

# Spiritual Care Nursing: Attitudes and Importance

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## The Conceptual Framework of Spiritual Care Nursing

The integration of spiritual care within the professional practice of nursing represents a crucial commitment to **holistic patient care**, acknowledging that human well-being encompasses physical, psychological, social, and spiritual dimensions. Spiritual care nursing is not merely an optional addendum to clinical routines; rather, it is viewed by many professional bodies, including the American Nurses Association (ANA), as an indispensable component of comprehensive, person-centered health provision. This framework necessitates that nurses recognize, assess, and address the spiritual needs of their patients, which may include needs related to meaning, purpose, hope, faith, love, relatedness, forgiveness, and transcendence. The effectiveness and consistency of this care, however, are fundamentally mediated by the attitudes held by the individual nurse toward spirituality and its role in the healthcare setting. If a nurse harbors skepticism, discomfort, or indifference, the provision of genuine spiritual support becomes compromised, regardless of institutional policies.

Understanding the conceptual foundation of spiritual care requires differentiating it clearly from religious care. While religion is one pathway through which spirituality may be expressed, spirituality itself is a broader concept, often described as the dimension that gives meaning and direction to life, especially during times of crisis, illness, or suffering. Spiritual care, therefore, involves creating an environment where patients feel safe to explore their existential concerns and draw upon internal resources for coping. This requires nurses to possess high levels of **empathy**, self-awareness, and sensitivity to diverse belief systems. When nurses adopt a positive attitude toward this framework, they are more likely to engage in behaviors such as active listening, presence, and facilitating access to chaplains or community resources, ensuring that the patient's entire spectrum of needs is addressed throughout the continuum of care.

The attitudes held by nurses are critical determinants of care quality because they dictate the level of importance assigned to spiritual assessment and intervention relative to other clinical tasks. A positive attitude often stems from an understanding that spiritual distress can manifest physically, exacerbating pain, anxiety, and depression, thereby impeding recovery. Conversely, negative attitudes often arise from a perceived lack of time, professional boundaries, or a fundamental misunderstanding of what spiritual care entails, often conflating it strictly with proselytization or complex theological discussions. The evolution of nursing standards continuously reinforces the professional obligation to integrate this care, yet sustained progress depends heavily on shifting individual attitudes from viewing spiritual care as an abstract ideal to recognizing it as a concrete, actionable element of daily professional responsibility.

## Defining and Differentiating Nurse Attitudes

In the context of psychological and sociological research, an attitude is defined as a relatively

enduring organization of beliefs, feelings, and behavioral tendencies directed toward a socially significant object, group, event, or symbol. When applied to spiritual care nursing, an attitude is the nurse's predisposition to respond favorably or unfavorably to the concepts, tasks, and responsibilities associated with addressing patients' spiritual needs. These attitudes are complex and typically possess three interconnected components: the cognitive, the affective, and the behavioral. The **cognitive component** involves the nurse's knowledge and beliefs about spiritual care--for instance, believing that spiritual health impacts physical recovery. The **affective component** relates to the feelings evoked by spiritual care, such as comfort, anxiety, or awkwardness when discussing death or meaning. Finally, the **behavioral component** reflects the actual readiness or intention to act, such as regularly asking patients about their sources of strength or facilitating prayer requests.

Differentiating these components is vital for effective training and intervention. A nurse might possess strong cognitive agreement--understanding theoretically that spiritual care is important--but simultaneously struggle with the affective component, experiencing high levels of discomfort or fear when engaging in deep spiritual discussions. This dissonance often prevents the behavioral component from manifesting positively, resulting in avoidance or superficial interactions. Furthermore, attitudes toward spiritual care are often distinguished along dimensions of personal relevance and professional responsibility. Some nurses may highly value their personal spirituality but struggle to integrate that into their professional role due to fears of violating professional boundaries or imposing their own beliefs. Conversely, others may view spiritual care strictly as a professional duty mandated by ethical codes, which, while ensuring compliance, may lack the genuine warmth and presence necessary for effective spiritual support.

The measurement of attitudes toward spiritual care attempts to capture the nuances between these components, moving beyond simple self-reporting of perceived importance. Research often reveals a significant gap between reported positive attitudes (cognitive and affective agreement) and actual implementation (behavioral component). This gap highlights the influence of contextual factors, such as workload and institutional support, but also underscores the deeply ingrained nature of personal attitudes. For attitudes to translate into consistent, high-quality spiritual care behaviors, they must be internalized, moving past mere intellectual acknowledgement to becoming a foundational element of the nurse's professional identity and ethical commitment. This transformation requires sustained reflection and often challenges the nurse to confront their own existential beliefs and comfort levels regarding human suffering and mortality.

## Factors Influencing Positive and Negative Attitudes

A multitude of factors, both internal and external, converge to shape a nurse's attitude toward the provision of spiritual care. One of the most significant internal factors is the nurse's own level of **personal spirituality** or religious commitment. Studies consistently show that nurses who report a

higher degree of personal spiritual well-being or who actively engage in religious practices tend to hold more positive attitudes toward addressing the spiritual needs of others. They often possess greater comfort discussing sensitive topics and a deeper appreciation for the role of faith and meaning in coping mechanisms. However, this factor is complex; while personal spirituality can foster positive attitudes, it can also pose a risk if the nurse lacks cultural humility, potentially leading to projection of personal beliefs onto the patient rather than meeting the patient where they are spiritually.

External factors, particularly **educational background** and professional experience, play a crucial role in attitude formation. Nurses who received comprehensive, mandatory education on spiritual care assessment and intervention during their formal training are statistically more likely to possess positive attitudes, primarily because education increases confidence and reduces anxiety associated with the unknown. Conversely, a lack of formal training often leads to negative or ambivalent attitudes stemming from feelings of inadequacy, a perceived lack of the necessary skills, or uncertainty about the scope of practice. Furthermore, the clinical environment itself shapes attitudes; nurses working in settings where spiritual care is visibly valued, modeled by senior staff, and supported by interdisciplinary collaboration (such as palliative care or hospice) often develop more positive attitudes than those in high-acuity, task-oriented environments where spiritual concerns may be marginalized.

Demographic variables, such as age, cultural background, and years of experience, also contribute to attitude heterogeneity. Older nurses, or those with more years of clinical experience, sometimes report greater comfort and positive attitudes, possibly due to increased exposure to diverse patient needs and greater wisdom regarding the human experience of illness. However, younger nurses who have received modern, holistic education may also exhibit highly positive attitudes, suggesting that formal curriculum integration can override the influence of years of practice. Cultural factors are paramount; in societies where spirituality is deeply embedded in the healthcare narrative, nurses may naturally possess more positive attitudes. In contrast, highly secularized environments may present greater challenges, requiring nurses to actively bridge the gap between scientific, evidence-based practice and the subjective, existential domain of spirituality, emphasizing the need for **professional competence** rather than personal faith.

## The Role of Education and Training

The inadequacy of formal education remains one of the primary systemic hurdles contributing to negative or uncertain attitudes toward spiritual care nursing. If nurses are not equipped with the requisite knowledge and practical skills, their confidence diminishes, leading to avoidance behavior rooted in fear of incompetence or ethical misstep. Effective educational programs must move beyond theoretical definitions to incorporate practical, experiential learning methods. This includes mandatory coursework detailing spiritual assessment tools, models of spiritual distress, and

techniques for therapeutic presence and active listening. Crucially, education must emphasize the difference between providing spiritual care and acting as a religious counselor, clearly delineating the nurse's role as a facilitator and supporter of the patient's own spiritual journey, rather than a provider of theological answers.

High-quality training programs are instrumental in transforming attitudes by addressing the affective component--the discomfort and anxiety associated with spiritual discussions. Techniques such as **reflective practice**, case studies involving complex spiritual distress, and simulated patient encounters where students practice conducting spiritual assessments (e.g., using the FICA or HOPE tools) can significantly reduce emotional barriers. When students are guided to explore their own spiritual beliefs and biases in a supportive academic setting, they become more self-aware and capable of maintaining professional objectivity while delivering compassionate care. This process helps nurses recognize that the goal is not to solve spiritual crises but to acknowledge them and provide respectful support, thereby reframing the task as manageable and appropriate within the nursing scope of practice.

Continuing professional development (CPD) is equally vital for reinforcing positive attitudes among practicing nurses, especially those who received limited spiritual care education during their initial training. Short, focused workshops utilizing interdisciplinary perspectives--bringing in chaplains, ethicists, and palliative care specialists--can provide practical strategies for integration into busy clinical workflows. Furthermore, institutional commitment to ongoing education signals to staff that spiritual care is a priority, thereby validating the effort required. Effective training, whether initial or ongoing, serves as a powerful antidote to negative attitudes, replacing uncertainty with competence and discomfort with confidence, ultimately solidifying the cognitive belief that spiritual care is both necessary and achievable within the demanding realities of modern healthcare.

## Identified Barriers to Implementation

Even when nurses report positive attitudes toward the importance of spiritual care, significant practical barriers often impede its consistent implementation, creating a gap between ideal practice and daily reality. The most frequently cited barrier is **time constraint** and heavy workload. In high-acuity settings, nurses often prioritize immediate physiological needs and critical tasks, viewing spiritual assessment as a non-urgent activity that can be postponed or skipped entirely. This perception is compounded by inadequate staffing levels and increasing administrative demands, which reduce the necessary margin of time required for deep, meaningful patient interaction--the cornerstone of effective spiritual support. If the institutional culture does not explicitly allocate time or resources for spiritual care documentation and intervention, even the most positive attitudes will struggle to translate into consistent action.

A second major barrier is the perceived lack of institutional and peer support. If spiritual care is not

integrated into official hospital policies, documentation systems, and performance evaluations, nurses may feel unsupported or risk being perceived by colleagues as unprofessional or inefficient when they prioritize spiritual conversations. Nurses are often reluctant to initiate complex spiritual discussions if they lack clear referral pathways to specialized resources, such as certified chaplains. When the interdisciplinary team fails to communicate about the patient's spiritual needs, the nurse may feel isolated in their attempts to provide holistic care. Furthermore, a lack of **leadership modeling**--where senior nurses and managers do not visibly prioritize or engage in spiritual care--can subtly reinforce negative attitudes among junior staff, suggesting that this domain of care is expendable.

Finally, personal discomfort and the fear of imposing beliefs serve as powerful psychological barriers, particularly when addressing patients with different religious or cultural backgrounds. Nurses may fear offending the patient, crossing professional boundaries, or initiating discussions they feel unqualified to handle. This fear often leads to avoidance or the adoption of overly generalized, superficial approaches to spiritual assessment. Overcoming this requires not only education but also the cultivation of **cultural humility**--the recognition that one cannot be an expert in every spiritual tradition, but one can always be an expert in asking open-ended questions and listening without judgment. When nurses understand that their primary role is one of compassionate presence and facilitation, rather than prescription, these psychological barriers tend to diminish.

## Impact on Patient Outcomes and Professional Satisfaction

Positive attitudes toward spiritual care nursing are strongly correlated with improved patient outcomes, underscoring the clinical relevance of this domain. When nurses confidently and genuinely integrate spiritual support, patients often report enhanced coping mechanisms, reduced anxiety, and a greater sense of peace, particularly at the end of life or during chronic illness management. Spiritual distress is known to amplify physical symptoms, including pain intensity and depression; therefore, effective spiritual intervention can indirectly improve physical health metrics. Providing opportunities for patients to express their existential concerns, connect with their source of hope, or reconcile feelings of guilt or regret contributes significantly to their overall quality of life and adherence to treatment plans. This demonstrates that positive nurse attitudes are not merely about kindness, but about delivering care that is clinically and ethically sound.

The impact of positive attitudes extends equally to the nurse's professional well-being and job satisfaction. Engaging in meaningful spiritual care allows nurses to fulfill the ethical mandate of holistic care, leading to a greater sense of purpose and professional integrity. When nurses feel they have truly connected with a patient on a deep, human level, they often experience lower levels of emotional exhaustion and burnout. The act of providing comfort and meaning, even in the face of profound suffering, reinforces the value and dignity of the nursing profession. Conversely,

when nurses feel compelled to ignore or suppress spiritual needs due to negative attitudes or lack of confidence, they may experience moral distress, feeling that they are failing to meet the full scope of their professional commitment, which contributes significantly to career dissatisfaction and attrition.

Moreover, positive attitudes foster a better therapeutic alliance between the nurse and the patient. Trust is deepened when a patient feels fully seen and heard, including their non-physical dimensions. This robust relationship facilitates communication, improves patient compliance, and enhances collaborative decision-making, especially in complex or sensitive situations. Therefore, the cultivation of positive attitudes toward spiritual care should be viewed not just as a matter of ethical nicety, but as a strategic imperative for improving both the human experience of illness and the sustainability of the nursing workforce. Institutions that invest in fostering positive attitudes are fundamentally investing in **quality assurance** and staff retention.

## Measuring Attitudes: Scales and Methodologies

Accurately measuring attitudes toward spiritual care is essential for research purposes, educational evaluation, and identifying specific areas where professional development is needed. Researchers utilize various psychometric instruments designed to quantify the cognitive, affective, and behavioral components of these attitudes. One widely recognized tool is the **Spiritual Care Attitude Scale (SCAS)**, which assesses the perceived importance of spiritual care, comfort level in providing it, and the perceived barriers to implementation. Other specialized tools may focus on specific populations, such as palliative care nurses, or on particular aspects, such as religious bias or cultural sensitivity. These scales typically employ Likert-type response formats, allowing participants to express the degree of their agreement or disagreement with a series of statements.

While quantitative scales provide reliable data on prevalence and correlations, qualitative methodologies offer invaluable depth by exploring the nuances and rationales underlying expressed attitudes. Methods such as focused interviews, reflective journaling, and thematic analysis of narrative data allow researchers to uncover the specific experiences--positive or negative--that have shaped a nurse's approach to spiritual care. For instance, a quantitative scale might indicate low confidence (negative attitude), but a qualitative interview might reveal that this lack of confidence stems from a single traumatic experience where the nurse felt ill-equipped to handle a patient's acute spiritual distress. Combining these methodologies (mixed methods research) provides the most comprehensive understanding, linking numerical data on attitude strength with the contextual factors that influence their formation and expression.

Challenges in attitude measurement include the risk of social desirability bias, where nurses may over-report positive attitudes because they understand the professionally acceptable response. To mitigate this, robust scales are designed with carefully worded items that indirectly assess comfort

and behavioral intention rather than relying solely on direct importance ratings. Furthermore, cross-cultural validity is a critical consideration. Instruments developed in one cultural context may not accurately reflect attitudes in another, necessitating rigorous translation, adaptation, and validation processes to ensure that the concept of spirituality being measured resonates appropriately within the target population of nurses. Effective measurement is the foundation upon which targeted educational and policy interventions can be built to systematically enhance **spiritual care competency**.

## Strategies for Fostering Positive Attitudes

Fostering positive attitudes toward spiritual care requires a multifaceted approach that addresses education, institutional culture, and individual reflection. At the institutional level, leadership must clearly articulate spiritual care as an organizational priority, not just an individual preference. This involves integrating spiritual care documentation into electronic health records, ensuring adequate staffing levels to allow time for meaningful interaction, and providing consistent access to interdisciplinary resources, particularly chaplaincy services. Policy changes that formally recognize and reward nurses who demonstrate excellence in holistic and spiritual care can significantly reinforce the behavioral component of positive attitudes, signaling that this domain is valued equally alongside technical proficiency.

Educationally, strategies must focus on experiential learning and self-reflection.

**Mandatory Curriculum Integration:** Ensuring all nursing students receive robust, standardized education on spiritual assessment and intervention techniques.

**Reflective Practice Groups:** Establishing small group forums where nurses can safely discuss challenging spiritual care situations, process their emotional responses, and learn from peer experiences.

**Interprofessional Training:** Conducting joint training sessions with chaplains, social workers, and palliative care teams to clarify roles, build referral confidence, and promote collaborative approaches.

**Mentorship Programs:** Pairing experienced nurses who demonstrate positive spiritual care attitudes with junior staff to model effective communication and presence.

These strategies help normalize spiritual discussions and reduce the perception that this type of care is complex or intimidating.

Ultimately, the most profound shift in attitude often comes from personal, sustained **self-reflection**. Nurses must be encouraged to explore their own existential beliefs, confront their comfort levels with suffering and death, and recognize how their personal worldview impacts their professional

interactions. Utilizing tools like journaling or guided meditation can enhance self-awareness, allowing nurses to approach patient spirituality with genuine curiosity and respect, rather than fear or judgment. By systematically addressing the cognitive, affective, and behavioral components through policy, education, and reflection, healthcare systems can transition from merely acknowledging the importance of spiritual care to ensuring that nurses possess the consistently positive attitudes necessary to deliver it effectively.

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