collected.

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Appendix A

Communication with Agency to Solicit Participation

Eileen Lawson
[redacted]

November 13, 2022

[redacted]

[redacted],

Dr. Shantha Balaswamy and I, an honors student at The Ohio State University, are conducting a survey to explore the extent to which hospice workers and volunteers integrate religion and spirituality into practice and what factors impact the integration of religion and spirituality.

We would like to invite your agency, [redacted], to participate in this survey. The survey is voluntary and confidential. We will not collect personally identifiable information. If your agency agrees to participate, we will send you an email that will include an embedded link to the online survey. We ask that you then make the survey available to your staff and volunteers who work in hospice care. Can we count on your agency to help distribute the online link to our survey?

I will follow up with you soon to confirm your organization's willingness to participate and to verify the email address where I can send the online survey link. Once we have compiled the responses from the completed surveys, we would be glad to share the results with you. If you have any questions, please reach out to either me or Dr. Balaswamy via email or phone.

Respectfully,

Eileen Lawson
OSU Bachelor of Science Social Work Student
[redacted]
THE OHIO STATE UNIVERSITY
Shantha Balaswamy, MSW, PhD
Associate Professor
Pronouns: she, her, hers
College of Social Work
[redacted]

Appendix B

Direct Solicitation to Survey Participants

Dear [redacted] Staff and Volunteers,

I would like to introduce myself. I am an honor student at Ohio State University majoring in social work. I am interning with [redacted] as part of my education. In addition to my internship, I am conducting a survey to explore the degree to which hospice workers and volunteers integrate religion and spirituality into their daily practice. Currently, we have limited knowledge in this practice area and the findings from this survey will help further inform practice in the field of Hospice care. The information from the completed surveys will add to our knowledge base about religion and spirituality in Hospice care in general.

Your participation in this survey will also help me to gather information to write my thesis as a social work honors student. I understand that your time is valuable. I hope that you will take a few minutes to help me out with this project.

> Participation is voluntary and confidential. No personally identifiable information will be gathered. The information you provide is confidential as only aggregate information from the survey will be reported. Identification numbers will be used to track and analyze data gathered. Your participation in this survey is greatly appreciated. This survey will take approximately 15 to 20 minutes to complete. If you are interested in participating in the survey, please click the link below.
>
> By clicking on the link, you are consenting to participate in this confidential voluntary survey. (Survey link will go here)

Please contact me at [redacted] if you have any questions regarding this survey.

Respectfully,

Eileen Lawson
OSU Bachelor of Science Social Work Student
[redacted]
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Appendix C

Consent to Participate in Research

The Ohio State University Consent to Participate in Research
Study Title: Factors Influencing Hospice Workers Use of Religion and Spirituality in Patient Care
Protocol Number: 2022E1202
Researcher: Shantha Balaswamy, MSW PhD, Eileen Lawson
Sponsor: None
This is a consent form for agreeing to participate in this research. It contains information about this study and what to expect if you decide to participate. Your participation is voluntary.

Purpose:
The information gathered through this survey will be used to better understand the degree to which religion and spirituality (R/S) are used in Hospice care and what influences the use of R/S. Research in this area is limited. The information from the completed surveys will add to our knowledge base about R/S in Hospice care. This knowledge base can be used to advance evidence-based practice in the field of Hospice care.

The risks are no greater than one would encounter in daily life. There may be no direct benefit to you, however the knowledge gained from this research may be used to advance evidence-based practice in the field of Hospice care.

Procedures/Tasks: You will click on link to open the survey. This survey will take approximately 15 to 20 minutes to complete. See survey link below.

You may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you.

This study has been determined to be Exempt by the Internal Review Board, OSU.

Contacts and Questions:
For questions, concerns, or complaints about the study, or you feel you have been harmed as a result of study participation, you may contact Shantha Balaswamy at [redacted] or Eileen Lawson at [redacted]
To discuss other study-related concerns or complaints with someone who is not part of our research team, you may contact the Office of Responsible Research Practices at [redacted] or [redacted].

I have read the above content and I voluntarily agree to participate in this study.

Please click the button below (Next) to proceed and participate in this study. If you do not wish to participate, please close out your browser window.

Appendix D

Online Survey

Influencing Hospice Workers Use Of Religion And Spirituality In Patient Care

[Click on this link to start the survey ……..]

[The following information will appear on the online survey:]

There at 2 Sections to this survey: Section I has short questions on background information, and Section II assesses your practice application of Religion and or Spirituality with patients in hospice care. There are no right or wrong answers, interest is in learning more about use of R/S by professionals and volunteers in hospice care.

Directions: select the one answer that best describes you or fill in the blank line to best answer the question.

Section I. Demographics: select the answer that best describes you or fill in the blank line to best answer the question.

Question Number	Question ID	Question	Values
1.	DEM 1	How do you identify yourself (please check)	1. American Indian. 2. Alaskan Native, 3. Asian, 4. Black or African American, 5. Native Hawaiian or other Pacific Islander, 6. White, 7. Other
2.	DEM 2	How old were you as of your last birthday?	List actual age
3.	DEM 3	What sex are you?	Male, Female, Self-Identify
4.	DEM 4	What is your professional background?	Social worker, Nurse Practitioner, Nurse, Health Aid, Chaplain/Rabbi/Priest, Other:_____
5.	DEM 5	What is your highest level of education?	

Question Number	Question ID	Question	Values
6.	DEM 6	How long have you practiced in your profession?	Years___Months____
7.	DEM 7	How long have you worked in a Hospice care setting?	Years___Months____
8.	DEM 8	What is your religious affiliation?	Christian, Jewish, Buddhist, Hinduism, Other_____
9.	DEM 9	How often do you attend religious services?	*1, 2, 3, 4, 5
10	DEM 10	To what extent do you consider yourself a religious person?	**1, 2, 3, 4, 5

- 1 = Never, 2 = Once or twice a year, 3 = Several times per year, 4 = Once a week, 5 = More than once a week.

** 1 = Not at all religious, 2 = Somewhat religious, 3 = Neither religious or nonreligious, 4 = Religious, 5 = Very Religious.

Section II: This section has 3 parts: 1) questions about your personal experiences with R/S, 2) questions of how you integrate R/S in your work with clients, and 3) questions about training you received and time constraints.

a) The following are statements about how you integrate R/S in your practice. Please state whether you agree or disagree with the statements regarding religious/spiritually integrated practice by selecting the most appropriate response based on your personal experience.

Question Number	Question ID	Question	Values
11	SE 1.	I gather a history from my clients about their religious/spiritual beliefs and practices.	*1,2,3,4,5
12.	SE 2.	I am able to recognize when my clients ae experiencing religious/spiritual struggles. (e.g., religious/spiritual tension or conflict with his/her Higher Power, religious/spiritual community, spiritual beliefs, etc.)	*1,2,3,4,5
13.	SE 3.	I consider the unique needs of diverse clients with different religious/spiritual backgrounds in my practice.	*1,2,3,4,5
14.	SE 4.	I am able to recognize when my clients utilize positive religious/spiritual coping strategies. (e.g.	*1,2,3,4,5

Question Number	Question ID	Question	Values
		trying to find a spiritual lesson in the presenting issue, etc.)	
15.	SE 5.	I am able to ensure my clients have access to religious/spiritual resources if they see this as an important aspect to their healing process. (e.g. religious/spiritual reading materials, pastoral counseling, contact information to local clergy, or a prayer room/place of worship).	*1,2,3,4,5
16.	SE 6.	I have the skills to discuss my clients' religious/spiritual strengths.	*1,2,3,4,5
17.	SE 17.	I feel confident in my ability to integrate my clients' religious/spiritual beliefs into their treatment.	*1,2,3,4,5
18.	SE 8.	I know when it is beneficial to refer my client to pastoral or religious counseling.	*1,2,3,4,5
19.	SE 9.	I feel as though I have the skills to discuss my clients' religious/spiritual struggles.	*1,2,3,4,5
20.	SE.10.	I am able to recognize when my clients utilize negative religious/spiritual coping strategies. (e.g. viewing the presenting issue as punishment from his/her Higher Power, etc.)	*1,2,3,4,5
21.	SE 11.	I know what to do when my client has religious/spiritual beliefs that I am unfamiliar with.	*1,2,3,4,5
22.	SE 12.	I am comfortable discussing my clients' religious/spiritual struggles.	*1,2,3,4,5

b) Next, are statements about the extent to which you integrate R/S in your practice. Please indicate the response to the right that best fits how much you agree or disagree with the statements regarding religious/spiritually integrated practice.

Question Number	Question ID	Question	Values
23	FE 1.	I have enough time to assess my clients' religious/spiritual background.	*1,2,3,4,5
24.	FE 2.	I have enough time to identify potential strengths or struggles related to my clients' religion/spirituality.	*1,2,3,4,5
25	FE 3.	My primary practice setting does not support the integration of religion/spirituality into practice.	*1,2,3,4,5

Question Number	Question ID	Question	Values
26.	FE 4.	I don't have enough time to think about incorporating a religious/spiritually integrated approach to practice.	*1,2,3,4,5
27.	FE 5.	Given the many issues that must be addressed in treatment, I still find time to integrate my clients' religion/spirituality if they communicate a preference for this.	*1,2,3,4,5
28.	FE 6.	I have been adequately trained to integrate my clients' religion/spirituality into treatment.	*1,2,3,4,5

c) Following statement assess the use of training in your practice. For this section, please indicate the response that best fits the *frequency* with which you currently engage in religious/spiritually integrated practice.

Question Number	Question ID	Question	Values
29.	RSI 1.	I seek out consultation on how to address clients' religious/spiritual issues in treatment.	**1,2,3,4,5
30.	RSI 2.	I involve clients in deciding whether their religious/spiritual beliefs should be integrated into their treatment.	**1,2,3,4,5
31.	RSI 3.	I conduct a spiritual assessment with each of my clients.	**1,2,3,4,5
32.	RSI 4.	I link clients with religious/spiritual resources when it may potentially help them (e.g., religious/spiritual reading materials, contact information to local clergy, or a prayer room/place of worship).	**1,2,3,4,5
33.	RSI 5.	I help clients consider ways their religious/spiritual support systems may be helpful.	**1,2,3,4,5
34	RSI 6.	I help clients consider the religious/spiritual meaning and purpose of their current life situations.	**1,2,3,4,5

* 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

** 1 = Never, 2 = Rarely, 3 = Some of the time, 4 = Often, 5 = Very Often

Suggestions and Comments:

a) What challenges do you face in implementing religion and/or spirituality in hospice care?

b) Do you have any suggestions on how to improve care in relation to the integration of religion and/or spirituality in hospice care?

Thank you for completing this survey!!!

Appendix E

Select Independent Variables and Dependent Variables Correlations

Table 12

Correlations Between Select Independent Variables and Dependent Variables								
		1	2	3	4	5	6	7
1.Use of Training in R/S	Correlation Coefficient	1.000						
	Sig. (1-tailed)	.						
	N	43						
2.Confidence in integrating R/S	Correlation Coefficient	.212	1.000					
	Sig. (1-tailed)	.092	.					
	N	41	41					
3. Linking Client to R/S Resources	Correlation Coefficient	.326*	.550**	1.000				
	Sig. (1-tailed)	.016	<.001	.				
	N	43	41	43				
4. Years of Experience in Professional Practice	Correlation Coefficient	.132	-.099	.012	1.000			
	Sig. (1-tailed)	.214	.278	.471	.			
	N	38	38	38	38			
5. Years of Experience in Hospice care	Correlation Coefficient	.336*	.239	.121	.107	1.000		
	Sig. (1-tailed)	.014	.066	.221	.261	.		
	N	43	41	43	38	44		
6. Frequency of Attendance R/S Services	Correlation Coefficient	.054	-.344*	.052	.301	.024	1.000	
	Sig. (1-tailed)	.380	.027	.385	.053	.446	.	
	N	34	32	34	30	34	34	
7. Consider Oneself Religious/ Spiritual	Correlation Coefficient	-.092	.109	-.140	.014	.073	-.205	1.000
	Sig. (1-tailed)	.293	.266	.205	.469	.333	.127	.
	N	37	35	37	33	37	33	37
* Correlation is significant at the 0.05 level (1-tailed).								
** Correlation is significant at the 0.01 level (1-tailed).								