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Walden University

College of Health Sciences

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Lesa Miller

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Review Committee
Dr. Amelia Nichols, Committee Chairperson, Health Services Faculty
Dr. Amy Wilson, Committee Member, Health Services Faculty
Dr. Sue Bell, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2015

Abstract

Health Care Clinicians' Compliance with Conducting Spiritual Assessments and Providing Spiritual Care to Infertile Women

by

Lesa Miller

MSN, American Sentinel University, 2012

MS, University of Maryland, Baltimore, 2005

BSN, Howard University, 2003

BA, Baruch College, 1997

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

December 2015

Abstract

Infertility is a disease that can cause psychological impairments in women, and the inability to achieve motherhood brings about cultural and social stigma. Spirituality is a protective element that may provide consolation to women experiencing infertility, yet the literature has shown that few clinicians conduct spirituality assessments or provide spiritual care to patients. The objectives of this scholarly project were to conduct an assessment to determine the needs of health care clinicians in regard to spirituality and spiritual patient care and to develop an educational module based on identified knowledge deficits. Guided by the knowledge-to-action cycle, a needs assessment was conducted in a small fertility clinic with 2 clinicians. The results of the assessment showed that the clinicians had not conducted spirituality assessments on their infertile patients and only sometimes provided spiritual care. An educational module and a posttest were developed and then validated by 3 doctorally-prepared nursing faculty members using a self-developed 10-question Likert-type evaluation scale. The materials were found to be clear, accurate, and easy to read by the nursing faculty. An implication of this scholarly project is that it will give clinicians the resources needed to create social change in health care by addressing the spirituality needs of women experiencing infertility. Future research includes a pilot study to implement the educational module with clinicians at the fertility clinic and to evaluate its effectiveness for enhancing spiritual care in practice.

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Dedication

First and foremost I want to thank God. His grace and mercy is sufficient for all. I would like to dedicate this degree to my children for keeping me on my toes during this venture. I want them to know that education is the key to the future.

Acknowledgments

I would like to thank my family, particularly my mom for stressing the need to be educated. I am extremely grateful to Dr. Nichols, Dr. Wilson, and Dr. Bell as my doctoral committee members. Their support and guidance helped me to accomplish my educational goal. I would also like to send a special thank you to Dr. Convey and Dr. Broadnax for their added support with my scholarly project. Lastly, I want to say thank you to Dr. Endicott, the chair of the IRB committee, for taking time out of her busy schedule to email me on an exemplar IRB application.

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Section 1: Overview of the Evidence-Based Project

Introduction

Infertility is defined as the "inability to conceive or carry a pregnancy to term after 12 months of trying to conceive. If you are over the age 35, the time of trying to conceive is reduced to 6 months" (RESOLVE, 2015a, para. 3). To be labeled "barren" is a cultural and social stigma that connotes shame on women similar to wearing a "scarlet letter." When the dream of obtaining natural motherhood is not reached, this adversity can have psychological effects on the woman (Cousineau & Domar, 2007; Kendall, 2008; Klock, 2011; Perkins, 2006). Due to the realization that motherhood is important in many cultures around the world, assessing spirituality and providing spiritual care to women who are experiencing infertility may enhance health outcomes. Spirituality is a protective factor that helps women to find meaning and purpose in life (Roudsari, Allan, & Smith, 2007). A component of spirituality that helps women experiencing infertility is connecting with one's self and finding inner peace.

The National Survey of Family Growth (NSFG) collects national measures for fertility problems in the United States (Chandra, Copen, & Stephen, 2013). Thus far, seven cycles of the NSFG have been conducted between 1973 and 2010. The NSFG (2002) reported that the number of married women who were infertile was 2.1 million (Chandra, Martinez, Mosher, Abma, & Jones, 2005). Their most recent data showed that 1.5 million women from 2006 to 2010 were experiencing infertility (Chandra et al., 2013). It was documented in 2002 that 11.5 percent of African American married women suffered from infertility, and 7.2 percent in 2006 to 2010 compared to their Caucasian counterparts 7.0 percent and 5.5 percent respectively (Chandra et al., 2005; Chandra et al., 2013). The NSFG (2013) also reported that 41% of the married

women with infertility had primary infertility in 2002, and 46% in 2006 to 2010 (Chandra et al., 2005; Chandra et al., 2013).

Primary infertility exists when a woman has never been able to get pregnant after a year of unprotected intercourse; whereas, in secondary infertility the woman has been pregnant at least once, but is having trouble conceiving again (World Health Organization, 2015). Goldstein (2011) estimated that approximately 30% of infertility cases are secondary in nature. According to RESOLVE, the National Infertility Association (2015b) 30% of infertility can be attributed to female factors.

Many women growing up in American society are taught that obtaining natural motherhood is a rite of passage into womanhood (Davis-Floyd, 2003). No one can predict whether obtaining motherhood will be a struggle or even unachievable. Many in American society have long emphasized that there is an expectation that all women will want to become mothers (Marsh & Ronner, 1996; Woollett, 1991). Womanhood has been synonymous to motherhood in American society and continues to be an identifying characteristic of the female. In non-Western societies, specific rites of passage are conducted often by the entire community to commemorate life changing events with "birth" being one of them (Davis-Floyd, 2003). According to Marsh and Ronner (1996):

> It is true that throughout American history there has been, to a greater or lesser degree, a cultural expectation that all women will want to become mothers. Those who express no maternal feelings might easily find themselves accused of unwomanliness. And if a woman marries, she is *expected* to reproduce. This "motherhood mandate" can – and has – stigmatized those whose unions are involuntarily childless as well as those who choose not to have children. (p. 5)

From a societal point of view, motherhood confirms a passage into adulthood for women. Woollett (1991) postulated that motherhood is also symbolically important in American society because it confirms a woman's female identity and sense of self. C. Toll, an infertility social worker stated that "I don't think people like their dreams derailed and that's what happens with infertility" (personal communication, April, 22, 2009). This statement confirms the need for health care clinicians to incorporate spirituality into the care of women with infertility to serve as a protective factor for this derailed dream.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the World Health Organization (WHO), the American Holistic Nursing Association (AHNA), the International Council of Nurses (ICN), and the American Nurses Association (ANA) support the use of spirituality as an integral part in the health and wellness of patients (AHNA, 2007; ANA, 2001; ICN, 2012; JCAHO, 2005; WHO, 1998). In fact, JCAHO (2005) requires health care organizations to conduct a spiritual assessment on a patient to ascertain the patient's religious association, as well as any beliefs or spiritual practices that are significant to the patient (p. 6). This mandate helps to ensure that health care clinicians are providing holistic care as an embodiment of spiritual wellness.

In addition, the National Organization of Nurse Practitioner Faculties (NONPF) included spirituality in its core competencies for nurse practitioner practice. Under the "Independent Practice Competencies" it specifies that the nurse practitioner "incorporates the patient's cultural and spiritual preferences, values, and beliefs into health care" (NONPF, 2012, p. 5). The Association of American Medical Colleges (AAMC) also recognizes in its publication, *Report III – Contemporary Issues in Medicine: Communication in Medicine, Medical School Objectives Project*, that physicians will need to understand how a patient's spirituality and culture

influences their discernment of health and illness, and especially with end of life care (AAMC, 1999). The duty bestowed on health care clinicians to assess for spirituality and provide appropriate spiritual care is an incumbent part of practice and should not be neglected in patient care.

People often turn to spirituality when dealing with crises in their lives. Health care clinicians play an important role in cultivating spirituality in individuals that can help them progress through their health challenges (Carron & Cumbie, 2011; Helming, 2009; Olson, Sandor, Sierpina, Vanderpool, & Dayao, 2006; Saguil & Phelps, 2012; Tanyi, McKenzie, & Chapek, 2009). Clinicians should be able to recognize spiritual distress in their patients which is manifested by a state of suffering associated with life's meaning (Caldeira, Carvalho, & Vieira, 2013). By doing so, a spiritual assessment and spiritual care can be added to the patient's plan of care as a component of their health and well-being. By analyzing and incorporating spirituality as a form of adaptation in evidence-based practice, health care clinicians can significantly promote physiological and psychological wellness (Carron & Cumbie, 2011; Puchalski, 2001). With this said, health care clinicians should use holistic care to support and foster spirituality in women as they face infertility. Effective assessment of spirituality and spiritual care is the premise in which health care clinicians can aid these infertile women in finding balance in their lives.

Problem Statement

Failure to conceive can cause a number of psychosocial issues and feelings of inadequacy in women. Infertility affects women in all racial groups. Spirituality has been documented to console women experiencing infertility (Roudsari, Allan, & Smith, 2007). Health care clinicians play an essential part assessing spirituality and providing spiritual care to patients. The major

barriers identified in the literature to conducting a spiritual assessment and providing spiritual care to patients is the lack of understanding of spirituality, how to conduct a spiritual assessment, and providing spiritual care among health care clinicians (Hubbell, Woodard, Barksdale-Brown, & Parker, 2006; McCauley et al., 2005; Saguil & Phelps, 2012; Tanyi et al., 2009).

The need for a system change by incorporating spirituality into health care is paramount to patients' health outcomes. Health care clinicians who do not support spirituality in their patients would be disregarding a fundamental part of patient care (Brush & Daly, 2000; Tanyi et al., 2009). Most of the time, health care clinicians focus their main attention to the physiological, but the holistic being needs to be cared for in order to maintain equilibrium for the whole person. Health care clinicians need to be educated on the concept of spirituality, how to conduct a spiritual assessment, and how to provide spiritual care to their patients (Carron & Cumbie, 2011, Lawrence & Smith, 2004). This will help clinicians to better identify patients that are suffering from spiritual distress as a result of their health challenges.

Purpose Statement and Project Objectives

The purpose of this scholarly project was to increase health care clinicians' knowledge of the importance of spirituality and improve compliance with conducting spiritual assessments and providing spiritual care to women experiencing infertility. The goal is to create a system change in health care by giving health care clinicians the tools needed to incorporate spirituality into their daily practice. The objectives of this scholarly project were to (a) conduct a needs assessment to assess the needs of health care clinicians in regards to spirituality and patient care, (b) create an educational module for health care clinicians caring for women experiencing infertility to incorporate spiritual assessment and spiritual care into the patient's plan of care, and

(c) to develop a posttest to assess health care clinicians' knowledge of spirituality, spiritual assessment, and providing spiritual care.

Needs Assessment

A review of the literature was a basis for assessing the need for the development of the educational module. Research showed that health care clinicians lack the fundamental understanding of spirituality (Balboni et al., 2014; McCauley et al., 2005). This lack of understanding is apparent in the noncompliance with conducting spiritual assessment and providing spiritual care to patients. In addition to the literature review, I conducted a needs assessment to better understand the use of spirituality among health care clinicians caring for women experiencing infertility. This needs assessment provided me with information to develop a more responsive delivery system (Kettner, Moroney, & Martin, 2013).

Evidence-Based Significance of the Project

Infertility is a disease that is considered a life crisis (Cooper, 2007; Gonzalez, 2000; Klock, 2011; Menning, 1977). As a result of the devastating issues that come with infertility, health care clinicians need to implement a holistic approach when caring for the women suffering from it. Spirituality has been found to be a source of comfort for people facing health care issues (Lopez, McCaffrey, Griffin, & Fitzpatrick, 2009; Meraviglia, 2006). The significance of spirituality as a protective factor requires health care clinicians to make this component a routine part of their patient care.

In a study conducted by Domar, Zuttermeister, and Friedman (1993), it was found that infertility causes psychological imbalances similar to those of heart disease, hypertension, and cancer. Infertility has also been reported as one of the most upsetting experience in the lives of infertile women (Freeman, Boxer, Rickels, Tureck, & Mastroianni, 1985). The impact of these

psychosocial problems associated with infertility is proof that health care clinicians need to tailor their care to protective factors that will yield positive outcomes. Spirituality has been reported in various studies as a source of comfort to women with infertility (Bliss, 1999; Ceballo, 1999; Domar et al., 2005; Frances-Fisher, 2005; Kress, 2005). Even with research supporting this fact, health care clinicians are still not using spirituality as a part of patient care.

A plethora of literature has been published on the barriers of spirituality interventions among health care clinicians (Brush & Daly, 2000; Ellis, Campbell, Detwiler-Breidenbach, & Hubbard, 2002; Ellis, Vinson, & Ewigman, 1999; Hubbell et al., 2006; McCauley et al., 2005; Tanyi et al., 2009; Vermandere et al., 2011). The lack of knowledge of spirituality and all its elements have been documented among the top three reasons for the deficiency of including spirituality into patient care (Brush & Daly, 2000; Helming, 2009; McCauley et al., 2005; Tanyi et al., 2009; Vermandere, 2011). This educational module will provide some of the needed resources for health care clinicians caring for women with infertility.

Implications for Social Change

The incorporation of spirituality in the lives of patients is paramount to health and wellness. By making this dimension of care a part of practice, health care clinicians will be complying with regulating bodies' governance that spirituality should be a part of patient care (AAMC, 1999; AHNA, 2007; ANA, 2001; ICN, 2012; JCAHO, 2005; NONPF, 2012; WHO, 1998). Health care clinicians should be given the necessary education to conduct a spiritual assessment and provide spiritual care. The education of health care clinicians is the needed resource to produce this social change. The lack of including spirituality could result in spiritual distress and the inability to maintain effective mental health in patients. The overall implication for social change is to provide clinicians with the needed tools to increase compliance with

conducting spiritual assessments and providing spiritual care. This will allow health care clinicians to provide spiritual support to women experiencing infertility so that they will be able to find meaning and resolution with their diagnosis.

Definitions of Terms

Health care clinicians: Advanced practice nurses, registered nurses, licensed practical nurses, physicians, and physician assistants who care for women experiencing infertility (Venes, 2013).

Infertility: The "inability to conceive or carry a pregnancy to term after 12 months of trying to conceive. If you are over the age 35, the time of trying to conceive is reduced to 6 months" (RESOLVE, 2015a, para. 3).

Primary infertility: The term used to describe "a woman that is unable to ever bear a child, either due to the inability to become pregnant or the inability to carry a pregnancy to a live birth" (WHO, 2015, para. 5).

Secondary infertility: The term used to describe "a woman that is unable to bear a child, either due to the inability to become pregnant or the inability to carry a pregnancy to a live birth following either a previous pregnancy or a previous ability to carry a pregnancy to a live birth" (WHO, 2015, para. 6).

Spirituality: The term used to describe "the propensity to make meaning through a sense of relatedness to dimensions that transcend the self in such a way that empowers and does not devalue the individual. This relatedness may be experienced intrapersonally (as a connectedness within oneself), interpersonally (in the context of others and the natural environment, and transpersonally (referring to a sense of relatedness to the unseen, God or a power greater than the self and ordinary resources)" (Reed, 1992, p. 350).

Spiritual Assessment: The "process by which health care providers can identify a patient's spiritual needs pertaining to medical care" (Anandarajah & Hight, 2001, p. 84).

Spiritual Care: A type of care that involves "identifying and working with that which gives the person their source of meaning, value and a sense if inner and outward connectedness" (Swinton, 2001, p. 24). Swinton (2001) postulates that "spiritual care in its widest sense pertains to strategies designed to endow meaning, value, hope and purpose to people's lives. Interventions here would include the development of meaningful personal relationships, meditation, enabling access to sources of value and so forth" (p. 38).

Spiritual Distress: The term to describe "a state of suffering related to the impaired ability to experience meaning in life through connectedness with self, others, world, or a Superior Being" (Caldeira, Carvalho, & Vieira, 2013, p. 82).

Assumptions

1. It is assumed that infertility can be a major psychological stressor for women experiencing infertility due to the norms associated with achieving motherhood in the American society.
2. Spirituality is also believed to be an important protective factor in dealing with infertility.
3. It is also assumed that the clinicians will answer the questions in the needs assessment truthfully.
4. The educational module and posttest will increase compliance to conducting spiritual assessments and providing spiritual care in clinical practice.

Limitations

1. A limitation of this scholarly project includes assessing health care clinicians' spiritual practices in a small fertility center.
2. This project was also limited to just developing an educational module and posttest; therefore, no attempt was made implement the educational module and posttest and to assess whether the clinicians implemented the knowledge in their patient care practice.

Summary

The psychosocial impact of infertility on women is a major issue that must be addressed in order to enhance holistic wellness. A means of impacting social change in this area is through education. Health care clinicians need education on spirituality, how to conduct spiritual assessment, and how to provide spiritual care to women experiencing infertility. This scholarly project was guided by a comprehensive review of the literature and the use of a conceptual model. An educational module and posttest was developed and evaluated in order to effect social change within practice. The impact of this social change will be greater knowledge of spirituality among health care clinicians and decreased spiritual distress in women experiencing infertility.

Section 2: Review of Scholarly Evidence

Literature Search

A review of the literature was conducted using OVID, Medline, CINAHL, PubMed, ProQuest Dissertations & Theses, and Web of Science. A combination of key words was used in the search engines. The key words were: *spirituality and infertility, and spirituality and infertility*. A total of 19 articles resulted from this search. Additional search terms used were: *spirituality and clinicians, spirituality and barriers, spiritual assessments and clinicians, spiritual assessments and barriers, spiritual care and clinicians, spiritual care and barriers*. Over 636 articles were found using these terminologies. Sixteen articles were selected for the literature review.

I tried to use literature that was published within the last 10 years; however, there was classic literature that was used due to its relevance. The use of classic literature highlights the historical origins of the subject matter. A combination of quantitative and qualitative literature from peer-reviewed journals was used in this scholarly project. The literature was comprised of articles pertaining to nurses, nurse practitioners, and physicians. The geographic subset of the literature was from the United States and Europe.

Review of the Literature

Spirituality and Infertility

The diagnosis of infertility can be a devastating, life altering experience for women. Spirituality has been found to be a solace to women who are experiencing infertility. Ceballo (1999) published a qualitative research study highlighting the stories of two African American women who spoke about the impact of infertility in their lives. One woman believed that she was “the only black woman walking the face of the earth that cannot have a baby” (Ceballo,

1999, p.12). A source of comfort for these women was the ability to find strength and resolution in their religious beliefs and spirituality. Spirituality as a source of resilience is a dimension of care that health care clinicians cannot afford to neglect. Domar et al. (2005) conducted a quantitative study to investigate the role of religiosity and/or spirituality in the development of psychological well-being in 195 infertile women. The results from their study showed that infertile women with higher levels of spiritual well-being reported fewer symptoms of depression and infertility-related stress. This suggests that spirituality plays an important role in the well-being of women experiencing infertility.

Additional qualitative studies have been conducted and found that spirituality is a phenomenon that gives infertile women the ability to experience meaning, purpose, and growth in life. Frances-Fisher (2005) conducted a phenomenological study to explore the meaning and experiences of spirituality in the lives of seven infertile Caucasian women. The personal meaning these women developed through spirituality allowed them to live life differently and find new purpose for their existence. Kress (2005) conducted a grounded theory study to explore spirituality among eight Caucasian women experiencing infertility. The women in this study experienced significant spiritual growth as a result of their infertility. Bliss (1999) conducted a qualitative study on 10 minority women to examine the experience of infertility among culturally diverse women. According to the researcher, religion/spirituality helped the participants cope with their infertility. Ticinelli (2012) studied 10 African American women in a grounded theory study to explore the psychological impact of infertility on these women. Through the midst of depressed feeling, sadness, and shock of infertility, these women turned to their spirituality for peace and future hope of obtaining motherhood.

In all, the review of the literature was limited in regards to exploring the use of spirituality and women experiencing infertility. This was further confirmed in a systematic review of the literature by Roudsari, Allan, and Smith (2007) that examined religion/spirituality and infertility. They found that there exists a remarkable gap in the literature on infertility and religion/spirituality. These researchers recommended that future studies should focus on religion/spirituality with infertility.

Barriers to Spirituality

Spiritual assessments and spiritual care are a fundamental part of patient care that can aid and embed in holistic care. However, research has shown that a lack of understanding of these elements are barriers to health care clinicians conducting spiritual assessments and providing spiritual care to patients (Balboni et al., 2014; McCauley et al., 2005; Vermandere, et al., 2011). Holistic health care must be provided to patients; therefore, a lack of education in this area is a barrier that needs to be tackled to increase patient health outcomes. McCauley et al. (2005) conducted a quantitative study on 78 managed care providers to measure beliefs and identify perceived barriers of integrating spirituality in patient care. The health care clinicians completed questionnaires and statistical analysis was conducted with *t* tests and ANOVA. The results revealed that 69% of the clinicians indicated that a lack of training was a barrier to integrating spirituality in patient care. McCauley et al. suggested that education in spirituality may help clinicians to overcome this barrier and give them the confidence needed to incorporate spirituality in their care.

Further quantitative research has been conducted to reconfirm the need for educational training in spirituality among clinicians. Hubbell et al. (2006) surveyed 65 nurse practitioners to discover how they integrate spiritual care into their practices. It was found that 73% of the nurse

practitioners rarely engaged in the selected spiritual care practices outlined in the survey. The researchers commented that many of the nurse practitioners communicated a lack of training in spirituality and contended that education may enhance spiritual care among nurse practitioners. In a quantitative study by Ellis, Vinson, and Ewigman (1999), 170 family physicians completed questionnaires to measure spiritual well-being, attitudes toward spirituality in health care, barriers to addressing patients' spiritual issues, and frequency of spiritual discussions. The physicians reported a lack of training in taking a spiritual history as the second frequent barrier to spiritual discussions. Ellis et al. (1999) note that future research should focus on methods to train physicians to address patients' spiritual issues.

Tanyi et al. (2009) conducted a qualitative study to investigate how family practice clinicians incorporate spirituality into patient care despite of their perceived barriers. The participants consisted of three medical doctors, five nurse practitioners and two physician assistants. All of the participants reported perceived barriers to spiritual care, one being uncomfortable with discussing spirituality due to the lack of formal training on the subject; however, the participants managed to provide some level of spiritual care in spite of the perceived barriers. Tanyi et al. support the need to educate clinicians on spirituality as a means to managing barriers to spiritual care.

Moreover, recent research conducted in larger samples revealed that clinicians continue to present with a lack of knowledge of spirituality which prevents them from using spirituality in practice. In a study by Berg et al. (2013), 334 physician assistants completed surveys to assess the attitudes and beliefs about spirituality and religiosity in their patient care. In support of the previous studies, these clinicians also mentioned that insufficient knowledge or training was also a barrier to integrating spirituality and religiosity in their patient encounters. A majority of the

physician assistants that participated in this study agreed that spirituality and religiosity should be a component added to their educational training (Berg et al., 2013). Balboni et al. (2014) performed a quantitative study on 339 nurses and physicians to assess their desire to provide spiritual care to terminally ill patients and potential barriers to spiritual care. The results showed that a lack of training was the only barrier identified by the majority of nurses and physicians associated with infrequent spiritual care to patients. The researchers contend that education in spiritual care holds promise in increasing the practice of spiritual care to enhance wellness in patients (Balboni et al., 2014).

A common reoccurring theme in the literature indicated that a lack of education on spirituality is a major barrier to adding this component to the patient's plan of care. Ellis, Campbell, Detwiler-Breidenbach, and Hubbard (2002) conducted a qualitative study on 13 family physicians to assess the means in which they addressed patients' spiritual issues and to explore barriers and facilitators to spiritual discussions. The physicians reported that one of several barriers to discussing spirituality with their patients due to the lack of comfort or training. Ellis et al. (2002) suggest that when training medical students and residents on spiritual assessments that perceived barriers, the physician's role, familiarity with situations that actuate questions on spirituality, and principles that guide the spiritual discussions should all be taken into context. Vermandere et al. (2011) conducted a qualitative evidence synthesis to investigate the views of general practitioners on their role of spiritual care along with the barriers and facilitators of this care. A reoccurring contextual barrier that was discovered by the authors was the lack of formal training perceived by the general practitioners. One of the implications for future research is to assess educational programs on spirituality for clinicians as well as postgraduate studies.

Conceptual Framework

The successful implementation of a project requires the use of a model that can help guide the progress from its assessment to evaluation stage. The knowledge-to-action (KTA) cycle (Figure 1) integrates knowledge translation through the process of knowledge creation and knowledge application (Graham et al., 2006). There is a need to close the gap between research dissemination and evidence-based practice which calls for the use of models such as the KTA model to enhance patient outcomes. The KTA model is a vivid conceptualization of the translation process equivalent to a funnel where knowledge moves through the cycle until it is endorsed and implemented (White & Dudley-Brown, 2012). This scholarly project was guided by the conceptual framework of the KTA model as a means of increasing spiritual assessments and care in practice among health care clinicians.

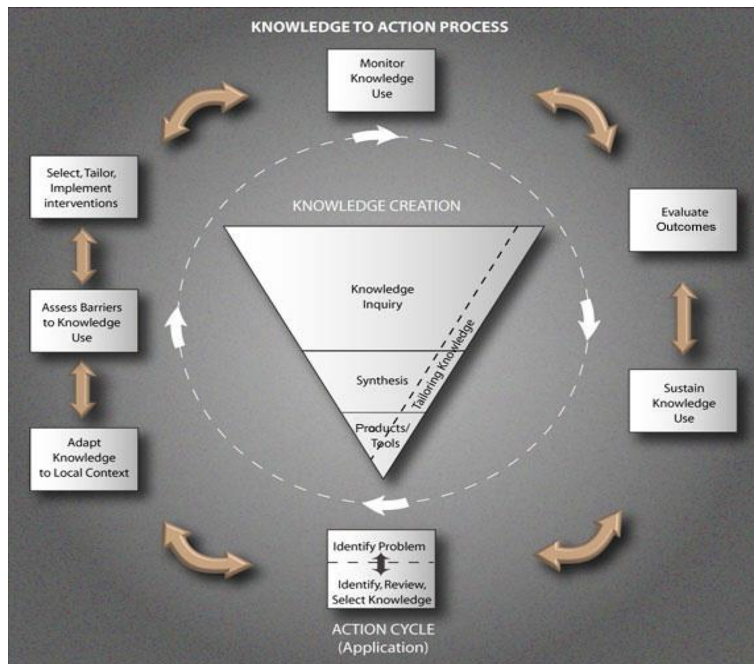

Figure 1. The Knowledge-to-Action (KTA) Cycle. From Graham, I., Logan, J., Harrison, M., Straus, S., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: Time

for a map? *Journal of Continuing Education in the Health Professions, 26*(1), 13-24. Adapted from the Canadian Institutes of Health Research (2015). Reprinted with permission.

The KTA model is divided into two main concepts: knowledge creation and action cycle (Graham et al., 2006). The knowledge creation concept consists of three phases of knowledge: knowledge inquiry, knowledge synthesis, and knowledge tools/products. The knowledge inquiry phase represents a host of primary sources in its natural state. The next phase, knowledge synthesis exemplifies the process of identifying, appraising, and synthesizing studies applicable to specific questions. The last phase, knowledge tools/products represents knowledge in a translucent, brief, and easy to use format with the intent of influencing stakeholders' actions and informational needs. The action cycle is the process that leads to the implementation of the knowledge. According to Graham et al. (2006) establishing knowledge to action is a complex and challenging process involving a dynamic exchange of knowledge between stakeholders that result in action.

The KTA model provides guidance for health care clinicians to integrate evidence-based practice into patient care through spiritual assessment and spiritual care. According to Terry (2015), stakeholder involvement is vital to practice change and should be elicited to increase program success. The use of this model allows for barriers to be assessed and interventions to be implemented to improve clinical compliance. In this scholarly project, the KTA model served as a systemic approach to understanding if an educational intervention on spirituality as a solution to the major barrier of providing spiritual assessment and spiritual care to patients would result in better patient outcomes.

Summary

The literature review offered a wealth of knowledge on the meaning of spirituality in the lives of infertile women. It also supported the need for health care clinicians to be educated on spirituality to enhance patient outcomes. The studies presented in the review of the literature further validated that a spirituality educational module may benefit clinicians as the lack of training was consistently documented as a deterrent to conducting spiritual assessments and providing spiritual care. The use of the KTA model reconfirms the need to implement tools/products (spirituality educational module) to be used by health care clinicians to improve spiritual wellness among their patients.

Section 3: Approach

Project Approach

The purpose of this project was to enhance health care clinicians' knowledge of spirituality and improve compliance with conducting spiritual assessments and providing spiritual care to women experiencing infertility. The first concept of the KTA cycle was accomplished through conducting a literature review. A needs assessment was conducted on fertility clinicians to assess the use of spirituality in their practice and the need for education. The next step called for the development of a tangible tool/product to be used by the stakeholders. Education is the means by which compliance and change can be achieved to improve patient outcomes (Hardin, 2015). The need to increase knowledge as a means of improving patient outcomes is the basis for this scholarly project. An educational module was developed to educate health care clinicians and a posttest was also developed to assess knowledge. The intervention that was created is in the form of a voice-over-PowerPoint educational module. The objectives for the educational module included:

1. Define spirituality, spiritual distress, spiritual assessment, and spiritual care.
2. Understand the importance of spirituality in the lives of women experiencing infertility.
3. Differentiate spirituality from religiosity.
4. Recognize the signs of spiritual distress in women experiencing infertility.
5. Discuss the major assessment tools for conducting a spiritual assessment.
6. Determine how and when to conduct a spiritual assessment.
7. Determine how to provide spiritual care to women experiencing infertility.

The voice-over-PowerPoint educational module takes approximately 30 minutes to view. A 15-question, multiple choice posttest will be taken after the educational module and the health care clinicians will need a score of 80% to pass the posttest. After two unsuccessful attempts to pass the posttest, the health care clinician will have to view the educational module again and retake the test. Future dissemination for this educational module involves submitting it for approval for continuing education credits at a professional health care organization.

Population and Sampling

The population for the needs assessment consisted of advanced practice nurses, registered nurses, licensed practical nurses, physicians, and physician assistants who directly care for women experiencing infertility. All other ancillary staff was excluded. A convenience sampling method was used to collect the data. Convenience sampling allows the researcher to select participants that are most conveniently available to them (Polit & Beck, 2014). The needs assessment was conducted at a small fertility center in the greater metropolitan area of Washington, DC. The clinic was made up of four staff members, two of which fit the criteria to participate in the needs assessment survey.

Data Collection

Protection of human subjects

Prior to initiating the scholarly project, the Institutional Review Board (IRB) approval from Walden University was sought to fulfill the requirements of conducting research on human subjects. The IRB is a group of individuals within an institution that reviews proposed research activities for the protection of human subjects (Terry, 2015). There was no initiation of data collection before IRB approval was obtained. The Walden University IRB approval number is 08-20-15-0429421.

A series of data collection steps were taken to ensure the privacy of the participants. There was no conflict of interest as the principal investigator did not have any affiliation with the site. The principal investigator approached the clinicians individually with a letter of invitation (Appendix A) and explained the purpose of the needs assessment survey and answered any questions. After the clinician agreed to participate, the survey and an envelope to seal the completed survey in was handed to them. No identifying information was used for the collection of the data. I remained onsite to collect the completed surveys. The data was stored according to the specifications in the IRB application. The completion of the needs assessment survey indicated implied consent; therefore, a written informed consent was not needed for this project. There was minimal risk involved to the clinicians participating in this survey. The potential ratio of risks to benefits of this scholarly project was clearly stated in the letter of invitation (Terry, 2015). The overall anticipated benefit of the needs assessment was to provide valuable knowledge of the spiritual practices of clinicians caring for women experiencing infertility in order to develop an effective education program on spirituality in health care.

Instrument

This scholarly project used a needs assessment survey to assess the needs of health care clinicians in regards to spirituality and patient care. A 12-question needs assessment survey (Appendix B) was developed by me after a thorough review of the literature. According to Polit and Beck (2014), ensuring adequate content validity is often achieved through the use of an expert panel. Prior to administering the needs assessment survey, a panel of experts consisting of a doctorally-prepared statistician with a specialization in instrumentation and two doctorally-prepared nursing faculty reviewed the survey for content validity. Suggestions were offered for clarification and rewording of two questions. Following the experts' recommendations, the

needs assessment survey was finalized and administered to the health care clinicians. The needs assessment survey was estimated to take between 5-10 minutes to complete. The first six questions consisted of demographic data: age, gender, race, Hispanic or Latino ethnicity, occupation, and number of years working as a clinician with infertile women. One question was a multiple choice question to assess the clinicians' knowledge of the meaning of spirituality. Three questions consisted of Likert-type scaling to indicate the level of importance that clinicians' placed on spirituality in their practice, whether or not the clinician conducts spiritual assessments, or provides spiritual care to their infertile female patients. One survey question asked what spiritual assessment tool was used. The last question assessed barriers preventing the clinician from conducting spiritual assessments or providing spiritual care.

Data Analysis

After the data collection process was complete, the data were ready to be analyzed. The IBM SPSS Statistics version 21 was the statistical software used to analyze the data. Descriptive statistics was used to describe the demographic characteristics and the use of spirituality among the clinicians in caring for women experiencing infertility. There was no intervention implemented after the need assessment. A Walden University and outside statistician assisted the principal investigator in proper coding of the data and analysis of the results.

Project Evaluation Plan

The evaluation of this project was based on a compilation of factors to ensure that the outcomes were or were not met (Zaccagnini & White, 2011). The objectives stated above guided this scholarly project. The voice-over-PowerPoint educational module is the needed resource to elicit change among clinicians. A four point, 10-question Likert-type scale was developed by me and given to three doctorally-prepared nursing faculty members to validate the voice-over-

PowerPoint educational module after viewing it. The 15-question multiple choice posttest was developed based on the educational module objectives and clinical vignettes incorporated to further learning. These same three faculties were given the posttest and were asked to mark any question/s that was/were unclear.

Summary

The purpose of this scholarly project was to conduct a needs assessment and develop an educational module and posttest that will enhance health care clinicians' compliance with conducting spiritual assessments and providing spiritual care to their patient population. The review of the literature has shown that spirituality is lacking in the care of patients despite its therapeutic elements. The spirituality educational module is intended for health care clinicians caring for women experiencing infertility. The use of a posttest will be to evaluate learning as evidenced by a passing score.

Section 4: Findings, Discussion, and Implications

Introduction

Infertility is a disease that causes psychological alterations in the women who experience it (Klock, 2011). As a result, women experiencing infertility often turn to spirituality to alleviate them in these times of crisis (Roudsari, Allan, & Smith, 2007). The role of the clinician is vital during this period in the promoting holistic care of the patient. However, clinicians frequently tailor their care to the physical being and neglect the psychosocial aspects of the patient. In the review of the literature, several barriers have been identified as to why clinicians do not incorporate spirituality into patient care (Balboni et al., 2014; Berg et al., 2013; McCauley et al., 2005; Tanyi et al., 2009; Vermandere, et al., 2011). A needs assessment was conducted to better understand the use of spirituality among clinicians in a small fertility center and to determine the need for education. In addition, an educational module and posttest was developed to assist clinicians in conducting spiritual assessments and providing spiritual care.

Results

The participant size for this needs assessment survey was a total of two ($N = 2$). The demographic characteristics (Table 1) were all coded as nominal data. One of the participants ($n = 1$) was in the age range of 55-64, while the other participant was in the 65+ age category. Among the two participants, one ($n = 1$) was male and the other ($n = 1$) was female. For the demographic characteristic of race, one participant was Black or African American ($n = 1$) while the other identified as Mixed Race. One participant selected, "yes," for Hispanic or Latino and the other chose, "no," for this question. For occupation, one participant ($n = 1$) was a registered nurse, and the other participant was a medical doctor. Lastly, for the years working as a clinician

with women experiencing infertility, one participant (n = 1) selected 6-15 years and the other (n = 1) chose 36+ years, which is a significant amount of time in this specialty area.

Table 1

Demographic Characteristics

Participant Demographics	Frequency
Age	
55-64	1
65+	1
Gender	
Male	1
Female	1
Race	
Black or African American	1
Mixed Race	1
Hispanic or Latino	
Yes	1
No	1
Occupation	
Registered Nurse	1
Medical doctor	1
Years working as a clinician with infertile women	
6-15	1
36+	1

Note. $N = 2$

One of the questions on the survey was a multiple choice question asking the participant how they would define spirituality. There were four letter choices (A, B, C, or D) for the question. As indicated in Table 2, one of the participants selected the correct answer, while the other participant chose the incorrect answer.

Table 2

Definition of Spirituality

	Frequency
C – Incorrect response	1
D – Correct response	1

Table 3 shows the results on how the participants felt the importance of spirituality was in their practice. This question used a Likert-type scale of *strongly disagree*, *disagree*, *agree*, and *strongly agree*. One participant strongly disagreed that spirituality was important to their practice. The other participant agreed that spirituality was important to their practice. The two participants remarkably differed as clinicians concerning the importance of spirituality in their practice.

Table 3

Importance of spirituality in your practice

	Frequency
Strongly Disagree	1
Agree	1

The participants were also asked if they conducted spiritual assessments on their female patients experiencing infertility (Table 4). The choices were based on a Likert-type scale ranging from *never* to *always*. Both of the participants selected "never" to this question.

Table 4

Do you conduct spiritual assessments?

	Frequency
Never	2

In terms of the question of what spiritual assessment tool (Table 5) was used by the clinician, one of the participants selected "do not use spiritual assessment tool." The other participant neglected to answer this question. It could be assumed that this participant did not answer this question because they never conduct spiritual assessments on their female infertile

patients and did not bother to look through the choices to select "do not use spiritual assessment tool". The missing response was given a code as "999" in SPSS.

Table 5

Spiritual assessment tool used

	Frequency
Do not use spiritual assessment tool	1
999	1

Table 6 displays the results of the participants' response to providing spiritual care to their female infertile patients. On a Likert-type scale ranging from *never* to *always*, both of the participants selected "sometimes" to providing spiritual care to their female patient experiencing infertility. The two participants shared the same frequency in providing spiritual care to their patients.

Table 6

Do you provide spiritual care to your female infertile patients?

	Frequency
Sometimes	2

Lastly, the survey asked the participants to check all the barriers that prevent them from conducting spiritual assessments or providing spiritual care to their female patients with infertility. An option for "other" was provided for the participant to specify any other barrier not listed. Table 7 shows that the only barrier preventing these clinicians from conducting spiritual assessment or spiritual care was the belief that it is not the role of the clinician to discuss spirituality with patients. Once again the participants shared another commonality in their responses in the needs assessment survey.

Table 7

Barriers to Spirituality

	Frequency
Lack of training	
No	2
Lack of time	
No	2
Personally uncomfortable	
No	2
Do not believe it is the clinician's role	
Yes	2
Spirituality is not important to you	
No	2
Other barriers	
No	2

Discussion of Findings

This scholarly project used a needs assessment to understand the use of spirituality by clinicians in caring for infertile women and to assess their needs for education. Valuable insight was obtained on the use of spirituality among clinicians in this small fertility center. The results of the needs assessment revealed that only one participant chose the correct definition of spirituality. Clinicians need to first understand what spirituality means to effectively add this dimension to the care of patients. Research supports that clinicians lack the understanding of spirituality and that this constitutes a barrier to spiritual discussions with patients (Ellis et al., 1999; Ellis et al., 2002; Tanyi et al., 2009). Therefore, assessing how clinician's define spirituality is an important step towards educating them on this concept.

One of the participants in the needs assessment strongly disagreed that spirituality was important to their practice. This suggests that this clinician does not have a thorough understanding of the value of spirituality in patient care. Spirituality is important to health care as it redefines hope in patients and helps them in recovering from their disease processes

(Helming, 2009). Clinicians need to be educated that spirituality is an imperative element to health care and can significantly enhance well-being.

The participants also revealed that they never conduct spiritual assessments on their female patient experiencing infertility. Once again this confirms that clinicians are not conducting spiritual assessments on patients and neglecting this important aspect of care. This supports other studies' findings that routine spiritual assessments are not being conducted on patients (Ellis et al., 1999; Ellis et al., 2002). The need for a social change in health care is necessary to get clinicians to conduct spiritual assessments. According to the Report of the Consensus Conference (2009) and in conjunction with the Biopsychosocial-Spiritual Model of Care, institutional policies must be integrated to include spiritual assessments in the patient's plan of care (Puchalski et al., 2009). This same report also recommends that spirituality should be considered a patient vital sign.

Even though both participants did not conduct spiritual assessments, they provided spiritual care "sometimes" to their female infertile patients. In the study conducted by Hubbell et al. (2006), the clinicians also did not routinely provide spiritual care to their patients. The participants in Tanyi et al.'s (2009) study did provide some level of spiritual care to their patients, but did not frequency document this care. Balboni et al. (2014) reported that a large minority of the nurses (39%) and physicians (41%) that they surveyed provided spiritual care less frequently than desired. Spiritual care is a therapeutic intervention that clinicians should use to propel healing in patients. Swinton (2001) posits that spiritual care as a therapeutic understanding allows clinicians to step into the experience of the patient and promote understanding and empathy. Proper education on these dynamics can assist clinicians in including spiritual care as a routine part of the patient's plan of care.

Research has shown that some clinicians believed that it was not their role to discuss spirituality with their patients (Balboni et al., 2014). This is apparent by the responses of the participants in the needs assessment that also believed it was not the clinician's role to discuss spirituality with patients. Even though the participants did not check off a "lack of training" as a barrier, the fact that they never conducted spiritual assessments was indicative that they lack knowledge of conducting spiritual assessments. Moreover, proper education on spirituality may assist clinicians in better understanding the role they play in holistic care. This starts with an educational program that will increase the knowledge of spirituality among clinicians caring for women experiencing infertility. A voice-over-PowerPoint educational module (Appendix C) was developed in this project study to address the objectives stated above.

Evaluation of the Educational Module and Posttest

After developing the educational module and posttest, validation of the two products was needed. A spirituality educational module evaluation form (Appendix D) was created using a four point Likert-type scale with possible responses of *strongly disagree*, *disagree*, *agree*, and *strongly agree*. It was given to three doctorally-prepared nursing faculty members to evaluate the educational module. Table 8 is a summary of the responses from the reviewers of the educational module. For the first question pertaining to a clear definition of spirituality, spiritual distress, spiritual assessment, and spiritual care, two reviewers chose "agree" while one chose "strongly agree." The statement on whether or not the educational module giving vital information on how to conduct spiritual assessment, two reviewers answered "agree" and one reviewer selected "strongly agree." One of the reviewers agreed with the educational module providing knowledgeable information on how to provide spiritual care to women experiencing infertility, while two strongly agreed. The fourth statement asked the reviewers if the clinical

vignettes further enhanced learning and one chose, “agree,” while two elected for “strongly agree.” The level of agreement for if the spirituality educational module flows sequentially was “agree” for one reviewer and “strongly agree” for two reviewers.

Two reviewers were in agreeance that the slides were not over crowded in the module and one chose disagree. To address this issue the educational module was reviewed once again and a few of the slides were amended to reduce crowding. For the seventh statement, two reviewers selected “agree.” However, one of the reviewers chose, "disagree," that the graphics within the educational module engages the learner. It was recommended that the graphics should have more diversity. Prior to implementation, I will make an effort to add more visual graphics to the educational module to represent a more diverse population. All of the reviewers agreed that the readability of the spirituality educational module was clear. Two of the reviewers also agreed that the length of the module was appropriate for the topic. On the other hand, one reviewer disagreed that the length of the educational module was appropriate for the topic. As previously mentioned, some of the slides were amended to reduce for crowding. I opted to retain all the vital information in the module, thereby, keeping the educational module to approximately 30 minutes. The last statement showed that one reviewer agreed that the spirituality educational module will be an asset to health care clinicians, and two selected “strongly agree.” One of the reviewers commented that the educational module provided an informative discussion of the spiritual assessment tools, but there was no statement on the evaluation form to rate this aspect of the module. However, I did account for this component in statement two that the educational module provided vital information on how to conduct a spiritual assessment.

In regards to the spirituality posttest (Appendix E), these same three reviewers were asked to mark any question/s on the posttest that was unclear. No one marked any question indicating that all of the questions were clear to the reader. Now that the educational module and posttest have been validated, the next step will be future implementation and evaluation of the outcomes at the fertility clinic.

Table 8

Results: Spirituality Educational Module Evaluation Form

Item	Strongly Disagree	Disagree	Agree	Strongly Agree
The spirituality educational module clearly defined spirituality, spiritual distress, spiritual assessment, and spiritual care.			2	1
The spirituality educational module gave me vital information on how to conduct a spiritual assessment.			2	1
The spirituality educational module provided me with knowledgeable information on how to provide spiritual care to women experiencing infertility.			1	2
The clinical vignettes further enhanced my learning.			1	2
The spirituality educational module flows sequentially.			1	2
The slides in the spirituality educational module were not over crowded.		1	2	
The graphics within the spirituality educational module engages the learner.		1	2	
The readability of the spirituality educational module was clear.			3	
The length of the spirituality educational module was appropriate for the topic.		1	2	
The spirituality educational module will be an asset to health care clinicians.			1	2

Note. $N = 3$

Recommendations to Stakeholders

After the development of the educational module and posttest, an evaluation plan will be needed to assist organizations in evaluating the test of change. The evaluation on the macro level is necessary to determine the impact of a program (Kettner, Moroney, & Martin, 2013). This process involves measuring the amount of spiritual support received by women experiencing infertility from their health care clinician. The stakeholders will evaluate the outcome measures by using a chart audit to determine the frequency of spiritual assessments and care. The nurse manager will be assigned to perform the chart audit. A 2 month retrospective chart audit will be conducted on the patients' charts prior to the educational module to assess for spiritual assessment and care. This process will determine the frequency of spiritual assessments and spiritual care being performed prior to the intervention. One month after the implementation of the educational module, the nurse manager will conduct a prospective chart audit every month for 6 months on the patients' charts to evaluate the frequency of spiritual assessments and care after the intervention. The prospective review will provide evidence of a social change among the health care clinicians. The nurse manager will compile the results and present them to the stakeholders for review.

Implications

Impact on practice and/or action

Several studies have been conducted to assess barriers to spirituality in patient care among clinicians (Balboni et al., 2014; Berg et al., 2013; Ellis et al., 2002; Hubbell et al., 2006; McCauley et al., 2005; Tanyi et al., 2009). The review of the literature with the support of the conducted needs assessment confirmed a need for education to increase the use of spirituality in patient care particularly with infertile women. Spirituality in patient care is supported by many

nursing and medical organizations (AAMC, 1999; AHNA, 2007; ANA, 2001; ICN, 2012; JCAHO, 2005; NONPF, 2012; WHO, 1998). Educating clinicians on the spiritual assessment and spiritual care should be included in the curriculum of nursing and medical schools. In addition, clinicians must also remember that they are providing holistic care to their patients.

Impact for future research

The findings of this needs assessment have vital implication for future research for clinicians caring for women experiencing infertility. This needs assessment should to be replicated in a larger, and more culturally diverse population. Additionally, with the inclusion of all licensed clinicians: advanced practice nurses, registered nurses, licensed practical nurses, physicians, and physician assistants. Lastly, future research should consist of conducting a pilot study of the developed educational module and posttest.

Impact on social change

Terhaar (2012) emphasized that investment in the practice environment helps clinicians improve patient outcomes. Applying spirituality to patient care is needed on a systematic level to change the current non-compliance of this protective commodity. Health care is an evolving system that requires clinicians to keep abreast with the current trends in evidence-based practice. Social change is an essential component of an organization's culture and is needed to promote evidence-based practice (Williams, 2012). The educational module and posttest may be the needed tool to assist clinicians in being compliant with conducting spiritual assessments and providing spiritual care.

Scholarly Project Strengths and Limitations

One of the major strengths of this scholarly project is that it provided valuable information on the use of spirituality in this small practice which supports the literature that

education is lacking on spirituality among clinicians. Some of the limitations of this project include a small participant size and a lack of a culturally diverse sample which can affect the generalizability of the results. Lastly, this project was limited in that it did not implement the educational module and posttest; therefore, I could not determine post knowledge after the educational module. There were no personal biases on my part that could influence the project outcomes.

Recommendations for Remediation of Limitations in Future Work

As mentioned in the limitations of this scholarly project, a recommendation for the future would be to conduct a needs assessment on a larger fertility center in which a greater number of participants can be recruited. Another recommendation would entail including participants from diverse backgrounds. Implementation of the educational module and posttest are also recommended for future work to assess the efficacy of the developed module and posttest. The recommendations listed above for stakeholders are also necessary to determine a test of change among the clinicians in that practice.

Analysis of Self

As scholar

This scholarly project has broadened my knowledge and awareness of the importance of evidence-based practice to health care. The Doctor of Nursing Practice program has prepared me to apply the scholarship of practice in nursing by identifying issues in nursing and creating tangible products/tools to solve the problem (Terry, 2015). Nurses have to keep abreast with the current trends in health care in order to maintain best practice. As a scholar, the use of evidence-based practice is necessary to create and refine practice to bring out a systematic social change in health care.

As practitioner

Clinicians play an essential role in providing holistic care to their patients. Spirituality is a major entity in health care that cannot be neglected. It is important for clinicians to understand that neglecting to provide spiritual support to patients can also result in increased medical costs due to unresolved spiritual conflicts (Koenig, 2012). As a women's health nurse practitioner, this scholarly project has given me the ability to be better apply the use of spirituality in my patient population.

As project developer

Planning a program is a major task that requires many factors. According to Kettner, Moroney, and Martin (2013) planning a program addresses specific needs and uses effective-based principles to serve its clients. As a project developer initiating a social change in patient care, my skills as a transformational leader have increased. Warrick (2011) postulates that transformational leaders are skilled individuals that champion change and transform organizations. These skills acquired will definitely aid me in my future endeavors in being a change agent in health care.

Summary

The altered psychological effects that infertility can have on women require interventions that will enhance the holistic being of the patient. Research has found that spirituality aids patients in their struggles of against health dilemmas particularly infertility (Roudsari, Allan, & Smith, 2007). Clinicians hardly ever conduct spiritual assessments and provide spiritual care to patients due to a lack of education of the dynamics of spirituality. The key to adding spirituality to the patient's plan of care lies in education of this concept. A needs assessment was conducted and provided valuable information to support the literature. An educational module was

developed and validated by three doctoral prepared nursing faculties. The posttest was created to test post knowledge of the educational module. Health care clinicians should acknowledge that spirituality holds promise in evidence-based practice in health care. Spirituality is a well needed intervention that must not be neglected in health care clinicians.

Section 5: Scholarly Product

Future Dissemination

Disseminating the finding of an evidence-based project is necessary to build knowledge in nursing, present new evidence for practice, and make recommendations for future studies (Oermann & Hays, 2011). This scholarly project will be disseminated by conducting a pilot study using the educational module and posttest in a fertility center on clinicians caring for women experiencing infertility. After developing an evidence-based project, a pilot study is useful to test run the new innovation and evaluate the outcomes (Polit & Beck, 2014). Another way of dissemination is to publish this scholarly project in a peer-refereed journal. According to Oermann and Hays (2011) some of the reasons to write an article are to share ideas within the discipline of nursing and disseminate evidence. The journal for publication will be the Journal of Nursing Research. Lastly, I intend to submit this educational module and posttest for approval for continuing education credits at a professional health care organization.

Summary

The future of health care relies on health care clinicians that are knowledge in providing care to increase patient outcomes. Women experiencing infertility go through many impaired psychological effects due to the inability to get pregnant (Kendall, 2008). Spirituality is a concept that allows for comfort and solace in the wake of adversity. The future of the educational module and posttest may be the tool needed to create a change in practice to keep clinicians compliant with conducting spiritual assessments and providing spiritual care.

Manuscript

Health Care Clinicians' Compliance with Conducting Spiritual Assessments and Providing Spiritual Care to Infertile Women

Lesa Miller, MSN, MS, BSN, BA, WHNP-BC, RNC

Abstract

Infertility is a disease that can cause psychological impairments in women, and the inability to achieve motherhood brings about cultural and social stigma. Spirituality is a protective element that may provide consolation to women experiencing infertility, yet the literature has shown that few clinicians conduct spirituality assessments or provide spiritual care to patients. The objectives of this scholarly project were to conduct an assessment to determine the needs of health care clinicians in regard to spirituality and spiritual patient care and to develop an educational module based on identified knowledge deficits. Guided by the knowledge-to-action cycle, a needs assessment was conducted in a small fertility clinic with 2 clinicians. The results of the assessment showed that the clinicians had not conducted spirituality assessments on their infertile patients and only sometimes provided spiritual care. An educational module and a posttest were developed and then validated by 3 doctorally-prepared nursing faculty members using a self-developed 10-question Likert-type evaluation scale. The materials were found to be clear, accurate, and easy to read by the nursing faculty. An implication of this scholarly project is that it will give clinicians the resources needed to create social change in health care by addressing the spirituality needs of women experiencing infertility. Future research includes a pilot study to implement the educational module with clinicians at the fertility clinic and to evaluate its effectiveness for enhancing spiritual care in practice.

Introduction

Infertility is a disease that has been defined as the "inability to conceive or carry a pregnancy to term after 12 months of trying to conceive. If you are over the age 35, the time of trying to conceive is reduced to 6 months" (RESOLVE, 2015a, para. 3). The inability to bear children is a cultural and social stigma that signifies shame on the woman. When the desire to achieve motherhood has not manifested, this misfortune can bring about psychological imbalances to the woman (Kendall, 2008). Due to the importance that many cultures around the world place on motherhood, assessing for spirituality and providing spiritual care to infertile women may promote psychological and physiological outcomes. The construct of spirituality has been found to aid women find meaning and purpose in life (Roudsari, Allan, & Smith, 2007). A fundamental element of spirituality that supports women experiencing infertility is relating with one's self intrapersonally and finding internal peace.

The National Survey of Family Growth (NSFG) estimated that 1.5 million women were infertile from 2006 to 2010. The NSFG (2013) also reported that 46% of married infertile women experienced primary infertility in 2006 to 2010. In addition, the NSFG reported that from 2006 to 2010, 7.2 percent of African American women experienced infertility as compared to Caucasian women at 5.5 percent (Chandra et al., 2013). RESOLVE (2015b) reported that 30% of infertility cases are associated to female factors.

Many professional health care organizations support the use of spirituality in patient care (AAMC, 1999; AHNA, 2007; ANA, 2001; ICN, 2012; JCAHO, 2005; NONPF, 2012, WHO, 1998). As a matter of fact, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 2005) mandates that health care organizations conduct a spiritual assessment on a patient to determine their religious affiliation as well as spiritual practices that might impact care

(p. 6). Health care clinicians must remember that they are providing holistic care to patients and spirituality is an intricate part of patient care.

Spirituality has been found to be a solace to people during times of health care dilemmas. Infertility is a disease that has been classified as a life crisis (Klock, 2011). The role of the clinician is crucial in assessing for spirituality and providing spiritual care to patients. A comprehensive review of the literature revealed that health care clinicians are not conducting spiritual assessments and providing spiritual care to patients due to a lack of understanding and education on this topic (Hubbell, Woodard, Barksdale-Brown, & Parker, 2006; McCauley et al., 2005; Saguil & Phelps, 2012; Tanyi et al., 2009). A system-wide change is needed to incorporate spirituality into health care to enhance patients' outcomes. For years clinicians has focused their attention on the physiological aspects of patients; however, holistic care should be the center of patient care. According to Tanyi et al. (2009) clinicians that do not support spirituality would be neglecting a paramount entity in patient care. For this reason, health care clinicians need education on spirituality, and how to conduct a spiritual assessment and provide spiritual care to patients (Carron & Cumbie, 2011, Lawrence & Smith, 2004). This action will give clinicians the knowledge to identify spiritual distress in patients and provide the appropriate care.

The conceptual framework that guided this scholarly project was the knowledge-to-action cycle (KTA) (Graham et al., 2006). This framework was used to develop a spirituality educational module and posttest for clinicians caring for women experiencing infertility. The objectives of this scholarly project were to (a) conduct a needs assessment to assess the needs of health care clinicians in regards to spirituality and patient care, (b) create an educational module for health care clinicians caring for women experiencing infertility to incorporate spiritual

assessment, and spiritual care into the patient plan of care, and (c) to develop a posttest to assess health care clinicians' knowledge of spirituality, spiritual assessment, and providing spiritual care. The overall goal is to create a social change in health care by providing clinicians the educational tools necessary to integrate spirituality in the care of their patients.

Methodology

A needs assessment survey was conducted on fertility clinicians to assess the use of spirituality with their infertile female patients and determine a need for training. A convenience sample of two from a small fertility center made up of four employees took part in the needs assessment. Before this project was initiated, a full review was sought and approved by Walden University's Institutional Review Board. The Walden University IRB approval number is 08-20-15-0429421. The principal investigator did not have any affiliation with the center; therefore, there was no conflict of interest. The clinicians were approached individually by the principal investigator to participate in the needs assessment. A letter of invitation was given to the clinician and any questions were answered. Once the clinician agreed to participate, the needs assessment survey and an envelope to seal the completed survey in was handed to them. No identifying data was used in this needs assessment survey. The completed survey indicated implied consent. The principal investigator collected the surveys on the same day.

A 12-question needs assessment survey was developed and validated by a panel of three doctorally-prepared faculty members, one of which was a statistician with a specialization in instrumentation. The use of an expert panel is often used to ensure adequate content validity of a tool (Polit & Beck, 2014). The survey consisted of: demographic data: age, gender, race, Hispanic or Latino, occupation, and years as a clinician working with infertile female patients. There was a multiple choice question assessing the clinicians' knowledge of the meaning of

spirituality. A four-point Likert-type question (*strongly disagree*, *disagree*, *agree*, and *strongly agree*) assessed the clinicians' level of importance that they placed on spirituality in their practice. Another question on a five-point Likert-type scale (*never, rarely, sometimes, very often, and always*) inquired whether or not the clinician conducts spiritual assessments. The next question asked which spiritual assessment tool was used by the clinician. Another question was based on the same five-point Likert-type scale to examine if the clinician provided spiritual care to their female patients experiencing infertility. Lastly, a multiple option question asked the clinician about barriers inhibiting them from conducting spiritual assessments or providing spiritual care. The needs assessment data were analyzed using IBM SPSS version 21. Descriptive statistics was used to describe the demographic characteristics and the use of spirituality of the clinicians caring for women diagnosed with infertility.

After the needs assessment, a voice-over-PowerPoint educational module was developed along with a 15-question posttest. The educational module takes approximately 30 minutes to complete. The objectives of the educational module were as follows:

1. Define spirituality, spiritual distress, spiritual assessment, and spiritual care.
2. Understand the importance of spirituality in the lives of women experiencing infertility.
3. Differentiate spirituality from religiosity.
4. Recognize the signs of spiritual distress in women experiencing infertility.
5. Discuss the major assessment tools for conducting a spiritual assessment.
6. Determine how and when to conduct a spiritual assessment.
7. Determine how to provide spiritual care to women experiencing infertility.

A 10-question Likert-type scale spirituality educational module evaluation form was developed and given to three doctorally-prepared nursing faculty members for validation. The level of agreeance were *strongly disagree*, *disagree*, *agree*, and *strongly agree*.

Results

The demographic characteristics of the participants included one male and one female. The age range was 55-64 and the 65+ category. In terms of race, one participant was African American and the other was of Mixed Race. One participant identified as Hispanic or Latino. The occupation of the participants was one registered nurse and one medical doctor. The years working as a clinician with infertile women were 6-15 years and 36+ years. The survey asked the participants to define spirituality in a multiple choice question and only one participant selected the correct answer. The participants were also asked how important they felt spirituality was to their practice. One participant selected "strongly disagree" and the other chose "agree".

The next question asked whether or not the participants conducted spiritual assessments on their female infertile patients. Both participants chose "never" to this question. The following question inquired about what spiritual assessment tool was used by the clinician. One participant selected from the list of choices "do not use spiritual assessment tool" and the other participant neglected to answer this question. An assumption to this nonresponse could be that since this participant never conducted spiritual assessments as indicated in the previous question they did not take the time to look for the choice "do not use spiritual assessment tool" from the list of choices to this question. The missing response was coded as "999" in SPSS. The needs assessment survey also inquired about the participants providing spiritual care to their female patients diagnosed with infertility. Both participants selected "sometimes" to this question. The final question surveyed the barriers to conducting spiritual assessments or providing spiritual

care to female infertile patients. The two participants responded that in was not the clinician's role to discuss spirituality with patients.

Discussion

The results of the needs assessment revealed that education is needed to aid these clinicians in understanding spirituality and incorporating it into their patient care. Understanding what spirituality means is the first step to educating clinicians. Research has confirmed that one of the barriers to engaging in spiritual discussion with patients is a lack of understanding of what spirituality means (Ellis et al., 1999; Ellis et al., 2002; Tanyi et al., 2009). Educating clinicians on the concept of spirituality may be a means by which to increase compliance of spirituality in health care.

The results of the needs assessment showed that one participant strongly disagreed that spirituality was important to their practice. Obviously this clinician does not have a thorough understanding of the therapeutic value that spirituality brings to the lives of patients. Helming (2009) emphasized that spirituality redefines hope in patients and aids them in recovering from their illness. Education is needed to inform clinicians that spirituality is a significant aspect to health care and can improve wellness.

The participants in this survey also responded that they never conduct spiritual assessments on their female infertile patients. These results support the literature that clinicians are not conducting routine spiritual assessments on patients (Ellis et al., 1999; Ellis et al., 2002). The health care system requires a social change to get clinicians to conduct spiritual assessments. In fact the Report of the Consensus Conference (2009) recommended that institutional policies must be incorporated to include spiritual assessments in the plan of care for patients (Puchalski et al., 2009). In addition, this report emphasized that spirituality be acknowledged as a vital sign.

Even though these participants responded that they never conduct spiritual assessments; however, they provided spiritual care sometimes to their female patients experiencing infertility. Hubbell and colleagues (2006) study also confirmed that the clinicians did not routinely provide spiritual care to patients. Tanyi et al. (2009) documented that the clinicians in their study did provide some level of spiritual care but did not frequency document the spiritual care. Balboni and colleagues (2014) reported that a large minority of nurses (39%) and physicians (41%) in their study provided spiritual care less often than desired. Spiritual care is therapeutic to patients and clinicians should use this intervention to promote healing in patients. Additionally, spiritual care should be viewed as a therapeutic understanding in which clinicians step into the patient's experience and promote understanding and compassion (Swinton, 2001). Proper training on the dynamics of spiritual care may assist clinicians in adding this intervention to patient care.

The participants in the needs assessment believed it was not the role of the clinician to discuss spirituality with patients. The study conducted by Balboni et al. (2014) also confirmed that some clinicians believed that it was not their role to engage spirituality in patients. Although both of the participants did not select a "lack of training" as a barrier, they never conduct spiritual assessments. This indicates that there may be a lack of knowledge in conducting spiritual assessments. Many clinicians lack the understanding of the value that spirituality plays in the lives of patients particularly infertile women. Educating clinicians on spirituality may assist them in understanding how vital their role is in holistic care. The development of an educational program may help increase the knowledge of spirituality among clinicians caring for female infertile patients.

This scholarly project was not without limitations. A major limitation was a small participant size and a lack of diversity in the sample which can affect generalizing the results.

Another limitation of this project is that it did not implement the educational module and posttest. Therefore, post knowledge could not be assessed to determine the efficacy of the educational module.

Implications

Studies have been conducted to assess various barriers of clinicians incorporating spirituality into patient care and has found that a lack of education is a leading factor (Balboni et al., 2014; Berg et al., 2013; Ellis et al., 2002; Hubbell et al., 2006; McCauley et al., 2005; Tanyi et al., 2009). Applying spirituality to the care of patients is necessary on a systematic level to change the current non-compliance of this protective factor. Social change is an integral component of an organization's culture and is required to promote evidence-based practice (Williams, 2012). The educational module and posttest may be the essential tool to facilitate clinicians in becoming compliant with conducting spiritual assessments and providing spiritual care. This needs assessment should be conducted in a larger and more diverse clinician population. Future research should also include conducting a pilot study on the developed educational module and posttest.

Conclusion

Infertility is a disease that not only affects the physiological aspect of a woman but also the psychological being (Cousineau & Domar, 2007; Kendall, 2008). For this reason, clinicians play an important role in not only restoring the physiological person but also the psychological. The concept of spirituality has been researched and found to be a source of comfort in the lives of women experiencing infertility (Domar et al., 2005; Frances-Fisher, 2005; Kress, 2005). Unfortunately, clinicians have been neglecting to use spirituality in patient care due to the lack of understanding of the dynamics of spirituality.

The needs assessment conducted has provided some beneficial information that supported the review of the literature. It is evident that education is lacking among many clinicians on the importance of spirituality in health care. Hubbell and colleagues (2006) conclude that education may aid clinicians in becoming more comfortable with implementing spirituality in their patient care. The development and validation of the educational module and posttest may be the key to helping clinicians become compliance with conducting spiritual assessment and providing spiritual care to women experiencing infertility.

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Appendix A

Letter of Invitation

You are invited to take part in a needs assessment survey on how health care clinicians incorporate spirituality in practice when caring for women experiencing infertility. The researcher is inviting advanced practice nurses, registered nurses, licensed practical nurses, medical doctors and physician assistants to be in the needs assessment. This needs assessment is being conducted by a researcher named Lesa Miller, who is a doctoral student at Walden University.

The purpose of this needs assessment is to get a better understanding of the spiritual practices of health care clinicians caring for women experiencing infertility. It will also aid the researcher in assessing the needs of health care clinicians in regards to spirituality and patient care.

If you agree to participate in the needs assessment, you will be asked to answer the survey questions which will take approximately 5-10 minutes to complete. You will also be provided with an envelope to seal the survey in and hand it to the researcher. Your participation in this needs assessment is a one-time event and will be completed once the survey is handed to the researcher. Any information you provide will be keep confidential.

This needs assessment is voluntary and no monetary compensation will be given. Your name will not be used in this survey and the data will only be shared with the researcher's supervising committee. By participating in this needs assessment and your completion of the survey will

account as your consent. The risk for participation is minimal with no potential benefit to the individual participant. However, the overall anticipated benefit of the needs assessment is to provide valuable knowledge of the spiritual practices of clinicians caring for women experiencing infertility in order to develop an effective education program on spirituality in health care.

Please feel free to contact the researcher, Lesa Miller, MSN, MS, BSN, BA, WHNP-BC, RNC at lesa.miller@waldenu.edu if you have any questions or concerns. If you want to discuss privately about your rights as a participant, you can call the university's research participant advocate at 1-800-925-3368 ext. 312-1210 or email at irb@waldenu.edu. Walden University's approval number for this study is 08-20-15-0429421 and it expires August 19, 2016.

Please retain this invitation letter for your records.

Appendix B

Needs Assessment Survey

Please place a check in the box for your response

1. Indicate your age range.

☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65+

2. What is your gender?

☐ Male ☐ Female

3. Please specify your race.

☐ White or Caucasian ☐ American Indian or Alaska Native

☐ Black or African American ☐ Hawaiian or Other Pacific Islander

☐ Mixed race

4. Are you Hispanic or Latino?

☐ Yes ☐ No

5. What is your occupation?

☐ Advanced practice nurse ☐ Medical doctor

☐ Registered Nurse ☐ Physician assistant

☐ Licensed practical nurse

6. Number of years working as a clinician with women experiencing infertility.

☐ < 1 ☐ 1-5 ☐ 6-15 ☐ 16-25 ☐ 26-35 ☐ 36+

7. How would you define spirituality?

a) Membership in an organized group and participation in rituals and practices pertaining to that denomination.

b) An individual's desire to achieve a goal in life.

c) Something which constitutes religious beliefs.

d) Making meaning through a sense of relatedness within oneself, others, the environment and a power greater than the self.

8. Do you feel spirituality is important in your practice?

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

9. Do you conduct spiritual assessments on your female patients experiencing infertility?

☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

10. What spiritual assessment tool do you use?

☐ FICA Spiritual History Tool ☐ Open Invite Mnemonic

☐ HOPE Questions ☐ FAITH Spiritual History

☐ SPIRITual History Tool ☐ JCAHO Spiritual Questions

☐ FACT Spiritual Assessment Tool ☐ CSI-MEMO

☐ Other (please specify):

☐ Do not use spiritual assessment tool

11. Do you provide spiritual care to your female patients experiencing infertility?

☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

12. Are there any barriers in preventing you from conducting spiritual assessments or providing spiritual care? (Check all answers that apply)

☐ Lack of training

☐ Lack of time

☐ Personally uncomfortable discussing spirituality with patients

☐ Don't believe it is the role of the clinician to discuss spirituality with patients

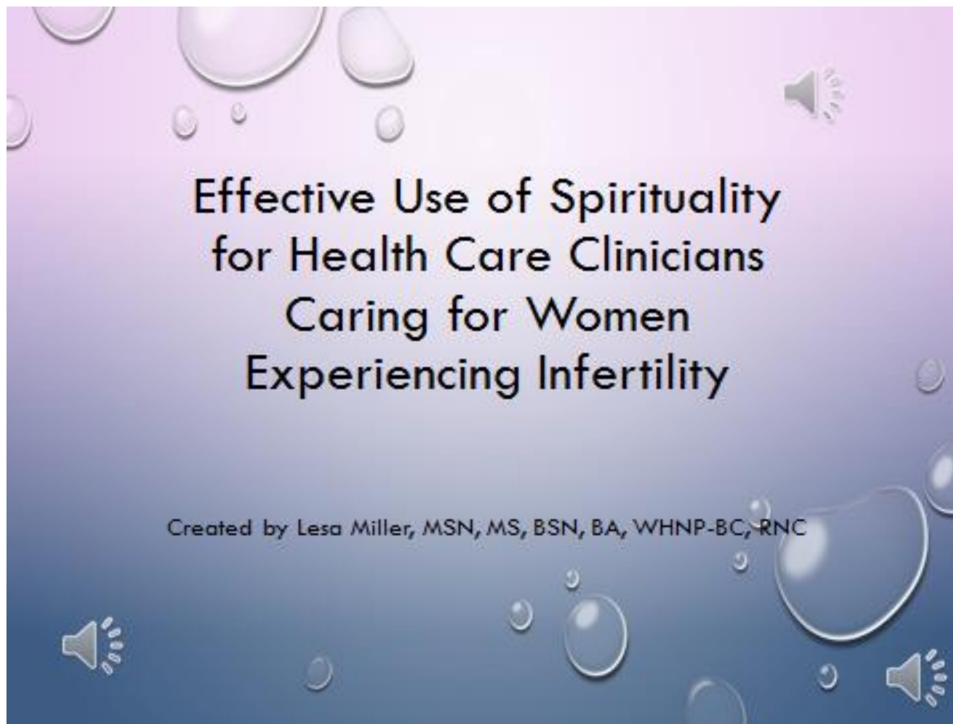
☐ Spirituality is not important to you as a clinician

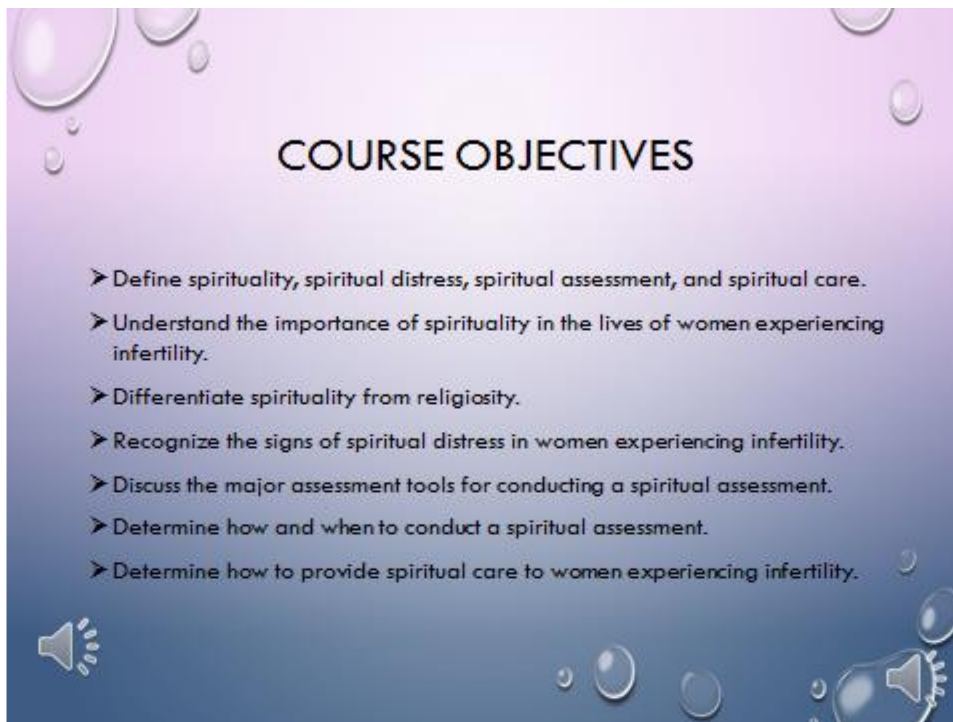
☐ Other (please specify):

Thank you for participating in this needs assessment survey.

Appendix C

Voice-over-PowerPoint Educational Module





INTRODUCTION

- Infertility is a life-altering disease that is considered a life crisis and can cause impaired psychological effects in women (Klock, 2011).
- Spirituality has been found to be a source of comfort to women experiencing infertility and is supported by several professional nursing and medical organizations.
- This educational module serves to enhance the knowledge of clinicians in conducting spiritual assessments and providing spiritual care to infertile women.

WHAT IS SPIRITUALITY?

Spirituality is defined as "the propensity to make meaning through a sense of relatedness to dimensions that transcend the self in such a way that empowers and does not devalue the individual. This relatedness may be experienced intrapersonally (as a connectedness within oneself), interpersonally (in the context of others and the natural environment), and transpersonally (referring to a sense of relatedness to the unseen, God or a power greater than the self and ordinary resources)" (Reed, 1992, p. 350).

WHAT IS SPIRITUAL DISTRESS?

Spiritual distress is "a state of suffering related to the impaired ability to experience meaning in life through connectedness with self, others, world, or a superior being" (Caldeira, Carvalho, & Vieira, 2013, p.82).

WHAT IS A SPIRITUAL ASSESSMENT?

A spiritual assessment is the "process by which health care providers can identify a patient's spiritual needs pertaining to medical care" (Anandarajah & Hight, 2001).

The spiritual assessment is an in-depth, continuous process that allows clinicians to assess their patient's need for spiritual care.

WHAT IS SPIRITUAL CARE?

Spiritual care "involves identifying and working with that which gives the person their source of meaning, value and a sense of inner and outward connectedness" (Swinton, 2001, p. 24).

WHY IS SPIRITUALITY IMPORTANT TO WOMEN EXPERIENCING INFERTILITY?

- People often turn to spirituality when dealing with crises in their lives. Spirituality is a protective factor that aids and embeds individuals experiencing psychological, and physiological impairments.
- Studies have documented that spirituality has been found to be a solace to women that are experiencing infertility (Domar et al., 2005; Frances-Fisher, 2005; Kress, 2005; Ticinelli, 2012).
- An essential component of spirituality that helps infertile women is connecting with one's self, finding inner peace, and meaning and purpose in life.

SPIRITUALITY VERSUS RELIGIOSITY

- Many people often confuse spirituality with religiosity. These two concepts are unique and have their own defining characteristics.
- Religiosity refers to membership in an organized entity and participation in rituals, beliefs, and other activities related to one's denomination; while spirituality encompasses an existential source of one's internalized beliefs, values, and faith (Moberg, 2008).
- An individual does not have to be religious in order to be spiritual.
- An alteration in spirituality can cause spiritual distress in individuals.

SIGNS OF SPIRITUAL DISTRESS

- Lack of hope
- Worthlessness
- Expresses guilt
- Anger
- Lack of meaning and purpose in life
- Lack of interest in spiritual or religious activities
- Fear
- Inability to experience transcendence
- Lack of control
- Express anger toward or abandonment from God/divinity
- Crying
- Alienation

Caldeira et al. (2013)

CLINICAL VIGNETTE

A 32 year old woman experiencing primary infertility presents for a subsequent visit and says to her doctor, "This is going to be my third cycle of IVF. I don't know why my body refuses to get pregnant. I have always dreamt of being a mother. Do you think God is punishing me for the abortion I had when I was younger?"

ASSESSING SPIRITUAL DISTRESS

- This patient is showing signs of spiritual distress as evidenced by her statements of lack of hope and meaning in life due to the inability to achieve motherhood.
- She also expresses guilt and abandonment by God from a previous abortion.
- Health care clinicians need to pay special attention to statements made by patients that indicate an impaired ability to experience meaning and purpose in life.
- This patient will benefit from spiritual care to relieve her symptoms of spiritual distress.

THE ROLE OF THE HEALTH CARE CLINICIAN

- Health care clinicians play an important role in cultivating spirituality in individuals which has been shown to be a source of resilience.
- Health care clinicians should use a holistic approach to support and foster spirituality in patients particularly women experiencing infertility.
- In fact, clinicians that neglect to support spirituality in their patients would be disregarding a vital part of patient care (Tanyi et al., 2009).
- In order for the clinician to be an effective tool in providing spiritual care, they must first acknowledge their own philosophy of spirituality.

Saguil & Phelps, 2012

WHY CONDUCT A SPIRITUAL ASSESSMENT?

Health care clinicians should conduct a spiritual assessment on all patients particularly those that face existential crises such as a diagnosis of a chronic illness, terminal disease, and individuals with psychological disorders. The spiritual assessment should be conducted for several reasons such as:

1. Learning about the patient's spiritual/religious beliefs, and those that will impact care.
2. To invite the patient to define what spirituality means to them.
3. Assess for spiritual distress as well as spiritual sources of strength.
4. Empower the patient to find meaning and purpose in their diagnosis.
5. Identify spiritual practices that may enhance outcomes.
6. The clinician should also use the spiritual assessment to make an appropriate referral to the Chaplain, social worker, or the patient's spiritual/religious leader as necessary.

Saguil & Phelps, 2012
Pulchalski, 2010

FINANCIAL BENEFITS

- Research conducted by Balboni and colleagues (2011) estimated a difference of $2,441 was spent in medical costs on patients during the end of life who reported receiving high support of spiritual needs from health care clinicians as compared with those patients that received less spiritual support.
- There was also a greater difference noticed among the participants of racial/ethnic minorities of $4,206 and those patients that had high religious coping of $4,060.

FINANCIAL BENEFITS

- The end of life is often a period where patients and families may demand for expensive medical care regardless of the poor prognosis.
- The patient's faith during the time of a health crisis can precipitate thoughts of doubt, and lack of faith in their belief system.
- Clinicians that neglect to take a spiritual assessment and provide spiritual care during this period so that patients/families can resolve spiritual conflicts increase the chance of prolonging the inevitable consuming large amounts of medical costs.

Koenig, 2012

WIDELY USED SPIRITUAL ASSESSMENT TOOLS

FICA SPIRITUAL HISTORY TOOL

- F – Faith and Belief: "Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress? If the patient responds "No" the clinician might ask, "What gives your life meaning?"
- I – Importance: "What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?"
- C – Community: "Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?"
- A – Address in Care or Action: "How would you like me, your health care provider, to address these issues in your health care?" Or ask the patient, "What action steps do you need to take in your spiritual journey?"

Puchalski & Romer, 2000

HOPE QUESTIONS

- **H** – Sources of **h**ope, meaning, comfort, strength, peace, love, and connection: What is there in your life that gives you internal support? What are your sources of hope, strength, comfort and peace? What do you hold on to during difficult times? What sustains you and keeps you going?
- **O** – **O**rganized religion: Do you consider yourself part of an organized religion? How important is this to you? What aspects of your religion are helpful and not so helpful to you? Are you part of a religious or spiritual community? Does it help you? How?

HOPE QUESTIONS

- **P** – **P**ersonal spirituality/practices: Do you have personal spiritual beliefs that are independent of organized? What are they? Do you believe in God? What kind of relationship do you have with God? What aspects of your spirituality or spiritual practices do you find most helpful to you personally?
- **E** – **E**ffects on medical care and end-of-life issues: Has being sick (or your current situation) affected your ability to do things that usually help you spiritually? (Or affected your relationship with God?) As a doctor, is there anything that I can do to help you access the resources that usually help you? Are you worried about any conflicts between your beliefs and your medical situation/care/decisions? Would it be helpful for you to speak to a clinical chaplain/community spiritual leader? Are there any specific practices or restrictions I should know about in providing your medical care?

Anandarahah, 2001

FACT: SPIRITUAL ASSESSMENT TOOL

- **F** – **F**aith (and/or Beliefs, Spiritual Practices): What is your **F**aith or belief? Do you consider yourself a person of **F**aith or a spiritual person? What things do you believe that give your life meaning and purpose?
- **A** – **A**ctive (and/or Available, Accessible, Applicable): Are you currently **A**ctive in your faith community? Are you part of a religious or spiritual community? Is support for your faith **A**vailable to you? Do you have **A**ccess to what you need to **A**pply your faith (or your beliefs)? Is there a person or a group whose presence and support you value at a time like this?

FACT: SPIRITUAL ASSESSMENT TOOL

- **C** – **C**oping (or **C**omfort); **C**onflicts (or **C**oncerns): How are you **C**oping with your medical situation? Is your faith (your beliefs) helping you **C**ope? How is your faith (your beliefs) providing **C**omfort in light of your diagnosis? Do any of your religious beliefs or spiritual practices **C**onflict with medical treatment? Are there any particular **C**oncerns you have for us as your medical team?
- **T** – Treatment Plan:

1. Patient is coping well
   a. Support and encourage.
   b. Reassess at a later date.
2. Patient is coping poorly
   a. Depending on the patient-clinician relationship and similarity in faith/beliefs, provide direct intervention. This option should be done with caution.
   b. Encourage the patient to speak with their own faith leader to address these spiritual concerns.
   c. Make a referral to the hospital chaplain.

LaRocca-Pitts, 2008

CSI-MEMO

- **CS** – Do your religious/spiritual beliefs provide **Comfort**, or are they a source of **Stress**?
- **I** – Do you have religious/spiritual beliefs that might **Influence** your medical decisions?
- **MEM** – Are you a **MEMber** of a religious/spiritual community, and is it supportive to you?
- **O** – Do you have any **Other** spiritual needs that you'd like someone to address?

Koenig, 2002
Koenig, 2007

SPIRITual: TAKING A SPIRITUAL HISTORY

- **S** – **S**piritual belief **S**ystem: What is your formal religious affiliation? Name or describe your spiritual belief system.
- **P** – **P**ersonal spirituality: Describe the beliefs and practices of your religion or spiritual system that you personally accept. Describe the beliefs or practices you do not accept. What does your spirituality/religion mean to you? What is the importance of your spirituality/religion in daily life?

SPIRITual: TAKING A SPIRITUAL HISTORY

- **I** – **I**ntegration with a spiritual community: Do you belong to any spiritual or religious groups or community? What is your position or role? What importance does this group have for you? Is it a source of support? In what ways? Does or could this group provide help in dealing with health issues?
- **R** – **R**itualized practices and **R**estrictions: Are there specific practices that you carry out as part of your religion/spirituality? Are there certain lifestyle activities or practices that your religion/spirituality encourages, or forbid? Do you comply? What significance do these practices and restrictions have for you? Are there specific elements of medical care that you forbid on the basis of religious/spiritual grounds?

SPIRITual: TAKING A SPIRITUAL HISTORY

- **I** – **I**mplications for medical care: What aspects of your religion/spirituality would you like to keep in mind as I care for you? Would you like to discuss religious or spiritual implications of health care? What knowledge or understanding would strengthen our relationship as physician and patient? Are there any barriers to our relationship based on religious or spiritual issues?
- **T** – **T**erminal events planning: As we plan for your care near the end of life, how does your faith impact on your decisions? Are there particular aspects of care that you wish to forgo or have withheld because of your faith?

Maugans, 1996

OPEN INVITE MNEMONIC

- **Open** – May I ask your faith background? Do you have a spiritual or faith preference? What helps you through hard times?
- **Invite** – Do you feel your spiritual health is affecting your physical health? Does your spirituality impact the health decisions you make? Is there a way in which you would like for me to account for your spirituality in your health care? Is there a way in which I or another member of the medical team can provide you with support? Are there resources in your faith community that you would like for me to help mobilize on your behalf?

Saguil & Phelps, 2012

FAITH SPIRITUAL HISTORY

- **F** – Do you have a spiritual **Faith** or religion that is important to you?
- **A** – How do your beliefs **Apply** to your health?
- **I** – Are you **Involved** in a faith community?
- **T** – How do your spiritual views affect your views about **Treatment**?
- **H** – How can I **Help** you with any spiritual concerns?

King, 2002

THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS QUESTIONS

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has a standard list of general questions that could be used for taking a spiritual assessment. Below are the questions:

- Who or what provides the patient with strength and hope?
- Does the patient use prayer in their life?
- How does the patient express their spirituality?
- How would the patient describe their philosophy of life?
- What type of spiritual/religious support does the patient desire?
- What is the name of the patient's clergy, ministers, chaplains, pastor, or rabbi?

JCAHO QUESTIONS

- What does suffering mean to the patient?
- What does dying mean to the patient?
- What are the patient's spiritual goals?
- Is there a role of church/synagogue in the patient's life?
- How does your faith help the patient cope with illness?
- How does the patient keep going day after day?
- What helps the patient get through this health care experience?
- How has illness affected the patient and his/her family?

jointcommission.org

GOD QUESTIONS

- **G – God**: Is God, spirituality, religion, or spiritual faith important to you?
- **O – Others**: Do you meet with others in a religious or spiritual community? If so, how often? How do you integrate with your faith community?
- **D – Do**: What can I do to assist you in incorporating your spiritual or religious faith into your medical care? Or, is there anything I can do to encourage your faith? May I pray with or for you?

Larimore & Peel, 2000 (as cited in Larimore, 2015)

HOW AND WHEN TO CONDUCT A SPIRITUAL ASSESSMENT

- Once the clinician has determined which spiritual assessment tool is feasible to use, it should be included in the normal health history of the patient's chart.
- The spiritual assessment is a comprehensive and ongoing assessment of the patient and provides health care clinicians with the tools to provide effective spiritual care to patients. The spiritual assessment was not designed to be a mere checklist for the clinician but rather an avenue to open discussion with the patient about their spiritual beliefs and needs.

Puchalski, 2010; Saguil & Phelps, 2012

HOW AND WHEN TO CONDUCT A SPIRITUAL ASSESSMENT

- A spiritual assessment is warranted on all new patients during their initial visit and annually during physical exams on established patients. If a clinician observes signs of spiritual distress in an established patient during a subsequent visit then another spiritual assessment is needed to provide appropriate spiritual care.
- In particular, clinicians should pay attention to patients that make positive or negative comments about their faith or spirituality as a means of initiating a discussion.

Saguil & Phelps, 2012

HOW AND WHEN TO CONDUCT A SPIRITUAL ASSESSMENT

- When assessing for spirituality it is vital for the clinician to document the patient's cultural, religious, and spiritual beliefs/practices that may affect their medical decisions. These should be respected and the clinician should provide adequate information on the patient's health issues so that they can make informed decisions.
- Clinicians should take note that praying is a spiritual care practice that should be initiated by the clinician with caution. If a patient requests that the clinician pray with them, this can be done depending on the clinician's comfort level or the clinician can simply remain in silence with the patient during the prayer.

Saguil & Phelps (2012)

ETHICAL CONSIDERATIONS

- It is important for clinicians to recognize that a discussion on spirituality is always centered on the patient and patient led.
- It is inappropriate for the clinician to ridicule a patient's belief system or force their spiritual/religious views on the patient.
- Questions on spirituality should convey openness to all beliefs, religious or non-religious patients with the purpose of focusing on the holistic person.
- Most importantly clinicians do not have to be experts in all spiritual or religious belief systems. The goal is to learn what is important to the patient.

Puchalski, 2010

CLINICAL VIGNETTE

A 39 year old woman presents for an initial infertility visit. She says to the nurse practitioner, "I have only one child and she is 10 years old. Over the past 3 years I have been trying to have a baby but can't get pregnant. I really want to have another child before it's to late. I pray often over this issue but my prayers seem to be going unanswered. Maybe it's just not my destiny."

USING THE FICA TOOL TO ASSESS THIS PATIENT

- **F** – (**Clinician**) Do you have spiritual beliefs that help you cope with stress? (**Patient**) "I attend church often and pray. I also enjoy listening to relaxing music and meditating during my quiet time."
- **I** – (**Clinician**) What importance does attending church, praying, listening to relaxing music and meditating have in your life? (**Patient**) "These things help me to get through the stress of dealing with not being able to get pregnant and life in general."
- **C** – (**Clinician**) Are you part of a spiritual or religious community? Is this of support to you and how? (**Patient**) "I have two friends that I get together with often that have been a source of comfort to me. They are not part of my church but they do keep me in their prayers.
- **A** – (**Clinician**) What action steps do you need to take in your spiritual journey? (**Patient**) "Discussing this has made me realize more how important my friends are to me. Im going to reach out to them more for comfort."

ASSESSMENT OF THE CLINICAL VIGNETTE

- In using the FICA Tool the nurse practitioner discovered that this patient does engage in spiritual practices. This is manifested by the patient praying, listening to music and meditation. She also attends a particular church often.
- The nurse practitioner can encourage the patient to bring a portable musical device with headphones so she can listen to her relaxing music while waiting to see her fertility clinician. Frequent bonding with her friends should also be emphasized. Another spiritual care intervention should be to encourage this patient to speak with her religious leader to address her feelings of not having her prayers answered by God.
- Now that a rapport has started between the nurse practitioner and the patient, the clinician should use this opportunity for future discussions on spirituality and spiritual care interventions.

WHY SPIRITUAL CARE?

- Swinton (2001) postulates spiritual care as a therapeutic understanding in which the clinician steps into the patient's experience and promotes and imparts understanding, compassion and empathy.
- Spiritual care practices are meaning centered and therapeutic to patients. Therefore, clinicians should use spiritual care practices to propel healing in patients.
- Clinicians can use spiritual care to assist patients experiencing spiritual distress to find meaning and purpose in life as it relates to their crises.

Ramezani, Ahmadi, Mohammadi & Kazemnejad (2014)
Swinton (2001)

SPIRITUAL CARE FOR INFERTILE WOMEN

- Providing spiritual care to women experiencing infertility is meant to enhance their spiritual well-being in the wake of their journey to achieve motherhood.
- Experiencing infertility is a sensitive period in the lives of women. Clinicians play an important role in supporting emotional wholeness in women with infertility and knowledge of spiritual care can aid clinicians in intervening with these women's crises.
- Spiritual care comprises of many different techniques to bring the woman back to spiritual well-being.

Roudsari, Allan, & Smith (2007)

SPIRITUAL CARE PRACTICES

- Maintain dignity
- Listening
- Meditation
- Music therapy
- Praying
- Fasting (as appropriate)
- Spiritual support groups
- Referral to spiritual advisor
- Holding hands
- Encourage attendance in church service
- Assist patient to identify sources of motivation
- Encourage reminiscence
- Reading supportive material

Kisvetrová et al. (2013), Sartori (2010) Sperry (2001)

CLINICAL VIGNETTE

A 29 year old female patient presents to the fertility clinic for a subsequent visit for her primary infertility. The patient says to the nurse, "I can't believe all the tests I have to go through. I'm getting a bit stressed out and I just started this process. How do women get through this?"

USING THE HOPE QUESTIONS TO ASSESS THIS PATIENT

- **H** – (**Clinician**) What is there in your life that gives you internal support? (**Patient**) "After work I enjoy going for long walks in the park. It's a time for me to clear my head. Being out in nature and smelling the air helps me to relax. I have inspirational books that I sometimes bring along and sit in the park and read. Sometimes I invite a couple of girl friends to join me in walking. We help each other out in times of trouble."
- **O** – (**Clinician**) Are you part of a religious or spiritual community? (**Patient**) "I don't attend church if that's what you mean. I'm not tied to any religious organization. My parents were not very religious so I never really had the church experience growing up. My walking buddies are my confidants and are supportive."

USING THE HOPE QUESTIONS TO ASSESS THIS PATIENT

- **P** – (**Clinician**) Do you have personal spiritual beliefs that are independent of organized? (**Patient**) "I don't consider myself spiritual if you mean religious." (**Clinician**) It doesn't necessarily have to mean religious, your spiritual beliefs are those things that give you meaning and purpose in life. (**Patient**) "Okay I see what you mean. I guess walking in the park and being one with nature helps me to connect with something outside of myself. The books I read also help to make me resilient."
- **E** – (**Clinician**) Has experiencing infertility affected your ability to do things that usually help you spiritually? (**Patient**) "Being unable to get pregnant has made me really question my womanhood. Sometimes I don't want to be bothered. I guess this has affected my frequency of going for walks".

ASSESSMENT OF THE CLINICAL VIGNETTE

- The HOPE Questions provided the nurse with valuable information of the patient's spiritual beliefs and practices. The patient uses walking in the park as a means of being close to nature, and her inspirational reading material to cope with stress.
- Even though this patient does not belong to a religious community, her walking buddies are part of her spiritual community as they offer an interpersonal connection to this patient.
- The nurse can encourage and support the patient in recognizing her sources spiritual practices as an ongoing process.

WRAP-UP

- Spirituality is a component of health care that clinicians cannot afford to neglect. Assessing for spirituality should be integrated in the plan of care of all patients.
- Clinicians should be aware of signs of spiritual distress and promote spiritual care to empower healing in patients.
- Lastly, ethical considerations are reminders to clinicians in conducting spiritual assessments and providing spiritual care while upholding the principles of beneficence and nonmaleficence.

Pulchalski (2010)

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Appendix D

Spirituality Educational Module Evaluation Form

Instructions: Please circle the answer that describes your agreement to each of the statements listed below.

Statements	Strongly Disagree	Disagree	Agree	Strongly Agree
1. The spirituality educational module clearly defined spirituality, spiritual distress, spiritual assessment, and spiritual care.	1	2	3	4
2. The spirituality educational module gave me vital information on how to conduct a spiritual assessment.	1	2	3	4
3. The spirituality educational module provided me with knowledgeable information on how to provide spiritual care to women experiencing infertility.	1	2	3	4
4. The clinical vignettes further enhanced my learning.	1	2	3	4
5. The spirituality educational module flows sequentially.	1	2	3	4

6. The slides in the spirituality educational module were not over crowded.	1	2	3	4
7. The graphics within the spirituality educational module engages the learner.	1	2	3	4
8. The readability of the spirituality educational module was clear.	1	2	3	4
9. The length of the spirituality educational module was appropriate for the topic.	1	2	3	4
10. The spirituality educational module will be an asset to health care clinicians.	1	2	3	4

Please provide any additional comments below.

Appendix E

Spirituality Posttest

Developed by Lesa Miller

Directions: Please circle the one best option

1. The initial step in conducting a spiritual assessment is for the health care clinician to:
   a) Gather information on various dominations.
   b) Share his or her views of spirituality with his or her patients.
   c) Examine his or her own personal beliefs and practices. **(Answer)**
   d) Engage in prayers with his or her patients.

2. The health care clinician is conducting an initial spiritual assessment on a 42 year old female patient experiencing primary infertility. This patient states that she has "almost lost hope of becoming a mother." The clinician should
   a) Be honest about her diagnosis.
   b) Recognize this as a sign of spiritual distress. **(Answer)**
   c) Tell her to give the treatment plan more time.
   d) Tell the female patient not to worry she is still young.

3. The concept of spirituality can best be defined as:
   a) Membership in an organized group and participation in rituals and practices pertaining to that denomination.

b) An individual's desire to achieve a goal in life.

c) Something which constitutes religious beliefs.

d) Making meaning through a sense of relatedness within oneself, others, the environment and a power greater than the self. **(Answer)**

4. The spiritual assessment is an ongoing process for the clinician to learn about the spiritual needs of their patients and discussions should be

a) Patient centered and patient led. **(Answer)**

b) Directed by the clinician to engage discussions.

c) Tailored to help the patient understand the clinician's spiritual views.

d) All of the above.

5. A clinician is caring for a 38 year old woman with secondary infertility. The patient says to the nurse, "I'm low in spirit would you pray with me?" The clinician does not consider herself as a spiritual or religious person. What would be the best clinician intervention?

a) Refer the patient to her religious leader.

b) The clinician should inform the patient that praying is not part of her duties.

c) Offer to remain with the patient during the prayer. **(Answer)**

d) Find another clinician that shares the same beliefs to pray with the patient.

6. The clinician is assessing spirituality in a female patient presenting with primary infertility for the first time, how should the clinician begin?

a) Ascertain the personal belief system of the patient. **(Answer)**

b) Giving the patient various religious literature and resources.

c) Making a referral to the chaplain.

d) Offer to pray with the client.

7. The nurse practitioner is caring for a 37 year old woman experiencing secondary infertility. She informs the nurse practitioner that there are certain treatments in her plan of care that conflicts with her spiritual beliefs. As this patient's clinician, what is the best course of action?

a) Tell the patient that these are her options if she wants to get pregnant.

b) Help the patient in getting the necessary information to make an autonomous informed decision. **(Answer)**

c) The nurse practitioner should give her own opinion of the situation.

d) The nurse practitioner can provide examples of what other patients have done in similar cases.

8. The doctor is conducting a spiritual assessment on a 40 year old female patient diagnosed with primary infertility. Upon assessment the doctor finds himself disagreeing with the patient on her personal spiritual beliefs. Which of the following statements poses an ethical dilemma?

a) "Your beliefs are really foreign to me. I can't believe people think that way." **(Answer)**

b) "That is interesting, please elaborate."

c) "I would really like to know more and how this affects your health decisions."

d) "As you're doctor, I am here to support your spiritual needs."

9. A female patient with infertility presents for a visit with her fertility clinician. She is crying and is anxious about all the fertility treatments. The clinician recognizes spiritual distress by which statement by the patient?

a) "My pastor is coming to pray for me and my husband tomorrow."

b) "I can't understand why God doesn't want to bless me with a baby." **(Answer)**

c) "I just don't feel like going out and socializing."

d) "When am I going to stop feeling this way?"

10. Upon assessment, a 28 year old infertile patient tells the physician assistant that she often reads Christian meditation books to boost her spirit and relieve stress. Which spiritual care intervention should the physician assistant recommend?

a) Tell the patient that stress is all in the mind.

b) Ask the patient to bring her reading material so that you can review them.

c) The clinician should provide his/her own recommended reading materials.

d) Encourage the patient to bring her inspirations books to her appointments. **(Answer)**

11. A Muslim patient tells her clinician that she will be starting her fasting for the Ramadan season and cannot keep up with some of the fertility treatments in her plan of care. The clinician's course of action is to:

a) Ask the patient when does her fasting period start and end so treatment can be rescheduled for another time. **(Answer)**

b) Remind the patient that she wants to get pregnant and she has to make some adjustments to achieve her goal.

c) Tell the patient fasting is contraindicated during her infertility treatments.

d) Let the patient know that as her clinician, you are first concerned with her physiological aspects of care.

12. A female patient has just completed her fourth unsuccessful cycle of IVF. She is devastated and feels she has nothing to live for. What is the best spiritual care intervention that the clinician can offer?

a) Let the patient's family deal with her emotions.

b) Tell the patient life has to go on.

c) Assist the patient in resolving her spiritual distress and to find other ways to parenthood. **(Answer)**

d) Make a referral to the Chaplain.

13. A 34 year old patient experiencing secondary infertility tells the clinician that going biking with her biking group gives meaning to her life as she fellowships with a group that shares a common interest. The clinician recognizes this as:

a) A patient hobby.

b) An ineffective way of coping with her infertility.

c) A religious activity.

d) A spiritual care practice that gives the patient meaning and purpose in life. **(Answer)**

14. Clinicians apply the use of spiritual care as a therapeutic understanding through:
    a) Helping the patient understand the clinician's feelings of spiritual care.
    b) Stepping into the patient's experience and promoting empathy. **(Answer)**
    c) Providing distractions so that the patient will not think of their diagnosis.
    d) Linking physical health with psychological health.

15. A doctor tells a fellow colleague, "I'm not an expert in all spiritual belief system or religions, how can I incorporate spirituality with my patients?" The colleague understands that the goal of incorporating spirituality in patient care is to:
    a) Lead most of the conservations about spirituality with the patient.
    b) Attend various conferences on different belief systems.
    c) Learn what is important to the patient. **(Answer)**
    d) Referral all spiritual assessments and care to the Chaplain.