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Documenting the Role of Spirituality in Improving Healthcare Outcomes for Vulnerable Populations

Antonia Monk Reaves

North Carolina A&T State University

A dissertation submitted to the graduate faculty

in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Department: Leadership Studies

Major: Leadership Studies

Major Professor: Dr. Forrest Toms

Greensboro, North Carolina

2014

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2014

Dedication

God, I dedicate this dissertation to you. I am thankful for the revelation you gave me during my first semester in the doctoral program that led to my dissertation topic. Recognizing that Jesus exhibited extraordinary leadership skills that inspired the Apostle Paul to go on to be one of the most influential leaders in our history, I was motivated to focus my research on a topic that would incorporate spiritual leadership. I dedicate my work as well to my maternal grandmother, my paternal grandfather, my parents, my children, my siblings, my sister-friends, and the love of my life.

Mama, on the day I was born, you proclaimed that I would one day be successful. Even when the doctors and nurses looked at you in amazement, you stood strong with an unshakable faith that your granddaughter would one day be someone that others would admire and emulate. You were living proof that if you have the faith to believe, all things are possible. Your journey here on earth ended far too early to see me succeed, but in your heart you still believed, you continued to pray that the granddaughter who read books to you would one day achieve great honors. This dissertation is dedicated in part to you for establishing a strong foundation for my life.

Granddaddy as I reflect on the cigar box you gave me on my first day of school to put my pencils in. I can’t help but get misty-eyed because your love for me helped to right so many wrongs. I never got to thank you for picking me up from school, making me homemade ice cream and spending one-on-one time with me. But I think my genuine love for you was abundantly clear. Your earthly journey was far too short, but I thank you for investing in my initial educational pursuits and helping me to see the humor in all things.

Mom, during our last conversation on this side of heaven you asked if I had been accepted into the graduate program. I could hear the disappointment when I said my GRE scores were not high enough and I needed to retake the test. You told me that it would happen (and it did, without a retake), if I had the faith to believe that God would do it. It is that type of faith that sustained me through graduate school and ultimately through the doctoral program. Even when it seemed an impossibility you always believed that one day people would call your first born daughter Doctor. Your faith in me never wavered, even as I completed my undergraduate degree with less than stellar achievement. Your unfailing love and faith ignited a fire in me to honor your wishes that I achieve the highest level of education possible. When the doctoral degree is conferred, I will accept it knowing that without your love, spiritual guidance and support for the first 31 years of my life, this achievement would not have been possible.

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My beloved children thank you for all the sacrifices you made so that I could spend many hours most weekends writing this dissertation. I know it was frustrating and often times inconvenient but I appreciate you. You are amazing children and the joys of my life.

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Biographical Sketch

Antonia Monk Reaves, Vice President and Senior Program Officer for the Cone Health Foundation, has more than 20 years of experience in nonprofit management, including project management, grant management, community building and strategic communications. She holds a master's degree in public administration with a concentration in nonprofit management and public personnel from the University of North Carolina at Greensboro. She also earned a postgraduate Advanced Certificate in Nonprofit Leadership from Duke University and completed Biblical studies at the Church of God in Christ Academy, graduating with honors. At the Foundation, she oversees all grant making efforts, works closely with grantees addressing access to care, mental health and substance abuse. She is passionate about improving the health status of the community and enjoys working with other community leaders to address the critical health issues facing community residents.

Reaves joined the Foundation in January 1999 as the Communications Director and Program Officer. Prior to joining the Foundation, Reaves worked five years as the Senior Community Collaborations and Initiatives Specialist/Bridges to Success Co-Project Director at United Way of Greater Greensboro, and for several years as Project Manager for the Robert Wood Johnson Foundation's Partners in Caregiving: Dementia Care and Respite Services Program. During her career she has also worked as Magnet School Recruitment Coordinator for the Greensboro City Schools, and Community Relations Director at the Greensboro Housing Authority. Personal accomplishments include being a Licensed Evangelist/Missionary, a former Instructor for Duke University's Nonprofit Management Certificate Program, a Graduate of Leadership Greensboro, and a recipient of the Greensboro Chamber of Commerce Leadership Medal.

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Abstract

This ethnographic study documented the outcomes of the congregational nursing program in clinical settings where leaders and caregivers included consideration of patient spiritual needs to improve health outcomes and reduce care disparities. Spiritual leadership (SL) was my guiding theoretical orientation. Compared to motivation-based theories of leadership, SL is the most inclusive of leadership theories that encompass ethics, values and religion.

My study addressed the following questions in congregational nursing health care programs: In what ways can the level of spiritual leadership be described and documented? How is spiritual leadership characterized and practiced? How can patient spiritual well-being be described and documented? How is patient spirituality characterized? Do patients perceive their spiritual well-being is influenced by the spiritual leadership of health care providers?

Drawing on the interpretivist/constructivist paradigm (Guba & Lincoln, 2005), my study employed case study methods (Flyvbjerg, 2011) to capture patterns involving spiritual leadership and patient perceptions regarding outcomes of including spirituality in their health care treatment plan. Healthcare organizations are becoming aware that the autocratic style of leadership is no longer effective, and institutions might be better served by employing spiritual leadership principles. My study has documented the strong connection between spiritual leadership, patient care and spiritual well-being. This study holds the potential to contribute to the body of knowledge surrounding the effectiveness of spiritual leadership in health care settings. It also has the potential to inform the way community health is delivered in the future to maximize effectiveness and improve overall health outcomes of target populations.

CHAPTER 1

Examining the Role of Spirituality in Overcoming Health Care Disparities

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

~ Dr. Martin Luther King, Jr.

This study documents the stakeholder perceptions of the outcomes of the congregational/parish nursing health care innovation in clinical settings in which caregiver/leaders included consideration of patient spiritual needs in order to improve health outcomes and reduce care disparities that originate in a lack of understanding. Only recently have any studies observed the phenomena of the impact of spirituality on health care and health outcomes (Katerndahl, 2008; Koenig, George & Titus, 2004; Puchalski, 2001b). As a result of this limited scholarship, knowledge of how the inclusion of spirituality in treatment plans can assist health care providers in designing culturally specific interventions based on the beliefs of patients, is definitely lacking (Figueroa, Davis, Baker, & Bunch, 2006). My research adds to the knowledge base on outcomes of health care innovations that include consideration of patient spiritual needs, by documenting stakeholder understandings of the outcomes of such practice within clinical settings. I argue that incorporation of spirituality in health care holds promise to improve health outcomes and ultimately reduce health care disparities that originate in a lack of understanding.

Health disparities continue to be pervasive in the Black community. Racially and ethnically diverse populations tend to receive a lower quality of health care than Whites, even when access-related factors such as patients' insurance status and income are controlled (Smedley, Stith, & Nelson, 2002). The sources of these disparities are complex, rooted in

historic and contemporary inequities, and involve many participants at multiple levels (Agency for Healthcare Research and Quality [AHRQ], 2003).

Nationally, health outcomes have generally improved for both Caucasians and African Americans in the last decade. However, even with all of the advances in medical technology and increased access to care for some populations, people of color remain disproportionately impacted by a greater incidence of major health problems (National Center for Health Statistics, 1998). Data indicate that African Americanss over time have higher incidence rates of morbidity and mortality than their Caucasian counterparts for nearly all physical health indicators (Williams & Rucker, 2000).

In the county of my three research sites, the disparities mirror those within the nation. In 2012, 360 (633 total) teens ages 15–19 of color gave birth, compared to 157 White teens and 75 Hispanics in the same age range. Mental illness occurs 30% more often among African American adults than non-Hispanic White adults. Suicide attempt rates are almost twice as high among Hispanic adults. In 2011, African-Americans in this county had an HIV Disease rate of 61.8 per 100,000 while the rate for Whites was 5.4 per 100,000; African Americans were 11 times more likely to be infected with HIV than Whites. Significant disparities and inequities exist in this locale (The State of Guilford County's Health Report, 2012).

The National Institute of Health (NIH) defines health disparities as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States" (NIH, 2011, "Health Disparities Defined," para. 3). Health disparities include inconsistencies in health care such as differences in access to medical care and differences in health outcomes and prevalence of modifiable risk factors (Saha, Arbelaez, & Cooper, 2003). The Centers for Disease Control (CDC) define health

disparities as “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Disparities often begin early in life, starting during childhood or adolescence” (CDC, 2013, “Health Disparities,” para. 1). Such disparities are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources (CDC, 2013). “ In addition to race and ethnicity, health disparities also exist on the basis of sex, age, income level, geography, sexual orientation, disability, and special health care needs” (http://www.cufhc.org/healthdisparities.htm).

According to the national results of the CDC’s Youth Risk Behavior Survey (Eaton et al., 2009), young people from racially and ethnically diverse groups in the U.S. suffer disproportionately from a number of preventable diseases and health problems. For example:

- Studies show that in comparison with white youth, Hispanic and black youth show higher prevalence of asthma, obesity, and type 2 diabetes. Sexually transmitted diseases, HIV/AIDS, and teenage pregnancy rates are elevated among Hispanic and black youth than among whites in the same age bracket. (HCP live, 2011)
- 2007 studies which represented a mere 15% of the population of the 13-19 year old age group of African- American youth, accounted for 68% of new HIV/AIDS cases belonging to said group. (Churches United for Healthy Congregations, 2013)

How might racial disparities in health care be addressed as we move forward into the 21st century? To start, we must recognize the reality of our present situation and be willing to openly acknowledge the fact that race and racial discrimination still play powerful roles in health care. While socioeconomic disparities such as poverty and the differences between urban, suburban and rural communities are significant and often exacerbate existing racial disparities, attempts to

focus on them to the exclusion of race and ethnicity amount to hiding from the problem. To address health disparities, early intervention is paramount. Broad sectors should be aware of the health care gap between racial and ethnic groups in the United States (Smedley et al., 2002). A comprehensive, multi-level approach is required to eradicate these disparities. Tackling this problem must begin with a paradigm shift with the manner in which leaders and caregivers address the health care needs of people of color. Servant leadership and spiritual leadership could show the way for caregiving that incorporates the spiritual component needed by many patients in general, and particularly patients of color (Schwartz & Tumblin, 2002).

Delivering high quality, affordable health care is increasingly becoming difficult for health care leaders and caregivers nationwide. With the current downturn in the U.S. economy, leaders and caregivers must grapple with making decisions based in large part on the costs of diagnosis and treatment, rather than solely on medical information and what is ideally best for the patient (Roberts & Berman, 2003). Health care is now more than ever before an issue of ethics. What must health care leaders and caregivers do to ensure that patients receive optimum care while also implementing policies and procedures designed to turn a profit?

Recognizing the need to make changes to improve the health outcomes of our nation's most vulnerable populations, health care leaders and caregivers are working to eliminate obstacles and impediments to success. Physician and other health care provider leadership is becoming an essential part of transforming the nation's health care industry. Health care leaders and caregivers are beginning to recognize the need to make the transition from the outdated transactional style of leadership—do this for me and I will do this for you—to more culturally inclusive leadership that recognizes both the secular and the spiritual needs of diverse patient populations (Schwartz & Tumblin, 2002).

As the economics of health care change, health care leaders and caregivers grapple with what they must do differently to increase revenue. Those in health care leadership possess the ability and authority to affect the quality and delivery of patient care services; it is important that they reconcile the role that values and ethics play in the delivery of health care services. Storey, Beeman, Asadoorian, and Cartwright (2008) looked at leader capacity to lead the charge to improve the quality and delivery of patient care services. Their findings emphasized the importance of leaders using their positions to demonstrate the role that values play in the delivery of health care services to patients.

While theorists and health care leaders continue to debate the efficacy of the integration of faith and health, research has shown that faith in a higher being has the capacity to help an individual cope with stress, deal with pain and overcome adversity (Puchalski, 2004). It is this same faith-based perspective that helps many physicians and clinicians to provide compassionate care to those they serve in various health care institutions (Puchalski, 2001a).

Documenting Stakeholder Perceptions of Outcomes of a Spirituality-Based Health Care Innovation

Grounded in the interpretivist/constructivist paradigm (Guba & Lincoln, 2005), my study employed ethnographic case study methods (Flyvbjerg, 2011) to capture patterns involving nurse/leader understandings regarding spiritual leadership, and patient perceptions of outcomes of including spirituality in their health care treatment plan. Data sources included questionnaires that looked at workplace spirituality (Fry, 2003) and patient spiritual well-being (Daaleman & Frey, 2004); focus group interviews (Kamberelis & Dimitriadis, 2011); individual interviews (Briggs, 1986; Hammersley & Atkinson, 2009) and “power sensitive conversations” (Bhavnani, 1993; Haraway, 1988); field observations (Hammersley & Atkinson, 2009) and field notes

(Emerson, Fretz, & Shaw, 2011); and analysis of institutional forms of documentation and artifacts (Hammersley & Atkinson, 2009; Peräkylä & Ruusuvuori, 2011). The two questionnaires distributed to study participants included the Fry (2003) Spiritual Leadership Assessment Instrument (SLA), and the Daaleman and Frey (2004) Spirituality Index of Well-Being (SIWB). The SLA looks at leadership and workplace spirituality. The SIWB is a valid and reliable instrument that can be used in health-related quality of life studies, in this case, patient spiritual well-being. In my study, the SLA was sent electronically to all nurse/leaders working in 67 different congregational nursing sites, and the SIWB distributed in paper copies to patient informants in three of the above clinical sites. Information from these instruments informed in-depth ethnographic interviews, observations, and document analysis conducted with five of the congregational nurses and three patients who completed these questionnaires and constituted key informants. Interview participants could be nominated by other informants in the study (Foster, 1998) but ultimately self-selected to participate.

Research Questions

My study addressed the following questions:

1. In what ways can the level of spiritual leadership in the congregational nursing health care program be described and documented? How is spiritual leadership characterized and practiced in this context?
2. In what ways can the level of patient spiritual well-being in this program be described and documented? How is the level of patient spirituality characterized?
3. Do patients perceive that their spiritual well-being is influenced by the spiritual leadership of health care providers? If so, in what ways is it influenced?

Definition of Terms

The following definitions were employed in my project:

- *Health equity*: The study of apparent differences that exist in the level of quality of both health and health care among different racial and ethnic populations (Braveman & Gruskin, 2003).
- *Racial and ethnic health disparities:* Similar to health equity and generally is used to describe avoidable differences in a person's health that result from a plethora of social disadvantages (Smedley et al., 2002).
- *Spirituality:* The definitions for this term vary widely. It can be defined as an individual's connection to self-chosen beliefs, values and practices that give meaning to life which inspires and motivates individuals to achieve their optimal being (Tanyi, 2002). Spirituality is an intentional quest for meaning, reflection, inner connectedness, creativity, transformation, sacredness and energy (Dent, Higgins, & Wharff, 2005).
- *Spiritual leadership*: Fry (2003) defines this term as a type of leadership that encompasses the values, attitudes and behaviors that are essential to fundamentally influence self and others so that they have a sense of spiritual survival through calling and membership.
- *Spiritual well-being:* Refers to the combination of a person's mental, emotional and physical health and well-being (Puchalski, 2004).

Delimitations and Significance

All informants were affiliated with the congregational/parish nurse program either as patient, or as health care clinician or leader providing needed services in a religious setting. Informants were drawn from a parish nurse program taking place within a limited geographical

area. The findings of my study may not necessarily be representative of the overall population who seek health care services via a local parish nurse program. Also, because most of the patients served were indigent and lacked health insurance and access to primary care services, the impact of this program on their health may be greater than for the population at large.

That being said, my study holds the potential to inform the field of health care and health research in terms of both research and practice. From a practitioner perspective, my findings can help health practitioners and health educators understand another methodology for addressing the needs of patients. Findings from my study have the potential to offer practical considerations for adaptations to current health care strategies. From a research perspective, my study holds promise to inform medical and nursing practice, epidemiologic research, and the design of community programming and public policy.

While up to this point spiritual leadership theory has been researched primarily by Fry (2003), the relationship between spirituality and health is now an emerging issue of interest. The findings from my research hold potential to inform efforts to reduce or eliminate disparities that exist both in health and health care for people of color, and the indigent and homeless.

Organization of the Research Report

Chapter 1 has provided an introduction to the research topic including the research questions, theoretical orientation, and significance. Chapter 2 sets out the theoretical/conceptual framework that grounds the project. Chapter 3 details the research methodology used in the study, including information on informants, kind of data gathered and analysis strategies. Chapter 4 and Chapter 5 examine themes that emerged from analysis of layered data sources. Chapter 4 focuses on congregational nurse perspectives and Chapter 5 focuses on patient perspectives. Chapter 6 consists of field accounts depicting my experiences with three homeless

women patients served, who participated in power-sensitive conversations with me over an extended period of time. A concluding chapter includes a discussion of how the study's findings might inform future research and practice.

CHAPTER 2

Spiritual Leadership Principles and Health Care

This chapter sets up the theoretical/conceptual framework that grounded my study of patient and nurse/leader perceptions within a parish nurse program, regarding the inclusion of spirituality in patient health care treatment plans. First I set out the worldview that forms the philosophic location for my work. Next I focus on literature at the intersection of faith and health in order to support an examination of the efficacy of integrating these two aspects of human experience, and examine the following theoretical and conceptual strands:

1. Spiritual leadership theory.
2. Spiritual leadership and organizational effectiveness.
3. The role of spirituality in health care.
4. Patient perceptions regarding spirituality and health care.
5. Caregiver perceptions regarding the integration of spirituality and leadership.

My review of the literature synthesizes these bodies of scholarship to ground an examination of one instance of spiritual leadership principles applied to positively impact both the organization and the people served.

The Interpretivist/Constructivist Worldview

The interpretivist/constructivist approach forms the worldview within which I carry out this research. This approach to knowledge production argues that knowledge is a constructed thing, that there are multiple truths, and that it is important to look for the complexity of informant views, rather than narrowing meaning into a few categories or ideas. According to this perspective, researchers attempt to establish rapport with informants, set up circumstances that foster an authentic sharing of information, and report the meaning of the phenomenon under

study from the view of informants (Guba & Lincoln, 2005). Members' meanings (Hammersley & Atkinson, 2009) constitute critical data sources. Knowledge is produced through the layering of multiple data sources and situated accounts, and the creation of rich, thick descriptions (Geertz, 1973).

This worldview is particularly appropriate for my work, as I seek to understand informants' perceptions of the efficacy of the inclusion of spirituality within health care decision-making. Nurse/leader and patient accounts, along with field observations, document analysis, and questionnaire responses, form my data sources for crafting a layered account of the phenomenon under study. Next I set the theoretical orientation that guides my work.

Spiritual Leadership Theory

Spiritual leadership (SL) is the study's guiding theoretical orientation. Compared to numerous motivation-based theories of leadership that have held sway over time, SL is the most inclusive of leadership theories that encompass ethics, values and some form of religion. SL theory also does a better job of focusing on aspects of human interaction in organizations, while at the same time addressing the spiritual component (Hicks, 2002). SL is defined by Fry (2003) as a causal theory that utilizes love, faith, and vision to motivate both leaders and their followers. According to Fry, if an organization is going to be transformed and ultimately successful, SL must stand as the guiding force. Within my examination of how nurse/leaders motivate their patients through the incorporation of vision, love and faith in a healthcare setting, SL appears to provide both nurse and patient with what they need for spiritual survival.

While a relatively new theory, SL is increasing in its perceived legitimacy. During the last 15 years the theory has gained traction: an increasing number of studies demonstrate its impact when applied in the workplace. Research indicates that spirituality can be particularly

effective at motivating employees (Dent et al., 2005). Across the past decade SL has been applied in a number of different kinds of workplaces, and particularly in the field of business. As a result of these attempts, more and more leaders are now considering the potential of SL on their decision-making, especially in terms of scaffolding human development (Dent et al., 2005). While applications of SL theory exist across a number of workplace domains, I focus on the use of SL in the health and wellness context. Dent et al. (2005) posit that leadership and spirituality are significant interrelated constructs strongly linked to workplace and environmental health, and overall human well-being. This premise grounds my study.

Fry (2003) contends that spirituality was largely neglected in earlier leadership theories, and argues that this component of leadership is needed to ensure that leaders tap into their core values and articulate these clearly to their followers. Fry compares characteristics of SL to those of other leadership theories including but not limited to transformational (Bass, 1997), transactional (Aarons, 2006), charismatic (Jacobsen & House, 2001), and servant leadership (Greenleaf, 2002). Benefiel (2005) and Fry (2005) agree that while spirituality constitutes a novel strand in leadership theory, leadership and spirituality are intimately related, and when addressed together in the workplace, yield positive benefits. Studies indicate that spirituality contributes to work driven by a sincere desire for transformation that is beneficial to both individuals and the organization as a whole (Benefiel, 2005; Fry, Vitucci, & Cedillo, 2005).

SL as envisioned by Fry is rooted in love, faith, and trust that are based on a common vision. Fry (2003) promotes SL as being able to:

1) Create a vision wherein leaders and followers experience a sense of calling in that their life has meaning and makes a difference.

2) Establish a social/organizational culture based on the values of altruistic love whereby leaders and followers have a sense of membership, feel understood and appreciated, and have genuine care, concern and appreciation for both self and others. (p. 695)

Nine variables of spiritual leadership theory have been reviewed and tested utilizing a survey instrument created by (Fry, Hannah, Noel, & Walumbwa, 2011) These include: (a) Inner life, (b) Altruistic love, (c) Hope/faith (d) Vision (e)Meaning/calling, (f) Membership, (g) Life satisfaction, (h) Organizational commitment, and (i) Productivity.

Inner life refers to a person's spiritual awareness and the capacity of an individual to channel that spiritual awareness in a manner that is inspiring, insightful and influential. It is inner life that guides the decision-making of those who tap into SL (Fry, 2003). Fry argues that the recognition of inner life as the source of SL is important for all who aspire to lead from a spiritual perspective. Such leaders must be fully aware of their own spirituality.

Altruistic love refers to the innate ability and willingness to act in the best interest of self and others.

Hope/faith are a powerful pair, in that hope is an expectation that what one wants will come to pass while faith is a strong belief with great certainty that indeed what one desires will come to pass.

Vision coupled with compassion for others is argued to be effective not only at transforming organizations, but also at improving the well-being of individuals. In order to motivate workers and provide followers with a sense of purpose or meaning, it is important for spiritual leaders to share their vision of the impact of goals attained (Fry, 2003). While theorists differ on key aspects of spirituality and what is needed to ensure that it is connected to leadership

in a manner that is effective, all agree on importance of the leader having a well-articulated vision (Hicks, 2002). Prior to 1980 little theorizing had been done on leadership vision. Then, with ever-increasing global competition in business, leaders realized that they needed to be more future-oriented in order to successfully compete.

Meaning/calling speaks specifically to individuals making a significant difference by bringing their thoughts, hopes and dreams to life. Calling is about taking action that will lead to fulfilling one's purpose in life (Fry, 2003). A sense of calling is the attribute that when used, makes a difference in the provision of service to someone else (Pfeffer, 2003). Fry (2003) argues that effective spiritual leaders must be fully aware of their vocation. It is vitally important that spiritual leaders know what they have been called to do, and work diligently to fulfill the call in a manner that improves the plight of those served.

Membership addresses the servant leader's need to be in the company of like-minded people. It fosters a sense of community by helping people recognize that they belong to a group. While those employing SL recognize the importance of addressing the calling on their life, they must do so in a manner that demonstrates a sincere need to be with and work with others who care in similar ways. Most individuals want to feel a part of a familial group or an organization of interest. It is through this sense of inclusion that people are motivated to go the extra mile to fulfill the spiritual leader's established vision (Pfeffer, 2003).

Life satisfaction forms yet another key construct within SL. Ryff and Singer (2001) propose that individuals who employ SL principles experience greater levels of satisfaction, joy and peace, along with improved mental well-being and overall health. Fry (2008) extended SL theory by applying constructs such as workplace spirituality, character ethics, and positive psychology, to foster positive human health, psychological well-being, and life satisfaction. He

argued that individuals who practice SL on a regular basis should score higher on a leadership assessment of life satisfaction. One way to measure life satisfaction is through the constructs available on Ryff and Singer's (2001) dimensions of well-being scale that assesses levels of joy, peace/serenity, and positive human health.

Organizational commitment and *productivity* have to do with motivation and the bottom line. Organizational commitment is directly linked to altruistic love and people generally become committed to organizations that convey this as a value. As a result of the variable hope/faith, individuals will generally work steadily to make sure they are productive in the workplace.

More than 50 studies demonstrate that spiritual and other value-based leadership models can have a unique level of impact on motivating followers (Bass, 1997; Bass, Avolio, & Atwater, 1996; Fry, Vitucci, & Cedillo, 2005; Givens, 2008; Malone & Fry, 2003; Shamir, House, & Arthur, 1993). Vision articulation, key aspect of value-based leadership, is motivational and encourages commitment and compliance (Fry, 2003). Researchers indicate that vision forms the point at which value-based leadership, charismatic leadership and SL intersect. These values-based leadership theories underscore the importance of the leader having a well-articulated vision that motivates the followers to act. In value-based leadership, it is important for the leader to articulate a vision that is based on the shared values of the organization or group of individuals (Malone & Fry, 2003).

Fry et al. (2005) studied longitudinal data gathered from members of a relatively new Apache Longbow helicopter attack squadron at Fort Hood, Texas. Their research aimed to test and validate SL as a causal model. The researchers hypothesized that "there would be positive relationships between the qualities of spiritual leadership, organizational productivity, and

organizational commitment" (p. 836). Based on responses from 181 informants, the study revealed that the squadron exhibited a number of attributes present in the SL model, but not all. More than 60% of the study participants reported high levels of meaning/calling, however less than 60% reported even moderate levels of vision, hope/faith and membership (Fry et al., 2005). While informants reported experiencing a high sense of calling, they did not appear to ground that sense of calling within a spiritual framework.

A common thread that runs through the descriptions of what spiritual leaders do is servant leadership. If servanthood is not a part of leadership, it cannot be properly characterized as SL. Servant leadership was formally established by Robert Greenleaf in the 1970s as a theory promoting the idea that leaders must be servants first and leaders later (Greenleaf, 2002). Greenleaf argued that servant leaders were more effective than other leaders, and that servant leadership held the potential to bring about radical transformation in organizations. Greenleaf contended that this transformation would happen as a result of recognizing and putting into practice:

- Listening to what others have to say.
- Accepting individuals the way that they are and conveying empathy for them.
- Developing highly effective powers of persuasion.
- Fostering community in the workplace.
- Recognizing that servant leadership starts with a sincere desire to change oneself. (as cited in Schwartz & Tumblin, 2002)

The intersection of spirituality and health holds the potential to radically transform the way health care is delivered (Fry et al., 2011; Miller & Thoresen, 2003). This transformation could lead to improved health outcomes for many patients who respond positively to spirituality

(Josephson & Peteet, 2007). In a groundbreaking article, *The Role of Spirituality in Health Care,* Puchalski (2001b) explored the role of spirituality in healthcare. She promotes the idea that healthcare providers must act in the best interest of their patients as whole individuals, not just physical bodies, in order to give optimal care. To give such care often means acknowledging patients' cultural and spiritual beliefs and values, and integrating those into the care plan. According to Puchalski, health care providers must take the time necessary to get to know their patients and their beliefs, and then use this information to determine the best methodology for treating each one. Puchalski acknowledges that caregivers must know when to insert themselves, and when they may need to employ the services of clergy/chaplains.

To assist caregivers with a strategy for bridging the spiritual-health care gap and asking values and culture-related questions with their patients, Puchalski (2001a) created the Spiritual Inventory Assessment. She uses the acronym FICA to stand for the components assessed: Faith, Importance, Community and Address in Care. Puchalski argues that people are finally becoming aware of the importance of spirituality and its integration with healthcare. As a result, caregivers are recognizing the need to acquire and practice more compassionate care inclusive of spirituality (Puchalski, 2001a).

Spiritual Leadership and Organizational Effectiveness

Fry (2003) is not alone in his assertion that leadership needs to be transformed to ensure that an organization is shaped in a way that benefits the individuals served. Over time several scholars have weighed in on the efficacy of transforming organizations through the theory of transformational leadership (Schwartz & Tumblin, 2002). Leadership theorist Bernard Bass & Bass, 2009) advocated that leaders should motivate their followers to change their behavior. According to Bass, leaders must develop the capacity to motivate or inspire, and must also be

willing to give individual consideration to their followers. I use this idea of the leader who is "willing to provide individual consideration" (Schwartz & Tumblin, 2002, p. 1424) to examine nurse health care providers' willingness to consider the individual and unique needs of patients, needs that go beyond attention to the body only. Transformational leadership can be employed by caregivers to incite patients to adopt healthy lifestyles through increasing their awareness of personal responsibility for behaviour, and invoking shared values.

Fry (2003) argues that with SL theory, a combination of values, attitudes and behaviors result in the intrinsic motivation of the one leading as well as the ones following. Spiritual leadership gives all involved a feeling of spiritual endurance through calling and membership, as portrayed in Figure 1, Fry's Model of Spiritual Leadership (Fry, 2003).

Figure 1. Model of spiritual leadership.

It is the combination of the values, attitudes and behaviors of leaders in supporting the spiritual needs of the followers that ultimately leads to improvement in terms of organizational

outcomes (Fry, 2003; Hicks, 2002). Once followers have a sense of spiritual survival through calling and membership, the time is right for:

> (1) Creating a vision wherein organization members experience a sense of calling in that their life has meaning and makes a difference.
>
> (2) Establishing a social/organizational culture based on altruistic love whereby leaders and followers have genuine care, concern and appreciation for both self and others, thereby producing a sense of membership and feel understood and appreciated. (Fry, 2003, p. 711)

Prominent qualities in SL theory include vision, altruistic love and hope/faith. Articulation of a clear vision holds the potential to appeal to major stakeholders, helps to delineate desired outcomes, and guides the journey necessary to arrive at a desired place. Vision inspires hope/faith and establishes a standard of excellence. Much like what is written in the Holy Bible, altruistic love includes nine expectations for those who love: forgiveness, kindness, integrity, compassion, honesty, patience, courage, trust and humility. Finally, hope/faith comes with an expectation that the leader and the follower have endurance, perseverance, challenging goals, and the desire to do whatever necessary to complete the task (Fry, 2003).

Although in the U.S. spirituality has been viewed by many as inappropriate in the workplace, this separation is artificial and can result in ineffective leadership or organizations (Hicks, 2002). While there are conflicting schools of thought, more recent studies document many who ascribe to the notion that people are equally physical and spiritual (Dent et al., 2005; Fry et al., 2011; Giacalone & Jurkiewicz, 2003), and consequently are more effective when allowed to acknowledge and utilize the wholeness of their personhood in the workplace. The initial separation of spirituality from the workplace was born out of the fear of religion resulting

in discrimination or oppression at work (Benefiel, 2005). While these fears are understandable in light of American history and the legal separation of church and state, spirituality can be incorporated into the workplace and improve organizational effectiveness without the mention religion per se.

Hicks (2002) notes that many businesses espouse the principles set out in Stephen Covey's (1989) *The 7 Habits of Highly Effective People*, which focuses on helping people understand character values and key principles in life. While it may not have been Covey's initial intent, this book is looked upon as a resource for aiding individuals with incorporating spirituality into the workplace (Hicks, 2002).

During the last decade Benefiel (2005) and Fry (2003) have argued that spirituality is a necessary component in the workplace in order to ensure ethical behavior, greater commitment, improved productivity, and overall job satisfaction. While SL is a relatively new field of theorizing, it is increasing in viability and rigor. There have been a limited number of empirical studies conducted on spirituality in organizations, and most have been quantitative (Fornicaiari & Lund Dean, 2004). A spiritual assessment instrument developed by Hamilton Beazley in 1997 was used with individuals to measure individual spirituality. Findings from its use suggest that there is a high correlation between "spiritual well-being and organizational openness, self-efficacy, and organizational commitment" (as cited in Benefiel, 2005, p. 725).

Other studies have resulted in similar findings. Ashmos and Duchon (2000) conducted a longitudinal study that attempted to measure workplace spirituality. After reviewing the literature they developed their own questionnaire which was administered to 696 employees working in four hospital systems in four cities: one in the mid-South, two in the Southwest and one in the Midwest. Their instrument looked at several dimensions of spirituality: inner life,

meaningful work, and community. It was constructed in three parts: spirituality and work, observations of the work unit, and observations of the organizational level. The researchers used descriptive statistics to analyze the data obtained. Their findings support the notion that people value having a job that is meaningful and purposeful. There were four dimensions that informants reported they valued at work: the first two are consistent with what is needed to build organizations that have a well-defined meaning and vision, and the third speaks directly to an individual's need to feel a sense of connection to those with whom they work on a regular basis. The fourth dimension revealed informants' views that people's feelings must be taken into consideration in the workplace. It matters both how people feel and how well they perform because the two are interrelated (Ashmos & Duchon, 2000).

Benefiel (2005) contends that organizations embrace spirituality out of a deep-rooted recognition of the need for help. It is through incorporation of spirituality that organizations start to transform. Companies begin to see employees who are motivated to work, and appear to be energized and more productive: attributes which improve the bottom line. Benefiel argues that once a workplace transforms itself into a learning organization, it is much easier to integrate spirituality. When spirituality is integrated into the workplace, leaders see the higher purpose in their existence and place their focus no longer solely on profitability, but give greater attention to the people who work for and those served by the company. The satisfaction, as noted by employees and those served by the company, ultimately leads to increased productivity and profitability (Benefiel, 2005).

As researchers continue to explore applications of spiritual leadership theory, organizations are challenged to establish business models that are spiritually-based and focus on their employees' spiritual well-being. Fry et al., 2011) argues that spirituality in the workplace

leads to “reduced absenteeism and turnover; and promotes higher levels of organizational performance” (p. 260), resulting in increased productivity and profitability.

Spirituality in Health Care

Researchers are divided on the role of spirituality in health care delivery. Thoresen (1999) documented evidence of a spiritual gap between health care leaders and patients. While only a small percentage of the American public indicates that they are agnostic or atheist, Thoresen found that nearly 50% of physicians describe themselves as such (Gallup, 2010). He argues that the training given to physicians is insufficient when it comes to giving compassionate care and taking the time to ascertain the value of spirituality on a patient’s health.

In 2007, the Pew Forum on Religion and Public Life (Lugo et al., 2008) carried out the U.S. Religious Landscape Survey, in which researchers conducted telephone interviews with 35,000 informants selected using numbers retrieved through random digit dialing. This study revealed that 92% of American adults say they believe in God, and 58% report that they pray daily. However, the researchers found that the professed faith of survey respondents did not appear to be in line with how they made ethical and moral decisions. While nearly 80% of respondents stated belief in the existence of “absolute standards of right and wrong,” only 29% cited reliance on their religion to explain these standards. Most respondents reported that they utilized common sense and their past experiences, while 9% reported reliance on philosophy and reason, and 5% on scientific information (Lugo et al., 2008).

Puchalski (2001b) reviewed the research on spirituality and healthcare, defined compassionate care, and discussed various aspects of spiritual care and the health advantages of caregivers understanding their patients’ spirituality. She defines compassionate care as caregivers who are in tune with their patients in the midst of their pain, work with them in a

holistic manner, and collaborate with them to develop a care plan rather than just directing them. Puchalski states that studies of the role of spirituality in health care generally address three significant areas: coping, mortality and recovery. She notes that individuals who are rooted in spirituality tend to live longer, have better coping mechanisms, utilize their beliefs to cope with illness, and their recovery is enhanced by their spiritual commitment.

Given the mounting evidence suggesting the benefits of integrating spirituality into health care practice, health care professionals need strategies for ensuring the success of this integration (Fry, 2003). Benefiel (2005) argues that caregivers should allow patients to take the lead in initiating discussion about spiritual beliefs. Once health care professionals get the buy-in from the patient (or parent of a child patient), they can then transform the healthcare delivery system (Benefiel, 2005) toward patient-centered care that includes spiritual well-being as a major goal. Such work is best done by caregivers who understand the value of transitioning from transactional to transformational leadership (Klitzman & Daya, 2005). Transactional leadership is based on an exchange model: you do this for me and I will do that for you (Aarons, 2006). Transformational leadership, on the other hand, seeks to transform the leader, the follower, and the organization (Klitzman & Daya, 2005). Spirituality should influence health care toward a transformation of the way providers approach the treatment of patients (Benefiel, 2005). Those providing the care with a spiritual emphasis center their efforts on the needs of the individual patient to ensure that these are addressed in a manner that suits each individual best.

Patient Perceptions Regarding Spirituality and Health Care

Spirituality takes on different meanings. Some argue that spirituality is a watered down version of religion, while others view it as something within each of us that transcends race, class and denomination (Hicks, 2002). Many argue that we are all spiritual beings whether we

worship a Supreme Being or not. Religion is profoundly ingrained in the rich cultural heritage of African Americans. For this population spirituality is intertwined into all aspects of life, including beliefs about health and illness (Polzer, 2005). Discussions about cultural issues or a group's culture are discussions about how the world operates:

> In looking at cultural difference it is important for the physician to sensitively provide compassionate care while effectively addressing: the language, knowledge, beliefs, assumptions and values that shape how we see the world and out place in it. (Polzer, 2005, p. 247)

Spirituality and health experiences are complex and differ depending on whether a patient is dealing with intrinsic or extrinsic spirituality (McBride, Arthur, Brooks, & Pilkington, 1998). McBride et al. (1998) in the late 1990s broke new ground in their examination of the relationship between a patient's experience of general health, any physical pain, and intrinsic spirituality. Utilizing a stratified random sample of 462 patients from a suburban family practice residency clinic, the researchers administered a spiritual assessment tool, the Index of Core Spiritual Experiences INSPIRIT, in addition to a survey on wellness, the Dartmouth Primary Care Cooperative Information Project (COOP). The COOP measurement system consists of nine scales designed to assess the functional status of a patient: three look specifically at overall well-being while two assess patient quality of life. The other four scales look at specific dimensions of functionality.

Ninety-five percent of those patients randomly selected to participate in the McBride et al. study ($N = 442$) returned the completed assessment tools. The data collected were analysed using two-way analysis of variance to enable researchers to ascertain deviations in patient reports of pain and health, while also looking at mean scores associated with perceived health of the

patients scoring at all levels, and segmented by gender. Findings from this research support the notion that moderate levels of spirituality lead to lower levels of pain among participating patients. The findings also demonstrate significant reported health differences across gender, with men self-reporting better levels of health than women. Additional research is needed that can examine the intersections of gender, spirituality, and health, as well as to unpack possible reasons for males giving self-reports of better health.

On the whole, spirituality appears to impact health. Differences in impact can cut across race or gender (Puchalski, 2001b). A number of studies explore these differences, particularly among elderly populations. For example, in 2007 Harvey and Silverman conducted a study with 88 African American and White men and women who were 65 years old and older residing in Alleghany County, Pennsylvania. The study looked at the role of spirituality in healthcare in terms of management of chronic illness among elderly populations, and found differences across race. African American elders reported a belief in divine intervention more often than their White counterparts, while elderly Whites appeared more inclined to combine their spirituality in multiple self-management practices than African American respondents. Harvey and Silverman surmised that in spite of the differences in how the intersection of spirituality and health was understood and acted upon by African Americans and Whites, spirituality appeared to be beneficial to elderly populations in coping with chronic illness.

While Harvey and Silverman (2007) looked at differences in perspectives by age and race among elderly patients with chronic illness, Arnold, Avants, Margolin, and Marcotte (2002) conducted an exploratory study of spirituality and health among drug-users, many who were also HIV/AIDS patients. This study looked at the effectiveness of spirituality on the healthcare of HIV/AIDS patients who were also methadone-maintained drug users. The study had two

additional foci: to observe the behaviour change of patients after the utilization of spiritual principles, from risky sexual practices to safe sexual activity; and to determine patient interest in a spiritually-based health intervention (Arnold et al., 2002). The study design included three focus group sessions, the administration of a survey to all focus group participants, and also to a group of 26 individuals who did not participate in the focus group sessions. Focus group and survey participants acknowledged that spirituality served as a buffer for them as they dealt with one of the most stressful times in their lives (Arnold et al., 2002). Participants also acknowledged that the spiritual aspect helped them in their efforts to recover from substance abuse addiction. The focus groups employed for this research were small and the researchers did not employ random sampling, however, thus limiting its generalizability.

In an exploratory qualitative study of the patient perspective, Daaleman, Cobb, and Frey (2001) conducted focus group interviews with 17 women with type 2 diabetes mellitus, and 18 women with no known medical issues. Their findings also indicate that when spirituality is integrated in a healthcare setting there can be a positive impact on the well-being of patients, "Participants tied the attitudes and practices of positive intentionality with agency, or the use or exertion of power through belief, practice or community" (p. 1503).

Over the last two decades, spirituality has increasingly become an integral part of the delivery of healthcare in this country (Daaleman et al., 2001). However, the literature reveals that there is still much to be learned about the patient's perspective. I next examine the literature on caregiver perspectives regarding the integration of spirituality into healthcare.

Caregiver Perceptions Regarding the Integration of Spirituality into Health Care

While studies of patient perceptions indicate that spirituality has the capacity to impact a person's health, the caregiver plays a key role in the success or failure of its integration. How do

caregivers perceive spirituality and its impact on health outcomes? Do caregivers recognize the potential efficacy of integrating spirituality into healthcare? Do they foster an environment that encourages patients to discuss spiritual issues? For many years study findings indicated that physicians thought differently from many Americans about the impact of spirituality on health (Daaleman & Frey, 1999). However, more recent research demonstrates that many caregivers now acknowledge the ways in which spirituality may impact their patients' health outcomes. Klitzman and Daya (2005) interviewed 50 health care providers—48 physicians, one dentist and one fourth year medical student—who had all been patients themselves suffering from a serious illness. These health care providers were between the ages of 25 to 87; 49 of them were White and one was Latino; 40 were men while 10 were women. More than half of the participants were HIV positive, while the others had chronic illnesses such as cancer or heart disease. The informants were asked to share their experience and beliefs about both religion and spirituality. Klitzman and Daya (2005) conducted this study to fill a gap in the literature. Up to that point little academic research had examined how caregiver views of spirituality impact their own health when they become patients. The methodology used for this qualitative study included two hour in-depth semi-structured interviews that focused on prior experiences. The research was conducted in multiple cities inclusive of New York, Seattle and Los Angeles. Using grounded theory the researchers audiotaped the interviews, developed transcripts, and analyzed the content. Most of the informants indicated that the onset of their medical condition did not increase or decrease their level of spirituality, however many discussed the growth of their spirituality as they endured the side effects of their respective illnesses. As they faced their own mortality, many of them recounted becoming more spiritual.

Catlin and Gage (2008) commissioned a study to obtain descriptive information on the spirituality and religiosity of caregivers. A random sample of academic American pediatrician faculty members from 13 different institutions received a web-based survey. A total of 116 physicians completed the survey. In terms of demographic characteristics:

- Fifty-two and six-tenths percent were women and 46.6 % were men; 0.9% did not provide gender information.
- Sixty-nine percent identified themselves as White, 3.4% as Black, 5.2% as Hispanic, 15.5% as Asian, and 2.6% as multiracial.
- Seventy-five percent were married while 6% were cohabitating; 7.8% were divorced, 2.6% separated, and 6.9% never married.

Nearly 90% of the respondents reported being raised in a religious family, with 67.2% indicating a current religious affiliation. More than half reported that they pray privately, and 58.6% stated that their spirituality impacted their interactions with patients. Thirty percent of the respondents indicated that they have not attended church in the past year, with 35% citing a belief in God with no doubts, while 24% indicated they believe but with some doubts. The respondents indicated that 37.1% of them are moderately spiritual, while 33.6 reported being slightly spiritual; an additional 12.1% reported that they were very spiritual. The results reveal that 40.5% of the physicians somewhat agree with the statement, “My spiritual or religious beliefs influence how I interact with patients and colleagues” (p. 1149); 19.8% strongly disagreed with the statement while 18.1% strongly agreed.

Ellis and Campbell (2004) discuss the findings of a qualitative study involving ten chronically or terminally ill patients who participated in semi-structured interviews. The patients indicated that sometimes caregivers create barriers by neglecting to acknowledge the spirituality

of the patients. At the same time, the patients readily acknowledged that health professionals who are supportive of their spiritual concerns are helpful in assisting them with other life issues that have the potential to impact their health.

Similarly, Ellis and Campbell (2004) examined the responses of 43 family physicians and 47 outpatients in a qualitative study which looked at the perceived roles for physicians dealing with people at the end of their life. The physicians saw their role in these situations as lifesaver, neutral scientist, guide, counselor, and intimate confidante, and stated that when patients perceive that their caregiver respects their spirituality they are more apt to discuss it during their office visit.

Outcomes and effectiveness research has provided a wealth of information about interventions that can improve patient experience and outcomes (King & Crisp, 2005). However research on the impact of SL practices has been limited until recently. There are mixed reviews in terms of the impact of spirituality on health and health outcomes. Some agree that belief in a higher power enables those who do cope better with stress and diagnosed illnesses (Sulmasy, 2009). However, some people disagree that spirituality or SL practices can actually impact health outcomes (Puchalski, 2001a).

As caregivers define their own level of spirituality they are forced to also grapple with ethics, professional boundaries, and competency relating to the incorporation of patient spirituality in healthcare. For the last decade caregivers have struggled to create a balance of responding positively to the spiritual needs of their patients, while remaining true to their own beliefs, and a desire to be professional and follow clinical protocols. Some caregivers ascribe to the notion that it is always inappropriate to talk with their patients about spiritual issues (Post, Puchalski, & Larson, 2000).

While some caregivers continue to grapple with this issue, research now indicates that a patient's spirituality has the capacity to contribute to their recovery from severe illnesses. Journal articles and specialty journals now focus on researching "the clinical relevance and importance of spirituality and religion as potential factors in coping with illness" (Post et al., 2000, p. 579). Caregivers are now challenged to support the spiritual and religious beliefs of their patients during clinical assessments: it is viewed as the right thing to do ethically.

In an effort to provide clarity the Association of American Medical Colleges commissioned a project to address the issue of patient spirituality in healthcare. The Medical School Objectives Project notes that caregivers

> . . . must seek to understand the meaning of the patients' stories in the contexts of the patients' beliefs and family and cultural values. They must avoid being judgmental when the patients' beliefs and values conflict with their own. (Post et al., 2000, p. 580)

Two years after the Medical School Objectives Project, Ellis, Campbell, Detwiler-Breidenbach, and Hubbard (2002) conducted research with 13 board-certified family physicians from Missouri using semi-structured interviews. In an effort to ensure diversity in this small sample population, the selection of participants was non-random manner. The interviews took place in the physicians' offices, were 45 minutes in length, and statements were reviewed and confirmed during the interview to ensure accuracy. Participants in this study were all White: three women and ten men ranging in ages from 37 to 63. In terms of religious affiliation, six were Christian, one was Jewish, three were Unitarian (of the Unitarians, one was primarily Buddhist, one primarily Muslim, the other one did not have a preference), one expressed no religious affiliation, and one was agnostic. The researchers used a software program designed primarily to organize textual materials to analyze interview data.

Table 1 gives an overview of the results relating to physician approaches in addressing spiritual issues. One physician expressed his belief that scientific evidence should inform actions in terms of talking with patients about spirituality:

> Every physician ought to be dealing with spiritual issues. For example, how can you rationalize not talking about spirituality to a patient with depression when you can prove scientifically that strengthening faith commitment helps them? It actually comes down to a quality of care issue. (Ellis et al., 2002, p. 251)

Table 1

Physicians' Approaches to Addressing Spiritual Issues

Techniques
• Use of cues • Spiritual discussion in context of broad issues • Use of open-ended questions • Use of specific screening questions • Gradual, stepwise approach to spiritual assessment • Direct approach in response to crisis • Asking spiritual questions at onset of relationship and again during crises • Eliciting patients' stories • Assessing and affirming patients' spiritual resources • Being with patients at time of death • Attending funerals, supporting family
Diagnostic Approach
• Active attention to patient cues and questions • Consideration of questions in context of patient's known spiritual background • Processing of questions to look for deeper spiritual questions and issues • Asking clarifying questions to assure accurate identification of spiritual issues • When appropriate, carefully offering therapies (answers, suggestions, or exercises) that are related to patient's questions and appropriate to patient's beliefs and values

Table 1

(Cont.)

Principles

- Be willing to take or set aside time for discussions of spiritual issues
- Empower patients to discuss spiritual issues
- Use patient-centered approach
- Be sensitive to patients' cultural and religious background
- Sitting and listening has value
- Use patient-centered reflection rather than providing answers to spiritual questions
- Attempt to heighten patients' self-awareness of spiritual strengths and resources rather than discussing philosophy and dogma
- Be sensitive to family members' views concerning spiritual discussion and intervention
- Approach spiritual discussions with gentleness and reverence
- Do not impose spiritual or religious views on patients

Summary

This chapter has reviewed relevant literature to construct a theoretical/conceptual framework to ground my study of the role of spirituality in health care. Bodies of scholarship examined include: the interpretivist/constructivist worldview, SL theory, SL and organizational effectiveness, the role of spirituality in healthcare, patient perceptions on spirituality and healthcare, and caregiver perceptions regarding the integration of spirituality and leadership. Chapter 3 sets out the research methods utilized in my study.

CHAPTER 3

Examining Nurses and Patients of a Congregational Nursing Program: Methods

This ethnographic study documented stakeholder perceptions of outcomes of the congregational/parish nurse health care innovation in several clinical settings in which nurse/leaders and caregivers incorporate consideration of patient spiritual needs in their treatment plans, in hopes of improving health outcomes and reducing care disparities that can originate in a lack of understanding. Drawing on the interpretivist/ constructivist paradigm (Guba & Lincoln, 2005), the study employed ethnographic case study methods (Flyvbjerg, 2011) to capture patterns involving nurse/leader understandings of spiritual leadership, and patient and caregiver perceptions regarding outcomes of including spirituality in their health care treatment plans.

> The interpretivist/constructivist worldview grew out of the philosophy of Edmund Husserl's phenomenology and Wilhelm Dilthey's and other German philosophers' study of interpretive understanding called hermeneutics (Eichelberger, 1989, as cited in Mertens, 2005, p. 12). Interpretivist/constructivist approaches to research have the intention of understanding "the world of human experience" (Cohen & Manion, 1994, p. 36), suggesting that "reality is socially constructed" (Mertens, 2005, p. 12). The interpretivist/constructivist researcher tends to rely upon the "participants' views of the situation being studied" (Creswell, 2003, p. 8) and recognizes the impact on the research of their own background and experiences. Constructivists do not generally begin with a theory (as with post-positivists); rather they "generate or inductively develop a theory or pattern of meanings" (Creswell, 2003, p. 9) throughout the research process. The constructivist researcher is most likely to rely on qualitative data collection methods and

analysis, or a combination of both qualitative and quantitative methods. (Mackenzie & Knipe, 2006, p. 196)

Quantitative data may be utilized in a way which anchors, supports or expands upon qualitative data and effectively adds to the interpretation or description of the phenomenon under study. In the case of the current study, while the methods include both qualitative and quantitative measures, the worldview of constructivism governs how data were analyzed and the findings reported. Interpretivist/constructivists ontology (e.g., what is reality?), epistemology (e.g., what is the relationship between the knower and the known?), and axiology (e.g., what are the expectations of the paradigm for both the aesthetic and ethical aspects of the work?) govern my work, rather than those of the mixed method worldview per se.

Data sources for the study employed and layered in fieldwork included two questionnaires that examined workplace spirituality (Fry, 2003) and patient spiritual well-being (Daaleman & Frey, 2004); focus group interviews (Kamberelis & Dimitriadis, 2011); individual interviews (Briggs, 1986; Hammersley & Atkinson, 2009) and “power sensitive conversations” (Bhavnani, 1993; Haraway, 1988); field observations (Hammersley & Atkinson, 2009) and field notes (Emerson, Fretz, & Shaw, 2011); and analysis of institutional forms of documentation and artifacts (Hammersley & Atkinson, 2009; Peräkylä & Ruusuvuori, 2011).

Questionnaires include the Fry (2003) Spiritual Leadership Assessment (SLA) Instrument that looks at leadership and workplace spirituality (Fry, 2003), and the Daaleman and Frey (2004) Spiritual Index of Well-Being (SIWB), which is a valid and reliable instrument that can be used in health-related quality of life studies. Information from these instruments informed and paralleled focus group interviews (Kamberelis & Dimitriadis, 2011); in-depth ethnographic interviews and power sensitive conversations, field observations and document analysis

(Bhavnani, 1993; Haraway, 1988), that were conducted with five congregational nurses and three patients who completed the questionnaires and who constituted key informants in the study; field observations (Hammersley & Atkinson, 2009); field notes (Emerson et al., 2011); and analysis of institutional forms of documentation and artifacts (Hammersley & Atkinson, 2009; Peräkylä & Ruusuvuori, 2011).

Research Questions

My study addressed the following questions:

1. In what ways can the level of spiritual leadership in the congregational nursing health care program be described and documented? How is spiritual leadership characterized and practiced in this context?
2. In what ways can the level of patient spiritual well-being in this program be described and documented? How is the level of patient spirituality characterized?
3. Do patients perceive that their spiritual well-being is influenced by the spiritual leadership of health care providers? If so, in what ways is it influenced?

Role of Researcher

As an interpretivist/constructivist researcher, I entered this project from a specific standpoint, equipped with background knowledge that both enhanced my ability to conduct the inquiry, and required continual interrogation. In my role as vice president of a health foundation, I grapple daily with the realization that a paradigm shift is needed in the delivery of health care services if there is ever to be a change in the health outcomes of members of marginalized groups. This realization is troubling when those with the capacity to make wide-sweeping changes choose instead to put their heads in the sand. As a licensed minister, I am a woman who supports the notion that spirituality can have a positive impact on an individual's health. While I

value the inclusion of spirituality in health care leadership and practice, I recognize the possibility that it may not be beneficial for everyone, and it was with this level of openness that I approached my research. While these standpoints—as a minister and vice president of a health foundation—provide me with insider knowledge that, according to *standpoint epistemology* (Smith, 1989) establish me as one of the people best-suited to conduct a study such as mine, I also entered my research cognizant of the importance of reflexivity (Hammersley & Atkinson, 2009). For example, while my standpoint as someone deeply situated within the sites and questions that form the focus of my inquiry made me the best possible person to know congregational nurses who have important stories to tell, I also know of the importance of including strategies for selecting informants that both include these potential informants and go beyond simply these. I was well aware of my standpoint on the issues involved in this research project, and continually challenged my perceptions with a keenly critical eye, particularly as my research progressed, so that I could hear as my data spoke to me, especially when this happened in ways I did not expect.

Recognizing the importance of employing methods that yield useful data, I worked to ensure a number of things:

- I worked to include a variety of informant perspectives by inviting diverse participants. Diversity amongst nurses was limited primarily to race and age with some notable differences in household income levels.
- I drew on multiple data sources to create a layered account (Creswell, 2008).
- I employed member checking to allow informants to verify the data collected from them.

While spirituality does not form an integral part of my own workplace, its potential to positively impact health outcomes is of great interest to me as a researcher and the ethical framework inherent in my own spirituality guides my work going forward.

Context of the Study

The study was set within a congregational nursing program. Congregational or parish nursing is recognized by the American Nurses Association as a specialty practice of nursing because its scope includes the intentional care of the spirit. Parish nursing is best defined as a community-based program designed to promote health and prevent chronic diseases based primarily on the holistic care of individuals. Its practitioners encompass seven functions as noted by Solari-Twadell and McDermitt (1999): “integrator of faith and health, health educator, personal health counsellor, referral agent, trainer of volunteers, developer of support groups and health advocate” (p. 3).

The parish nurse program within which my study took place was established in October 1998 and became fully operational in 1999 with ten congregations that were paired with nurses to provide free health education, screenings, consultations and referrals. Since its inception, the program has mushroomed to 67 congregational affiliates. Some of these churches have registered nurses who are paid to work ten hours a week serving the adult membership and people from the surrounding neighborhoods. A number of churches and other faith institutions have volunteer registered nurses who provide the same type of care that the paid nurses provide. Other faith institutions may have a lay health coach who provides general health education and puts up monthly bulletin boards that focus on relevant health issues. In its tenth year of existence, this program reported that their nurses made many referrals for free mammograms to

women who could not afford to pay for one, while providing more than 11,000 screenings for serious medical conditions such as hypertension and diabetes.

According to progress reports submitted to a local funder, the parish nurse program has been instrumental in improving the quality of life for a number of people, but has yet to develop an evaluation mechanism that can clearly demonstrate quantifiable outcomes. Up to 2009, the program has relied on anecdotal stories to promote the program and raise funds to expand from the initial ten congregations to the 67 that either have a nurse or a lay health coach. Nurses from these congregations were invited to participate in my study.

Setting

This ethnographic study took place in three homeless shelters in an urban city. Location 1 is a facility that provides overnight shelter for many of the community's chronic homeless population. It is governed by a faith-based organization and strives to show compassion to all who enter the shelter whether they are coming for food, an overnight stay or emergency assistance paying their utilities. This facility also has a food pantry and provides low-wealth families with groceries. Location 2 is an innovative day resource center for homeless individuals and also for those who are on the verge of homelessness. It provides registered participants with hot showers, opportunities to wash their clothing, job readiness skills, primary healthcare services and mental health intervention. Location 3 is a short-term shelter that provides temporary housing for single men and women in addition to providing nutritional food, emergency assistance, case management and transitional housing for homeless families. Two of these locations are situated in low-wealth areas of this urban city while the other one is located within walking distance of the downtown, a university and a private college.

Ethical Considerations

Prior to beginning the research process, I completed the Institutional Review Board (IRB) application and submitted for approval. This was necessary due to the fact that human subjects are a part of my research study. The IRB is charged with making sure research is designed in a manner that protects the rights and welfare of humans participating as subjects in the research. In my efforts to conduct my research with the highest of ethical standards, I included the following in my research process to ensure that the study is highly ethical.

- Data were stored on a password-protected computer and access remains restricted.
- Participants' information that is on written documents is stored in a locked file cabinet to ensure security if their accounts.
- Data were collected anonymously and confidentially.
- Confidential data were recorded and analyzed anonymously.
- All of the audio recordings were immediately transcribed and the audio recording destroyed.

Articulating the Process

To clearly articulate the process employed in this ethnographic account, I have included a quantitative phase that informed the qualitative aspect of my research study. A circular flowchart is included that depicts the recursive process involved to complete this study, which is followed by a detailed accounting of the methodology utilized, the instrumentation, data collection, and data analysis. The flowchart (see Figure 2) outlines the four major components of my fieldwork and analysis. While I describe these here in this discussion of methodology as individual components, it is important to remember that ethnographic fieldwork is recursive and

may take place on parallel lines at the same time. The process is not linear (Hammersley & Atkinson, 2009). Analysis begins with each field decision.

Figure 2. Research flowchart.

That said, Field Component I, included the distribution, administration, and collection of ethnographic data. In Component I, I distributed, administered and collected two surveys: one involving the nurses, and one involving the homeless patients. Component II included conducting two focus group interviews with nurses. During this same time, I spent time in the three homeless shelters observing the population served and trying to gain a better understanding of the study participants in their environment. I asked no questions, just simply observed and made field notes of my observations. Component III also included interviews with three congregational nurses and the two nurses who lead the program; and intense field observations

of, and power sensitive conversations with, three homeless patients. Component IV of the study involved a review of programmatic artifacts which included looking at quarterly progress reports submitted to a funder, annual reports, and a ten year written review of the program.

Participants

All participants, including nurse/leaders and health care providers, homeless patients, and program leaders, were affiliated with the parish nurse program. Participants for the two surveys included congregational nurses from 44 churches, and 65 of the homeless patients in their care at three local shelters.

Nurses

The Congregational Nurse Program is made up of 67 program sites, 44 of these sites have a congregational nurse while the remaining 23 have a Lay Health Coach. There were 44 eligible nurses and 41 of them participated in this study.

Homeless Patients

The 65 homeless patients that made up the sample for this study were all frequent users of three shelters in an urban city in the southeast section of our country. Of that sample, 36 were homeless males and 23 were homeless females and six individuals who chose not to divulge their gender.

Instrumentation/Measures

The instrumentation of this study included a quantitative survey for nurses, a quantitative survey for homeless patients in Component I. Component II included observations for nurses and patients, interviews, field notes and review of institutional documentation. The interview guides I used in both individual and focus group interviews provided prompts for informant recall. They were constructed as openly as possible; to avoid leading questions that prescribe

informant responses in too narrow a range. In this section we will examine the research instruments and tools used in this study.

Component I

Spiritual Leadership Assessment (SLA). The SLA instrument, which is included in Appendix A, opens with demographic items on ethnicity, socioeconomic status, education level, age and gender. Forty items follow that focus on nine variables of Spiritual Leadership Theory: inner life, vision, altruistic love, hope/faith, meaning/calling, life satisfaction, organizational commitment and productivity. These items have answer options that were developed utilizing a 5-point Likert type scale ranging from 1= strongly disagree, to 5 = strongly agree. Items include: "I understand and am committed to my organization's vision" (vision); "I have faith in my organization and I am willing to "do whatever it takes" to ensure that it accomplishes its mission" (faith); "The leaders in my organization are honest and without false pride" (altruistic love); and "The work I do is meaningful to me" (meaning/calling). The questionnaire ends with an open-ended item: "Please identify one or more issues that you feel needs more attention." groups that were held. Because the focus groups were limited to those who completed the SLA, the 29 focus group participants actually represent 70.9% of eligible nurses.

The process of data collection started upon receiving approval from the Institutional Review Board at North Carolina A&T State University. Initial data collection involved administering the two questionnaires over a 30-day period of time to assist in documenting the level of spiritual leadership among congregational nurse/leaders using the Fry (2003) Spiritual Leadership Assessment instrument (SLA). This instrument has been employed extensively in looking at leadership and workplace spirituality (International Institute of Spiritual Leadership, 2014). Fry, Vitucci, and Cedillo (2005) tested the SLA empirically which resulted in the

author's initial assertions that there was a positive relationship that existed between spiritual leadership, spiritual well-being, work productivity and organizational commitment. Chen and Li (2013) validated the SLA using a sample of 591 employees from different organizations in China and Taiwan. The Chinese military police comprise the second sample of 122 subjects that were recruited for the validation sample while 369 U.S. Army soldiers were used for the cultural comparative sample.

Spiritual Index of Well-Being (SIWB). The leadership of the congregational nurse program assisted me with sending the link to the survey out to all of the nurse/leaders via e-mail with weekly reminders. Forty items follow that focus on nine variables of spiritual leadership theory: Inner life, Vision, Altruistic love, Hope/faith, Meaning/calling, Life satisfaction, Organizational commitment and Productivity. These items have answer options that were developed utilizing a five-point Likert type scale ranging from 1= strongly disagree, to 5 = strongly agree. Items include: "I understand and am committed to my organization's vision" (Vision); "I have faith in my organization and I am willing to 'do whatever it takes' to ensure that it accomplishes its mission" (Faith); "The leaders in my organization are honest and without false pride" (Altruistic love); and "The work I do is meaningful to me" (Meaning/calling). The results of the survey informed the questions that were developed for the two focus groups that were held to capture information from the nurse/leaders in this program. In an effort to accommodate the varying schedules of the nurses, one focus group was held mid-day and the second one was held the following evening. Both were well-attended.

While the nurses were completing the SLA, I began frequent visits to the three designated sites to talk with homeless clients to explain my study and solicit their support in completing the survey instrument. Patient levels of spiritual well-being were documented utilizing the

Daaleman and Frey (2004) Spiritual Index of Well Being (SIWB) Instrument. The SIWB is a 12-item, cross sectional assessment tool designed to examine a dimension of spirituality linked to subjective well-being in patient populations. It was developed using qualitative methods and subsequently conceptualized with two dimensions of spirituality: self-efficacy and life scheme. Six of the items on this 12-item tool focus on self-efficacy, while the remaining six address life scheme. This assessment tool, which is highlighted below, is designed to measure one dimension of spirituality linked to spiritual well-being in patient populations, has previously been used as a mechanism to assess a dimension of health and well-being in a number of peer-reviewed studies among a variety of populations (Frey, Daaleman, & Peyton, 2005). This instrument is in the public domain and written permission has been granted to utilize this assessment tool as a part of this study. Paper copies of SIWB questionnaires were distributed to interested patients at three of the 67 congregational nursing sites (Appendix B). The sites utilized were those exclusively serving homeless clients.

Daaleman and Frey (2004) conducted a cross-section survey in multiple sites utilizing a systematic sampling of 523 adults at a primary care outpatient clinic. They ascertained the reliability of this assessment instrument by using SPSS to employ Cronbach's Alpha and test-retest. In addition, they determined the validity of the instrument through confirmatory factor analysis of the SIWB (see Table 2).

> Confirmatory factor analysis found the following fit indices: chi2 (54, $n = 508$) = 508.35, $P < .001$; Comparative Fit Index = .98; Tucker-Lewis Index = .97; root mean square error of approximation = .13. The index had the following reliability results: for the self-efficacy subscale, alpha = .86 and test-retest $r = 0.77$; for the life scheme subscale, alpha

= .89 and test-retest $r = 0.86$; and for the total scale alpha = .91 and test-retest $r = 0.79$, showing very good reliability. (p. 499)

Table 2

Fit Indices for Spirituality Index of Well-Being (N = 508)

Index	Test Value	*p*-Value
χ^2	508.35	$< .001$
Comparative Fit Index	0.98	
Tucker-Lewis index	0.97	
Root mean square	0.13	

Source: Daaleman and Frey (2004)

Component II

Focus group process (nurses). I determined how many focus groups to conduct based on pre-established meeting schedules of the nurses and then generated focus group questions based on SLA results. Once the questions were established, I developed the script. Using a semi structured interview guide I asked questions that were answered by all of the participants. I conducted two focus group sessions where I brought with me the focus group script, a notebook and two audio recorders.

Component III

Interview process (nurses). All of the nurses were asked the same set of initial questions via a one-hour phone interview with follow-up questions that were based on their initial responses. As a result of the follow-up questions, no two interviews were alike, however the information gleaned from the five nurses was quite similar in nature and led to some common themes that helped to support Spiritual Leadership Theory. Eligibility for participation in the interviews was limited to the congregational nurses who served the three homeless shelters and

the two nurses who served as coordinator and assistant coordinator of the program. E-mails were sent to the five nurses offering them a choice of phone interview dates and times. The interviews, designed to last 45 to 60 minutes, were audio recorded. The researcher used an interview protocol sheet to guide the interviewees through the questions and take notes about them. The researcher asked follow-up questions during the interview to gain clarity or if it was deemed necessary to have more information than was initially shared by the nurse. In brief, the protocol involved the following steps: (a) Identification of nurses who will be involved; (b) Identification of the information needed; (c) Development of a list of eligible nurses to be interviewed; (d) Development of an interview script that was inclusive of what to say when setting up the interview sessions, what to say at the beginning of the interview and what to say to conclude the interview; (e) Received informed consent of the interviewees; and (f) Developed an interview guide that contained a short list of open-ended questions.

Focus group process (nurses). Nurses were recruited for the two focus groups after completion of the SLA. Of the 44 nurses who completed the survey, 29 participated in the focus groups. The initial focus group of 18 congregational nurses was held at 12 noon on September 11, 2013 while the second one was held on September 12 with 11 nurses in attendance. Eligibility criteria were any local congregational nurse who completed the SLA. Exclusion criteria were individuals who were not congregational nurses and those nurses who did not complete the SLA. The results of the survey helped to inform the questions asked at the two focus groups. I had planned to include a co-facilitator for focus groups whose members include individuals with cultural backgrounds different from mine, to create a balance and invite richer engagement from informants. However, this was not necessary because focus groups were limited to nurses who were either Caucasian or African American.

During the 90-minute focus group, the only instruments utilized were the survey that was administered and a prepared script which included the questions to be asked of the nurse participants. At the outset of the two focus groups, participants were required to complete an informed consent form. Participants were informed that all responses would be confidential and that their anonymity would be maintained throughout this research study and beyond. Each of the two focus group sessions was audio recorded to ensure accuracy of the focus group transcripts

Data Collection Procedures

The process of data collection started upon receiving approval from the Institutional Review Board at North Carolina A&T State University. Initial data collection was quantitative in nature consisting of responses to two surveys (SLA & SIWB) that were scheduled for 30 days but were extended for an additional 30 days to increase the sample. The qualitative and ethnographic data was collected through focus groups, interviews, power sensitive conversations, observations, review of program artifacts and case studies. Due to the nature of the ethnographic study, collecting data was not a linear or systematic process but for clarity study results will be presented in that manner.

Spiritual Leadership Assessment. I attempted to document the level of spiritual leadership among congregational nurses and program leaders using the Fry (2003) Spiritual Leadership Assessment instrument (SLA). For my purposes the SLA was reformatted and administered through SurveyMonkey®, a free online software and questionnaire tool (Appendix A). The leadership of the Congregational Nurse Program assisted me with sending the link to the survey to all of the nurses with seven weekly reminders via e-mail every Friday morning over the course of eight weeks. A total of 41 nurses anonymously completed the survey online and

once they completed the survey and saved it, I was able to retrieve the 41 completed surveys via the SurveyMonkey® website.

The questionnaires were provided online to the nurses via SurveyMonkey®. Fry sent an official copy of his assessment tool along with his permission for me to utilize it in my study. Findings from my use of his instrument will be shared with Fry after final approval of my dissertation.

Spiritual Index of Well-Being. Recognizing that the perception of health impacts a person's recovery, my study sought to explore the perceptions of patients as well as nurses. While the nurses were completing the SLA, I began frequent visits to the three designated sites to talk with homeless clients to explain my study and solicit their support in completing the survey instrument. I offered to read the paper survey to the homeless patients but quickly discovered that most of them were more than capable of reading and understanding the 12-item survey. Patients' spiritual well-being was documented utilizing the Daaleman and Frey (2004) Spiritual Index of Well Being. Paper copies of SIWB questionnaires were distributed to interested patients at three of the 67 congregational nursing sites (Appendix B). The sites utilized were those exclusively serving homeless clients). Over the course of four weeks I collected the surveys onsite from the homeless patients that were present and willing to complete the survey. This required visiting each site twice which resulted in 65 completed surveys. At each site it was announced that I was doing a survey to ascertain the impact of spirituality on the healthcare received. I reviewed the informed consent form and after getting signed forms distributed the 12-item survey. I offered to read the survey, if anyone needed assistance.

Focus groups. The results of the SLA informed the questions that were developed for the two focus groups that were held to capture information from the nurses in this program. In

an effort to accommodate the varying schedules of the nurses, one focus group ($n = 18$) was held mid-day and the second one ($n = 11$) was held the following evening. The initial focus group, held at lunchtime, was comprised of a cross-section of the congregational nurse program. The second focus group was held the next evening and was attended by a diverse group of female nurses. In an effort to allow the greatest amount of freedom and anonymity, the leaders of the program were not present for either of the focus groups. As the researcher, I facilitated the focus group discussion, recorded the discussion on audio recorders and also took copious notes by hand. Each participant was asked to count off to establish numbers for themselves so that in the transcription, I would be able to group the comments of each participant in case there was a pattern of significance that was worthy of noting in the findings or implications.

Observations. Questionnaire data formed a foundation for launching on-site observations, and interviews and document analysis to acquire a deeper understanding of the relationship between spiritual leadership and patient and nurse/leaders' perceptions of the role of spirituality in health care. While questionnaire data provides a *breadth of information* from larger numbers of respondents, observations, and interviews and document analysis provide *depth of information* from three congregational nursing sites. The three sites in which observations of the program in action, and interviews and document analysis were chosen primarily because my keenest interest was in the impact of congregational nursing on the most vulnerable populations. I purposefully selected sites for deeper inquiry that had the greatest diversity of patient needs: those with ethnic and racial difference, poverty impact, and the homeless. Field notes (Emerson, Fretz, & Shaw, 2011) were taken during the observations, and fleshed out into full field accounts as soon as possible after every observation experience. I observed the nurses as they performed activities and questioned them about the way they treated

homeless patients, which helped me to ascertain the methodology used in treating patents while also clarifying how the nurses integrate spirituality into the clinical care provided. This textual data was explored inductively using content analysis to generate categories and explanations.

Interviews. Questionnaire data also informed the drafting of my interview guides for use with individuals and focus groups. Initially, I planned to select sites for deep inquiry that had nurse/ caregivers and program leaders who I deemed were the most likely to reveal authentic information to me. However, after narrowing the population of patients down to homeless clients at three shelters, I decided to limit my interviews to the five nurse/leader nurses who interfaced with the homeless clients. The five nurses selected included three congregational nurses, and the coordinator and assistant coordinator for the program. Follow-up interviews were conducted by telephone, as convenient for the congregational nurses or program leaders. In individual interviews my role was to prompt discussion, listen deeply, and follow up on key points that emerged in my informant's account. Within focus group interviews I exerted care to spread verbal interaction across all participants so that no one person dominated the discussion or unduly influenced other participants.

Observations afforded me an opportunity to see how the nurses and program leaders incorporated spirituality in the care they gave to their patients. It became necessary to have an additional follow-up conversation with each of the four nurses, and these were done onsite and offered yet another opportunity for observation of the program in action. I met with each of these nurses once for a follow-up conversation that lasted 30–45 minutes. Follow-up conversations with the leadership were for an hour each. Over the five-month period, I frequented the three facilities during their hours of operation in an effort to gain a greater appreciation for the environment where the services are rendered., spending a total of 40 hours of

observation: 20 hours at Location 1 (8 am–12 noon), 12 hours at Location 2 (after 5 pm) and 8 at Location 3 (after 6 pm).

Institutional forms of documentation and artifacts. Nurse leadership gave the researcher copies of artifacts for review and analysis at the onset of the research study.

Case study. This case study involved three homeless women who participated in a series of power-sensitive conversations over a five-month period for a total of 48 hours of interview. Participants were interviewed either at their living environment or at a local restaurant. The focus of the interviews was to learn firsthand the challenges faced by the homeless as well as the strengths, steadfastness and faith.

While the SIWB survey results offered guidance for the discussion, I took full advantage of the hours spent with the women to observe their surroundings, culture and environment. These observations resulted in a number of open-ended questions about their culture and behavior. At the beginning of our time together, I simply shared the focus of my research and then allowed them to talk freely about their journey. I interjected questions only to gain clarity or to gently guide the patient in those instances where I desired more information about what might have been shared. I made a minimum of three contacts with each of the three women, who were all homeless when I met them. I followed up via phone to ensure accuracy of the field notes taken during power-sensitive conversations and observations.

Quantitative Data Analysis Procedures

Spiritual Leadership Assessment. Questionnaire data were analyzed using the Statistical Package for the Social Sciences (SPSS). I exported the data from SurveyMonkey® to SPSS and then ran appropriate queries to analyze it. I examined the data to ensure that there were no data entry errors. The data were maximized for all responses.

To begin the analytical process I summarized the descriptive statistics, then reviewed target research variables and compared those to the type of variables that exist in my own data. I examined the data for the presence of dichotomous groups, or continuous variables. Utilizing SPSS I determined the best analytical test. The best option was the independent samples *t*-test. The resulting data yielded a series of graphs and charts to clearly articulate a descriptive, inferential analysis. In addition, I gained descriptive statistics that articulate the demographic information for all respondents. From the resulting questionnaire data I drew ideas about key themes to explore in observations and interviews, as well as questions or prompts for use in the interview guides I used with nurses. In addition, I ran the Levene's test to assess the differences in variability between two distributions and the Test for Equality of Means which was done to get the *t*-test results (*t*-value, degrees of freedom, and *p*-value).

Spirituality Index of Well-Being. All of the data from the 65 paper survey collected was manually inputted into SurveyMonkey®. I analyzed this data using the SPSS. I exported the data from SurveyMonkey® to SPSS and then ran appropriate queries to analyze it. I examined the data to ensure that there were no data entry errors. The data were maximized for all responses. Utilizing SPSS I determined the best analytical test. The best option was the independent samples *t*-test. The resulting data yielded a series of graphs and charts to clearly articulate a descriptive, inferential analysis. Descriptive analyses were performed using SPSS, which was inclusive of demographic information shared by survey respondents. Reliability was calculated by internal consistency. Survey results revealed common themes that were utilized to further analyze the patient's perspective of the impact of the spirituality on their health. I used SPSS to perform a bivariate correlation to determine if self-efficacy and life scheme are linearly related to each other. I initially executed a scatterplot to ensure that my assumptions were

satisfied and then performed the analysis. In addition, I ran the Levene's test to assess the differences in variability between two distributions and the Test for Equality of Means which was done to get the t-test results (*t*-value, degrees of freedom, and *p*-value).

Ethnographic Data Analysis

Ethnographic analysis starts with the very design of the study and was recursive throughout the entire research project. As each decision was made, an analysis took place. I decided where to go; what to observe and what to ignore; whom to interview; what documents and artifacts to examine, if any; what to write down in field notes, how to organize the data, which themes needed further examination, right down to the final written report. Further, following Rosaldo (1989) I understood and respected what my informants told me as a first-order analysis in its own right: as an informant chooses what to tell a researcher, s/he creates her/his own analysis of the information in question.

In the field I made field jottings (Emerson et al., 2011) when deeper note taking was obtrusive, and then fleshed these out into full field accounts immediately after exiting the field. Every interview was recorded in field notes as well as audio recorded, using jottings later fleshed out into full field accounts. As I transcribed audio recordings—and I did all transcription myself, so as to remain as close to my data as possible—I created an index (Hammersley & Atkinson, 2009) of emerging themes. I constantly compared field notes from each interview session with the audio recording of each, to look for congruencies as well as discrepancies in my emerging understandings of each event. Indexing was used rather than coding, so that anomalies could get equal attention with more consistent patterns. Informants completed member-checking on all transcriptions, to assure that their intended meanings were accurately captured.

Comparison of indexed themes yielded conceptual fields that became theme-focused sections of chapters as evidenced later in this final research report. Discrepant cases—the anomalies—received full attention depending upon their significance in the final research analysis.

Data for ethnographic analysis included field notes from observations, transcripts of audiotaped focus groups and in-depth interviews as well as field notes from these, and analysis of any documents and artifacts my informants chose to share with me.

Focus groups. The audio recordings for each of the two focus groups were transcribed and indexed to look earnestly as an interpretivist/constructivist researcher for multiple realities rather than looking for one objective reality as it relates to spirituality and health. In Norman K. Denzin's words, "Objective reality will never be captured. In depth understanding requires the use of multiple validities, not a single validity, a commitment to dialogue is sought in any interpretive study" (Denzin, 2010, p. 271). In an effort to bring meaning to the words captured, the indexing was utilized to identify themes which were then organized in a coherent manner after reading the transcription extensively. Utilizing thematic case analysis, I focused on organization and rich descriptions of the data set. It was my goal to go beyond simply counting phrases or words in the transcripts but to work to identify implicit and explicit ideas within the research data (Hammersley & Atkinson, 2009).

Interviews. I initially contemplated using CAQDAS (Computer Assisted Qualitative Data Analysis) which is generally used to assist researchers with data coding, management and analysis. However, desiring to stay true to interpretivism, I chose to do the analysis without any technological assistance because computer analysis does not supplant the interpretive nature of indexing or coding. I reviewed the notes from each of the interviews, reviewed the audio

recordings and made a verbatim record of each of the interviews and indexed the data independently and then compared the data from each of the interviews to determine common themes. Once those themes were identified, I compared those themes to the nine variables of spiritual leadership theory to ascertain if the data served to support the theoretical framework of the study for this dissertation. Where the two sets of data intersected, is where I focused my analysis and recommendations. To accomplish this, I used thematic case analysis (Hammersley & Atkinson, 2009) as noted above for focus groups.

Case Studies

The five months spent observing three homeless women and participating in power sensitive conversations was in itself an analysis with the researcher serving as the probing instrument. The case studies themselves represent an analysis of sorts in that it reflects a self-analysis of their lives and their perceptions of how the congregational nurse program has impacted their spiritual health and spiritual well-being. The case studies are written in the ethnographic style of a field tale but stays true to the voice of the three homeless women.

Institutional Forms of Documentation and Artifacts

Program leaders shared their 2011 Annual Report and A Bridge to Wholeness (10-year programmatic overview). The Annual Report is a comprehensive accounting of program accomplishments, program outcomes, a summary of Lay Health Coach Program, Progress Reports and Stories of Impact. The ten-year programmatic overview includes program highlights, stories of impact, community impact and evidences of lives saved through nurses. I used these documents as a means to validate the findings obtained during the research study. The documents also provided rich program data over the last 11 years that help to inform the study.

Meanings Captured and Their Potential to Inform

My study used nurses, program leadership and patient questionnaires for breadth of inquiry across 44 congregational nursing sites, and ethnographic observations, interviews, and document and artifact analysis within three sites for depth of understanding. Participants were delimited to the nurses, program leaders, and patients who were all part of a spiritually-based health care program. The questionnaires utilized in the study have been fully vetted and over time have proven to be reliable and valid (Fry, 2003; Daaleman & Frey, 2004). While congregational nursing is an exemplary program, and the study has the potential to inform the field, it is important to recognize that informants are delimited to one program in one North Carolina metropolitan city that is closely affiliated with one local health system.

Despite its limitations my study holds the potential to contribute to the body of knowledge surrounding the effectiveness of spiritual leadership in health care settings. It also has the potential to inform the way community health is delivered in the future to maximize effectiveness and improve overall health outcomes of target populations. Spiritual leadership theory when appropriately utilized holds the potential to transform the way healthcare is delivered in this country. This transformation should lead to improved health outcomes particularly for the most vulnerable populations.

Following the ethnographic tradition of “writing culture” my findings are shared in a series of chapters (Hammersley & Atkinson, 2009) rather than just one, as is more typical of the positivist writing and reporting style. Chapter 4 examines the spiritual nature of the leadership provided by the congregational nurses through their care of patients. Chapter 5 analyzes patient perceptions of their congregational nursing care. Chapter 6 provides the research context through field accounts (Emerson et al., 2011) focusing on three patients whose accounts

shattered any misconceptions about what it means to be homeless. Chapter 7 discusses findings along with implications for practice and future research.

CHAPTER 4

The Spiritual Leadership of Congregational Nurses: A Labor of Love

Chapter 3 presented the methods for collecting and analyzing data documenting stakeholder perceptions of the role of spirituality in improving healthcare outcomes for vulnerable populations. This chapter examines the perspectives and worldviews of the caregivers, which includes three congregational nurses, and the coordinator and assistant coordinator for the program. It draws on data gathered from the Spiritual Leadership Assessment (SLA) questionnaire, along with two focus groups, five structured phone interviews, and power-sensitive conversations with the nurse/leaders who work directly with mentally and physically ill homeless patients in the community where my study was set.

The local faith-based nursing program was established in this community in 1998 and became fully operational in 1999. It was developed in an effort to increase access to care by reducing some of the major barriers for low-wealth families in need of health care services. The program was able to do this by placing nurses in local churches, synagogues and temples in addition to homeless shelters, which reduced the transportation barrier to access. The program provides all of its services at no cost to the patients, makes referrals to low or no-cost primary care services, provides bus passes and vouchers to cover the cost of prescribed medications.

SLA Data Analysis and Emergent Themes

To begin documenting nurse/leader perspectives the SLA was administered anonymously via Survey Monkey to those nurses in the Congregational Nurse Program. Data were analyzed utilizing the Statistical Package for the Social Sciences (SPSS) predictive analytics software to perform a *t*-test and Levene's Test for Equality of Variances, which is used for a variable

calculated for multiple groups. In addition, SPSS was used to determine the Chronbach's Alpha for the SLA.

Demographic Data on Respondents

Forty-one nurse/leaders out of a possible 44 (93%) completed the Spiritual Leadership Assessment (2003), which looks at the nine variables of spiritual leadership theory that were developed by Fry (2011). As noted in Chapter 2, the nine variables include: (a) Inner life, (b) Vision, (c) Altruistic love, (d) Hope/faith, (e) Meaning/calling, (f) Membership, (g) Life satisfaction, (h) Organizational commitment, and (i) Productivity.

All of the nurse/leaders in the program were female, with a minimum of a bachelor's degree in nursing. Of the 41 who participated in the survey, 24 were Caucasian, 11 were African American, and the remaining six listed their race/ethnicity as "other" as noted in the pie chart below in Figure 3.

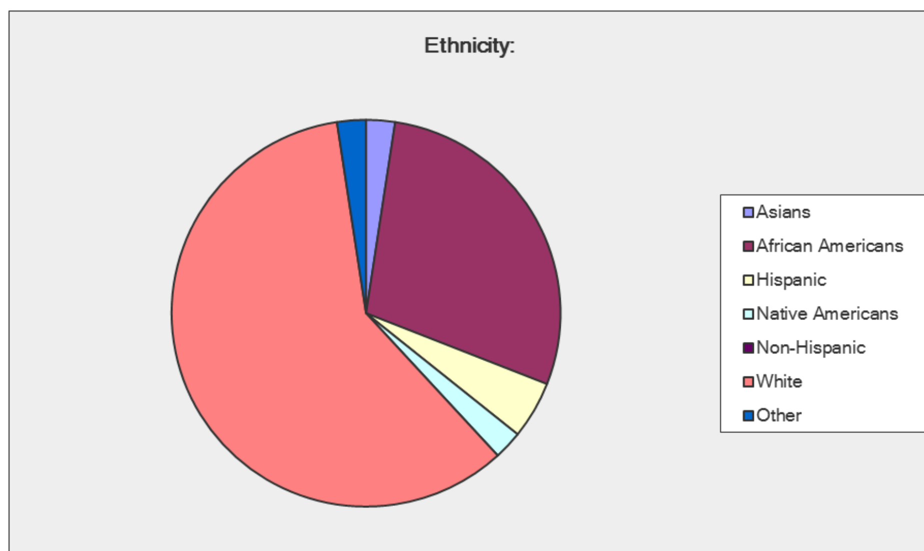

Figure 3. Participants' ethnicity.

The nurse/leadersnurses ranged in age from 35 (n = 3 for those 35–44) to over 75 (n = 1) with the greatest number of reporting their ages in the range of 55 to 64 (n = 18) and 64 to 74 (n = 10) and six indicating their age in the 45 to 54 range as noted on the chart in Figure 4.

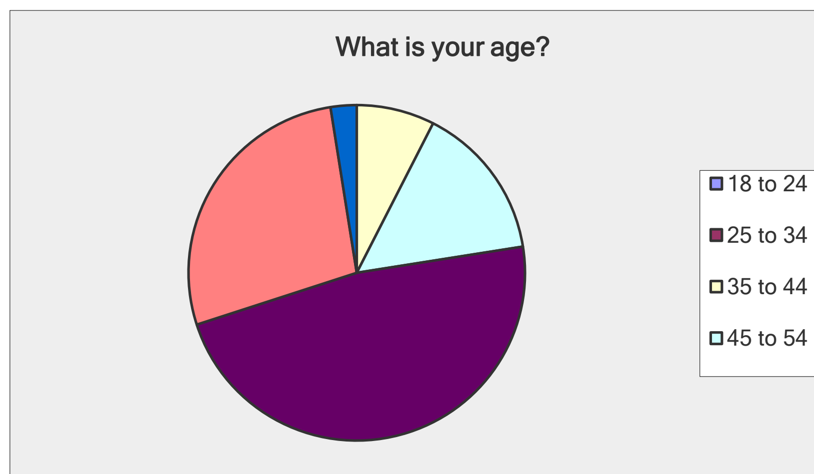

Figure 4. Participants' age.

The nurse/leaders participating in the study reported incomes in all of the income brackets given on the survey. Upon inquiry, it was revealed that some are retired and only work ten hours per week as a congregational nurse while others have fulltime jobs and this is their part-time job. Others had varying work schedules and some nurses work for two faith institutions and are paid for 15–20 hours. All of these different situations help to explain the variance in income, coupled with the fact the question asked for household income rather than individual income. As indicated in Figure 5, most of the nurse/leaders reported a household income of $75,000 and $99,999 ($n$ = 14) while there were a total of 13 who indicated an income between $25,000 and $75,000. A total of five reported household incomes in excess of $100,000, with one of those indicating their household income was between $175,000 and $199,999.

In terms of the highest level of education completed, the majority of nurse/leaders indicated they graduated from college with a four-year degree (n = 21) and many of them completed graduate school (n = 16). A few completed three years of college (n = 3) and one indicated she completed some graduate school work. On the chart in Figure 6, the legend shows

all of the options that were given to indicate education level although for this study all respondents answered by selecting one of the last four response options.

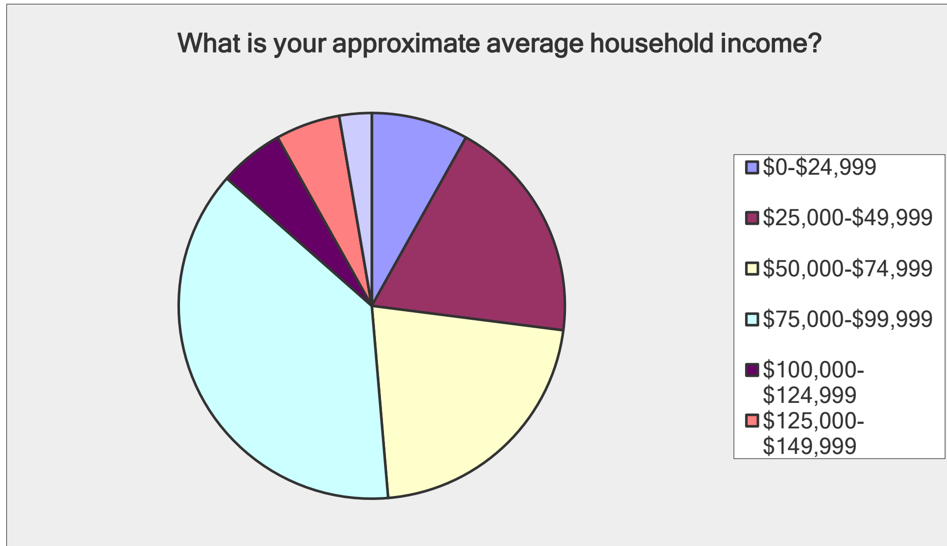

Figure 5. Participants' average household income.

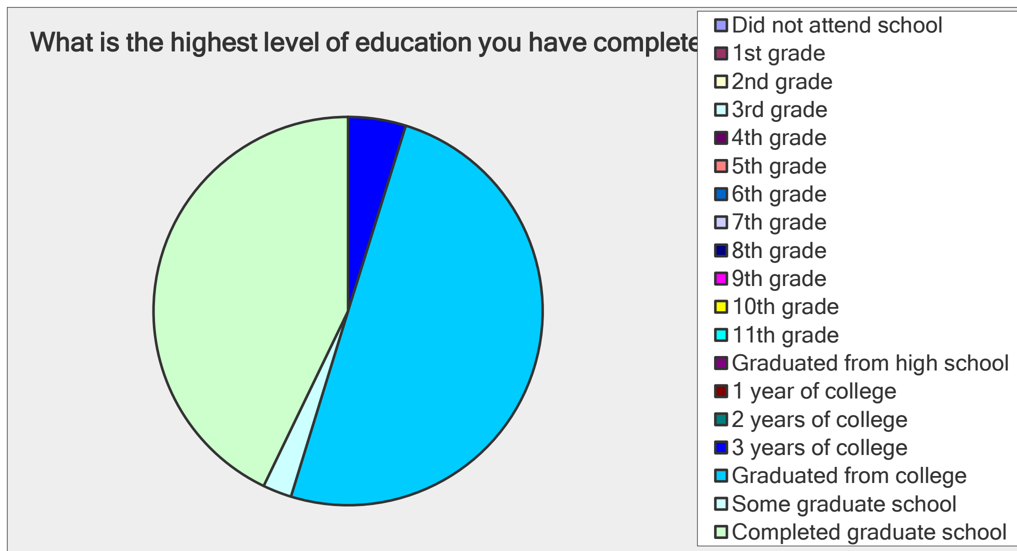

Figure 6. Participants' highest level of education.

Descriptive Analysis of the Variables

As noted earlier, Spiritual Leadership Theory consists of nine variables: Vision, Hope/faith, Altruistic/love, Meaning/calling, Inner-life, Organizational commitment, Productivity and Satisfaction with life. There are a number of ways to look at this data to ascertain nurse/leader perceptions, the outcomes of this study of the congregational nurse program. Given that the nurse/leaders varied in ethnicity, age, income and education level, the data is examined descriptively. It is important to examine all the data in this manner. Since all of the nurses are female, gender difference was not a factor in the results of this survey, but may be important to look at in future studies inclusive of male nurses. Table 3 shows the mean and standard deviation by each variable segmented by Caucasian and African American.

Table 3

Group Statistics for Congregational Nurses by Ethnicity

Variable	Ethnicity_3	*N*	*M*	*SD*	SE Mean
Vision	Caucasian	24	4.5000	.54673	.11160
	African American	11	4.5682	.38876	.11722
Hope/Faith	Caucasian	24	4.4236	.51658	.10545
	African American	11	4.4773	.46710	.14084
Altruistic Love	Caucasian	24	4.4833	.58359	.11913
	African American	11	4.4864	.37953	.11443
Meaning/Calling	Caucasian	24	4.7014	.37180	.07589
	African American	11	4.8409	.25673	.07741
Membership	Caucasian	24	4.4896	.54911	.11209
	African American	11	4.5227	.43952	.13252
Inner-Life	Caucasian	24	4.5417	.45101	.09206
	African American	11	4.7091	.33898	.10221
Organizational Commitment	Caucasian	24	4.2750	.61521	.12558
	African American	11	4.2818	.34298	.10341
Productivity	Caucasian	24	4.1493	.51133	.10438
	African American	11	4.4545	.31261	.09426
Satisfaction w/Life	Caucasian	24	3.9500	.63861	.13036
	African American	11	4.1455	.49064	.14793

Vision: describes the organization's journey and why we are taking it; defines who we are and what we do. (Fry, 2008, p. 116)

The 24 Caucasians completing the survey had a median score of 4.50 out of a possible 5, with a standard deviation of .54673, while African-Americans had a mean score of 4.57 with a standard deviation of .39.

Hope/faith: the assurance of things hoped for, the conviction that the organization's vision/ purpose/ mission will be fulfilled. (Fry, 2008, p. 116)

African-Americans (n = 11) had a mean score of 4.57 with a standard deviation of .47, while Caucasians (n = 24) had a mean score of 4.42 with a standard deviation of .52.

Altruistic love: a sense of wholeness, harmony, and well-being produced through care, concern, and appreciation for both self and others. (Fry, 2008, p. 117)

Caucasians (n = 24) had a mean score of 4.48 with a standard deviation of .58, while African-Americans (n = 11) had a mean score of 4.49 with a standard deviation of .38.

Meaning/calling: a sense that one's life has meaning and makes a difference. (Fry, 2008, p. 117)

African-Americans (n = 11) had a mean score of 4.84 with a standard deviation of .26, while Caucasians had a mean score of 4.70 with a standard deviation of .37. Based on ethnicity, this variable had the highest mean scores.

Membership: a sense that one is understood and appreciated. (Fry, 2008, p. 117)

Caucasians (n = 24) had a mean of score of 4.49 with a standard deviation of .55, while African-Americans (n = 11) had a mean score of 4.52 with a standard deviation of .44.

Inner-life: the extent to which one has and seeks an inner spiritual awareness. (Fry, 2008, p. 117)

African-Americans (*n* = 11) had a mean score of 4.71 with a standard deviation of .34, while Caucasians (*n* = 24) had a mean score of 4.54 with a standard deviation of .45.

Organizational commitment: the degree of loyalty or attachment to the organization. (Fry, 2008, p. 118)

Caucasians (*n* = 24) had a mean score of 4.27 with a standard deviation of .62, while African-Americans had a mean score of 4.28 with a standard deviation of .34.

Productivity: efficiency in producing results, benefits, or profits. (Fry, 2008, p. 118)

African-Americans (*n* = 11) had a mean score of 4.45, with a standard deviation of .09 while Caucasians had a mean score of 4.15 with a standard deviation of .51.

Satisfaction with life: one's sense of subjective well-being or satisfaction with life as a whole. (Fry, 2008, p. 118)

Caucasians (*n* = 24) had a mean score of 3.95 with a standard deviation of .64, while African-Americans had a mean score of 4.15 with a standard deviation of .15. Based on ethnicity, this variable had lowest of the mean scores.

Key SLA Findings

In reviewing the results of the SLA and looking specifically at the variances by variables, some noteworthy differences emerged, particularly as relates to ethnicity and income level. Several variables stand out because the mean scores are substantially higher for three of the variables than they are for the other six. In addition, one variable is significantly lower than the remaining eight.

The fact that Meaning/calling is highly rated regardless of race or economic status speaks well for the congregational nurse program that formed the focus of my study. The literature indicates that workplace spirituality is enhanced by "calling or transcendence of self"

(Fry, 2008, p. 107). Altruistic love is defined by Fry (2003) as "a sense of wholeness, harmony and well-being produced through care, concern and appreciation for self and others." As noted in Table 4, Fry (2003) contended that "underlying the definition for altruistic love are 11 values which are operationalized through positive affirmations and grounded in personal actions" (p. 712).

Table 4

Values of Hope/Faith and Altruistic Love as Personal Affirmations

1. **Trust/loyalty:** In my chosen relationships, I am faithful and have faith in and rely on the character, ability, strength, and truth of others.

2. **Forgiveness/acceptance/gratitude:** I suffer not the burden of failed expectations, gossip, jealousy, hatred, or revenge. Instead, I choose the power of forgiveness through acceptance and gratitude. This frees me from the evils of self-will, judging others, resentment, self-pity, and anger and gives me serenity, joy, and peace.

3. **Integrity:** I walk the walk as well as talk the talk. I say what I do and do what I say.

4. **Honesty:** I seek truth and rejoice in it and base my actions on it.

5. **Courage:** I have the firmness of mind and will, as well as the mental and moral strength, to maintain my morale and prevail in the face of extreme difficulty, opposition, threat, danger, hardship, and fear.

6. **Humility:** I am modest, courteous, and without false pride. I am not jealous, rude, or arrogant. I do not brag.

7. **Kindness:** I am warm-hearted, considerate, humane, and sympathetic to the feelings and needs of others.

8. **Empathy/compassion:** I read and understand the feelings of others. When others are suffering, I understand and want to do something about it.

9. **Patience/meekness/endurance:** I bear trials and/or pain calmly and without complaint. I persist in or remain constant to any purpose, idea, or task in the face of obstacles or discouragement. I pursue steadily any project or course I begin. I never quit in spite of counter influences, opposition, discouragement, suffering, or misfortune.

10. **Excellence:** I do my best and recognize, rejoice in, and celebrate the noble efforts of my fellows.

11. **Fun:** Enjoyment, playfulness, and activity must exist to stimulate minds and bring happiness to one's place of work. I therefore view my daily activities and work as not to be dreaded yet, instead, as reasons for smiling and having a terrific day in serving others.

Source: Fry (2003), p. 712

On the SLA, the nurse/leaders had a mean score of 4.51 for both Altruistic love and Membership. For Altruistic love there were five statements/questions that were grouped together to determine the mean, median, mode and standard deviation. The statements are noted below:

1. (Q1) The leaders in my organization "walk the walk" as well as "talk the talk."
2. (Q10) The leaders in my organization are honest and without false pride.
3. (Q12) My organization is trustworthy and loyal to its employees.
4. (Q22) The leaders in my organization have the courage to stand up for their people.
5. (Q31) My organization is kind and considerate toward its workers, and when they are suffering, wants to do something about it.

Fry (2003) defines Membership as a sense that one is understood and appreciated. Ninety-seven percent of the nurse/leaders strongly agreed with the questions combined to determine the mean score of 4.51.

1. (Q3) I feel my organization appreciates me, and my work.
2. (Q9) I feel my organization demonstrates respect for me, and my work.
3. (Q21) I feel I am valued as a person in my job.
4. (Q32) I feel highly regarded by my leaders.

As it relates to income, the data indicates that those nurse/leaders with the highest household income ($75,000 or more) tended to have higher mean scores on Meaning/calling than those who made less than $74,999. The 19 nurses with incomes of $75,000 or more had a mean score of 4.86 versus 4.73 for the nurses making less than $75,000. While not statistically significant, this difference may be worth exploring in future research. Ashmos and Duchon (2000) indicated in their research findings that Inner life is an important aspect of workplace spirituality. Survey results showed that most nurse/leaders reported being aware of their Inner

life, with the overall mean score at 4.61, with 11 African Americans reflecting a mean score of 4.71 versus 4.54 for 24 Caucasian nurses. (See Table 5 for descriptive statistics on Meaning/calling based on income.)

Table 5

Descriptive Statistics for SLA by Income

		N	M	SD	Std. Error	95% Confidence Interval for Mean Lower Bound	95% Confidence Interval for Mean Upper Bound	Min	Max
Vision	Less $74,999	16	4.4375	.48734	.12183	4.1778	4.6972	3.50	5.00
	$75,000 or more	19	4.6579	.41003	.09407	4.4603	4.8555	4.00	5.00
	Total	35	4.5571	.45409	.07676	4.4012	4.7131	3.50	5.00
Hope/Faith	Less $74,999	16	4.4010	.43271	.10818	4.1705	4.6316	3.75	5.00
	$75,000 or more	19	4.6053	.46634	.10699	4.3805	4.8300	3.75	5.00
	Total	35	4.5119	.45650	.07716	4.3551	4.6687	3.75	5.00
Altruistic/Love	Less $74,999	16	4.4375	.45735	.11434	4.1938	4.6812	3.60	5.00
	$75,000 or more	19	4.6184	.44572	.10226	4.4036	4.8333	3.80	5.00
	Total	35	4.5357	.45367	.07668	4.3799	4.6916	3.60	5.00
Meaning/Calling	Less $74,999	16	**4.7344**	.32234	.08059	4.5626	4.9061	4.00	5.00
	$75,000 or more	19	**4.8553**	.30409	.06976	4.7087	5.0018	4.00	5.00
	Total	35	**4.8000**	.31389	.05306	4.6922	4.9078	4.00	5.00
Membership	Less $74,999	16	4.3750	.38730	.09682	4.1686	4.5814	4.00	5.00
	$75,000 or more	19	4.6579	.41003	.09407	4.4603	4.8555	4.00	5.00
	Total	35	4.5286	.41908	.07084	4.3846	4.6725	4.00	5.00
Inner/Life	Less $74,999	16	4.7000	.34254	.08563	4.5175	4.8825	4.00	5.00
	$75,000 or more	19	4.5789	.38236	.08772	4.3947	4.7632	3.80	5.00
	Total	35	4.6343	.36456	.06162	4.5091	4.7595	3.80	5.00
Organizational_ Commitment	Less $74,999	16	4.1875	.38966	.09741	3.9799	4.3951	3.60	4.80
	$75,000 or more	19	4.4632	.43232	.09918	4.2548	4.6715	3.80	5.00
	Total	35	4.3371	.43052	.07277	4.1893	4.4850	3.60	5.00
Productivity	Less $74,999	16	4.2240	.39758	.09940	4.0121	4.4358	3.50	5.00
	$75,000 or more	19	4.3684	.45161	.10361	4.1508	4.5861	3.50	5.00
	Total	35	4.3024	.42783	.07232	4.1554	4.4493	3.50	5.00
Satisfaction w/ Life	Less $74,999	16	3.9750	.37148	.09287	3.7771	4.1729	3.20	4.60
	$75,000 or more	19	4.1158	.64400	.14774	3.8054	4.4262	3.20	5.00
	Total	35	4.0514	.53433	.09032	3.8679	4.2350	3.20	5.00

In terms of income, the overall mean score was 4.80, which is inclusive of 4.73 for the 16 nurse/leaders reporting a household income less than $75,000, versus a mean score of 4.85 for the 19 with household incomes in excess of $75,000. Six respondents left this question blank on the assessment.

Whether spiritual leaders or not, most leaders will agree that an effective leader is one who has a vision that is easily articulated and that compels followers to get behind them. Kriger and Seng (2005) argued that spirituality impacts the values of leaders and that this determined the level of organizational commitment (by subordinates) to the overall goals and direction established by the leader.

The results of the SLA survey completed by 41 of the 44 congregational nurses yielded the highest ratings in the areas of Meaning/Calling, Inner Life, and Vision (see Table 6). The mean score for Meaning/Calling was 4.78 out of a possible five, while it was 4.61 for Inner Life, and 4.54 for Vision.

Table 6

Descriptive Statistics for Select SLA Variables by Race

						95% Confidence Interval for Mean			
		N	*M*	*SD*	Std. Error	Lower Bound	Upper Bound	Min	Max
Vision	Caucasian	24	4.5000	.54673	.11160	4.2691	4.7309	3.25	5.00
	African American	11	4.5682	.38876	.11722	4.3070	4.8294	4.00	5.00
	Other	6	4.6250	.44017	.17970	4.1631	5.0869	4.00	5.00
	Total	41	4.5366	.48593	.07589	4.3832	4.6900	3.25	5.00
Inner/Life	Caucasian	24	4.5417	.45101	.09206	4.3512	4.7321	3.60	5.00
	African American	11	4.7091	.33898	.10221	4.4814	4.9368	4.00	5.00
	Other	6	4.7000	.30332	.12383	4.3817	5.0183	4.20	5.00
	Total	41	4.6098	.40485	.06323	4.4820	4.7375	3.60	5.00
Meaning/ Calling	Caucasian	24	4.7014	.37180	.07589	4.5444	4.8584	4.00	5.00
	African American	11	4.8409	.25673	.07741	4.6684	5.0134	4.25	5.00
	Other	6	4.9583	.10206	.04167	4.8512	5.0654	4.75	5.00
	Total	41	4.7764	.32673	.05103	4.6733	4.8796	4.00	5.00

For Meaning/Calling, the six nurse/leaders who reported their race as “other” reflected a means score of 4.96 versus 4.84 for 11 African- Americans and 4.70 for 24 Caucasians. While race was not used as an indicator of effectiveness as a spiritual leader, a breakdown of scores by

race is useful to examine, given that a survey done in 2009 by the Pew Research Center indicated that more African -Americans reported religion being important to them than their Caucasian counterparts.

Satisfaction with Life

While not statistically significant, Caucasian nurse/leaders reported lower satisfaction with life ratings on the Spiritual Leadership Assessment (SLA) than African-American nurses. In fact their mean score of 3.95 was the only rating below 4.0 for the nine-set of rating pairings. The overall mean score for this subscale was 4.04, which includes six nurse/leaders who reported their race as other (Asian, Hispanic, Native American, unspecified) with a composite mean score of 4.23. Because the African-American rating was 4.14, the difference between the two noted races is not statistically significant, but it may be of interest to note that Caucasians tended to report being less satisfied with their lives than their African- American counterparts. Satisfaction with life is one of the key constructs of spiritual leadership theory and it is from one's satisfaction with her/his own life, that s/he is able to spread love, joy and compassion to others.

Fry (2005) theorized that SLA participants who practice spiritual leadership on a personal level tend to score higher on the Satisfaction with Life subscale because they experience peace and joy in their life. It was surprising when the nurse/leaders who demonstrate great compassion for their patients scored low on Satisfaction with Life.

There were five statements used to determine life satisfaction scores on the SLA as noted below:

1. (Q6) The conditions of my life are excellent.
2. (Q24) I am satisfied with my life.
3. (Q27) In most ways my life is ideal.

4. (Q35) If I could live my life over, I would change almost nothing.
5. (Q40) So far I have gotten the important things I want in life.

Correlation of Spiritual Leadership Variables

Utilizing PASW Statistics 18 (formerly SPSS Statistics), which is a comprehensive software package designed to analyze data; I calculated the correlation coefficient for the variables in the SLA. This was done in an effort to examine and ascertain the relatedness between the nine variables that comprise spiritual leadership theory. While literature indicates some relationships between the variables, it was important to determine any correlations present within my data, for this study as it will help to fully understand the results and also provide some insight in terms of implications for future research. For the purposes of this study the Pearson Product Moment Correlation (noted as Pearson's Correlation on all charts) of 0.6 to 0.8 is considered a moderate positive relationship and 0.8 to 1.0 is a strong positive relationship.

Vision. It has a moderate or high positive relationship with all variables with the exception of Satisfaction with life, where the correlation coefficient was .526, which reflects a relatively low positive relationship. The most linear relationship was between Vision and Organizational commitment, with a correlation coefficient of .876.

Hope/Faith. The most linear relationships existed between Hope/faith and Meaning/calling (.786), Hope/faith and Organizational commitment (.786) and Hope/faith and Altruistic Love. (.712). Hope/faith had a somewhat moderate positive relationship with Inner-life (.588),); and low positive relationships with Membership (.543), Productivity (.526) and Satisfaction with life (.523).

Altruistic Love. It has a high positive relationship with Organizational commitment (.847), Vision (.806), Membership (.747) and Hope/faith (.712). Meaning/ calling (.669),

Productivity (.651) and Inner-life (.629) also reflected strong linear relationships. The lowest positive relationship was between Altruistic love and Satisfaction with life.

Meaning/Calling. Hope/faith (.786) and Organizational commitment (.706) had high positive relationships, along with Vision (.676), Altruistic love (.669),) and Inner-life (.615). The lowest positive relationships were with Satisfaction with life (.543), Membership (.537),) and Productivity (.500).

Inner-life. The correlations with Inner-life were considerably lower than with the other variables, which was quite surprising given the relative importance of Inner-life as it relates to spiritual leadership:

As shown in Figure 7, personal spiritual leadership requires an inner life practice that is the source of hope/faith in a vision of service of others through personal values based on altruistic love. By committing to a vision of service to our key stakeholders, we discover a calling to make a difference in other peoples' lives and, therefore, have a sense that our life has meaning and purpose (http://iispiritualleadership.com/spiritual-leadership-coaching/). This relationship is illustrated visually below (Fry & Slocum, 2008, p. 91)

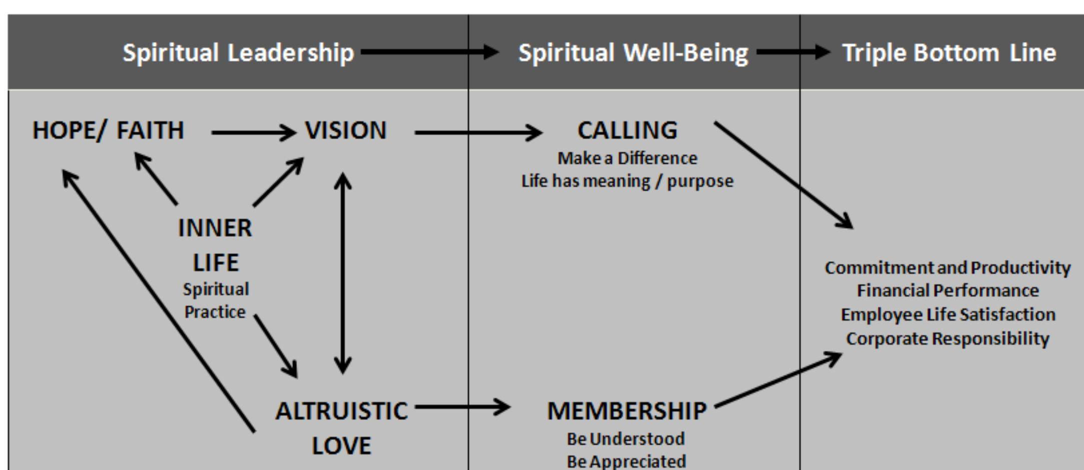

Figure 7. The Personal Spiritual Leadership Model. (Fry & Slocum, 2008)

Now that we have examined the correlations between the variables, it is important for us to examine the variances that exist in the data by demographics. Does race or ethnicity have an impact on the linear relationships of variables? What are the correlations when controlled for age? How does income impact the variable correlations? Does the amount of education one has have an impact on the linear relationship with spiritual leadership variables? The results of my study indicate that there are some significant differences among the linear relationships of variables based on ethnicity and income.

Linear Relationships by Ethnicity

Correlation matrices of the leadership variables for ethnicity are presented in Appendix E. The correlations for African Americans ranged from .033 to .896 while the correlations for Caucasians ranged from .358 to .897. In the category of other, the correlations ranged from -.201 to .982, representing both the lowest and the highest correlations among ethnic groups. Comparing ethnicity, there were some substantive differences. The variables that were most highly related were membership and vision for those who indicated other for their ethnicity. Whereas generally there were high positive relationships between variables for Caucasian nurses participating in the survey, there are very low positive relationships between several of the nine variables amongst the African American nurses. In fact, two of the variables were close to a negative relationship.

Membership and hope/faith had a correlation coefficient of .033 for African-Americans compared to .645 for Caucasian nurses. Membership and meaning/calling had a low correlation coefficient of .257 for African American nurses while Caucasians had a relatively high positive relationship at .632. Hope/faith and vision (.840) had a high positive relationship amongst the Caucasian nurses but these same two variables (.560) a moderate positive relationship with

African American nurses. With regard to organizational commitment and meaning/calling (.418), African American nurses had a low positive relationship compared to Caucasian nurses who had a high positive relationship with the same two variables (.786). Please refer to the charts below for full review of variable relationship variances by ethnicity and income level.

Correlation matrices of the leadership variables based on household incomes of either $74,000 and less or $75,000 or more are presented in Appendix E. The correlations for household incomes $74,000 or less range from -.251 to .803 while the higher income bracket indicates a range of .316 to .896. The variables that were most highly related for both income levels were vision and organizational commitment.

Organizational commitment. The Pearson Correlation reveals a positive relationship between Organizational commitment and the other eight variables. This finding supports the notion that organizational commitment is necessary to fully realize the other eight variables of spiritual leadership. Vision (.876), Membership (.865), and Altruistic love (.847) all have high positive relationships with Organizational commitment as reflected by their correlation coefficient. Hope/faith (.786), Meaning/calling (.706), Productivity (.649), Inner-life (.632), and Satisfaction with life (.602) also reflected strong linear relationships with Organizational commitment. Fry (2003) argued as follows:

> Thus, this intrinsic motivation cycle based on vision (performance), altruistic love (reward), and hope/faith (effort) results in an increase in ones sense of spiritual survival (e.g., calling and membership) and ultimately positive organizational outcomes such as increased:

1. organizational commitment—people with a sense of calling and membership will become attached, loyal to, and want to stay in organizations that have cultures based on the values of altruistic love, and
2. productivity and continuous improvement (Fairholm, 1998)—people who have hope/faith in the organization's vision and who experience calling and membership will "do what it 'takes' in pursuit of the vision to continuously improve and be more productive." (p. 714)

Productivity. Vision (.700) had the highest positive relationship with Productivity, followed by Altruistic love (.651), Membership (.649) and Organizational communications. Satisfaction with life (.551), Hope/faith (.526),) and Meaning/calling had moderately high positive relationships with Productivity, while Inner-life (.478) had a low positive relationship.

Satisfaction with life. The correlations for this variable were all positive but overall were low to moderate in terms of the linear relationship of the variables. Organizational commitment (.602) was the only variable with a relatively moderate/high correlation. Productivity (.551), Meaning/calling (.543), Vision (.526), Hope/faith (.523), and Altruistic love (.500) all have a moderate linear relationship with Satisfaction with life.

Correlations with Demographic Variables

In addition to correlations across SLA variables, I also examined the variances that exist in the data by demographics. My SLA demographics indicate that there are some significant differences among the linear relationships of variables based on ethnicity and income.

Appendix E presents correlation matrices of the SLA variables for ethnicity. The correlations for African-Americans ranged from .033 to .896, while correlations for Caucasians ranged from .358 to .897. In the category of "Other," the correlations ranged from -.201 to .982,

representing both the lowest and the highest correlations by ethnicity. The variables that were most highly related were Membership and Vision for those who indicated "Other" for their ethnicity. Generally there were high positive relationships between variables for Caucasian nurse/leaders participating in the survey, whereas very low positive relationships existed across several of the nine variables among the African-Americans. Membership and Hope/faith had a correlation coefficient of .033 for African-Americans, compared to .645 for Caucasians. Membership and Meaning/calling had a low correlation coefficient of .257 for African-American nurse/leaders, while Caucasians had a relatively high positive relationship at .632. Hope/faith and Vision (.840) had a high positive relationship among the Caucasian nurse/leaders but these same two variables (.560) showed a moderate positive relationship with African-Americans. With regard to Organizational commitment and Meaning/calling (.418), there was a low positive relationship with African-Americans compared to Caucasians, where a high positive relationship held across the same two variables (.786).

Correlation matrices of the leadership variables based on household incomes of either $74,000 and less, or $75,000 or more are presented in Appendix E. The correlations for household incomes $74,000 or less range from -.251 to .803, while the higher income bracket indicates a range of .316 to .896. The variables that were most highly related for both income levels were vision and organizational commitment.

Key Ethnographic Qualitative Findings

Ethnography is gathering the writing of culture. Its purpose is to understand, as much as possible, what might be going on within a social setting, and then to tell a story about what was observed that is as faithful as possible to the realities of informants. Ethnographic data was collected from the nurse/leaders in several ways: focus group interviews, individual interviews

and power sensitive conversations, and from congregational nursing program documents and artifacts shared with me. While ethnography is normally written as a single story or a series of stories that draw on multiple data sources at once to document themes that arise in the data, in this research report the data from each source is reported separately.

Data from Focus Groups

Ethnographic data collection began with questions were asked of two focus groups comprised of congregational nurse/leaders nurses who had all completed the spiritual leadership assessment. The questions were developed based on the findings from the assessment: (a) “What are the barriers to work group. There were four statements in the SLA that made up the productivity subscale: (a) In my department everyone gives his/her best effort. “How does the Congregational Nurse Program’s vision inspire your best efforts? (b) In my department work quality is a high priority for all workers. “What drives you to provide high quality services to vulnerable populations? (c) My work group is very productive, “What are the spiritual practices that you participate in that impact the care you give? (d) My work group is very efficient in getting maximum output from the resources (money, people, equipment, etc.) available. “How do your spiritual values impact the choices you make? and (e) “Please share any additional comments that you would like to share about the SLA. The responses to the four statements helped to frame the discussion in the two focus groups that were held with nurse/leaders.

Work Group Productivity and Efficiency

Fry (2008) defines productivity as efficiency in producing results, benefits or profits. According to Fry (2003), “The purpose of spiritual leadership is to create vision and value congruence across the strategic, empowered team and individual levels and, ultimately, to foster higher levels of organizational commitment and productivity” (p. 693). There were four

statements in the SLA assessment that made up the productivity subscale: (a) In my department everyone gives his/her best efforts, (b) In my department work quality is a high priority for all workers, (c) My work group is very productive, (d) My work group is very efficient in getting maximum output from the resources (money, people, equipment, etc.) available. The responses to these four statements, contained in the SLA helped to frame the discussion in the two focus groups that were held with congregational nurses.

My focus group interview guide, developed based on nurse/leader responses to the SLA, included the following discussion prompts:

a. What are the barriers to work group productivity and efficiency?
b. How does the congregational nurse program's vision inspire your best performance?
c. What are the spiritual practices that you participate in that impact the care you give?
d. How do your spiritual values impact the choices you make?
e. Please share any additional comments that you would like to share about the congregational nurse program.

Ethnographic interview guides (Hammersley & Atkinson, 2009) differ from interview protocols per se. The interview guide provides the ethnographer with a focus and openers for conversation, and a checklist for making sure relevant topics get addressed at the time, or later in follow-up interviews; however the topics may not all get addressed, or addressed in any set order, and other topics may be posed at any time. Ethnographic interviewing provides as open a field as possible for responses, knowing that the researcher cannot anticipate everything that needs to be discussed in order to capture informants' realities. The realities the nurse/leaders shared with me during the two focus groups are documented below.

Focus Groups

Buy-in. Successful parish nurse programs have complete buy-in from all facets of church (synagogue, temple, etc.) leadership. The lack of buy-in is a barrier to success that was noted by a number of nurse/leaders who were informants in my study. In addition to buy-in, nurses cited the constant struggle to balance ministry and fulltime work. One nurse put it this way: "*There is so much to do and when it's a totally volunteer group it's hard to get people to do stuff and taking responsibility for some things that we can't possibly do as nurses.*"

Infrastructure support. A number of nurses indicated that they were in need of a computer or tablet to increase their efficiency. Others indicated that not having an office phone was often a barrier to providing optimal care to the patients:

- *So many resources require use of computers as it should be a part of the resources we have as nurses.*
- *It would be very helpful to have a work phone.*
- *I agree, we need to have work phone.*
- *Having a computer or tablet would increase efficiency. A lot of time is spent on social issues, prior to addressing medical needs.*

Vision. Fry (2003) indicates that spiritual leadership theory is intended to create vision and value. He emphasizes three qualities of spiritual leadership: Vision, Altruistic love, and Hope/faith. Vision is characterized as consisting of the following: (a) broad appeal to stakeholders, (b) defines the destination and journey, (c) reflects high ideals, (d) encourages hope/faith, and (e) establishes a standard of excellence. When asked in the focus groups sessions to explain how the congregational nurse program's vision inspires their best performance, the nurse/leaders had varied responses:

- *It provides a vehicle/avenue to actually live out my call.*
- *It allows you to put your faith in action and helps to define my true calling.*
- *The vision allowed me to combine knowledge as a nurse with my faith to minister more holistically to members of local congregations.*
- *I have never encountered a congregational nursing program like this before that empowered me to meet a need and be helpful in preventing wellness.*
- *It is significant—most of the people know who the nurse is in a particular church and when someone is ill they will seek you out because they trust you. We have shown that we can be trusted.*
- *It is so wonderful to work with someone who can ask for prayer.*
- *I want to help the program fulfill its mission and meet its goals.* I *think the church members see us as approachable and they know that we will keep their information confidential.*
- *We get to see tangible outcomes as we work to fulfill the vision of the program. I, personally enjoy gaining the trust of the patients I serve.*

Spiritual practices. Prayer is the practice that was consistently mentioned by a significant number of congregational nurse/leaders during the focus group sessions:

- *I pray when asked and often inquire about prayer when they don't ask.*
- *Prayer is impactful and makes a difference. It seems to help the patients with their faith and brings peace to stressful situations.*
- *Prayer over the phone with those I serve and in small group sessions helps to build trust.*
- *Prayer and praise reports are keys to the healing of ill patients. I also recite Bible verses with patients that speak to their situations.*

- *I appreciate the fact that I can invite my patients to attend any church and I can pray for those who want prayer.*
- *During the lunch break, I enjoy being able to witness to some of our clients.*

Spiritual values. Nurses consistently talked about their desire and call to serve others and how this colored their decision-making in terms of the choices they made in their career:

- *Based on my beliefs, I love people unconditionally, not judgmental.*
- *Everything we do is about my values.*
- *Everyone who happens to be a nurse and a Christian wants to serve – It is my desire to give to those in need.*
- *My spiritual values guide my choices which are not always popular but I'm at peace with my desire to serve the homeless and other low-wealth populations.*
- *I treat people the way I want to be treated—always show respect and compassion.*
- *There is something in me that make me want to help the less fortunate.*
- *I'm Christian and I am guided by the Ten Commandments. The greatest commandment is to love so I try to show love to all of my patients as I serve them.*

Data from Individual Interviews and Power-sensitive Conversations

After the focus groups, I made phone appointments with the leaders of this program, and with the nurses who primarily work with the homeless population. The phone interviews were designed to document the voices of these spiritual leaders. Hearing the authentic voices and their accounts of these spiritual leaders' views, values and beliefs was insightful. It afforded me an opportunity to look into the hearts of the nurse/leaders. It quickly became evident from their responses that congregational nursing wasn't just a part-time job to them, but, indeed a calling. Congregational nursing gave them an opportunity to do something that had meaning; it was an

opportunity to help the homeless improve their quality of life while attending to their social, emotional and health needs. Themes emerging within these interviews are discussed below.

Dorothy who has been a congregational nurse for 13 years explained that people are looking for connectors of faith and health. For the last decade, she has been an advocate for the homeless population in need of medical care and medications, and worked tirelessly to ensure that the homeless patients she encountered received the appropriate medical treatment in a timely manner.

Trust/Integrity

The theme that flowed through all five phone interviews with the nurse/leaders was trust. The nurses talked about the importance of gaining the trust of their patients to ensure ultimate effectiveness of the program. Nurses address mind, body and spirit because as stated previously, congregational nursing is a faith-based program. The congregational nurses meet individuals in their faith institution or neighborhood setting, which helps them to establish a relationship of trust and respect. This program offers an ongoing opportunity for individuals to have a trusting relationship with a health professional that is not based on ability to pay and time allocation per patient. Dorothy, who has been a congregational nurse for13 years, explained that people are looking for connectors of faith and health. Dorothy stated that "*people in our role are often thought of as angels so they open up to us more. Patients feel like we are nonjudgmental nurses who show our love for God and others on a daily basis.*"

Charlotte, a retired public health nurse who became a congregational nurse seven years ago, spent countless hours at one of the local shelters attending to the needs of those who were present. When she arrived, the homeless clients of the shelter were generally waiting to be seen. Some just wanted to talk and share their private struggles. They knew she couldn't address all of

their health and social issues, but they could trust her with their secrets with no fear of retaliation or judgment. Trust was very important and without it most of the patients would not share needed information that would allow the nurse to help the whole person: "*They value the care I give them and the confidentialit*y *I provide. Some of my patients think I'm their angel sent to help them with their illness.*"

Charlotte said that her patients developed trust in her over time once she was able to demonstrate that she was a woman of integrity who could be trusted to follow through on any promise made.

Communication through Prayer: Prayer and Listening

There was unanimity among the nurse/leaders that effective communication was the key to their success, and they all indicated that to be effective they had to be willing to listen to the patients and pray about each situation. Most patients were willing to participate in prayer, but there were a few who were apprehensive or reluctant to do so openly. The nurses followed the desires of the patients, and instead, for those who were not willing to pray openly, the nurses prayed for them privately during their own private prayer time. Caring for their patients went well beyond the ten hours per week that nurses were paid to provide care: "*The Congregational Nurse Program is a part of my journey through life and I'm so excited about it. It never gets boring, never gets old.*"

Suzette, the assistant coordinator of the program, indicated that she routinely joins the coordinator in organized prayer for the program. She indicated that they have intentional prayer about what they were doing, where they were going, asking God to help influence them. She stated her belief that prayer was one of the keys to their success: "*Prayer is free so I use it often,*

that and a lot of listening. Regardless of my job, I think my approach would be the same but I'm sure my praying would not be acceptable."

Charlotte indicated that the congregational nurse program allowed a unique freedom to embrace and express their spirituality. Charlotte offered prayer during patient hospital visits and after their discharge when they were back at the shelter or in temporary housing: "*I can talk with them about their health and their faith. I can also pray with them and that makes a significant difference in how they view their prognosis.*"

Not only did the spirituality component of the program impact the patients, but it had implications for the nurse/leaders as well: "*If I did not have this position, I would not be as spiritually happy as I am now. It fits me like a glove and I love it.*"

Archival Data and Informant Accounts of the Impact of the Congregational Nursing Program

While it was the intent of my study to examine stakeholder perceptions of document the impact of integrating spirituality into healthcare. Archival program materials as well as informant accounts clearly document, it would be irresponsible not to share some of the success stories that the congregational nurse program had realized over time. To date, no one has developed a mechanism to effectively evaluate the program in a quantitative manner; so much of what had been captured since its inception has been anecdotal. Many people have been helped who would have died had the nurse not been there at the right time to offer help or provide a means for them to be seen by a physician. In talking with people in the larger community where the Congregational Nurse Program is located, it is evident that people have been positively impacted, particularly at-risk populations. Annually the program's outcome statistics reflect the efforts of congregational nurses to do health assessments and interventions that include

connecting individuals with a primary care physician practice, obtaining medications, and providing access to connecting with community resources, health counseling, and advocacy to address a variety of issues.

Listed below are brief summaries of a few success stories. There are many success stories that could be shared that have been captured over time. Unfortunately, there are even more that were never captured, not because of negligence but because the focus has been on helping sick people get well and maintain their healthy status, rather than on keeping score or making notes to prove that the work produces great outcomes.

The program's coordinator had tracked lives saved over time, but readily acknowledged that her list was not exhaustive:

> *To the best of our knowledge, 101 individuals have had a direct lifesaving intervention by a Congregational Nurse since we began the program in 1999. This does not include the indirect interventions that included health assessments with undiagnosed conditions, accessing care and obtaining medications that have had a dramatic impact. Indirectly, we have also coordinated with the Congregational Social Work Education Initiative Program and Congregational Nurse Program Behavioral Health Nurse that have had numerous examples of aborted suicides over the past six years.*

Power-sensitive Conversations

During the power sensitive conversations, three nurses working exclusively with homeless persons and two congregational nurse program leaders shared success stories and their perspective of the impact of the program.

All of them acknowledge that they are grateful for the opportunity to meet individuals where they are in the community and to work diligently to empower their patients to be whole:

"*We know that the program has been able to impact individuals who often seek healthcare on an acute, episodic basis due to lack of access to care and inability to pay.*"

Barbara's Story

A retired behavioral health nurse, she works well with the homeless patients particularly those who are mentally ill and/or have a substance abuse issue. Susie would have died without the Congregational Nurse Program intervention. Homeless for two decades, over 70 and dependent on walker for mobility, this elderly woman had a multitude of health issues that were exacerbated by her mental illness and living conditions. For 20+ years she moved from shelter to hotel to shelter every 30–60 days. Often, in between her shelter and hospital stays, she made her home on the streets. I engaged her, let her know she could trust me and then I armed her with people who could help her manage her mental illness and others to provide her with transportation to medical appointments. I also arranged for someone to help her with daily living activities that she had never done without assistance and supervision. She is now stable, taking her medications and receiving counseling. The counselor is trying to help her with her mental condition which includes a hoarding disorder. She has permanent housing, access to transportation and someone comes twice a week to clean her apartment and do laundry.

Charlotte's Story

Charlotte recounted how during the last few years she has prevented some hospitalizations, decreased overuse of emergency departments for non-emergent needs, and increased access to care and awareness of community resources. She treated a critically ill AIDS patient who had been diagnosed but had not received medical care. His health had debilitated to a point where he struggled to walk. She arranged for him to get medications and a walker and personally delivered to him at his local church. The patient said, "It felt like Christmas."

Charlotte also helped him to get housing and disability benefits. He now had a new lease on life, an opportunity to live and not die.

Dorothy's Story

Dorothy stated that she never gets an opportunity to see the outcomes for some of the people she helps because they move on to the next town, to the next shelter. She met with great success in helping two patients overcome their crack cocaine addiction. After many years of drug use, they had major dental problems. Dorothy made referrals for them to get extensive dental work. She helped both of them with food and shelter and continuously prayed for them. After years of living on the streets, in a drug-induced stupor with little food to eat, they were now living in their own home and had an opportunity for a much better life.

Leadership

Angela and Suzette. The congregational nurse program that formed the focus of my study was established by Angela in 1998 with a seed grant from the Duke Endowment to establish nurses in ten congregations. This funding received local support from the onset by the Cone Health Foundation. Angela, the program's current leader, had established it, along with Suzette had grown this program to its current state, which now has 75 congregational affiliations. It is important to note that included in that number are both paid and volunteer nurses. In addition, as mentioned previously, this ministry includes nurses at local shelters.

Angela, in a power-sensitive conversation, shared her personal spirituality, her calling, and the successes of the program she established 14 years ago. She stated her belief that she was on an amazing journey, guided by a higher power, and awakes every morning with great anticipation of where her journey will take her, who she will be led to help, and who will be touched enough to lend a helping hand to those most in need of care:

> *I often say that everything in my past led me to this wonderful passion and calling. I was fortunate to be a preacher's kid so religion and spirituality have played a key role in my life. I cannot remember ever wanting to be anything else but a nurse. I felt as a teenager that I would be a medical missionary but life challenges took me on a different path and kept me close to family. In previous roles as a Medical-Surgical Nurse, a Nursing Director of twelve clinics for the underserved and a community case manager, I feel that God equipped me for my current role. In the position of Coordinator for the Congregational Nurse Program, I have been able to use my ambulatory nursing skills, healthcare and community relationships and expertise in working with the underserved to develop, implement and expand the Cone Health Congregational Nurse Program. In this role, I can focus on improving the health status of my community with a whole person approach—body, mind and spirit. In my previous areas of practice, we could not address the spiritual component of an individual. To now practice in a specialty that includes the value of spirituality in being whole is truly a blessing.*

Suzette said of Angela:

> *I am not sure where* [Angela] *gets her vision, but she has a heart of gold. I think she prays for the nurses daily along with the patients they serve.*

Suzette's assertion proved correct. Angela, the leader of the congregational nursing program readily acknowledged that prayer was a major component of her leadership, and that she not only prayed for the nurses and the patients, but also for the wisdom to make sound decisions, and for the resources needed to carry out the mission of the program. Angela said she knew that spirituality had played a huge role in shaping how she shows up as a leader. She shared the key components of quality leadership that she tries to live by:

- *God has given me individual gifts to use to impact His people as His human hands and heart. I have choice as to how effectively I cultivate and use those gifts. It is not about me but about how I use what I have been entrusted with for others.*
- *I continually need to learn and grow. I don't have all the answers. I need to live out that golden rule of do unto others!*
- *Truly listening to another person is a gift you give to them and yourself. To try to understand another point of view or reasoning may change the decision or outcome.*
- *With experience comes the knowledge that sometimes a decision can be made as a team effort. There are other times when a leader has to take the more difficult road and make hard decisions when it is morally right or will impact the greater good. A good leader walks a careful line in being fair and just.*
- *You need to try to treat all the same and play by the same rules. One of my favorite sayings is that 'people don't care how much you know until they know how much you care.'*
- *Prayer is a key component in seeking guidance in what we do and the direction of the program. I have countless times that I seemed to be at an impasse in making a decision or dealing with a difficult issue. When I turn that over to God in prayer I always have a sense that He will respond and guide my decisions and actions. Countless times I have looked back in amazement at how God guided a decision and path that worked out for good.*

Suzette stated that "*nurses show love and have a caring attitude. They are able to walk with patients in ways no one else has ever walked.*"

Key Ethnographic Findings

After talking with the nurse/leaders in focus groups, phone interviews and power-sensitive conversations, and looking at the program data they shared with me, it became evident that to be a success at congregational nursing: (1) The individual nurse must sense or know that s/he is called to this work. (2) The vision of the program must be clearly articulated in a manner that will lead to organizational commitment, a sense of membership and productivity. (3) Two-way communication is important between the patient and the nurse, and this involves both praying and listening. (4) In order to be effective at serving the homeless population and perhaps other low-wealth patients, it is important to establish trust at the onset of services and to make good on all assertions to ensure that patients know that the nurse is an individual with integrity that they can trust to not only provide medical care but attend to their social and emotional needs as well.

Summary

Data from the SLA and ethnographic field research clearly demonstrate that the nurse/leader informants from the congregational nursing program that was the focus of my study saw the program as a success, and viewed spirituality as their central tool for helping patients as well as themselves. Chapter 5 sets out patient perspectives on their spiritual well-being and personal outcomes of participation in a congregational nursing program.

CHAPTER 5

Patient Perspectives on Their Congregational Nurses

Chapter 4 chronicled the viewpoints and worldviews of the congregational nurse/leaders. This chapter explores the impact of the congregational nurse program from the patient perspective, and includes an assessment of their individual sense of spiritual well-being at the time of the study while they were in care. For the purposes of this study, the vulnerable population served was delimited to homeless individuals, most of whom experienced behavioral health challenges. This chapter will explore the impact of the congregational nurses from the patient's perspective which will include an analysis of the impact of the spirituality component of the care received.

While the patients involved in this study were all homeless, they were different in many ways. Their individual journeys to homelessness were as wide-ranging as their mental and physical illnesses. In spite of all of their differences, there was some commonality related to their perspectives on the nursing program that became an integral part of their lives.

Patients' perspectives were ascertained in a number of ways which included their completion of a written survey (Daaleman & Frey, 2004), my three field observations which lasted five months focused on three individuals within the homeless culture being studied, and power-sensitive conversations (Bhavnani, 1993; Haraway, 1988) with them. The Spirituality Index of Well-Being (SIWB) was completed by 65 homeless individuals at three separate locations which included a day center for the homeless, a night shelter, and a shelter where homeless people were able to have a private one-bedroom apartment for a short period of time.

Descriptive Statistics

Nearly 58% (*n* = 35) of the 65 survey respondents were African American while 31% (*n* = 19) were Caucasian. The additional 11% included Hispanics, biracial, and unspecified individuals (see Figure 8).

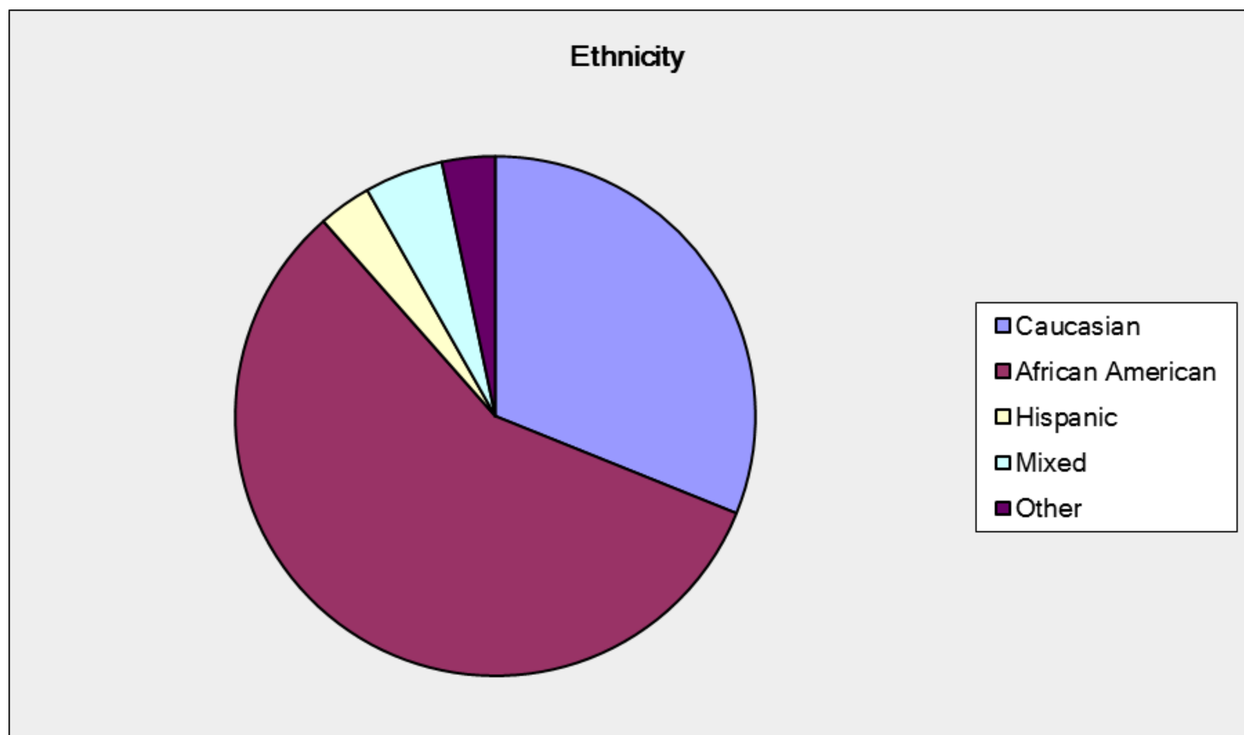

Figure 8. Survey respondents' ethnicity.

The survey was completed by 36 homeless men and 23 women ranging in age from 20 to over 66 years of age, with 61% being male. Six people skipped the gender question so for the purposes of the study their gender is unknown. Thirty-five percent (*n* = 21) were 41–50 while 18.3% were 21–30 and 18.3% were 31–40. An additional 16.7% were 51–65 and 10% were 66 or over (see Figures 9 and 10).

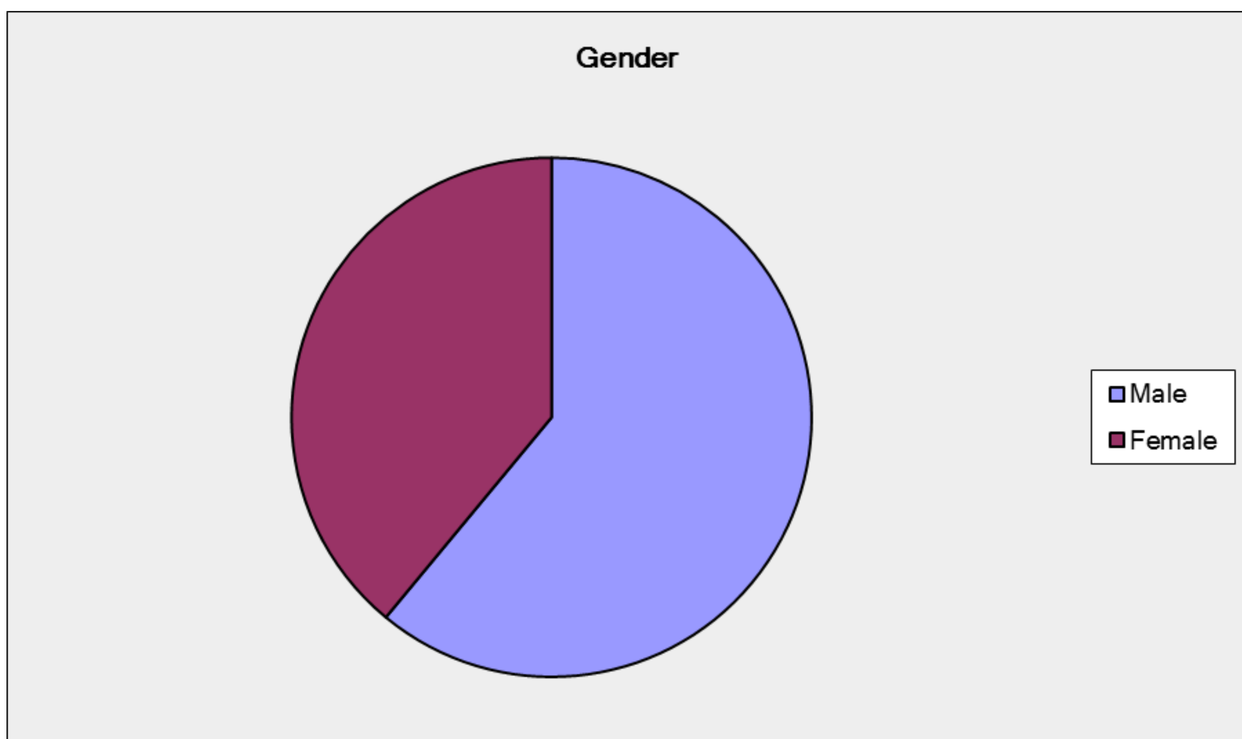

Figure 9. Survey respondents' gender.

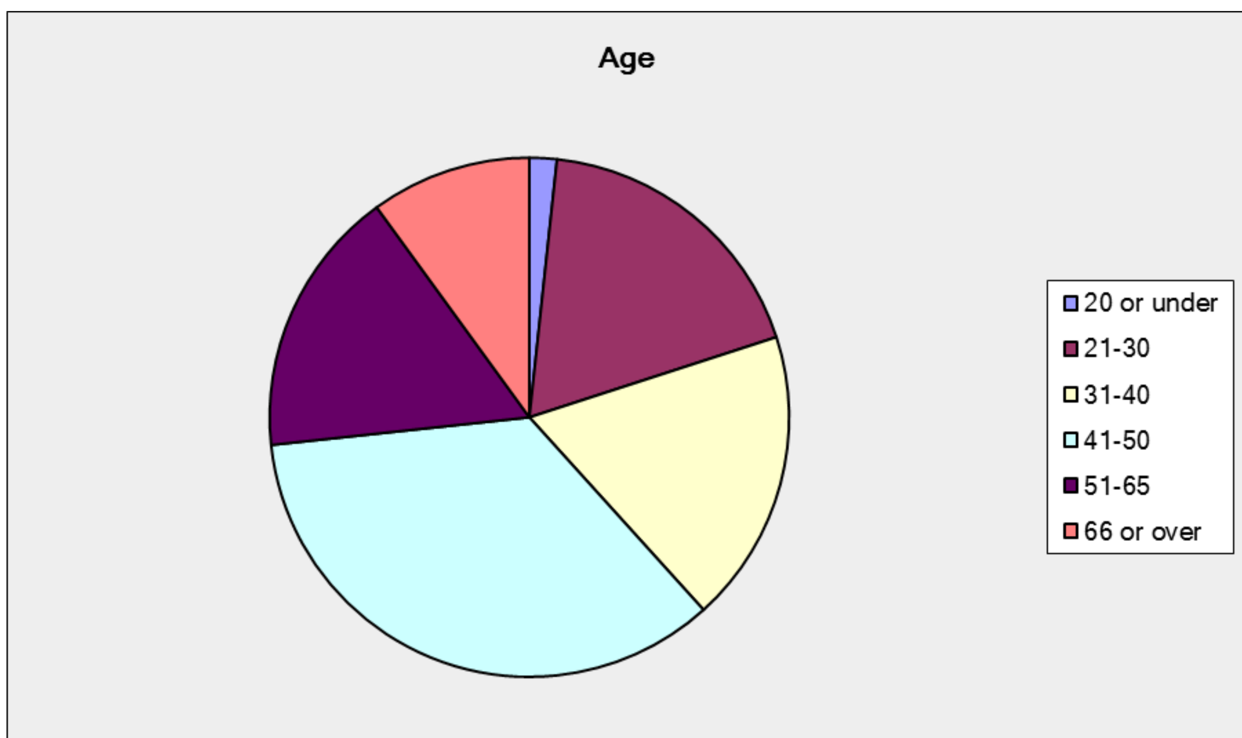

Figure 10. Survey respondents' age.

Based on survey results, 88% (n = 52) of the respondents had incomes under $20,000, although 51.7% reported either attending college or being a college graduate. An additional 8.5% (n = 5) reported incomes ranging from $21,000-$30,000, as noted in Figure 11. It is important to note that 26% had less than a high school education while an additional 22.4% had a high school diploma or General Educational Development (GED) certificate of completion (see Figure 12). It is important to note that 26% had less than a high school education while an additional 22.4% had a high school diploma or General Educational Development (GED) certificate of completion.

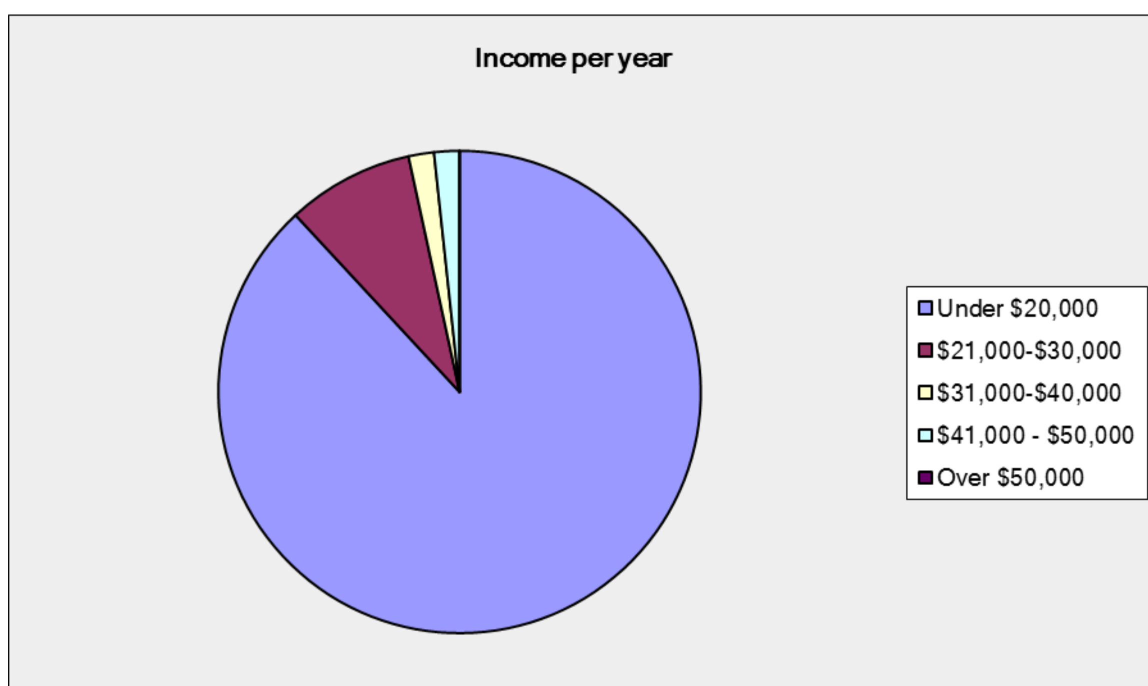

Figure 11. Survey respondents' yearly income.

The 65 homeless patients participating in this study were from three locations within one urban city: 23.4% (n = 15) were from Location 1, 31.3% (n = 20) were from Location 2 and 45.3% (n = 29) were from Location 3. One person skipped the question that asked the survey participants to indicate their shelter location.

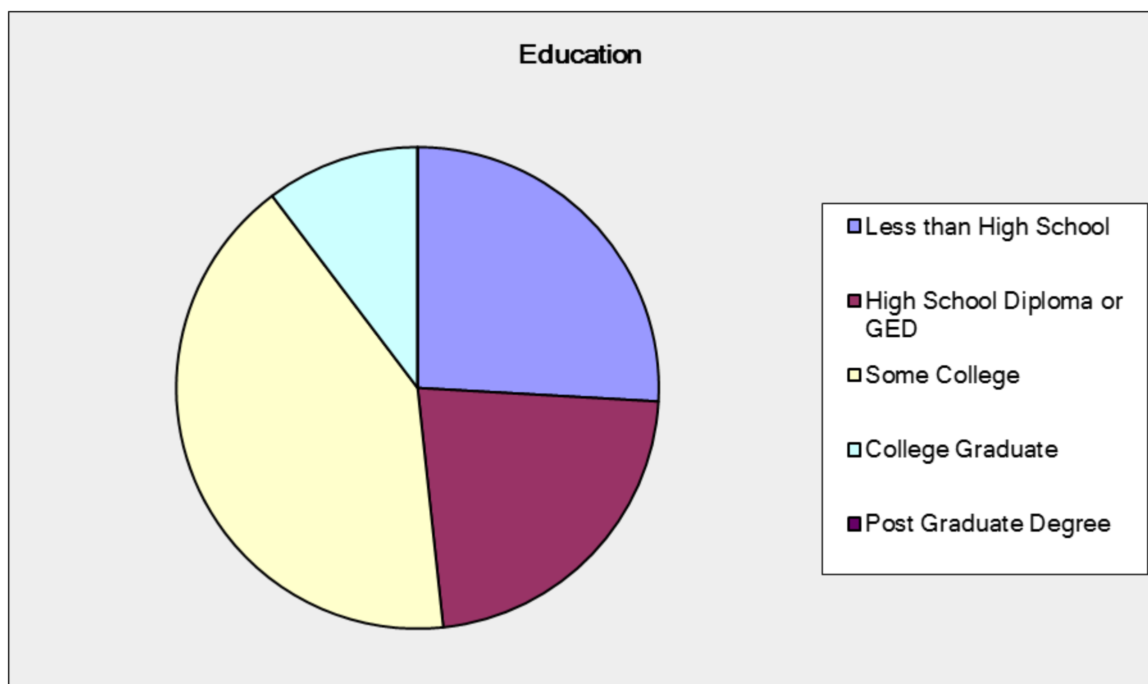

Figure 12. Survey respondents' highest level of education.

SIWB

The developers of the Spirituality Index of Well-Being (SIWB) designed this survey because there was a lack of similar instruments available to assess the usefulness of spirituality in patient populations. While the survey instrument was developed with some inherent limitations, it is a useful tool to determine the effect of spirituality on the spiritual well-being of individuals.

Employing PASW (formerly SPSS), I used Cronbach's Alpha to validate the efficacy of each of the 12 items of this survey inclusive of the two subscales: self-efficacy and life scheme. Not only was the overall survey internally consistent, but each of the subscales were as well. As indicated in Table 7, the Well Being Total Scale Score $\alpha = .910$. The Subscale Score for Self-Efficacy (SE) $\alpha = .795$ and the Subscale score for Life Scheme (LS) $\alpha = .905$.

Table 7

Reliability Statistics for Self-Efficacy, Life Scheme, and Well-Being Total Scale

	Self-Efficacy Scale	Life Scheme Scale	Well-Being Total Scale
Cronbach's alpha	.795	.905	.910
Number of items	6	6	12

Patient perspectives were ascertained in a number of ways which included analysis of their completion of a written survey, the Spirituality Index of Well-Being (Daaleman & Frey, 2004), and field observations, interviews and power sensitive conversations (Bhavnani, 1993; Haraway, 1988) involving three homeless patients which extended over a period of five months. The SIWB was completed by 65 homeless individuals at three separate locations which included a day center for the homeless, a night shelter, and a shelter where homeless people were able to have a private one-bedroom apartment for a short period of time. Similarly to Chapter 4, the data are reported by source.

Data from the Spirituality Index of Well-Being

Respondent demographics. Nearly 58% (n = 35) of the 65 survey respondents were African-American, while 31% (n = 19) were Caucasian. The additional 11% included Hispanics, biracial, and unspecified individuals.

The developers of the Spirituality Index of Well-Being (SIWB) designed this survey because there was a lack of similar instruments available to assess the usefulness of spirituality in patient populations. Self-efficacy (a) can predict specific behaviors, (b) results in specific behaviors, and (c) is based on behavioral change and one's desire and motivation to achieve a set goal completely and effectively (Adegbola, 2011). Life scheme is defined as the ability of an individual to view the world in a positive manner and one's own life within that world

(Daaleman & Frey, 2004). In Location 1, 80% (*n* = 12) were male and 20% (*n* = 3) were female. In Location 2, 68.4% (*n* = 13) of the patients were male and 31.6% were female. In Location 3, 45.8% (*n* = 11) were male and 54.2% were female.

As defined in the *South Online Journal of Nursing*, self-efficacy is the belief in one's ability to execute a course of action for a required task pertaining to day to day symptom and disease management. Self-efficacy (a) can predict specific behaviors, (b) results in specific behaviors, and (c) is based on behavioral change and one's desire and motivation to achieve a set goal completely and effectively (Adegbola, 2011). Life scheme is defined as the ability of an individual to view the world in a positive manner and one's own life within that world (Daaleman & Frey, 2004).

Descriptive Analysis of the Variables

Self-efficacy. The survey contained the following six statements relative to the self-efficacy domain. Respondents were asked to give their opinions on a five-point Likert scale ranging from "strongly agrees" to "strongly disagrees": (1) There is not much I can do to help myself: With a rating average of 4.12, 31 strongly disagreed with this statement, 20 disagreed, six were neutral, seven agreed and one strongly agreed; (2) Often, there is no way I can complete what I have started: With a rating average of 3.98, 23 strongly disagree with the statement, 24 disagreed, 11 were neutral, five agree and one strongly agreed; (3) I can't begin to understand my problems: With a rating average of 3.75, 23 strongly disagreed, 22 disagreed, six were neutral, six agreed, seven strongly agreed with the statement and one skipped the question; (4) I am overwhelmed when I have personal difficulties and problems: With a rating of 3.16, 13 strongly disagreed, 17 disagreed, 11 were neutral, 13 agreed,10 strongly agreed and one person skipped the question; (5) I don't know how to begin to solve my problems: With a rating

average of 3.85, 20 strongly disagreed, 27 disagreed, seven were neutral, ten agreed and one strongly agreed; (6) There is not much I can do to make a difference in my life: With a rating average of 4.15, 30 strongly disagreed, 21 disagreed, nine were neutral, four agreed and one strongly agreed.

Life scheme. The remaining six statements focused on life scheme domain and again respondents were asked to give their opinions on a five-point scale Likert ranging from "strongly agree" to "strongly disagree": (7) I haven't found my life's purpose yet: With a rating average of 3.57, 18 strongly disagreed, 18 disagreed, 14 were neutral, 8 agreed and five strongly agreed while two skipped the question; (8) I don't know who I am, where I came from, or where I am going: With a rating average of 4.24, 33 strongly disagreed, 19 disagreed, five were neutral, five agreed and one strongly agreed while two skipped the question; (9) I have a lack of purpose in my life: With a rating average of 4.14, 30 strongly disagreed, 21 disagreed, 10 were neutral, one agreed and three strongly agreed; (10) In this world, I don't know where I fit in: With a rating average of 4.06, 29 strongly disagreed,19 disagreed, nine were neutral, two agreed and four strongly agreed while two skipped the question ; (11) I am far from understanding the meaning of life: With a rating average of 4.06, 27 strongly agreed, 25 disagreed, four are neutral, five agreed and three strongly agreed while one skipped the question; (12) There is a great void in my life at this time: With a rating average of 3.43, 20 strongly disagreed, 16 disagreed, 11 were neutral, eight agreed and 10 strongly agreed.

Quantitative Findings

The results of the SIWB indicate that there are some areas of concern both under self-efficacy and life scheme. In particular, under self-efficacy the rating average for statement 4 was 3.16 which is really a neutral rating to: I am overwhelmed when I have personal difficulties and

problems. While 30 disagreed at some level, there were 23 that agreed they were overwhelmed and an additional 11 that weighed-in basically in the middle answering neither yes I am overwhelmed or no I am not.

Respondents from Location 1 had significantly lower self-efficacy, life scheme and Spiritual Index of Well-Being Total scores than respondents from both Location 2 and Location 3. Scores on the survey's subscales and total scores were not significantly different between respondents from Locations 2 and 3. To ascertain what might have led to the statistical significance in Location 1 vs both Location 2 and Location 3, I segmented the demographic data by Location to analyze the differences. Table 8 illustrates the statistical significance of the difference. After running the survey data through PASW, I was able to ascertain the p-values, showing significant differences for Location 1. The *p*-value for Location 1 was 0.02 for Self-Efficacy (SE) compared to 0.51 for Location 3 and 0.03 for Location 2. The *p*-value for Location 1 for Life Scheme (LS) was 0.01 compared to 0.38 for Location 3 and 0.05 for Location 2.

Table 8

Means, Mode, and Standard Deviations of the SIWB by Location

		Means			Mode			SD		
Location	*N*	SE	LS	SIWB Total	SE	LS	SIWB Total	SE	LS	SIWB Total
1	15	3.36	3.36	3.35	3.50	3.67	3.58	0.85	1.04	0.85
2	20	4.08	4.17	4.13	4.17	4.25	4.38	0.82	0.78	0.73
3	29	3.94	4.02	3.98	4.00	4.00	4.00	0.68	0.94	0.77

Ethnicity. As noted in Table 9 the greatest difference lies in the percentage of Caucasians in Location 1 vs Location 2 and vs Location 3. Thirty percent of the patient study

participants at Location 2 were Caucasian while 46% of the patients at Location 3 were Caucasian compared to less than one percent at Location 1. Could a fewer number of Caucasians negatively impact the spiritual well-being scores?

Table 9

Frequencies of Ethnicity by Location

Location	African Americans	Caucasians	Hispanics	Mixed	Other
1	9	1	2	1	0
2	13	6	0	1	0
3	12	12	0	1	1

Income. There were really no major differences in income from Location 1 vs Location 2 and Location 3. At each of the three locations the overwhelming majority of patients reported incomes of less than $20,000 with a few indicating incomes between $21,000 and $30,000. Nothing in this quantitative data is indicative of a rationale for such a difference in spiritual well-being in Location 1 (see Table 10).

Table 10

Frequencies of Income Categories by Location

Location	Under $20,000	$21,000-$30,000
1	92.9%	7.1%
2	90%	5%
3	83.3%	12.5%

However, qualitative data gathered through observations provide some rationale for the differences. The patients at Location 1 are chronically homeless and have been for years while those at Location 2 and 3 were comprise mainly of individuals who experienced episodic homelessness.

Education. In looking at the data for the three locations, there were some similarities among the homeless patients as it relates to the amount of education acquired. In Location 1, the largest percentage of homeless patients had less than a high school diploma followed closely by those with some amount of college experience while Location 3 indicated that more than half of its patients had some college experience. In Location 2, the homeless patients were varied in their level of educational achievement. It stands to reason, that the lower social well-being score may very well be tied to the level of educational achievement (see Table 11).

Table 11

Frequencies of Level of Education by Location

Location	Less than HS	High School Diploma/ GED	Some College	College Graduate	Post Graduate
1	6	3	5	1	0
2	6	5	5	2	0
3	3	4	14	3	0

Gender. In Location 1, 80% (n = 12) were male and 20% (n = 3) were female. In Location 2, 68.4% (n = 13) of the patients were male and 31.6% were female. In Location 3, 45.8% (n = 11) were male and 54.2% were female. It appears that Location 1 has the greatest percentage of men while the other two are more balanced. It is possible that the prevalence of men negatively impacts the individual spiritual well-being.

Correlation of Spiritual Well-Being Subscales

Much like what was done with the SLA, I used PAWS Statistics 18 to analyze the SIWB data. I calculated the correlation coefficient for the two subscales: Self-Efficacy and Life Scheme. The Pearson Correlation with everyone (n = 65) reporting was .737 for both life

scheme and self-efficacy which means that the two subscales have a high positive relationship as noted in the Table 12.

Table 12

Correlations for Self-Efficacy and Life Scheme for All Respondents

		SE	LS
SE	Pearson Correlation	1	.737**
	Sig. (2-tailed)		.000
	N	65	65
LS	Pearson Correlation	.737**	1
	Sig. (2-tailed)	.000	
	N	65	65

** Correlation is significant at the 0.01 level (2-tailed).

In an effort to do a comprehensive analysis of the survey results, I ran the correlations analysis by demographics and location to determine what works best for the homeless population. As indicated in Table 13, there is a strong positive relationship (.857) between self-efficacy and life scheme for the 19 Caucasians who participated in the SIWB assessment at one of the three shelters in the study.

The correlation between self-efficacy and life scheme for the 35 African Americans who took the assessment was also positive but not quite as strong of a linear relationship (.677) as it was in the Caucasian population (see Table 14). The linear relationship of self-efficacy and life scheme was also strong (.748) for those seven homeless patients who self-identified as Other (see Table 15).

All of the other demographic correlations had similar results but one interesting observation, as the fact that regardless of education the correlation between self-efficacy and life scheme remained consistently strong at .695 for those with less than a high school education and those with a high school education or more. While self-efficacy and life scheme has a strong

positive relationship in both male and female populations, the difference in their level of correlation was significant. Females had a correlation coefficient of .841 which is strong compared to men who had a correlation coefficient of .649 which is a relatively high positive linear relationship. As it relates to age, the strength of the linear relationship between self-efficacy and life scheme generally tends to be higher in older adults participating in the study (see Table 16 and note the decrease in 51–65 age group).

Table 13

Correlations for Self-Efficacy and Life Scheme for Caucasians[a]

		SE	LS
SE	Pearson Correlation	1	.857**
	Sig. (2-tailed)		.000
	N	19	19
LS	Pearson Correlation	.857**	1
	Sig. (2-tailed)	.000	
	N	19	19

** Correlation is significant at the 0.01 level (2-tailed).
[a] Ethnicity = 1

Table 14

Correlations for Self-Efficacy and Life Scheme for African Americans[a]

		SE	LS
SE	Pearson Correlation	1	.677**
	Sig. (2-tailed)		.000
	N	35	35
LS	Pearson Correlation	.677**	1
	Sig. (2-tailed)	.000	
	N	35	35

** Correlation is significant at the 0.01 level (2-tailed).
[a] Ethnicity = 2

Table 15

Correlations for Self-Efficacy and Life Scheme for Other Ethnicity[a]

		SE	LS
SE	Pearson Correlation	1	.748
	Sig. (2-tailed)		.053
	N	7	7
LS	Pearson Correlation	.748	1
	Sig. (2-tailed)	.053	
	N	7	7

** Correlation is significant at the 0.01 level (2-tailed).
[a] Ethnicity = 3

Table 16

Correlation between Self-Efficacy and Life Scheme by Age Group

Age	Correlation
21–30	.628
31–40	.714
41–50	.778
51–65	.722
66+	.885

Finally, let's look at the correlation of self-efficacy and life scheme by location which in this case of course are the three shelters used to conduct this research study with the homeless population. A review of the data reveals a relatively high positive relationship at all three locations with the lowest one being at Location 1 (.612) where the data has also shown there is the lowest self-efficacy, lowest life scheme and lowest spiritual well-being total scores. Location 3 had the strongest positive linear relationship with a correlation coefficient of .834 (see Tables 17–19).

Table 17

Correlations for Self-Efficacy and Life Scheme for Location 1[a]

		SE	LS
SE	Pearson Correlation	1	.612*
	Sig. (2-tailed)		.015
	N	15	15
LS	Pearson Correlation	.612*	1
	Sig. (2-tailed)	.015	
	N	15	15

* Correlation is significant at the 0.05 level (2-tailed). [a] Location = 1

Table 18

Correlations for Self-Efficacy and Life Scheme for Location 2[a]

		SE	LS
SE	Pearson Correlation	1	.679**
	Sig. (2-tailed)		.001
	N	20	20
LS	Pearson Correlation	.679**	1
	Sig. (2-tailed)	.001	
	N	20	20

** Correlation is significant at the 0.01 level (2-tailed). [a] Location = 2

Table 19

Correlations for Self-Efficacy and Life Scheme for Location 3[a]

		SE	LS
SE	Pearson Correlation	1	.834
	Sig. (2-tailed)		.000
	N	29	29
LS	Pearson Correlation	.834	1
	Sig. (2-tailed)	.000	
	N	29	29

** Correlation is significant at the 0.01 level (2-tailed). [a] Location = 3

Qualitative Analysis

Institutional forms of documentation & artifacts. While there were limited institutional documents made available for me to review for my study, the information contained within these documents was rich. One of the documents, *A Bridge to Wholeness*, was created prior to their 10 year celebration as a mechanism to highlight the successes of the program from 1999 to 2009. Integrating spirituality into the health care services they provide in fait institutions and homeless shelters, they have realized many impressive health outcomes for indigent patients in the urban city where the program is housed. A few of those interventions and outcomes are noted here as a means of demonstrating the impact of this program:

- Administered more than 9,000 influenza vaccines.
- Averted more than 100 emergency room visits since 2007 as the result of program interventions.
- Obtained medications for more than 1,400 individuals since 2007.
- Assisted more than 3,000 low-income individuals with access to healthcare since 2007.
- Nineteen lives saved from 2007 to 2009.

Power sensitive conversations. Three of the 65 survey respondents volunteered to be observed and interviewed one-on-one. Many hours were spent over a five-month period with each of these three homeless people in an effort to listen to their stories as they shared their respective journeys to homelessness and how they handled their plight in life. While their journeys were unique, as they talked two common themes emerged that shed some light on the effectiveness of the congregational nurse program and the impact it had on the individual patients served.

Trust. After years of being mistreated, used, abused, lied on, lied to, and left alone on the streets with no resources, it becomes quite difficult to trust anyone. What is real? How does one differentiate between truth and fabrication? Who is genuinely interested in helping rather than exploitation? Who can be trusted? Where does one go to find authentic people who can be trusted with deeply guarded secrets that have that have the potential to harm an individual if shared with someone who can't be trusted to keep the information and not share it with others? Is it possible to find a medical provider who sees the human need for care versus the one who is blinded by the patient's inability to pay for care? How does one go from being labeled as uninsured, homeless, poor or indigent to status as a human being in need of medical intervention regardless of ability to pay? Isn't healthcare a basic human right, or is that just outside the United States?

Sadie stated that:

Until I met my nurse, I had no trust in doctors or nurses because they all made me uncomfortable, in fact I often felt like just another charity case. There were many occasions that I felt like the quality of care I received was based on my inability to pay.

Sadie said it had been her experience to have providers talk at her and about her to the nurse or medical assistant, rather than to look at her and engage in a meaningful dialogue that would surely result in far better outcomes. If only the doctor could stop looking at his watch and notice the fragileness of the patient, and seek to understand the underlying cause of their health status and economic instability. If only the patient could believe the doctor was genuinely interested in helping her/him to become healthy, —trust just might be possible.

Savannah, after many years of domestic violence coupled with schizophrenia, had great difficulty trusting anyone or anything. While she stated her belief that trust in her medical

provider would surely improve her health outcomes and her satisfaction with the care received, she was reluctant to ". . . *let my wall down and open myself up for more pain and rejection.*" She was indeed caught between a rock and a hard place with no resources to make life-changing decisions for her health and well-being.

> *When I opened my eyes in the hospital and saw a face smiling at me, I felt a sense of relief; I could immediately tell that this nurse was different, when she asked if it was okay to pray with me.*

Savannah's instincts led her to trust that this nurse was genuine about her interest in helping her to improve her health condition, and secure permanent housing for her and her son. She never asked if Savannah had insurance, or how much she could afford to pay out of pocket. All of her questions centered around Savannah's health needs, ability to get prescriptions filled and whether or not she was receiving behavioral health services to help her cope with her mental illness. Savannah said, "*Because I thought she cared, it was easier to trust her with my private struggles and I was eager to do what she asked of me.*"

Homeless for two decades, Susie was used to doing everything on her own. Despite her mental illness, she was left alone to take care of herself for the first time in her adult life at the age of 50. What was she to do and how would she be able to survive? Who could or should she trust? Not knowing the potential pitfalls in blindly trusting strangers, Susie found herself often the victim of people who only seemed to care when she had money to spend. Two weeks into the month, with the disability check expended, she often found herself alone on the streets with nowhere to live and no food to eat. Visits to the local hospital emergency department generally were ineffective, and Susie became a frequent user of the hospital's behavioral health services. Her last visit to the emergency department started out business as usual but ended dramatically

different. After being assessed by both a medical doctor and a clinical psychologist, Susie received a visit by a nurse of a faith-based program. "*She said she wanted to help me develop a plan to stay healthy and get my own place to live. She asked me to trust her to do what was best for me*."

Susie was not certain that the nurse knew what was best for her and wondered why everyone thought the best way to help her was to find her a place to stay. What was wrong with living in the shelter? Why did well-meaning people assume that all homeless people desired a home? Was being alone in a home better than living in a shelter surrounded by people to talk to and people for Susie to help? In spite of all of her health challenges, she wanted nothing more than to help others in need. "*My trust in the nurse saved my life. Without her help and the help of the people she found to help me, I probably would be dead right now*."

Compassion. Former President Theodore Roosevelt once said, "People don't care how much you know until they know how much you care." These words ring true in reference to the three homeless women who allowed me to enter their lives and reality. Pulchalski (2001a) notes in her article that, "compassionate care calls physicians to walk with people in the midst of their pain, to be partners with patients rather than experts dictating information to them." It is this type of care that is given by the parish nursing program involved in this study. The recipients of this care indicate that the compassion that they are shown gives them the courage that is needed to do what is necessary to manage their health care needs while struggling to secure food and shelter.

Puchalski (2001a) indicates that there are multiple elements of compassionate care, and most of these were employed by the nurses in the congregational nurse program. Puchalski (2001a) encourages providers to use all of these elements, whenever deemed appropriate:

- Practicing compassionate presence—i.e., being fully present and attentive to their patients and being supportive to them in all of their suffering: physical, emotional, and spiritual
- Listening to patients' fears, hopes, pain, and dreams
- Obtaining a spiritual history
- Being attentive to all dimensions of patients and their families: body, mind, and spirit
- Incorporating spiritual practices as appropriate
- Involving chaplains as members of the interdisciplinary health care team

Fearful that the nurse or the social worker would attempt to take her child, Savannah was very apprehensive. Her fears were alleviated when she experienced compassionate care from her congregational nurse. She indicated that she was surprised when the social worker actually helped her instead of taking her child from her.

> *After receiving this special care from the nurse and getting help from the social worker, I can honestly say that all my needs are met. I feel the love of God and the love of my nurse; it just doesn't get any better than this.*

Savannah now believes she has the courage and the support needed to manage her physical and mental illnesses while taking care of her son who has multiple health challenges. The compassion shown by the nurse increased her faith in God and her trust in the medical community.

While the 44 nurses were all as unique as their patients, the one thing that was consistent was the quality of care they gave to each patient and the genuine compassion they each had for their patients.

I am very thankful for the compassionate care that I received from my nurse because without her I don't know where I would be today. I would probably be dead or on the streets, bald-headed from pulling my hair out from all the stress.

Sadie said her faith never wavered during her decades on the streets but now that she has survived her greatest trial she says her faith was strengthened because she now knows firsthand what happens to those who put their trust in a higher being and those medical providers who give compassionate care to their patients.

I don't know how to measure spirituality. But, I know I am more spiritual because of all I gained from the congregational nurse. She is not just our nurse; she seems like a part of the family.

While this chapter focused on the results of the SIWB and the data gathered from the power-sensitive conversations, it is important to note that the homeless patients were uniform in conveying the importance they placed on both trust and compassion. These, of course, are two components of one of the qualities of spiritual leadership: altruistic. As we look at altruistic love which is an integral part of spiritual leadership theory, it is done cognizant of the fact that it is inclusive of trust/loyalty as well as empathy/compassion. The literature also defines altruistic love as being inclusive of both trust and compassion. Fry (2003) wrote:

A term often used synonymously with charity, altruistic love, and the values comprising it is manifested through unconditional, unselfish, loyal, and benevolent care, concern, and appreciation for both self and others. For spiritual leadership theory, altruistic love is defined as a sense of wholeness, harmony, and well-being produced through care, concern, and appreciation for both self and others. Underlying this definition are the

values patience, kindness, lack of envy, forgiveness, humility, selflessness, self-control, trust, loyalty, and truthfulness. (p. 712)

CHAPTER 6

The World of the Homeless

Chapter 5 provided findings from the SIWB and ethnographic case methods involving homeless patients involved in the study. Chapter 6 focuses on the voices of three homeless patients to paint vivid portraits, blended with my own voice to provide clarity as needed. The accounts of Sadie, Savannah, and Susie provide insight into the unique journeys each experienced on their way to homelessness. I have used pseudonyms to mask their identities, and those of all informants.

Stoic, exasperated, and incredulous are adjectives that describe each of these women at different places along their journeys. These dispel the notion that there is a typical homeless person. Each arrived at homelessness through unique courses. None were alcoholics or criminals. We tend to hold stereotypical ideas of how certain kinds of people should look, smell, talk, and how they arrive at this place called "homeless." Entering the lives of these women over the course of my field research brought to light my own misperceptions about this population. Two of the three had children, and two of the three had been married. They were of varying ethnicities and approached their spiritual needs in their own unique ways. Two were diagnosed with mentally illness. All experienced homelessness in some form or fashion: one for only a few weeks, while another for more than two decades and the third one somewhere in between. All credit their spirituality with helping them through the most difficult times in their lives. All hold in common their love for the women in the faith-based nursing program, which, according to their accounts, helped to provide them with compassionate care, people they could trust, and a sense of stability and security.

The chapter provides ethnographic field tales (Van Maanan, 1988) that focus on the three homeless patients to whom I had the greatest access. Findings are then summarized at the close of the chapter.

Savannah: God Is My All in All

Standing outside the restaurant, she looked apprehensive, ill at ease, and almost aghast. After what seemed like five minutes, however, she mustered the courage to open the door and enter. While there were not many people there, it took me a minute or so to catch her attention. It was clear that Savannah was distracted and uncomfortable.

Born in the northeastern part of the United States, she had been forced to leave when she was nine. Her parents sent her and her sister to live with extended family members in Puerto Rico for four years, where they were immersed in their parents' culture and language. While she missed her parents, Savannah recounted only fond memories of her time in Puerto Rico.

Bilingual. Intelligent. Not the stereotypical characterization of a homeless person. This mother of four had a husband, was close to completing her associate's degree in Business Administration, and aspired to be a bookkeeper for a small company. Her status seemed so "normal" that I struggled to ascertain how it was that she could be homeless. Perhaps there was a mix-up and I contacted the wrong person. I mean after all, she drove to the restaurant to meet me in her own car. She was clean and personable. Why didn't she look, sound or smell like a homeless person? How was it that she was articulate in both Spanish and English?

God Is My All in All

God is my protection.
God is my all in all.
God is my guide and direction.
God is my all in all.

God is my joy in time of sorrow.
God is my all in all.
God is my today and tomorrow.
God is my all in all.

God is the joy and the strength of my life;
He moves all pain, misery, and strife.
He promised to keep me, never to leave me.
He's never ever come short of His word.

I've got to fast and pray, stay in His narrow way,
I've got to keep my life clean every day;
I want to go with Him when He comes back,
I've come too far and I'll never turn back.

According to Savannah, this song by Rev. James Cleveland centered and reminded her that God was her source, and through her belief in him all things were possible. Savannah had three daughters who were 30, 22, and19, and one son age nine. She was also a victim of domestic violence. After suffering for 18 years, she finally found the courage to leave. This move shielded her from physical abuse but the mental abuse continued. She recounted that even while separated she felt like a prisoner in her own home. Her spouse He moved into her new neighborhood and found pleasure in stalking her and making threats over the phone. It wasn't until he threatened that he would beat her son "to a pulp" that she made a decision to leave town for good.

Savannah's estranged husband refused to take into consideration that his son was a special needs child incapable of giving him the kind of respect he desired as a father. He viewed the child as disrespectful and in need of punished for it. Paul, the child, was born with Spina Bifida, which most people associate with compromised mobility. However, this disease also impacted Paul's capacity to control mental ability and inhibited him from exercising the self-control needed for appropriate behavior. In addition, Paul had hip dysplasia, scoliosis, and suffered chronic neck and back pain which were the result of having a tethered spinal cord.

With $300 and her car, Savannah left her home in a northeastern state to do her laundry, and just kept driving. There was no plan to drive to homelessness. She decided that for the safety of her son she needed to be as far from her estranged husband as she could manage to get, with her limited resources. She made it to North Carolina and spent some of the limited funds she had to secure a hotel room for one night.

She and her son both slept well that night but when it was time to check out of the hotel, she was panic-stricken. Where would she go next? How would she finance this next move with only a few dollars left in her purse? How would she feed her son? With no address, how would she get her disability check? Perhaps it was irresponsible on her part to just keep driving with no known destination.

Diagnosed with schizophrenia, anxiety disorder, and depression in 1997, Savannah was institutionalized. She spent ten days in a mental institution and the authorities at that time threatened to take her daughters from her. This experience caused her to become fearful of losing her son; she drove to North Carolina hoping to protect him there. Depression set in but she knew she had to seek help to keep them from living on the streets. She had to always be careful about her emotions, although this was extremely difficult given the fact that she was schizophrenic. After an unexplained collapse, she was taken to the hospital where a battery of tests helped the doctors determine that she had Brugada Syndrome, a heart rhythm disorder.

Back in her car, Savannah drove in search of help and landed at a shelter. Unfamiliar with her surroundings, she did not know where it was but stated her belief that God guided her to it. She was anxious after breakfast when she was to meet with a social worker. The thought of doing this caused her much distress. After all, she knew they had the power to both help and hurt her. Losing her son would be the most hurtful experience for Savannah. But she recounted

how she felt some comfort in her belief that God would not lead her to a place that was not equipped with people who cared and wanted to help.

Wringing her hands and looking down, with her son at her right side, she shared with the social worker a brief overview of her life and her current situation. She also mentions that she was close to finishing her associate's degree.

> *I would love to be a bookkeeper but I am afraid that with my mental illness, I may not measure up to the standards needed to be successful in this area. Interviewing is too stressful for me, so I am sure no one will hire me.*

With no apparent judgment, this social worker asked to pray for her and then reached out and gave her a very loving hug. Savannah did not know what would happen next but she felt a sense of comfort knowing that this was a Christian social worker who showed compassion. Savannah said this was a person who quickly won her trust.

As the social worker introduced Savannah to a nurse she assured her that they would find temporary housing for her and her son. The nurse explained that she was there to assess Savannah's medical condition and to ensure that she had current medications and understood how to take each of them. Savannah She entered the shelter in fear that someone might try to take her son away from her, but that feeling was quickly alleviated. Savannah was overwhelmed with the kindness of the nurse. At last she felt like there were people who genuinely cared about her well-being. Finally someone was willing to go the extra mile to meet the unique needs of both Savannah and her son. Armed with a voucher to fill all of her prescriptions, and another voucher for temporary lodging and resources to secure food, Savannah left the shelter with a new lease on life.

Why was the nurse so nice? Were the words she spoke genuine? Would she really keep her word and come to the motel to check on me in a few days? Was it her faith that made her treat me like a real person with feelings and not like a poor person looking for the next handout? Was I dreaming or did I just get treated with respect, compassion and love? I am naturally leery of strangers and generally keep my guard up to ensure that I am not hurt. The compassion shown to me by the social worker and the nurse has restored my faith in medical staff. I believe God brought me here. I don't really need anything other than food, shelter and clothes for my son. I just want to serve the Lord. I asked for help and God answered the door because I obey him.

While she was grateful for the compassion and generosity of all who helped her, Savannah was a little disappointed when she arrived at the motel where she was to stay until they could find her an apartment. The motel was in an impoverished area of the city and the people hanging outside of the building created much anxiety for Savannah. Fortunately her son saw all of this as an exciting adventure, and was excited to see where they would be sleeping. The room was sparsely furnished and had very worn curtains and linens, but it did look clean. Her son found great joy in the television that had the basic cable channels. Within minutes he was engrossed in a movie that lulled him to sleep. Savannah was left up alone, scared, and not quite sure what to do. Throughout the night for two weeks people knocked on the door or the window to see if she had anything she "could give to them." She was terrified, herself, but happy that the lateness of the hour found her son sound asleep so he had no idea of the threatening knocks and the potential harm that could come to them in this seedy motel. "*It was very scary. All through the night there was disturbing movement outside of our room.*"

The sunlight brought them a day closer to what Savannah hoped would be a new home for her and Paul. The daylight also meant a visit from one of the social workers or a nurse from the faith-based nursing program. Savannah was grateful for all of their support and guidance but more importantly she was glad to finally have people she could trust who treated her with compassion.

> *The nurse kept her word. She visited me and made sure all was well. Sensing my nervousness, she offered to accompany me to the apartment complex where I was going seeking a more permanent residence. I was in control, but I felt guided. I did all the leg work but I definitely felt God's presence. Now, I feel like a Princess in my apartment. My son dreamed when he was seven that he would move to this apartment. The health professionals that I see have been more compassionate than the regular doctors and nurses. They encourage you more and recognize the ultimate power of God, who gives me strength. I owe the nurses my very life. Had I not encountered them I am certain I would be dead and my son would be in foster care. My nurse saved my life and I am eternally grateful.*

Sadie: They Gave Us Faith When I Was Ready to Give Up

I try to put myself in Sadie's shoes to imagine her life: I can only imagine what it must be like to have to decide whether to buy food for my family or medication for my life threatening illnesses. How will the utilities be paid? How will the rent be paid this month? Will the doctor have mercy again and give me more medication samples, or will he be too busy to even care?

I can only imagine what it must be like to wake in the morning to the bright sunlight or the downpour of rain while lying wrapped in blankets with the ground as my bed. Guess I made

the wrong decision. Maybe I needed the apartment more than the medicine. Or did I? How does one prioritize needs when each decision has life-changing implications?

I can only imagine what it must be like. A car is now my mode of transportation but also my place of residence. The restroom of the nearest restaurant is used to freshen up as needed. Will the nurse see me this time or will my plight in life cloud her vision? Can anyone imagine what it is really like to be sick and homeless? Can anyone truly understand how it feels to be very present but yet invisible to so many, and avoided by most others? Can anyone really imagine what it must be like to never have a dream come true?

DREAMS

Dreams are possible
Dreams come true you know
Dreams take time to grow
If you believe
Dreams are achievable
Dreams they never go
Dreams are a part of you
If you believe in your dreams
Thought you couldn’t but can
Thought you wouldn’t but you will
All things are possible
Nothing’s unreachable
If you believe in your dreams
You may have messed up, start again
Thought you failed, you can win
All things are possible
Nothings unreachable
If you believe in your dreams

This song by Vashawn Mitchell is full of encouragement for those who believe. I can only imagine what it must be like to dream of being a nurse but never be able to graduate from high school. Pregnant at 16 and forced to drop out in the tenth grade—all chances of becoming a nurse seemed to be gone. What once was a young girl’s dream had become a young woman’s nightmare.

Sadie's son suffered scarlet fever at the age of three and nearly died. Shortly thereafter her daughter got sick and she had to nurse her back to health while she, herself, was suffering physically because of kidney damage. It was at this time that Sadie came to the realization that her dream was not just deferred but shattered, and replaced with a nightmare. Her life while fully awake was indeed devastating, demoralizing, and overwhelmingly disappointing. She no longer believed she could achieve. All hope was gone and replaced with despair, devastation, and debacle.

After working as a cafeteria manager for a school system for 9.5 years, her physician took her out because of her deteriorating health. Not only was she suffering from kidney damage but she also had congestive heart failure and arterial hypertension. Her damaged kidney was further compromised as the result of taking her prescribed medication incorrectly. Without a job, Sadie eventually lost her house, and then her car. No one had bothered to explain her benefits to her. She blames no one for her plight in life but she does wish that someone at her place of employment had cared enough to share that rather than quit, she had the option for short or long term disability.

Homeless, living in a car for several weeks, she truly thought she was at her lowest point until two weeks later, when the car which was doubling as a home was repossessed for non-payment. How could this be happening to her? Where were the all her family members that she supported throughout her life? Did they not care? Were they incapable of showing compassion and love for her?

She had been there for everyone in her family, but when she needed help the most, she found herself all alone. Growing up she didn't have a real connection with organized religion, nor was her family very spiritual, but Sadie heard at an early age that you reap what you sow.

She believed this to be true and spent the early years of her life trying to do good, be good, — often at the expense of what might be best for her.

Her boyfriend, the father of her two children, arranged for his family of four to move into the garage of his mother's home. While grateful for a safe place to sleep, Sadie felt a great sense of failure and could not understand why her boyfriend's mother would not at least temporarily allow them to stay in the home. She felt like she had failed as a mother. Her heart ached for her children who had no sense of normalcy anymore. They had gone from living in a house to a car and now their own grandmother's garage. Often during their brief stay in the garage, her family was denied access to the kitchen and bathroom. Sick for days at a time after dialysis, sometimes Sadie could barely make it out of bed to walk to the bathroom, but often faced a locked door with no one willing to unlock it for her or her children. Unable to stay silent any longer, she faced her children's grandmother and shared her disappointment that there was no love shown to the children, and the absence of compassion for her at the time of greatest need. She discussed how much it hurt for their grandmother to show love to their cousins but to all but ignore them. She talked about being denied bathroom privileges for days on end, and her children being picked on for coming to school in need of a good bath. She naively thought the outcome would at least be positive for her children, but it was not. On this day, she reached perhaps her lowest point when she and her children were told to leave the garage and never return. On this day her elevated blood pressure reached 225/198 from the stress of all she was going through. This, coupled with congestive heart failure, resulted in a stroke. Sadie was hospitalized for a week and a half. She stated her belief that the stroke actually saved her life.

When I met Sadie she was homeless, unemployed, on kidney dialysis, and battling with high blood pressure, diabetes, and congestive heart failure. She lacked a high school diploma,

but even with her limited education she knew that the seeds of support and love she had sown across her days had not multiplied to the fruits of help needed for her to sustain life.

While there was some fruit to show for the seeds sown, such as two healthy children — one ten and the other one 19—Sadie was still far from her dream of becoming a nurse. She was in the process of completing the requirements for her GED, which had been delayed multiple times during the four years she took care of her ill mother, who eventually died at the age of 46. Sadie now only has memories of her mother, who died after experiencing a massive heart attack.

Sadie grew up poor, herself, raised by a single mom who worked two jobs in her endless effort to make ends meet for the family. While it was not always evident, she knew her mom loved her, and Sadie loved her mom unconditionally. Born in Texas and raised in Colorado, the journey to North Carolina did not yield positive results for Sadie and her family. Following a man, Sadie's mother had moved to North Carolina on the promise that he would marry her soon thereafter. Once they moved, Sadie said "he flipped the script." This left Sadie's mother all alone to care for her children in a town and state that had no known relatives to help support them.

Sadie reflected on a time when loving her mother was not so easy, but Sadie said her love for her never wavered. One memory from a list of several horrible experiences happened when Sadie was nine. Sadie was molested by the brother of her mother's former roommate. Her mother took her to the hospital for an examination. She would later find out she had a sexually-transmitted disease contracted from the rapist. He was sentenced to three years in prison. This horrific experienced colored the way Sadie regarded men. She felt no man could be trusted and that all were likely to do the same thing to her if given a chance. Sadie described this as a "hurtful situation . . . very hard."

The local Department of Social Services (DSS) sent a Child Protective Services social worker to their home to investigate. The DSS social worker told Sadie's mother that no men could be in their house, and that if she violated that order they would remove Sadie from the home. Disregarding the order, Sadie's mother met a man and allowed him to move into their home. DSS then removed Sadie from the home, and because her father was unwilling to step up and be there for his daughter, she was placed in foster care for six months. While it was hard and she did not understand, Sadie kept on loving.

Sadie recounted that it was unconditional love, coupled with her faith that fueled her desire to take care of her ill mother for four years, even at the risk of never realizing her own personal dreams. Sadie's care for her mother caused her to neglect her own health and limited her ability to spend quality time with her own children. Given an opportunity to rewrite history, would she change her decision to put her life on hold indefinitely? Absolutely, not. Sadie was adamant that she had done the right thing, and was grateful that she was afforded the opportunity to serve her mother as she transitioned from earth to her final resting place.

People assume that homelessness is a result of individual laziness and unwillingness to secure and sustain a job that pays a living wage. While this may be the case for some, it is not indicative of all homeless people. The journey to homelessness is generally one paved with good intentions that are sidelined as the result of a series of unfortunate, unforeseen occurrences that cause a multitude of detours.

Prior to her kidney damage, Sadie was a hard worker with dreams of being in the medical field. Diagnosed with diabetes at 17, she had an innate desire to help others. After landing in the hospital in 2012 from the stroke, Sadie had benefitted from a nurse's help. While hospitalized she told her nurse that she had nowhere to live. The nurse was quick to share with Sadie

information about a local faith-based nursing program that might have the resources she needed to secure post-hospital care, medication and housing.

This parish nursing program provided Sadie and her family with a temporary place to live while helping her daughter secure school uniforms and school supplies. "*They gave us faith when I was ready to give up on life. Our assigned nurse is our adopted grandmother and a real friend*."

Sadie said had it not been for the nurses who showed her love and compassion before she left the hospital, she "*would not be here, probably be dead somewhere or living on the streets*." This journey has been laden with hard struggles for Sadie and her family. Through it all, her faith in God was unwavering and she held on to the belief that God will never put more on you than you can bear.

Sadie's journey was laden with many devastating struggles for her and her family. Through it all, Sadie stated that her faith in God was unwavering, and she held on to the belief that God will never put more on you than you can bear. "*Thankful. Blessed. Favored.*" These are the words Sadie used to articulate how she felt once the parish nurses became an integral part of her care. Not just health care, these nurses had provided holistic care for Sadie and her two children, while also being supportive of the boyfriend who had been her sole caretaker. Having someone who genuinely cared seemed to give Sadie a new lease on life; the future finally promised to be better for her and her family. Her son had been able to complete high school and headed to the armed forces. Sadie's daughter had become active in school and received much-needed counseling. While still living in a hotel, the family was on the waiting list for transitional housing as my fieldwork ended. Without the nurses, Sadie was convinced that she would be living on the streets, bald-headed from pulling her hair out from the stress of being homeless.

Susie: Still in the Fire

It was a cool, breezy day in April. The sky was overcast accompanied by a slight drizzling rain. The parking lot was quite full but the lobby of the apartment building was virtually empty. Upon approaching the entrance, an elderly woman short in stature, with steel gray eyes matched by her salt and pepper hair, greeted me with a hearty hello even though her face painted a dismal picture. Her face, framed by her slightly curly hair, was the portrait of conflict, disillusionment, neglect and fear, all intertwined with self-control and a heart eager to please.

As I entered her apartment on that cool, rainy day I expected to find a middle-aged woman who looked disordered and with, perhaps, a less than pleasing odor. While my heart is eager to help, I readily admit that until I met Susie I had my own biases and preconceived notions of how homeless people look and smell. My preconceptions however were coupled with an insatiable desire to know how they understood their situations, and what had taken place that resulted in their homelessness.

As we walked down the long, winding hallway to a flight of stairs and through what felt like an endless corridor to an elevator, Susie began to quietly sing in the dimly lit hallway to her modest apartment:

Shackled by a heavy burden, beneath a load of guilt and shame.
Then the hand of Jesus touched me, and now I am no longer the same.
He touched me, Oh He touched me, and oh the joy that floods my soul.
Something happened and now I know, He touched me and made me whole.

Since I met this blessed Savior, Since He cleansed and made me whole,
I will never cease to praise Him. I'll shout it while eternity rolls.

He touched me, Oh He touched me, and oh the joy that floods my soul.

Something happened and now I know, He touched me and made me whole.

If singing this song could make Susie whole, the manifestation of its prophecy would have been realized at least 20 years ago. As we entered Susie's sparsely furnished one-room apartment she invited me to sit at her new kitchen table nicely covered with a red and white checkered plastic tablecloth. Her eyes immediately zeroed in on several small holes in the tablecloth which she apologized for profusely, while assuring me that by Christmas there would surely be a new one, free of holes, on the table.

Susie had been —independent in personality from her very beginning, but like an infant, always in need. Born in 1941 in a small rural town in Virginia, Susie learned at an early age that after four miscarriages her mother was disappointed when she arrived as a live birth. Weighing in at only two pounds and blue in color, no one thought she would live; Susie's mother hoped she would die. However baby Susie stayed in the hospital for five months and defied all of the odds. She was not the boy her mother had wanted, but she was a living breathing baby with both abnormalities and possibilities. Imagine growing up raised by a mother who resents your very birth. Most called Susie's mother "mom", one called her "wife", but Susie saw her as a roaring furnace and called her "fire." Perhaps, Susie said, things would have been easier for everyone if I had been born dead. After all, she would not have experienced rejection a birth, abuse in childhood and rape during marriage. ". . . *things would have been easier for everyone if I had been born dead.*" She would not have experienced rejection a birth, abuse in childhood, and rape during marriage.

Was there a curse or some dark secret that led to the cloud that seemed to loom over Susie's life, snatching away any glimpse of happiness? Many secrets have been realized since

her birth 71 years ago, but Susie said that these were things never to be spoken of, and just the mention of their existence caused her anxiety. For the past 21 years she has suffered from homelessness and mental illness, causing her to lose most of her personal possessions, including furniture and a television given to her by her home church in Virginia. She has frequented numerous shelters and lived in many apartments in both North Carolina and Virginia, but generally would become anxious after a while and return to the homelessness that was, at least, a way of life she knew well. How could this be safe? How could this be preferred?

Always desiring to be independent, regardless of her need to rely on others, Susie often exhausted her financial resources without paying her rental obligations. She did this when she traveled to see friends in faraway places, —although most of her travels included 60 day stays in shelters. During the last 21 tumultuous years, many people had come into her life to rescue her, not conscious that the very "fire" that they wanted to rescue her from was the fire that Susie sees as her protection from harm.

With deep Christian roots, Susie stated that she was an active member of four churches and loved to sing Tim Hill's song, "He's Still in the Fire." Susie recounted that, just as Like Jesus was a long time ago, she was "in the fire," and that was where she found the strength to carry on. After all, if Jesus is still in the fire, how could she possibly be safe out here on her own? Susie craves the independence and freedom of the homeless life, — but is always in need; she has lots of hutzpah, but remains mentally ill nevertheless.

Fifty-seven years ago, Susie struggled to breathe and make sense of her life as her seventh grade teacher stuffed her into a junior high school locker and turned the combination to ensure that she was safely locked in this small steel box. Why did this happen? Did it really occur or is this one of *Sus*ie's delusions? To this day the mystery remains. In Susie's view, her

mother saw this event as just yet another reason why her birth was a mistake. While her dad came to Susie's rescue inquiring as to why a trained professional teacher would stuff his daughter in a locker, he remained silent about this deep, dark secret until his death.

Unwanted at birth, mistreated by teachers, mocked by classmates, Susie said she would never share what led to her being expelled in the seventh grade, but that this was indeed a defining moment in her life. The steel gray locker matching the gray of her eyes is symbolic of Susie's life: —a box with questionable contents, limited usage, with potential for many secrets under surveillance, closely guarded. Could it be that there was something different about Susie? Delusions were more than plentiful and it was —difficult for Susie to ascertain the delusions from reality.

While space was limited, Susie found some solace in the locker. After all she was safe from any human harm as long as the door to the locker remained locked. She could get used to the cramped quarters if it meant no one would violate her. Was there inappropriate behavior in her home? Was she abused or treated unfairly at school? The answers are not known because after all, according to Susie, these were things never to be spoken of. Did this defining moment in the seventh grade somehow serve also as a foreshadowing of what would take place in her life as an older adult? Susie indicates that she is forbidden to speak about what led to her expulsion and her parents took this secret to the grave.

After this incident, Susie was removed from public school and suffered a nervous breakdown. According to Susie no documentation exists to prove it, but the seventh-grade teacher hit Susie on several occasions. However, according to Susie, no one wants to discuss what took place prior to the locker incident.

Life had not been easy for Susie, yet she had a warm smile and optimistic viewpoint. While she worked diligently to manage her own affairs, she often fell short of her goals. Sometimes she expended her monthly disability check in one week by signing it over to a local motel. Why do this in favor of securing permanent housing? According to Susie, there is a greater level of perceived safety in the homeless community—at least that is the reality in her mind.

Susie rocked side to side when she reflected on the 80s, as this was not a good time period for her. In 1989 a nervous breakdown resulted in a three month hospital stay that ended abruptly when she left against medical advice. Her memory was slightly fuzzy but she remembered her daddy dying and waking up on a hospital psychiatric ward. With no education beyond the seventh grade, she never worked and never had children. Her parents took care of her until that horrible day in 1989 when her daddy died. That day was still a blur to Susie because it was on this day that she started on a downward spiral resulting in two decades of homelessness.

While she was 40 when it all happened, when she awakened her mind went back to another traumatic event in her life—the car accident. On a rural winding road in a country town in Virginia as she walked casually down the shoulder she was struck by a candy apple red Oldsmobile. The impact of the hit landed Susie in a nearby ditch. Badly injured, she suffered a broken right arm and leg which prevented her from walking. What started out as a nice day during her 21st birthday ended with her confined to a wheelchair for eight months. Her father cared for her during this time, while her mother kept her at arm's length, showing no signs of concern and or desire to help her.

Age 71 at the time of my fieldwork, Susie had been in her new apartment for six weeks and relied on a motorized walker to navigate through her apartment building, and down the streets of Greensboro. To Susie, her birthday was a constant reminder of that 21st birthday with nothing to celebrate. Her birthday was a reminder of "being in the fire" so close to being burned but then being saved from this tormenting nightmare, —only to awaken to the reality of being born premature to a mother who would have been happier if you had died. The only saving grace was a dad who seemed to adore her, or at least he was thoughtful enough to at least pretend to care. For Susie it was—it's all so confusing, difficult to know reality from illusion. Dad the rescuer, the keeper of the big secrets, the provider, and the priest of the home, had failed miserably at protecting Susie from harm. She learned at an early age that God was indeed the only one who could help her, and this caused her to spend lots of time in church.

After her release from the hospital, Susie married a man she met while receiving mental health counseling. Mentally ill and an alcoholic, he had little to offer but managed to convince Susie to marry him. After a few years of marriage, one night in their one room apartment Susie's husband violated her. According to her account, he forced her to perform oral sex against her will, and raped her anally. She managed to escape that night and has been on the run since that time. As she talked about this incident she cautioned me that her husband was outside of the window seeking to do her harm. She became anxious, and then suddenly silent. It may be time to uproot again; after all, this apartment may not be safe. Susie began to contemplate where she might find shelter for 60 days. If only he would leave her alone. I looked out the window but no one was there.

Disillusionment may very well have caused Susie to take a metal clothes hanger and put it around her neck, tighten it, and pull it up from the top in an effort to commit suicide. Not

once, not twice, not three times or four, but five times this year. After a lengthy stay at a local mental health facility, she was released with an ample supply of needed medications, keys to an apartment, and a team of people to assist her in getting to medical appointments and to run errands. Finally a chance of stability after 21 years, or was it? Susie said she had plans to travel pretty soon, because she was feeling anxious again. There just wasn't much safety in this dwelling, at least not in Susie's mind.

As my day with Susie ended I was reminded of a Tim Hill song that Susie had sung at her home church in Virginia. She loved this song, symbolic of her life because in spite of multiple suicide attempts, and numerous efforts by well-meaning people to rescue her from homelessness, in her mind "the fire" of homelessness is the safest place she knows because after all:

> He's still in the fire and he's walking in the flame; and He'll be there to help you when you call in Jesus name; and he can still deliver by His almighty power while here below it's good to know He's still in the fire.

Faith Under Fire

While it is impossible to fully understand what it might be like to have a life journey dead end at homelessness, it is important to understand that while those of us on the outside see all of the negative implications of this destination, the three women whose stories appear above are, nevertheless, sustained by unwavering faith, their ever increasing spirituality, and their individual prioritizations of what really matters. They each seem to have the tenacity, fortitude, and level of spirituality needed to see the glass as half full and to take life's challenges as opportunities to fully exercise their faith in God. Against all odds, they are examples of the capacity to improve —mentally, physically, and emotionally —with compassionate care.

Compassionate care is what the congregational nurse program can provide for such individuals, and it appears that such care can make all the difference for the Savannahs, Sadies and Susies of the world. Savannah had much going against her: mental illness (schizophrenia, anxiety disorder, and depression) as well as spousal abuse that took her into the world of homelessness. She also had dreams and aspirations, and had been working hard toward these. Her experiences with social services had taught her to be fearful, and as much as she valued her relationship with her son, she did not want to risk losing him in the process of "getting help." Savannah found resonance in a congregational nurse who was trustworthy and met her where she was in terms of her guiding faith.

Sadie had put her family first to the detriment of her own health and dreams of becoming a nurse. Caring for sick family members, she herself suffered from kidney damage, congestive heart failure and arterial hypertension. No one—no one at work, in her family, or any friend or agency—had explained to her the options for short and long term disability, and she landed on the street. The stroke that landed her in the hospital had brought with it a stroke of luck, however, because that was where Sadie made contact with a parish nurse who assisted her and her family to begin a new life. Through it all Sadie's faith allowed her to view herself as favored and blessed.

Susie was born into the world as an unwanted child, suffered abuse in childhood, and was the victim of marital rape. The world of her youth was full of secrets, and her account made it difficult to understand whether her story of being locked in a steel gray locker at school was a cause of her mental illness, or a result of it. As with Savannah and Sadie, the "help" that person—any of us at one time or another in our lives—might need never came until the parish

nurse program entered her life. For Susie, though, despite her faith, the “fire” of homelessness still seemed safer than trusting in others and the things these others might provide for her.

The stories of these three women contain similar threads: physical and mental illness, abuse, the lack of anyone to trust, and the sheer abandonment by the rest of humanity that can occur for a person through no apparent wrong-doing of her own. Faith was also prominent in these women’s accounts and that faith was reflected when each one made contact with a congregational nurse.

CHAPTER 7

Outcomes of Spiritual Leadership within a Congregational Nursing Program

Over the last two decades, spirituality has increasingly been recognized as an integral part of the delivery of healthcare in this country. However the literature reveals that there is still much to be learned about patient as well as caregiver/leader perspectives. For example, in an exploratory study of the patient perspective, Daaleman et al. (2001) conducted focus group interviews with 17 women with type 2 diabetes mellitus and 18 women with no known medical issues. The outcome of this study was the realization that spirituality integrated in a healthcare setting can have a positive impact on the well-being of patients: "Participants tied the attitudes and practices of positive intentionality with agency, or the use or exertion of power through belief, practice or community" (p. 1503).

Outcomes and effectiveness research has provided a wealth of information about interventions that can improve patient experience and outcomes. However, research on the impact of spiritual leadership practices has been limited until recently. There are mixed reviews in terms of the impact of spirituality on health and health outcomes. Many agree that belief in a higher power enables those who hold this view to cope better with stress and diagnosed illnesses (Benefiel, 2005, Fairholm, 2004, Ferguson, 2000; Houston & Sokolow, 2006, Milliman et al., 2003; Reave, 2005). However, some may disagree that spirituality or spiritual leadership practices can impact health outcomes (Jamison, 2006, Benson et al., 2006). My research sought to capture patterns involving spiritual leadership among caregiver/leaders and patient perceptions regarding outcomes of including spirituality in their health care treatment plan. SLA responses demonstrated that 70.1% of the spiritual leaders of the Congregational Nurse Program showed high levels of spirituality, significantly higher than other types of leadership styles. SIWB

responses by patients, as well as ethnographic data from extensive fieldwork with patients, nurses and program administrators indicate that the spiritual leadership style present within this program appeared to positively impact the health outcomes of homeless patients.

Summary

This study documented stakeholder perceptions of outcomes of the congregational/parish nursing health care innovation in clinical settings in which leaders and caregivers include consideration of patient spiritual needs in order to improve health outcomes and reduce care disparities. It captured the realities of patients served and nurse caregivers, as well as those of the program's administrators. The levels of spiritual leadership among nurses in the program were analyzed using their responses to the Fry (2003) Spiritual Leadership Assessment Instrument (SLA), and ethnographic data from field observations and interviews that included focus groups, individual interviews and power sensitive conversations. Patient spiritual well-being was analyzed using responses to the Daaleman and Frey (2004) SIWB, and field data from observations, individual interviews and power sensitive conversations. Information from the SLA Instrument, and the SIWB, informed my fieldwork and which aimed to provide a deeper, contextualized and more authentic documentation of the realities of patients and nurses. Data from all sources were layered, compared and contrasted to craft as comprehensive a picture as possible of informant perspectives on outcomes of the congregational nurse program, as well as the levels of spirituality across stakeholders.

The study sought answers to three fundamental questions that afforded an opportunity to document the role of spirituality in improving healthcare outcomes for vulnerable populations:

1. In what ways can the level of spiritual leadership in the congregational nursing health care program be described and documented? How is spiritual leadership characterized and practiced in this context?
2. In what ways can the level of patient spiritual well-being in this program be described and documented? How is the level of patient spirituality characterized?
3. Do patients perceive that their spiritual well-being is influenced by the spiritual leadership of health care providers? If so, in what ways is it influenced?

Utilization of both quantitative and ethnographic methods yielded rich data that not only helped me craft an understanding of the attitudes and behaviors of homeless patients served, and the congregational nurses who care for them, but also offered insight about leaders, both nurses and program administrators, who employ spiritual leadership principles in their workplace.

Regardless of income, gender, education race/ethnicity or age, the majority of the participants in this study recognized the value of spirituality in leadership and the potential is has to positively impact health outcomes for vulnerable populations such as the homeless patients that were a part of this ethnographic study. Based on the results of this study, it is apparent that the spiritual level of the nurses in the aggregate is relatively high and fairly consistent with limited variations due to demographics. It is also safe to surmise that the homeless patients in this study overall had reasonable high levels of spiritual well-being. Of the three women who participated in the five months of power-sensitive conversations, they each attribute their improved spiritual well-being in part to the compassionate care received from the congregational nurse coupled with their faith in God. It is important to note that there were many who indicated a relatively high level of spiritual well-being on the assessment and because there was no follow-

up done post-assessment, it is impossible to know at what point they reached that level and what were the positive contributing factors.

Spiritual Leadership and Congregational Nurses

During my fieldwork I engaged in dialogue with congregational nurses in two focus groups, after their completion of Fry's (2003) Spiritual Leadership Assessment. The results of the SLA coupled with the two focus group discussions, followed up with power-sensitive conversations with five individual nurses, yielded rich information about the spiritual leadership present in this congregational nursing program.

The Spiritual Leadership Assessment (Fry, 2003) examined nine variables: vision, hope/faith, altruistic love, meaning/calling, membership, inner live, organizational commitment, productivity and satisfaction with life. The literature indicates that the two things that must be done by leaders to fully realize spiritual leadership include (Fry, 2008):

1. Creating a vision wherein leaders and followers experience a sense of calling so that their lives have purpose, meaning and makes a difference, and
2. Establishing an organizational culture based on the values of altruistic love whereby leaders and followers have a sense of membership, feel understood and appreciated, and have genuine care, concern, and appreciation for BOTH self and others. (p.109)

Fry (2008) argues that "To implement spiritual leadership, leaders, through their attitudes and behavior, model the values of altruistic love as they jointly develop a common vision with followers" (p. 113). Implementing spiritual leadership effectively requires a workplace climate that embraces the freedom to express spirituality. During my power-sensitive conversations with the nurses, it became evident that the congregational nursing environment made it much easier

for them to freely do their work in an effective manner, utilizing their spirituality to assist them in providing health care to their patients.

Duchon and Plowman (2005) defined workplace spirituality based on three aspects: (a) a recognition that employees have an inner life; (b) an assumption that employees desire to find work meaningful; and (c) a commitment by the company to serve as a context or community for spiritual growth. Although its planners had not read this literature, the Congregational Nurse Program exemplified Duchon and Plowman's definition of workplace spirituality in the program's initial development. This became evident during my power-sensitive conversation with the leader of this program. It could also be argued that the program was similar in nature to Giacalone and Jurkiewicz's (2003) depiction of workplace spirituality and the need for the leaders to have a vocation or calling to do the work. Giacalone and Jurkiewicz advocated for a holistic approach to work, which was the foundational basis for the Congregational Nurse Program.

It was evident from my fieldwork data that while the nurses were not familiar with spiritual leadership theory per se, they were in fact employing spiritual leadership principles described in the literature within their work with the homeless population. Either in conversation or via responses to the SLA instrument, all of the nurses reported a belief that they were making a difference in the lives of the people they served in the homeless shelters. Being able to incorporate spirituality into the work they did as nurses appeared to be personally meaningful to the nurses. The nurses scored 4.1 or higher on eight of the nine spiritual leadership variables, with African American scores range from 4.28 on Organizational Commitment, to 4.84 on Meaning/Calling. Their Caucasian counterpart scores ranged from 4.14 on Productivity, to 4.7

on Meaning/Calling. Satisfaction with Life was slightly lower at 3.95 for Caucasian nurses and 4.1 for African-Americans.

Overall, these results mirrored my expectations that the nurses would score relatively high on spiritual leadership and demonstrate a sense of wholeness and spiritual well-being. Fry and others might predict that effective spiritual leaders would score high on Altruistic Love. Fry (2003) notes that the qualities of Altruistic Love include: (a) forgiveness, (b) kindness, (c) integrity, (d) empathy/compassion, (e) honesty, (f) patience, (g) courage, (h) trust/loyalty, and (i) humility. In conversations with the congregational nursing care patients, it was evident that because they were treated with kindness and compassion, they developed a trust and rapport with the nurses and a desire to comply with medical directives that they had a better chance of understanding for themselves. The patients talked about the lack of compassion shown to them by mainstream medical providers, and how little they trusted the medical profession, as a result of the way they had previously been treated. The compassionate, competent and consistent support and guidance received from the congregational nurses appeared to have been instrumental in saving lives, lowering blood pressures, increasing self-esteem, and improving the overall health of most of the patients seen by nurses in that program.

Spiritual Well-Being among the Homeless Patients Served

While the patients who responded to the SIWB had all struggled with multiple challenges that had led them to their state of homelessness, the mean scores for both Self-efficacy and Life Scheme were quite high, 3.83 and 3.92, respectively, out of a possible 5. Given these results, the patients' spiritual well-being can be characterized as consistent with the spiritual aspects of their lives. Although they had failed at maintaining a home, being gainfully employed, and in many cases securing their cars and other personal belongings, they expressed the belief that they had

the capacity to right past wrongs. The love and compassion shown by the congregational nurses to these patients had renewed their faith, restored their trust in health providers, but most importantly it appeared to have met them on their own ground spiritually, reinforcing their spiritual well-being in ways that had positive medical as well as adjustment outcomes for them.

The results noted in Table 20 represent *t*-test comparisons of self-efficacy and life scheme of homeless patients by location. As indicated in Chapter 6, respondents from Location 1 had significantly lower Self-efficacy, Life Scheme, and SIWB Total Scores than respondents from locations 2 and 3.

Table 20

Comparison of t-test Results of Select Variables by Location

Location	Self-efficacy	Life Scheme	SIWB-Total
1	3.36^{ab}	3.36^{ab}	3.35^{ab}
2	4.08^{a}	4.17^{a}	4.13^{a}
3	3.94^{b}	4.02^{b}	3.98^{b}

Note. Values with the same superscripts are significantly different from each other.

The survey results were validated during extensive time in the field with three homeless women; all of whom at one time or another in their lives had suffered from a lack of self-esteem. They readily admitted that there had been times when they were not motivated to continue their journey. Having someone demonstrate that they cared about them, listen to them as they shared their struggles, meet them where they are in terms of their spiritual lives, and consistently give compassionate care, did much to increase their trust level, intensify their faith, and support them in doing what was necessary to improve their health.

Spiritual Leadership and Spiritual Well-Being

In extensive one-on-one conversations with the three homeless women it was obvious that all felt a debt of gratitude for their nurses. While the congregational nurses each see hundreds of people throughout the year, the impact three of them had on these three homeless women made each one feel as if they had their very own private duty nurse. Providing compassionate care, leading with a level of integrity that causes patients to trust, and clearly articulating their genuine desire to help has done much to improve the lives of the three women who shared their life stories with me.

Although all three homeless women had been shattered by misfortune that would have brought any of us down during their life journeys, the spiritual leadership of the nurses was instrumental in increasing their well-being, spiritually and otherwise. While it is never possible to completely characterize the influence of the nurses, the words spoken by the patients during power-sensitive conversations with me indicate that they had each come to a dead end in terms of hope for a better life, until they received a visit from a special nurse who radically transformed their health and spiritual well-being.

Descriptive statistics from surveys administered to the homeless population in congregational care indicate that in spite of life’s challenges, both self-efficacy and life scheme were relatively high regardless of gender, age, race or ethnicity. Results of running Cronbach’s Alpha on the SIWB reflect internal consistency for both the self-efficacy and the life scheme scale, as noted in Tables 21 and 22.

Table 21

Scale: Total Scale

Case Processing Summary			
		N	%
Cases	Valid	56	86.2
	Excluded[a]	9	13.8
	Total	65	100.0

[a] Listwise deletion based on all variables in the procedure.

Table 22

Reliability Statistics

Cronbach's Alpha	*N*
.910	12

Limitations

This study realized a number of limitations that are noteworthy particularly as a means of informing researchers who may expound on certain aspects of this study:

1. This ethnographic study documented the role of spirituality in healthcare for vulnerable populations in one program, in one urban city in North Carolina which yielded a small sample size.
2. Lack of access (after multiple attempts over a 12-week period) to official permission to utilize several well-being instruments limited my ability to compare assessment tools to ascertain the one that might be the best one for the homeless population.
3. Limited time to observe the population due to transient nature of the homeless people.
4. My study's findings are situated and unique to this site; similar studies conducted in other locations could have very different findings for a host of reasons. However the data

collected in my study provide ample grounding for all warrants, as well as for future research.

Implications of Findings

My study is significant because it stands as the first of its kind to examine spirituality within a congregational nurse program. In the United States there are more than 15, 000 registered nurses serving as congregational nurses. In addition nearly 25 other countries have established congregational nursing programs. The results of this study should serve as a tool for other programs to expand or strengthen their programs. As such it has far-reaching implications.

Implications for practice. The faith-based congregational nursing program which formed the focus of my research was established 16 years ago, and initially patterned after the traditional parish nursing programs of the 1970s. However, over time it has evolved into a comprehensive health care program that had mushroomed from its humble beginnings of 10 congregations to 75 affiliated programs. With this growth came an integration of evidence-based practices that had served to strengthen its effectiveness. In addition, its leadership had been proactive in terms of forecasting its needs and developing programs, policies and partnerships to ensure its continued success.

Advice to congregational nursing programs, based on my findings, would be to:

1. Ensure there is buy-in from the congregational leaders (e.g., Pastor, Rabbi, etc.) before establishing a nursing program.
2. Ensure that nurses have everything they need to be successful which would be inclusive of a laptop for each nurse to maintain patient records and prepare data reports needed to substantiate the outcomes of the program.

3. Implement programs exclusively in congregations that are willing to leave the four walls of the church/synagogue/temple to provide for the health needs of vulnerable populations in nearby communities and neighborhoods.
4. Recognize that tens hours per week will not suffice for many congregations that reach out to vulnerable populations, so it is imperative to build the money needed to secure the nurse for additional hours.

Advice to medical experts who deal with homeless and other vulnerable populations, based on my findings would be to:

1. Ascertain and then maintain a delicate balance between professional boundaries and the spiritual needs of your patient.
2. Acknowledge that most patients respond positively when they receive compassionate care from their medical provider.
3. Attain the trust of patients in an effort to increase effectiveness of care. This can be done, by the physicians and other medical providers clearly demonstrating their integrity.

Implications for leadership. Leading with compassion holds the potential to yield positive results in terms of work productivity, life satisfaction and organizational commitment. Fry and Mattherly stated that,

> Spiritual leadership involves motivating and inspiring workers through a transcendent vision and a culture based in altruistic values to produce a more motivated, committed and productive workforce. In such an organization, where employees' spiritual needs are met and aligned with organizational objectives, this higher motivation, commitment and productivity has a direct impact on organizational processes and outcomes which in turn impacts customer satisfaction and ultimately, organizational performance. (in press, p. 1)

The leadership of this spiritually-based Congregational Nurse Program appeared to embrace the teachings of Fry (2003) who encourages leaders to develop an intrinsic motivation model that is inclusive of "vision, hope/faith, altruistic love, theories of workplace spirituality, and spiritual survival" (p. 696).

Providing health care with compassion to low-wealth patients had yielded positive results in the Congregational Nurse Program. This group of nurses has managed to reduce the barriers that contributed to the health disparities of many of their patients. With more than 100 documented lives saved, this spiritually-based healthcare program was making great strides in terms of developing a new service delivery model of care particularly for the indigent population.

Advice to the leaders of the program I studied would include:

1. Clearly articulate the vision of the program and ensure that all those you hire are in support of furthering the mission and vision.
2. Encourage all nurses to maintain a spiritual practice.
3. Survey participants regularly to ensure that the services provided and the manner in which they are being provided meet the perceived needs of the target population.

Advice to leaders of other similar programs or to leaders of programs that provide care for homeless and vulnerable populations:

1. Circumvent all preconceived notions about the way a particular group of people, think, behave and respond to medical directives.
2. Understand and appreciate the differences in the people you serve and find ways to demonstrate that you genuinely care about them beyond their illness.

3. Treat your staff with kindness and demonstrate the importance of integrity, trust and compassion in the workplace to ensure productivity.
4. Ensure that spirituality is laced through all aspects of your program while being sensitive to the varying religious believers and non-believers on your staff.

While my study focused on spirituality and health, it appears based on literature that spirituality has an impact on various areas when leaders employ spiritual leadership theory principles. In Fry's (2003) spiritual leadership theory one of the nine variables is organizational commitment. He indicated that, "Employees who have hope/faith in the organization's vision and who experience calling and membership will become attached, loyal to, and want to stay in organizations that have cultures based on the values of altruistic love" (Fry and Matherly, p. 6).

Regardless of the discipline, it is important for all leaders to empower their team and ensure that each member of the team feels like they are understood and appreciated. If successfully employed spiritual leadership will result in both self-motivation and also will enable leaders and their followers to motivate others. This study has helped me to realize that spiritual leadership has the potential to impact my life in such a way that I am compelled to do what allows me to experience meaning in my life and at the end of the day I feel a sense of accomplishment. It fuels individuals with what they need to make a difference whether that is in the field of health, business or education.

Implications for future research and policy/theory. Needed are studies that look at the role of spirituality in other congregational nurse care settings, as the location of the program may have profound implications for its success. It would also be interesting to further examine the difference in SLA scores for Whites and African Americans while also conducting a research project to ascertain if there would be a difference if all of the medical practitioners were male

versus female. While the survey results saw no differences in gender for the homeless population, we were not able to do the same analysis for the leaders since they were all women.

As we look toward future research and subsequent implementation of spiritual principles in healthcare institutions, it will be vital to develop a robust plan to achieve transformation. This plan would require health care leaders to work toward achieving those things that are within their control, and simultaneously to influence as much as possible the building of other avenues toward transformation that may be out of their direct control.

The transformation of healthcare must begin at the top of our nation's healthcare institutions. It is difficult to imagine a transformed organization without a transformed leader. The tough changes required will not be brought about by leaders who are not committed to the long-term process, and willing to take significant risks to drive out needless deaths, pain, waste, delays, and helplessness. Now that existing scholarship has thoroughly examined the role of spirituality in healthcare leadership and scrutinized why these two things are important to examine together, the findings of my study support the assertion that spirituality does have a positive impact on health and health outcomes.

While there is no one style of leadership for healthcare leaders that permeates healthcare organizations, it is apparent that trust and integrity are indeed important in order to win the confidence of patients. Healthcare organizations are increasingly becoming aware that the autocratic style of leadership is no longer effective, and that health care institutions might be better served by employing spiritual leadership principles. My study has documented the strong connection between spiritual leadership, patient care and spiritual well-being.

Conclusions

This ethnographic study used two assessment tools to inform the qualitative portion of this research. Ethnographic methods employed in this study included focus groups, phone interviews, power-sensitive interviews, observations and review and analysis of institutional forms of documentation and artifacts. The analysis of the quantitative data served as a means to ascertain the level of spiritual leadership in the congregational nursing health care program and the level of patient spiritual well-being. While the surveys provided aggregate data of how people scored the statements contained on the two assessments, the qualitative process provided opportunities to dig deeper, to clarify the meaning behind the numbers and to humanize this study.

Meaning/calling is one of the nine variables of spiritual leadership theory and most of the nurses agree that it is necessary for a person to have an understanding of what they are called to do and to come to the realization that their life has meaning. SLA results reveal that this variable had the highest mean score as segmented by ethnicity. This validates the feedback received in both focus groups and individual interviews with the nurses. The nurses believed that they were called to be congregational nurses and the care they provide supports the notion that their life has meaning. I also took note of the fact that the nurses mean score for inner-life and membership was also substantial. These results echo Fry's explanation of his theory. In the causal model of spiritual leadership, Fry (2003) illustrates that calling and membership when combined produces organizational commitment and productivity.

As it relates to the homeless patients, this study taught me that it is possible to have spiritual well-being even in the midst of chaos. The five months spent with the three homeless women taught me that it is possible to be at peace and to be content with life regardless of

personal failures if you are spiritually healthy. It seems to give one a peace that surpasses any scientific explanation. Even after losing their job, their home, their car and for many of them their actual family, they are able to find an inner peace that enables them to have the faith to believe that they can survive the challenges they have to face. This spiritual well-being helps them to believe again and most importantly helps them to trust others again. It is through this ability to trust, that their lives are redirected in such a manner that leads to improved physical and mental well-being.

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Appendix A

Spiritual Leadership Assessment Instrument

Survey Questions

Please take the time to fill out this survey. It is not necessary for you to write or sign your name on the form. Although this survey is anonymous and names will not be recorded, we ask that you answer all the questions as accurately as you can. Thank you.

Organization______________________ Department_______________________

Ethnicity: 1. Caucasian ____ 2. African American ____ 3. Hispanic ____

4. Mixed____ 5. Other ____

Income per year: 1. Under $20,000 ____ 2. $21,000-$30,000 ____ 3. $31,000-$40,000 ____

4. $41,000-$50,000 ____ 5. $Over $50,000 ____

Education: 1. Less than High School ____ 2. High School diploma or GED

3. Some College ____ 4. College Graduate ____ 5. Post Graduate Degree ____

Age: 1. 20 or under ____ 2. 21-30 ____ 3. 31-40 ____ 4. 41-50 ____ 5. 51-65 ____ 6. 66 or over

Gender: 1. Male ____ 2. Female ____

Please answer the following questions concerning the people you mostly work with using these responses:

1 = Strongly Disagree 2 = Disagree 3 = Neither Agree nor Disagree 4 = Agree 5 = Strongly Agree

1. The leaders in my organization “walk the walk” as well as “talk the talk.” ____

2. The work I do makes a difference in people’s lives. ____

3. I feel my organization appreciates me, and my work. ____

4. I feel like “part of the family” in this organization. ____

5. I feel hopeful about life ____

6. The conditions of my life are excellent. ____

7. I really feel as if my organization’s problems are my own. ____

8. I have faith in my organization and I am willing to “do whatever it takes” to ensure that it accomplishes its mission. ____

9. I feel my organization demonstrates respect for me, and my work. ____

10. The leaders in my organization are honest and without false pride. ____
11. I would be happy to spend the rest of my career with this organization. ____

12. My organization is trustworthy and loyal to its employees. ____

13. I care about the spiritual health of my co-workers. ____

14. The work I do is meaningful to me. ____

15. I persevere and exert extra effort to help my organization succeed because I have faith in what it stands for. ____

16. I demonstrate my faith in my organization and its mission by doing everything I can to help it succeed. ____

17. The work I do is very important to me. ____

18. I understand and am committed to my organizations vision. ____

19. In my department, everyone gives his/her best efforts. ____

20. In my department, work quality is a high priority for all workers. ____

21. I feel I am valued as a person in my job. ____

22. The leaders in my organization have the courage to stand up for their people ____

23. My job activities are personally meaningful to me. ____

24. I am satisfied with my life. ____

25. I consider myself a spiritual person. ____

26. My organization has a vision statement that brings out the best in me. ____

27. In most ways my life is ideal. ____

28. My organization's vision is clear and compelling to me. ____

29. My work group is very productive. ____

30. My organization's vision inspires my best performance. ____

31. My organization is kind and considerate toward its workers, and when they are suffering, wants to do something about it. ____

32. I feel highly regarded by my leaders. ____

33. My work group is very efficient in getting maximum output from the resources (money, people, equipment, etc.) we have available. ____

34. I maintain a spiritual practice (e.g., spending time in nature, prayer, meditation, reading inspirational literature, yoga, observing religious traditions, writing in a journal). ____

35. If I could live my life over, I would change almost nothing. ____

36. I set challenging goals for my work because I have faith in my organization and want us to succeed. ____

37. I talk up this organization to my friends as a great place to work for. ____

38. My spiritual values influence the choices I make. ____

39. I feel a strong sense of belonging to my organization. ____

40. So far I have gotten the important things I want in life. ____

Please identify 1 or more issues that you feel need more attention

1. ____

2. ____

3. ____

4. ____

Other Comments:

____
____
____
____

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- Fry, Jody W
-
- Jun 22, 2011

To

- Antonia Reaves

Attachments

- SLTSurveyKeyRev2.doc
- SLTStateOfArt.PDF

Download All

Antonia,

Survey attached along with an article that explains the theory behind it.. You have my permission to use it. Just please keep me informed of your progress and findings.
Dr. Louis W. (Jody) Fry
Professor
Texas A&M University - Central Texas
1901 South Clear Creek Rd.
Killeen, TX 76549
254-519-5476 Office
lwfry@ct.tamus.edu

----- “Antonia Reaves” <antonia_reaves@yahoo.com> wrote:
> From: “Antonia Reaves” <antonia_reaves@yahoo.com>
> To: “Jody W Fry” <lwfry@ct.tamus.edu>
> Sent: Tuesday, June 21, 2011 12:53:16 PM GMT -06:00 US/Canada Central
> Subject: Re: Spiritual Leadership Theory
>

Dr. Fry:

Thanks for your prompt response. Please let me know how I can obtain permission to utilize the Spiritual Leadership Assessment Instrument for my dissertation research. I would like to use it during the quantitative phase of my modified sequential explanatory methods study, to measure the spiritual leadership of a local parish nurse program. Thanks again!

Antonia Monk Reaves, MPA
Seek peace and pursue it. Psalm 34:14

Appendix B

Spirituality Index of Well Being Scale

Please take the time to fill out this survey. It is not necessary for you to write or sign your name on the form. Although this survey is anonymous and names will not be recorded, we ask that you answer all the questions as accurately as you can. Thank you.

Ethnicity: 1. Caucasian ____ 2. African American ____ 3. Hispanic ____4. Mixed____ 5. Other ____

Income per year: 1. Under $20,000 ____ 2. $21,000-$30,000 ____ 3. $31,000-$40,000 ____4. $41,000-$50,000 ____ 5. $Over $50,000 ____

Education: 1. Less than High School ____ 2. High School diploma or GED 3. Some College ____ 4. College Graduate ____ 5. Post Graduate Degree ____

Age: 1. 20 or under ____ 2. 21-30 ____ 3. 31-40 ____ 4. 41-50 ____ 5. 51-65 ____ 6. 66 or over

Gender: 1. Male ____ 2. Female ____

Spirituality Index of Well Being Scale:

Instructions: Which response best describes how you feel about each statement?

Statement	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1.) There is not much I can do to help myself.	1	2	3	4	5
2.) Often, there is no way I can complete what I have started.	1	2	3	4	5
3.) I can't begin to understand my problems.	1	2	3	4	5
4.) I am overwhelmed when I have personal difficulties and problems.	1	2	3	4	5
5.) I don't know how to begin to solve my problems.	1	2	3	4	5
6.) There is not much I can do to make a difference in my life.	1	2	3	4	5
7.) I haven't found my life's purpose yet.	1	2	3	4	5
8.) I don't know who I am, where I came from, or where I am going.	1	2	3	4	5
9.) I have a lack of purpose in my life.	1	2	3	4	5
10.) In this world, I don't know where I fit in.	1	2	3	4	5
11.) I am far from understanding the meaning of life.	1	2	3	4	5
12.) There is a great void in my life at this time.	1	2	3	4	5

----- Message from “Daaleman, Timothy P” <tim_daaleman@med.unc.edu> on Tue, 2 Apr 2013 15:26:03 -0400 -----

“Reaves, Antonia” <Antonia.Reaves@conehealth.com>,
To: <frey@ku.edu>,
<vpeyton@ku.edu>

Subject: RE: SWBI

Antonia,

The SIWB is in the public domain and you have our permission to use the scale.

Best wishes with your research, TPD

From: Reaves, Antonia [mailto:Antonia.Reaves@conehealth.com]
Sent: Tuesday, April 02, 2013 2:52 PM
To: Daaleman, Timothy P; frey@ku.edu; vpeyton@ku.edu
Subject: SWBI

Good Afternoon:

I hope that you are doing well. I am a doctoral candidate at North Carolina A&T State University currently working on my dissertation. Drawing on the interpretivist/constructivist paradigm, my study employs case study methods to capture patterns involving spiritual leadership and patient perceptions regarding outcomes of including spirituality in their health care treatment plan.

I am writing to request use of the Spiritual Well-Being Index to ascertain patient spiritual well-being. I would like to distribute the surveys in late April.

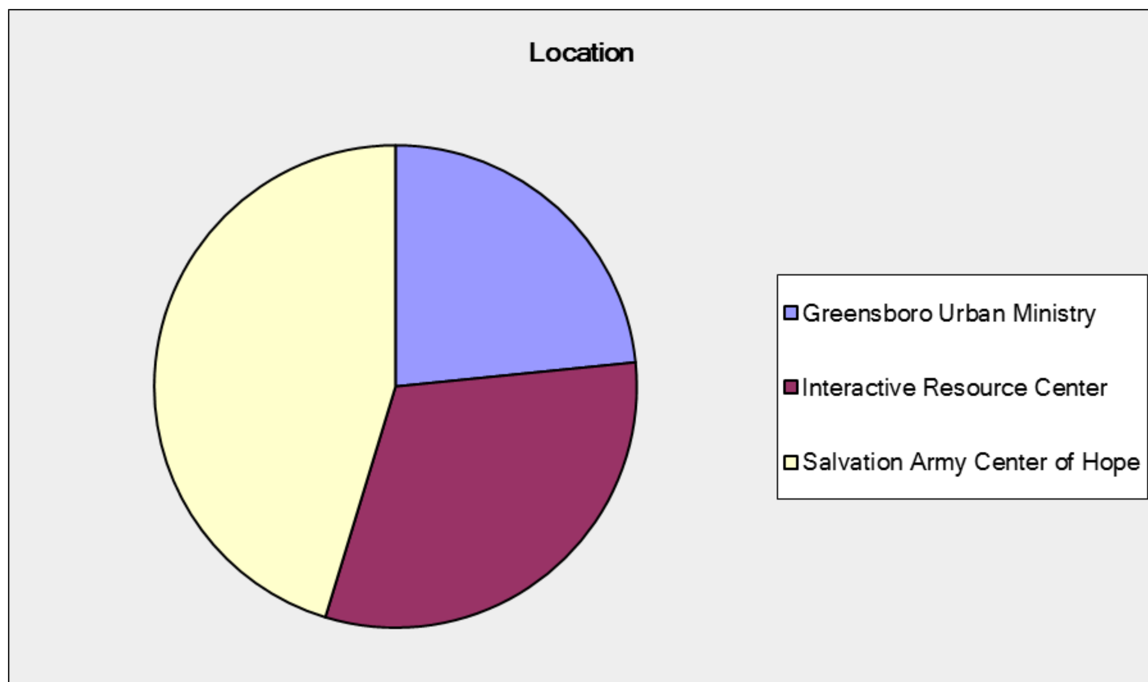
Please send me an e-mail notification indicating approval. Thanks in advance for your prompt consideration of this request.

All the best,

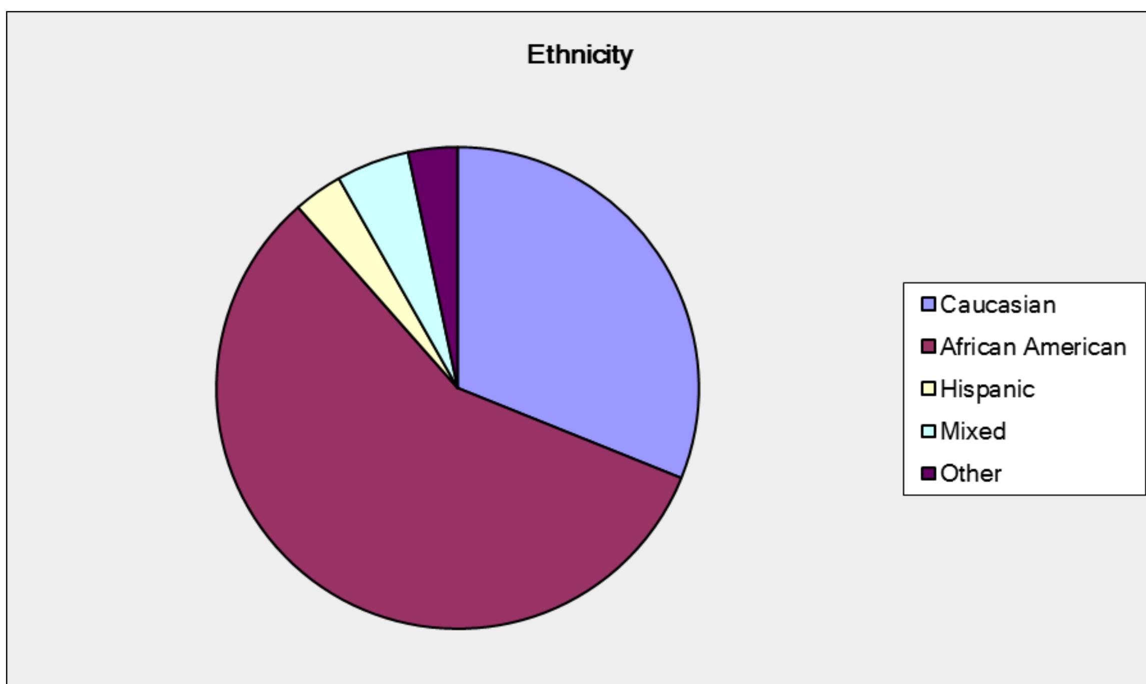
Antonia

Appendix C

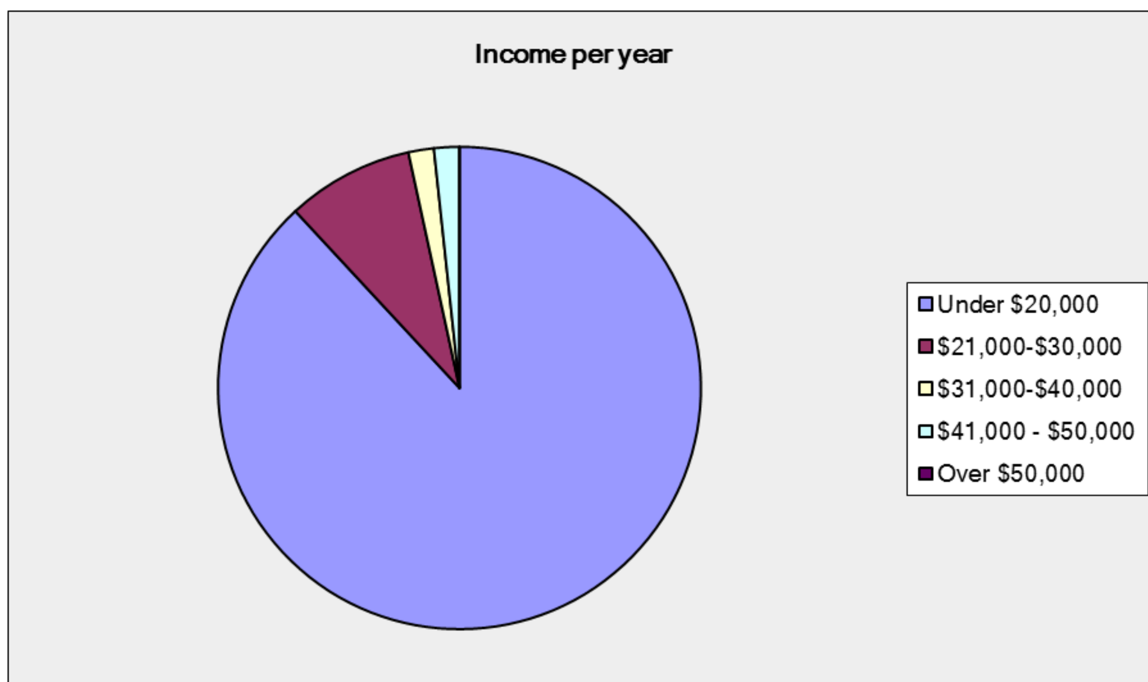
Homeless Survey Descriptive Statistics



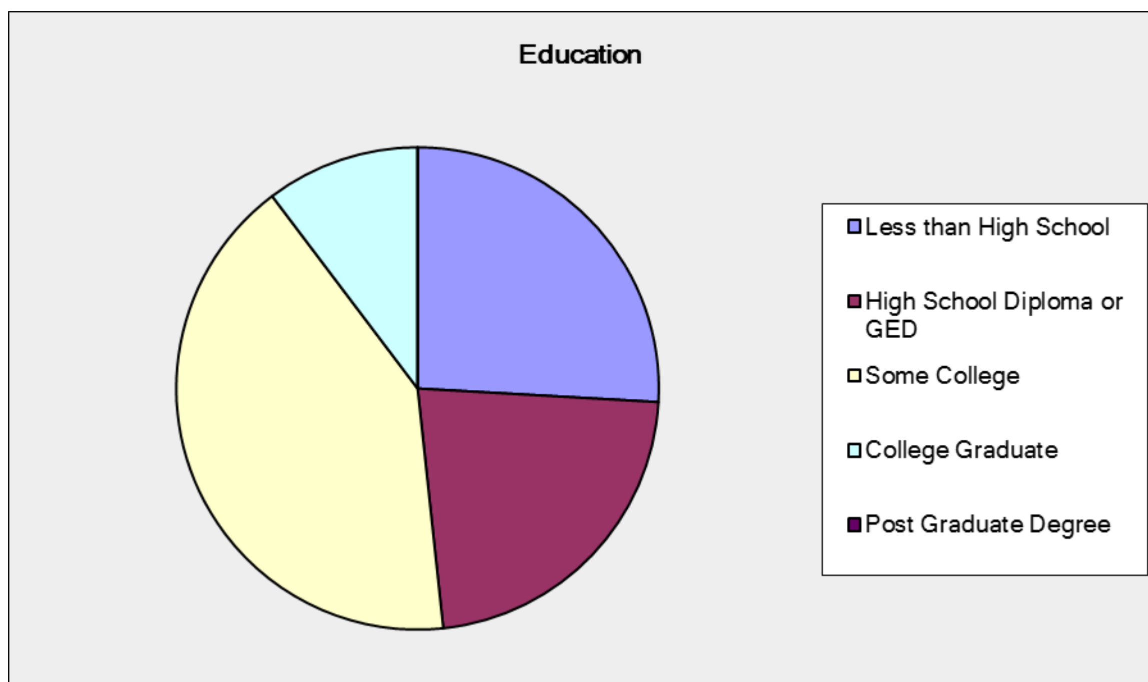
Location		
Answer Options	**Response Percent**	**Response Count**
Greensboro Urban Ministry	23.4%	15
Interactive Resource Center	31.3%	20
Salvation Army Center of Hope	45.3%	29
	answered question	**64**
	skipped question	**1**



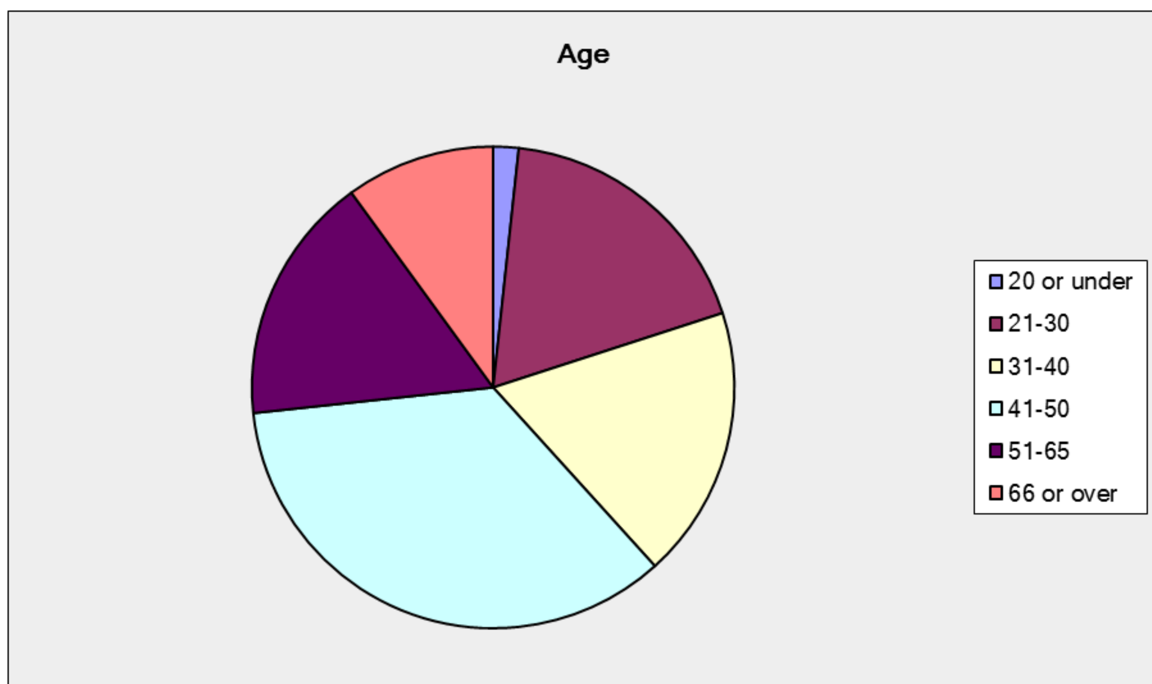
Ethnicity		
Answer Options	**Response Percent**	**Response Count**
Caucasian	31.1%	19
African American	57.4%	35
Hispanic	3.3%	2
Mixed	4.9%	3
Other	3.3%	2
Other (please specify)		0
	answered question	61
	skipped question	4



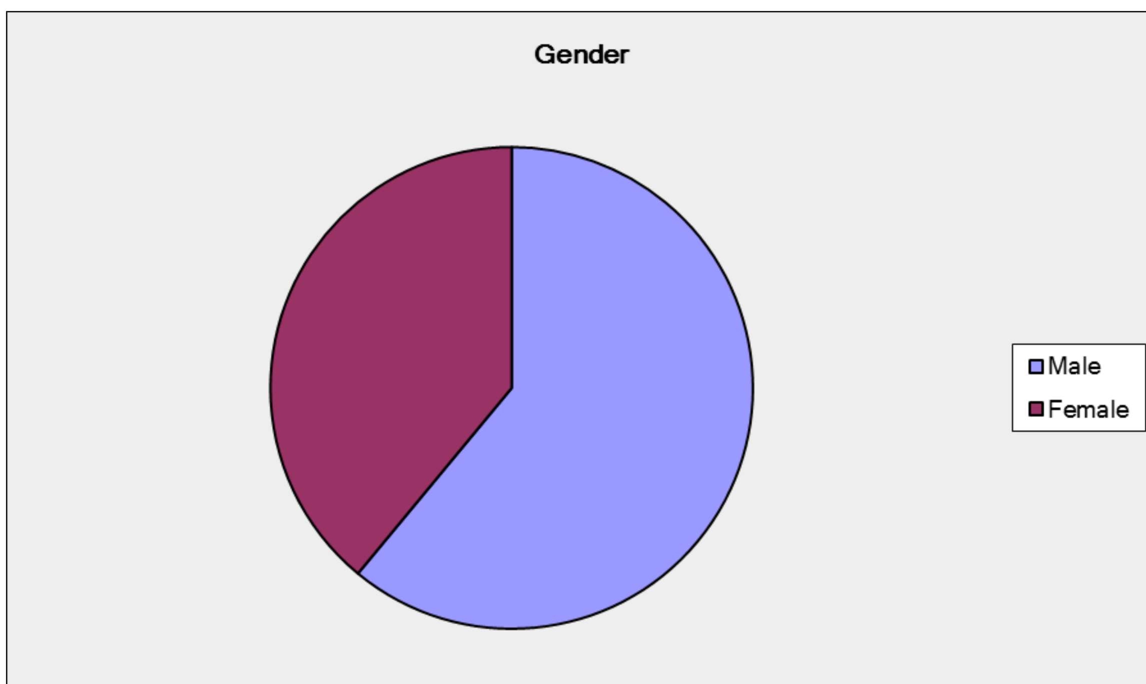
Income per year		
Answer Options	Response Percent	Response Count
Under $20,000	88.1%	52
$21,000-$30,000	8.5%	5
$31,000-$40,000	1.7%	1
$41,000 - $50,000	1.7%	1
Over $50,000	0.0%	0
	answered question	59
	skipped question	6



Education		
Answer Options	Response Percent	Response Count
Less than High School	25.9%	15
High School Diploma or GED	22.4%	13
Some College	41.4%	24
College Graduate	10.3%	6
Post Graduate Degree	0.0%	0
	answered question	58
	skipped question	7



Age		
Answer Options	Response Percent	Response Count
20 or under	1.7%	1
21-30	18.3%	11
31-40	18.3%	11
41-50	35.0%	21
51-65	16.7%	10
66 or over	10.0%	6
	answered question	60
	skipped question	5



Gender		
Answer Options	Response Percent	Response Count
Male	61.0%	36
Female	39.0%	23
	answered question	59
	skipped question	6

Appendix D

Spiritual Leadership Assessment
Descriptive Statistics for Congregational Nurse Program

T-Test

Group Statistics for Congregational Nurses

	Ethnicity_3	*N*	*M*	*SD*	SE Mean
Vision	Caucasian	24	4.5000	.54673	.11160
	African American	11	4.5682	.38876	.11722
Hope_Faith	Caucasian	24	4.4236	.51658	.10545
	African American	11	4.4773	.46710	.14084
Altruistic_Love	Caucasian	24	4.4833	.58359	.11913
	African American	11	4.4864	.37953	.11443
Meaning_Calling	Caucasian	24	4.7014	.37180	.07589
	African American	11	4.8409	.25673	.07741
Membership	Caucasian	24	4.4896	.54911	.11209
	African American	11	4.5227	.43952	.13252
Inner_Life	Caucasian	24	4.5417	.45101	.09206
	African American	11	4.7091	.33898	.10221
Organizational_Commitment	Caucasian	24	4.2750	.61521	.12558
	African American	11	4.2818	.34298	.10341
Productivity	Caucasian	24	4.1493	.51133	.10438
	African American	11	4.4545	.31261	.09426
Satisfaction_w_Life	Caucasian	24	3.9500	.63861	.13036
	African American	11	4.1455	.49064	.14793

		N	*M*	*SD*	Std. Error	95% Confidence Interval for Mean		Min	Max
						Lower Bound	Upper Bound		
Vision	Caucasian	24	4.5000	.54673	.11160	4.2691	4.7309	3.25	5.00
	African American	11	4.5682	.38876	.11722	4.3070	4.8294	4.00	5.00
	Other	6	4.6250	.44017	.17970	4.1631	5.0869	4.00	5.00
	Total	41	4.5366	.48593	.07589	4.3832	4.6900	3.25	5.00
Hope_Faith	Caucasian	24	4.4236	.51658	.10545	4.2055	4.6417	3.50	5.00
	African American	11	4.4773	.46710	.14084	4.1635	4.7911	3.75	5.00
	Other	6	4.6667	.40825	.16667	4.2382	5.0951	4.00	5.00
	Total	41	4.4736	.48571	.07586	4.3203	4.6269	3.50	5.00
Altruistic_Love	Caucasian	24	4.4833	.58359	.11913	4.2369	4.7298	2.80	5.00
	African American	11	4.4864	.37953	.11443	4.2314	4.7413	3.80	5.00
	Other	6	4.6333	.57155	.23333	4.0335	5.2331	3.80	5.00
	Total	41	4.5061	.52490	.08198	4.3404	4.6718	2.80	5.00
Meaning_Calling	Caucasian	24	4.7014	.37180	.07589	4.5444	4.8584	4.00	5.00
	African American	11	4.8409	.25673	.07741	4.6684	5.0134	4.25	5.00
	Other	6	4.9583	.10206	.04167	4.8512	5.0654	4.75	5.00
	Total	41	4.7764	.32673	.05103	4.6733	4.8796	4.00	5.00
Membership	Caucasian	24	4.4896	.54911	.11209	4.2577	4.7215	2.75	5.00
	African American	11	4.5227	.43952	.13252	4.2275	4.8180	4.00	5.00
	Other	6	4.5833	.49160	.20069	4.0674	5.0992	4.00	5.00
	Total	41	4.5122	.50296	.07855	4.3534	4.6710	2.75	5.00
Inner_Life	Caucasian	24	4.5417	.45101	.09206	4.3512	4.7321	3.60	5.00
	African American	11	4.7091	.33898	.10221	4.4814	4.9368	4.00	5.00
	Other	6	4.7000	.30332	.12383	4.3817	5.0183	4.20	5.00
	Total	41	4.6098	.40485	.06323	4.4820	4.7375	3.60	5.00
Organizational_Commitment	Caucasian	24	4.2750	.61521	.12558	4.0152	4.5348	2.40	5.00
	African American	11	4.2818	.34298	.10341	4.0514	4.5122	3.80	4.80
	Other	6	4.3667	.42740	.17448	3.9181	4.8152	3.60	4.80
	Total	41	4.2902	.52048	.08129	4.1260	4.4545	2.40	5.00
Productivity	Caucasian	24	4.1493	.51133	.10438	3.9334	4.3652	3.00	5.00
	African American	11	4.4545	.31261	.09426	4.2445	4.6646	4.00	5.00
	Other	6	4.5833	.37639	.15366	4.1883	4.9783	4.00	5.00
	Total	41	4.2947	.47401	.07403	4.1451	4.4443	3.00	5.00
Satisfaction_w_Life	Caucasian	24	3.9500	.63861	.13036	3.6803	4.2197	2.80	5.00
	African American	11	4.1455	.49064	.14793	3.8158	4.4751	3.40	5.00
	Other	6	4.2333	.48028	.19607	3.7293	4.7374	3.60	5.00
	Total	41	4.0439	.58054	.09066	3.8607	4.2271	2.80	5.00

		N	M	SD	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
Vision	Less $74,999	16	4.4375	.48734	.12183	4.1778	4.6972	3.50	5.00
	$75,000 or more	19	4.6579	.41003	.09407	4.4603	4.8555	4.00	5.00
	Total	35	4.5571	.45409	.07676	4.4012	4.7131	3.50	5.00
Hope_Faith	Less $74,999	16	4.4010	.43271	.10818	4.1705	4.6316	3.75	5.00
	$75,000 or more	19	4.6053	.46634	.10699	4.3805	4.8300	3.75	5.00
	Total	35	4.5119	.45650	.07716	4.3551	4.6687	3.75	5.00
Altruistic_Love	Less $74,999	16	4.4375	.45735	.11434	4.1938	4.6812	3.60	5.00
	$75,000 or more	19	4.6184	.44572	.10226	4.4036	4.8333	3.80	5.00
	Total	35	4.5357	.45367	.07668	4.3799	4.6916	3.60	5.00
Meaning_Calling	Less $74,999	16	4.7344	.32234	.08059	4.5626	4.9061	4.00	5.00
	$75,000 or more	19	4.8553	.30409	.06976	4.7087	5.0018	4.00	5.00
	Total	35	4.8000	.31389	.05306	4.6922	4.9078	4.00	5.00
Membership	Less $74,999	16	4.3750	.38730	.09682	4.1686	4.5814	4.00	5.00
	$75,000 or more	19	4.6579	.41003	.09407	4.4603	4.8555	4.00	5.00
	Total	35	4.5286	.41908	.07084	4.3846	4.6725	4.00	5.00
Inner_Life	Less $74,999	16	4.7000	.34254	.08563	4.5175	4.8825	4.00	5.00
	$75,000 or more	19	4.5789	.38236	.08772	4.3947	4.7632	3.80	5.00
	Total	35	4.6343	.36456	.06162	4.5091	4.7595	3.80	5.00
Organizational_Commitment	Less $74,999	16	4.1875	.38966	.09741	3.9799	4.3951	3.60	4.80
	$75,000 or more	19	4.4632	.43232	.09918	4.2548	4.6715	3.80	5.00
	Total	35	4.3371	.43052	.07277	4.1893	4.4850	3.60	5.00
Productivity	Less $74,999	16	4.2240	.39758	.09940	4.0121	4.4358	3.50	5.00
	$75,000 or more	19	4.3684	.45161	.10361	4.1508	4.5861	3.50	5.00
	Total	35	4.3024	.42783	.07232	4.1554	4.4493	3.50	5.00
Satisfaction_w_Life	Less $74,999	16	3.9750	.37148	.09287	3.7771	4.1729	3.20	4.60
	$75,000 or more	19	4.1158	.64400	.14774	3.8054	4.4262	3.20	5.00
	Total	35	4.0514	.53433	.09032	3.8679	4.2350	3.20	5.00

						95% Confidence Interval for Mean			
		N	*M*	*SD*	Std. Error	Lower Bound	Upper Bound	Minimum	Maximum
Vision	35 - 64	27	4.4815	.46475	.08944	4.2976	4.6653	3.25	5.00
	65 and older	11	4.6364	.54041	.16294	4.2733	4.9994	3.50	5.00
	Total	38	4.5263	.48557	.07877	4.3667	4.6859	3.25	5.00
Hope_Faith	35 - 64	27	4.4599	.50657	.09749	4.2595	4.6603	3.50	5.00
	65 and older	11	4.5000	.43301	.13056	4.2091	4.7909	4.00	5.00
	Total	38	4.4715	.48097	.07802	4.3134	4.6296	3.50	5.00
Altruistic_Love	35 - 64	27	4.3981	.55893	.10757	4.1770	4.6193	2.80	5.00
	65 and older	11	4.7636	.32023	.09655	4.5485	4.9788	4.20	5.00
	Total	38	4.5039	.52484	.08514	4.3314	4.6765	2.80	5.00
Meaning_Calling	35 - 64	27	4.7809	.31534	.06069	4.6561	4.9056	4.00	5.00
	65 and older	11	4.7955	.31261	.09426	4.5854	5.0055	4.00	5.00
	Total	38	4.7851	.31038	.05035	4.6831	4.8871	4.00	5.00
Membership	35 - 64	27	4.4630	.52671	.10137	4.2546	4.6713	2.75	5.00
	65 and older	11	4.6136	.46588	.14047	4.3007	4.9266	4.00	5.00
	Total	38	4.5066	.50833	.08246	4.3395	4.6737	2.75	5.00
Inner_Life	35 - 64	27	4.5778	.40510	.07796	4.4175	4.7380	3.60	5.00
	65 and older	11	4.7273	.37173	.11208	4.4775	4.9770	4.00	5.00
	Total	38	4.6211	.39671	.06436	4.4907	4.7514	3.60	5.00
Organizational_Commitment	35 - 64	27	4.2407	.55626	.10705	4.0207	4.4608	2.40	5.00
	65 and older	11	4.4000	.41952	.12649	4.1182	4.6818	3.60	5.00
	Total	38	4.2868	.51996	.08435	4.1159	4.4578	2.40	5.00
Productivity	35 - 64	27	4.1944	.48701	.09373	4.0018	4.3871	3.00	5.00
	65 and older	11	4.5076	.34852	.10508	4.2734	4.7417	4.00	5.00
	Total	38	4.2851	.46926	.07612	4.1308	4.4393	3.00	5.00
Satisfaction_w_Life	35 - 64	27	3.9926	.54767	.10540	3.7759	4.2092	3.20	5.00
	65 and older	11	4.1818	.56182	.16939	3.8044	4.5593	3.40	5.00
	Total	38	4.0474	.55104	.08939	3.8662	4.2285	3.20	5.00

Appendix E

Spiritual Leadership Assessment Correlations

Table E1

Spiritual Leadership Assessment Variable Correlations—All Respondents

		V	H_F	A_L	M/C	M	I_L	O_C	P	S_L
	Pearson Correlation	1	.794**	.806**	.676**	.816**	.634**	.876**	.700**	.526**
V	Sig. (2-tailed)		.000	.000	.000	.000	.000	.000	.000	.000
	N	41	41	41	41	41	41	41	41	41
	Pearson Correlation	.794**	1	.712**	.786**	.543**	.588**	.786**	.526**	.523**
H_F	Sig. (2-tailed)	.000		.000	.000	.000	.000	.000	.000	.000
	N	41	41	41	41	41	41	41	41	41
	Pearson Correlation	.806**	.712**	1	.669**	.747**	.629**	.847**	.651**	.500**
A_L	Sig. (2-tailed)	.000	.000		.000	.000	.000	.000	.000	.001
	N	41	41	41	41	41	41	41	41	41
	Pearson Correlation	.676**	.786**	.669**	1	.537**	.615**	.706**	.500**	.543**
M/C	Sig. (2-tailed)	.000	.000	.000		.000	.000	.000	.001	.000
	N	41	41	41	41	41	41	41	41	41
	Pearson Correlation	.816**	.543**	.747**	.537**	1	.527**	.865**	.649**	.469**
M	Sig. (2-tailed)	.000	.000	.000	.000		.000	.000	.000	.002
	N	41	41	41	41	41	41	41	41	41
	Pearson Correlation	.634**	.588**	.629**	.615**	.527**	1	.632**	.478**	.453**
I_L	Sig. (2-tailed)	.000	.000	.000	.000	.000		.000	.002	.003
	N	41	41	41	41	41	41	41	41	41
	Pearson Correlation	.876**	.786**	.847**	.706**	.865**	.632**	1	.649**	.602**
O_C	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000		.000	.000
	N	41	41	41	41	41	41	41	41	41
	Pearson Correlation	.700**	.526**	.651**	.500**	.649**	.478**	.649**	1	.551**
P	Sig. (2-tailed)	.000	.000	.000	.001	.000	.002	.000		.000
	N	41	41	41	41	41	41	41	41	41
	Pearson Correlation	.526**	.523**	.500**	.543**	.469**	.453**	.602**	.551**	1
S_L	Sig. (2-tailed)	.000	.000	.001	.000	.002	.003	.000	.000	
	N	41	41	41	41	41	41	41	41	41

Note. V=Vision, H_F=Hope_Faith, A_L=Altruistic_Love, M_C=Meaning/Calling, M=Membership, I_L=Inner_Life, O_C=Organizational_Commitment, P=Productivity, S_L=Satisfaction_w_Life
*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

Table E2

Spiritual Leadership Assessment Variable Correlations—Caucasian

		V	H_F	A_L	M/C	M	I_L	O_C	P	S_L
V	Pearson Correlation	1	.840**	.824**	.713**	.833**	.661**	.885**	.713**	.529**
	Sig. (2-tailed)		.000	.000	.000	.000	.000	.000	.000	.008
	N	24	24	24	24	24	24	24	24	24
H_F	Pearson Correlation	.840**	1	.729**	.805**	.645**	.683**	.867**	.522**	.574**
	Sig. (2-tailed)	.000		.000	.000	.001	.000	.000	.009	.003
	N	24	24	24	24	24	24	24	24	24
A_L	Pearson Correlation	.824**	.729**	1	.724**	.810**	.647**	.888**	.683**	.539**
	Sig. (2-tailed)	.000	.000		.000	.000	.001	.000	.000	.007
	N	24	24	24	24	24	24	24	24	24
M/C	Pearson Correlation	.713**	.805**	.724**	1	.632**	.596**	.786**	.421*	.597**
	Sig. (2-tailed)	.000	.000	.000		.001	.002	.000	.040	.002
	N	24	24	24	24	24	24	24	24	24
M	Pearson Correlation	.833**	.645**	.810**	.632**	1	.577**	.897**	.696**	.482*
	Sig. (2-tailed)	.000	.001	.000	.001		.003	.000	.000	.017
	N	24	24	24	24	24	24	24	24	24
I_L	Pearson Correlation	.661**	.683**	.647**	.596**	.577**	1	.675**	.385	.358
	Sig. (2-tailed)	.000	.000	.001	.002	.003		.000	.063	.086
	N	24	24	24	24	24	24	24	24	24
O_C	Pearson Correlation	.885**	.867**	.888**	.786**	.897**	.675**	1	.688**	.621**
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000		.000	.001
	N	24	24	24	24	24	24	24	24	24
P	Pearson Correlation	.713**	.522**	.683**	.421*	.696**	.385	.688**	1	.550**
	Sig. (2-tailed)	.000	.009	.000	.040	.000	.063	.000		.005
	N	24	24	24	24	24	24	24	24	24
S_L	Pearson Correlation	.529**	.574**	.539**	.597**	.482*	.358	.621**	.550**	1
	Sig. (2-tailed)	.008	.003	.007	.002	.017	.086	.001	.005	
	N	24	24	24	24	24	24	24	24	24

Note. V=Vision, H_F=Hope_Faith, A_L=Altruistic_Love, M_C=Meaning/Calling, M=Membership, I_L=Inner_Life, O_C=Organizational_Commitment, P=Productivity, S_L=Satisfaction_w_Life
*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

Table E3

Spiritual Leadership Assessment Variable Correlations—African American

		V	H_F	A_L	M/C	M	I_L	O_C	P	S_L
V	Pearson Correlation	1	.560	.896**	.621*	.648*	.886**	.816**	.697*	.598
	Sig. (2-tailed)		.073	.000	.042	.031	.000	.002	.017	.052
	N	11	11	11	11	11	11	11	11	11
H_F	Pearson Correlation	.560	1	.661*	.801**	.033	.491	.418	.335	.409
	Sig. (2-tailed)	.073		.027	.003	.923	.125	.200	.314	.212
	N	11	11	11	11	11	11	11	11	11
A_L	Pearson Correlation	.896**	.661*	1	.668*	.699*	.875**	.870**	.711*	.678*
	Sig. (2-tailed)	.000	.027		.025	.017	.000	.001	.014	.022
	N	11	11	11	11	11	11	11	11	11
M/C	Pearson Correlation	.621*	.801**	.668*	1	.257	.736**	.418	.524	.281
	Sig. (2-tailed)	.042	.003	.025		.446	.010	.201	.098	.402
	N	11	11	11	11	11	11	11	11	11
M	Pearson Correlation	.648*	.033	.699*	.257	1	.720*	.749**	.554	.493
	Sig. (2-tailed)	.031	.923	.017	.446		.012	.008	.077	.123
	N	11	11	11	11	11	11	11	11	11
I_L	Pearson Correlation	.886**	.491	.875**	.736**	.720*	1	.776**	.759**	.617*
	Sig. (2-tailed)	.000	.125	.000	.010	.012		.005	.007	.043
	N	11	11	11	11	11	11	11	11	11
O_C	Pearson Correlation	.816**	.418	.870**	.418	.749**	.776**	1	.504	.659*
	Sig. (2-tailed)	.002	.200	.001	.201	.008	.005		.114	.027
	N	11	11	11	11	11	11	11	11	11
P	Pearson Correlation	.697*	.335	.711*	.524	.554	.759**	.504	1	.341
	Sig. (2-tailed)	.017	.314	.014	.098	.077	.007	.114		.305
	N	11	11	11	11	11	11	11	11	11
S_L	Pearson Correlation	.598	.409	.678*	.281	.493	.617*	.659*	.341	1
	Sig. (2-tailed)	.052	.212	.022	.402	.123	.043	.027	.305	
	N	11	11	11	11	11	11	11	11	11

Note. V=Vision, H_F=Hope_Faith, A_L=Altruistic_Love, M_C=Meaning/Calling, M=Membership, I_L=Inner_Life, O_C=Organizational_Commitment, P=Productivity, S_L=Satisfaction_w_Life
*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

Table E4

Spiritual Leadership Assessment Variable Correlations—Other Ethnicity

		V	H_F	A_L	M/C	M	I_L	O_C	P	S_L
V	Pearson Correlation	1	.974**	.616	.696	.982**	-.112	.930**	.830*	.307
	Sig. (2-tailed)		.001	.193	.125	.000	.832	.007	.041	.553
	N	6	6	6	6	6	6	6	6	6
H_F	Pearson Correlation	.974**	1	.743	.800	.914*	.000	.955**	.868*	.272
	Sig. (2-tailed)	.001		.091	.056	.011	1.000	.003	.025	.602
	N	6	6	6	6	6	6	6	6	6
A_L	Pearson Correlation	.616	.743	1	.543	.486	.254	.595	.635	.024
	Sig. (2-tailed)	.193	.091		.266	.328	.627	.213	.175	.964
	N	6	6	6	6	6	6	6	6	6
M/C	Pearson Correlation	.696	.800	.543	1	.581	.162	.879*	.759	.238
	Sig. (2-tailed)	.125	.056	.266		.226	.760	.021	.080	.650
	N	6	6	6	6	6	6	6	6	6
M	Pearson Correlation	.982**	.914*	.486	.581	1	-.201	.873*	.766	.325
	Sig. (2-tailed)	.000	.011	.328	.226		.702	.023	.076	.530
	N	6	6	6	6	6	6	6	6	6
I_L	Pearson Correlation	-.112	.000	.254	.162	-.201	1	.093	.438	.686
	Sig. (2-tailed)	.832	1.000	.627	.760	.702		.862	.385	.132
	N	6	6	6	6	6	6	6	6	6
O_C	Pearson Correlation	.930**	.955**	.595	.879*	.873*	.093	1	.891*	.435
	Sig. (2-tailed)	.007	.003	.213	.021	.023	.862		.017	.388
	N	6	6	6	6	6	6	6	6	6
P	Pearson Correlation	.830*	.868*	.635	.759	.766	.438	.891*	1	.645
	Sig. (2-tailed)	.041	.025	.175	.080	.076	.385	.017		.166
	N	6	6	6	6	6	6	6	6	6
S_L	Pearson Correlation	.307	.272	.024	.238	.325	.686	.435	.645	1
	Sig. (2-tailed)	.553	.602	.964	.650	.530	.132	.388	.166	
	N	6	6	6	6	6	6	6	6	6

Note. V=Vision, H_F=Hope_Faith, A_L=Altruistic_Love, M_C=Meaning/Calling, M=Membership, I_L=Inner_Life, O_C=Organizational_Commitment, P=Productivity, S_L=Satisfaction_w_Life
*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

Table E5

Spiritual Leadership Assessment Variable Correlations—Not Reported

		V	H_F	A_L	M/C	M	I_L	O_C	P	S_L
V	Pearson Correlation	1	.897*	.995**	.805	.958**	.896*	.967**	.987**	.557
	Sig. (2-tailed)		.015	.000	.054	.003	.016	.002	.000	.251
	N	6	6	6	6	6	6	6	6	6
H_F	Pearson Correlation	.897*	1	.851*	.847*	.765	.771	.821*	.879*	.638
	Sig. (2-tailed)	.015		.032	.033	.076	.073	.045	.021	.173
	N	6	6	6	6	6	6	6	6	6
A_L	Pearson Correlation	.995**	.851*	1	.792	.980**	.918**	.979**	.988**	.560
	Sig. (2-tailed)	.000	.032		.060	.001	.010	.001	.000	.248
	N	6	6	6	6	6	6	6	6	6
M/C	Pearson Correlation	.805	.847*	.792	1	.724	.883*	.748	.821*	.824*
	Sig. (2-tailed)	.054	.033	.060		.103	.020	.088	.045	.044
	N	6	6	6	6	6	6	6	6	6
M	Pearson Correlation	.958**	.765	.980**	.724	1	.929**	.991**	.970**	.574
	Sig. (2-tailed)	.003	.076	.001	.103		.007	.000	.001	.233
	N	6	6	6	6	6	6	6	6	6
I_L	Pearson Correlation	.896*	.771	.918**	.883*	.929**	1	.934**	.920**	.810
	Sig. (2-tailed)	.016	.073	.010	.020	.007		.006	.009	.051
	N	6	6	6	6	6	6	6	6	6
O_C	Pearson Correlation	.967**	.821*	.979**	.748	.991**	.934**	1	.971**	.629
	Sig. (2-tailed)	.002	.045	.001	.088	.000	.006		.001	.181
	N	6	6	6	6	6	6	6	6	6
P	Pearson Correlation	.987**	.879*	.988**	.821*	.970**	.920**	.971**	1	.606
	Sig. (2-tailed)	.000	.021	.000	.045	.001	.009	.001		.202
	N	6	6	6	6	6	6	6	6	6
S_L	Pearson Correlation	.557	.638	.560	.824*	.574	.810	.629	.606	1
	Sig. (2-tailed)	.251	.173	.248	.044	.233	.051	.181	.202	
	N	6	6	6	6	6	6	6	6	6

Note. V=Vision, H_F=Hope_Faith, A_L=Altruistic_Love, M_C=Meaning/Calling, M=Membership, I_L=Inner_Life, O_C=Organizational_Commitment, P=Productivity, S_L=Satisfaction_w_Life
*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

Table E6

Spiritual Leadership Assessment Variable Correlations—Income Less Than $74,999

		V	H_F	A_L	M/C	M	I_L	O_C	P	S_L
V	Pearson Correlation	1	.667**	.699**	.550*	.728**	.599*	.803**	.557*	.249
	Sig. (2-tailed)		.005	.003	.027	.001	.014	.000	.025	.353
	N	16	16	16	16	16	16	16	16	16
H_F	Pearson Correlation	.667**	1	.508*	.755**	.361	.371	.684**	.194	.274
	Sig. (2-tailed)	.005		.044	.001	.170	.157	.003	.472	.305
	N	16	16	16	16	16	16	16	16	16
A_L	Pearson Correlation	.699**	.508*	1	.547*	.499*	.366	.706**	.678**	.430
	Sig. (2-tailed)	.003	.044		.028	.049	.163	.002	.004	.097
	N	16	16	16	16	16	16	16	16	16
M/C	Pearson Correlation	.550*	.755**	.547*	1	.350	.347	.635**	.289	.331
	Sig. (2-tailed)	.027	.001	.028		.183	.188	.008	.277	.211
	N	16	16	16	16	16	16	16	16	16
M	Pearson Correlation	.728**	.361	.499*	.350	1	.503*	.718**	.311	.093
	Sig. (2-tailed)	.001	.170	.049	.183		.047	.002	.241	.733
	N	16	16	16	16	16	16	16	16	16
I_L	Pearson Correlation	.599*	.371	.366	.347	.503*	1	.350	.330	-.251
	Sig. (2-tailed)	.014	.157	.163	.188	.047		.184	.211	.347
	N	16	16	16	16	16	16	16	16	16
O_C	Pearson Correlation	.803**	.684**	.706**	.635**	.718**	.350	1	.299	.237
	Sig. (2-tailed)	.000	.003	.002	.008	.002	.184		.261	.376
	N	16	16	16	16	16	16	16	16	16
P	Pearson Correlation	.557*	.194	.678**	.289	.311	.330	.299	1	.244
	Sig. (2-tailed)	.025	.472	.004	.277	.241	.211	.261		.363
	N	16	16	16	16	16	16	16	16	16
S_L	Pearson Correlation	.249	.274	.430	.331	.093	-.251	.237	.244	1
	Sig. (2-tailed)	.353	.305	.097	.211	.733	.347	.376	.363	
	N	16	16	16	16	16	16	16	16	16

Note. V=Vision, H_F=Hope_Faith, A_L=Altruistic_Love, M_C=Meaning/Calling, M=Membership, I_L=Inner_Life, O_C=Organizational_Commitment, P=Productivity, S_L=Satisfaction_w_Life

*Correlation is significant at the 0.05 level (2-tailed).

**Correlation is significant at the 0.01 level (2-tailed).

Table E7

Spiritual Leadership Assessment Variable Correlations—Income $75,000 or More

		V	H_F	A_L	M/C	M	I_L	O_C	P	S_L
V	Pearson Correlation	1	.834**	.739**	.695**	.773**	.607**	.896**	.606**	.695**
	Sig. (2-tailed)		.000	.000	.001	.000	.006	.000	.006	.001
	N	19	19	19	19	19	19	19	19	19
H_F	Pearson Correlation	.834**	1	.752**	.750**	.453	.714**	.819**	.515*	.586**
	Sig. (2-tailed)	.000		.000	.000	.051	.001	.000	.024	.008
	N	19	19	19	19	19	19	19	19	19
A_L	Pearson Correlation	.739**	.752**	1	.677**	.648**	.664**	.801**	.316	.503*
	Sig. (2-tailed)	.000	.000		.001	.003	.002	.000	.187	.028
	N	19	19	19	19	19	19	19	19	19
M/C	Pearson Correlation	.695**	.750**	.677**	1	.528*	.761**	.728**	.460*	.544*
	Sig. (2-tailed)	.001	.000	.001		.020	.000	.000	.047	.016
	N	19	19	19	19	19	19	19	19	19
M	Pearson Correlation	.773**	.453	.648**	.528*	1	.324	.802**	.550*	.558*
	Sig. (2-tailed)	.000	.051	.003	.020		.177	.000	.015	.013
	N	19	19	19	19	19	19	19	19	19
I_L	Pearson Correlation	.607**	.714**	.664**	.761**	.324	1	.694**	.321	.606**
	Sig. (2-tailed)	.006	.001	.002	.000	.177		.001	.180	.006
	N	19	19	19	19	19	19	19	19	19
O_C	Pearson Correlation	.896**	.819**	.801**	.728**	.802**	.694**	1	.586**	.778**
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.001		.008	.000
	N	19	19	19	19	19	19	19	19	19
P	Pearson Correlation	.606**	.515*	.316	.460*	.550*	.321	.586**	1	.647**
	Sig. (2-tailed)	.006	.024	.187	.047	.015	.180	.008		.003
	N	19	19	19	19	19	19	19	19	19
S_L	Pearson Correlation	.695**	.586**	.503*	.544*	.558*	.606**	.778**	.647**	1
	Sig. (2-tailed)	.001	.008	.028	.016	.013	.006	.000	.003	
	N	19	19	19	19	19	19	19	19	19

Note. V=Vision, H_F=Hope_Faith, A_L=Altruistic_Love, M_C=Meaning/Calling, M=Membership, I_L=Inner_Life, O_C=Organizational_Commitment, P=Productivity, S_L=Satisfaction_w_Life
*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

Table E8

Spiritual Leadership Assessment Variable Correlations—Age Not Reported

		V	H_F	A_L	M/C	M	I_L	O_C	P	S_L
V	Pearson Correlation	1	.982	.988	1.000**	.971	1.000**	.988	.918	.982
	Sig. (2-tailed)		.121	.099	.000	.154	.000	.099	.260	.121
	N	3	3	3	3	3	3	3	3	3
H_F	Pearson Correlation	.982	1	.999*	.982	.999*	.982	.941	.976	.929
	Sig. (2-tailed)	.121		.022	.121	.033	.121	.220	.139	.242
	N	3	3	3	3	3	3	3	3	3
A_L	Pearson Correlation	.988	.999*	1	.988	.996	.988	.952	.968	.941
	Sig. (2-tailed)	.099	.022		.099	.055	.099	.199	.161	.220
	N	3	3	3	3	3	3	3	3	3
M/C	Pearson Correlation	1.000**	.982	.988	1	.971	1.000**	.988	.918	.982
	Sig. (2-tailed)	.000	.121	.099		.154	.000	.099	.260	.121
	N	3	3	3	3	3	3	3	3	3
M	Pearson Correlation	.971	.999*	.996	.971	1	.971	.922	.986	.908
	Sig. (2-tailed)	.154	.033	.055	.154		.154	.254	.106	.275
	N	3	3	3	3	3	3	3	3	3
I_L	Pearson Correlation	1.000**	.982	.988	1.000**	.971	1	.988	.918	.982
	Sig. (2-tailed)	.000	.121	.099	.000	.154		.099	.260	.121
	N	3	3	3	3	3	3	3	3	3
O_C	Pearson Correlation	.988	.941	.952	.988	.922	.988	1	.845	.999*
	Sig. (2-tailed)	.099	.220	.199	.099	.254	.099		.360	.022
	N	3	3	3	3	3	3	3	3	3
P	Pearson Correlation	.918	.976	.968	.918	.986	.918	.845	1	.826
	Sig. (2-tailed)	.260	.139	.161	.260	.106	.260	.360		.381
	N	3	3	3	3	3	3	3	3	3
S_L	Pearson Correlation	.982	.929	.941	.982	.908	.982	.999*	.826	1
	Sig. (2-tailed)	.121	.242	.220	.121	.275	.121	.022	.381	
	N	3	3	3	3	3	3	3	3	3

Note. V=Vision, H_F=Hope_Faith, A_L=Altruistic_Love, M_C=Meaning/Calling, M=Membership, I_L=Inner_Life, O_C=Organizational_Commitment, P=Productivity, S_L=Satisfaction_w_Life
*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

Table E9

Spiritual Leadership Assessment Variable Correlations—Age = 35–64

		V	H_F	A_L	M/C	M	I_L	O_C	P	S_L
V	Pearson Correlation	1	.827**	.842**	.715**	.773**	.621**	.903**	.717**	.551**
	Sig. (2-tailed)		.000	.000	.000	.000	.001	.000	.000	.003
	N	27	27	27	27	27	27	27	27	27
H_F	Pearson Correlation	.827**	1	.693**	.781**	.460*	.645**	.757**	.540**	.449*
	Sig. (2-tailed)	.000		.000	.000	.016	.000	.000	.004	.019
	N	27	27	27	27	27	27	27	27	27
A_L	Pearson Correlation	.842**	.693**	1	.656**	.756**	.603**	.853**	.620**	.457*
	Sig. (2-tailed)	.000	.000		.000	.000	.001	.000	.001	.016
	N	27	27	27	27	27	27	27	27	27
M/C	Pearson Correlation	.715**	.781**	.656**	1	.480*	.658**	.650**	.549**	.473*
	Sig. (2-tailed)	.000	.000	.000		.011	.000	.000	.003	.013
	N	27	27	27	27	27	27	27	27	27
M	Pearson Correlation	.773**	.460*	.756**	.480*	1	.537**	.859**	.657**	.406*
	Sig. (2-tailed)	.000	.016	.000	.011		.004	.000	.000	.036
	N	27	27	27	27	27	27	27	27	27
I_L	Pearson Correlation	.621**	.645**	.603**	.658**	.537**	1	.632**	.393*	.381
	Sig. (2-tailed)	.001	.000	.001	.000	.004		.000	.042	.050
	N	27	27	27	27	27	27	27	27	27
O_C	Pearson Correlation	.903**	.757**	.853**	.650**	.859**	.632**	1	.665**	.531**
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000		.000	.004
	N	27	27	27	27	27	27	27	27	27
P	Pearson Correlation	.717**	.540**	.620**	.549**	.657**	.393*	.665**	1	.611**
	Sig. (2-tailed)	.000	.004	.001	.003	.000	.042	.000		.001
	N	27	27	27	27	27	27	27	27	27
S_L	Pearson Correlation	.551**	.449*	.457*	.473*	.406*	.381	.531**	.611**	1
	Sig. (2-tailed)	.003	.019	.016	.013	.036	.050	.004	.001	
	N	27	27	27	27	27	27	27	27	27

Note. V=Vision, H_F=Hope_Faith, A_L=Altruistic_Love, M_C=Meaning/Calling, M=Membership, I_L=Inner_Life, O_C=Organizational_Commitment, P=Productivity, S_L=Satisfaction_w_Life

*Correlation is significant at the 0.05 level (2-tailed).

**Correlation is significant at the 0.01 level (2-tailed).

Table E10

Spiritual Leadership Assessment Variable Correlations—Age = 65 and Older

		V	H_F	A_L	M/C	M	I_L	O_C	P	S_L
V	Pearson Correlation	1	.694*	.783**	.552	.900**	.577	.816**	.602*	.289
	Sig. (2-tailed)		.018	.004	.079	.000	.063	.002	.050	.389
	N	11	11	11	11	11	11	11	11	11
H_F	Pearson Correlation	.694*	1	.865**	.739**	.682*	.249	.853**	.304	.534
	Sig. (2-tailed)	.018		.001	.009	.021	.461	.001	.364	.090
	N	11	11	11	11	11	11	11	11	11
A_L	Pearson Correlation	.783**	.865**	1	.817**	.667*	.547	.834**	.361	.352
	Sig. (2-tailed)	.004	.001		.002	.025	.082	.001	.275	.289
	N	11	11	11	11	11	11	11	11	11
M/C	Pearson Correlation	.552	.739**	.817**	1	.605*	.289	.839**	.226	.432
	Sig. (2-tailed)	.079	.009	.002		.049	.388	.001	.504	.184
	N	11	11	11	11	11	11	11	11	11
M	Pearson Correlation	.900**	.682*	.667*	.605*	1	.341	.870**	.469	.467
	Sig. (2-tailed)	.000	.021	.025	.049		.304	.001	.146	.147
	N	11	11	11	11	11	11	11	11	11
I_L	Pearson Correlation	.577	.249	.547	.289	.341	1	.462	.519	.299
	Sig. (2-tailed)	.063	.461	.082	.388	.304		.153	.102	.371
	N	11	11	11	11	11	11	11	11	11
O_C	Pearson Correlation	.816**	.853**	.834**	.839**	.870**	.462	1	.433	.628*
	Sig. (2-tailed)	.002	.001	.001	.001	.001	.153		.183	.039
	N	11	11	11	11	11	11	11	11	11
P	Pearson Correlation	.602*	.304	.361	.226	.469	.519	.433	1	.145
	Sig. (2-tailed)	.050	.364	.275	.504	.146	.102	.183		.670
	N	11	11	11	11	11	11	11	11	11
S_L	Pearson Correlation	.289	.534	.352	.432	.467	.299	.628*	.145	1
	Sig. (2-tailed)	.389	.090	.289	.184	.147	.371	.039	.670	
	N	11	11	11	11	11	11	11	11	11

Note. V=Vision, H_F=Hope_Faith, A_L=Altruistic_Love, M_C=Meaning/Calling, M=Membership, I_L=Inner_Life, O_C=Organizational_Commitment, P=Productivity, S_L=Satisfaction_w_Life
*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

Appendix F

Spirituality Index of Well-Being Variable Correlations

All Respondents

Correlations

		SE	LS
SE	Pearson Correlation	1	.737**
	Sig. (2-tailed)		.000
	N	65	65
LS	Pearson Correlation	.737**	1
	Sig. (2-tailed)	.000	
	N	65	65

**. Correlation is significant at the 0.01 level (2-tailed).

Location = Greensboro Urban Ministry

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.612*
	Sig. (2-tailed)		.015
	N	15	15
LS	Pearson Correlation	.612*	1
	Sig. (2-tailed)	.015	
	N	15	15

*. Correlation is significant at the 0.05 level (2-tailed).
a. Location = 1

Location = Interactive Resource Center

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.679**
	Sig. (2-tailed)		.001
	N	20	20
LS	Pearson Correlation	.679**	1
	Sig. (2-tailed)	.001	
	N	20	20

**. Correlation is significant at the 0.01 level (2-tailed).
. Location = 2

Location = Salvation Army Center of Hope

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.834**
	Sig. (2-tailed)		.000
	N	29	29
LS	Pearson Correlation	.834**	1
	Sig. (2-tailed)	.000	
	N	29	29

**. Correlation is significant at the 0.01 level (2-tailed).
a. Location = 3

Age = 21-30

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.628*
	Sig. (2-tailed)		.038
	N	11	11
LS	Pearson Correlation	.628*	1
	Sig. (2-tailed)	.038	
	N	11	11

*. Correlation is significant at the 0.05 level (2-tailed).
a. Age = 2

Age = 31-40

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.714*
	Sig. (2-tailed)		.014
	N	11	11
LS	Pearson Correlation	.714*	1
	Sig. (2-tailed)	.014	
	N	11	11

*. Correlation is significant at the 0.05 level (2-tailed).
a. Age = 3

Age = 41-50

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.778**
	Sig. (2-tailed)		.000
	N	21	21
LS	Pearson Correlation	.778**	1
	Sig. (2-tailed)	.000	
	N	21	21

**. Correlation is significant at the 0.01 level (2-tailed).
a. Age = 4

Age = 51-65

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.722*
	Sig. (2-tailed)		.018
	N	10	10
LS	Pearson Correlation	.722*	1
	Sig. (2-tailed)	.018	
	N	10	10

*. Correlation is significant at the 0.05 level (2-tailed).
a. Age = 5

Age = 66 +

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.885*
	Sig. (2-tailed)		.019
	N	6	6
LS	Pearson Correlation	.885*	1
	Sig. (2-tailed)	.019	
	N	6	6

*. Correlation is significant at the 0.05 level (2-tailed).
a. Age = 6

Gender = Males

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.649**
	Sig. (2-tailed)		.000
	N	36	36
LS	Pearson Correlation	.649**	1
	Sig. (2-tailed)	.000	
	N	36	36

**. Correlation is significant at the 0.01 level (2-tailed).
a. Gender = 1

Gender = Females

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.841**
	Sig. (2-tailed)		.000
	N	23	23
LS	Pearson Correlation	.841**	1
	Sig. (2-tailed)	.000	
	N	23	23

**. Correlation is significant at the 0.01 level (2-tailed).
a. Gender = 2

Ethnicity3 = Caucasian

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.857**
	Sig. (2-tailed)		.000
	N	19	19
LS	Pearson Correlation	.857**	1
	Sig. (2-tailed)	.000	
	N	19	19

**. Correlation is significant at the 0.01 level (2-tailed).
a. Ethnicity = 1

Ethnicity_3 = African American

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.677**
	Sig. (2-tailed)		.000
	N	35	35
LS	Pearson Correlation	.677**	1
	Sig. (2-tailed)	.000	
	N	35	35

**. Correlation is significant at the 0.01 level (2-tailed).
a. Ethnicity = 2

Ethnicity_3 = Other

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.748
	Sig. (2-tailed)		.053
	N	7	7
LS	Pearson Correlation	.748	1
	Sig. (2-tailed)	.053	
	N	7	7

a. Ethnicity_3 = 3

Education_2 = High School or Less

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.695**
	Sig. (2-tailed)		.000
	N	28	28
LS	Pearson Correlation	.695**	1
	Sig. (2-tailed)	.000	
	N	28	28

**. Correlation is significant at the 0.01 level (2-tailed).
a. Education_2 = 1

Education_2 = Greater than high school

Correlations[a]

		SE	LS
SE	Pearson Correlation	1	.695**
	Sig. (2-tailed)		.000
	N	28	28
LS	Pearson Correlation	.695**	1
	Sig. (2-tailed)	.000	
	N	28	28

**. Correlation is significant at the 0.01 level (2-tailed).

a. Education_2 = 1

Appendix G

IRB Documents

Research Study:
Documenting the Role of Spirituality in Improving Healthcare

Participants needed to complete surveys and discuss health program.

Come enjoy light refreshments!
Surveys will be distributed on
July 13, 2013, 12 Noon @ IRC
July 20th, 12 Noon@ Center of Hope

NC A&T DIVISION OF RESEARCH AND ECONOMIC DEVELOPMENT
1601 East Market Street
Greensboro, NC 27411
(336) 334-7314
Web site: http://www.ncat.edu/~divofres/compliance/irb/index.php
Federalwide Assurance (FWA) #00000013

To: Antonia Reaves
From: Behavioral IRB

Authorized signature on behalf of IRB

Approval Date: 7/12/2013
Expiration Date of Approval: 7/11/2014
RE: Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)
Submission Type: Initial
Expedited Category: 7.Surveys/interviews/focus groups,6.Voice/image research recordings
Study #: 13-0156
Study Title: Documenting Client and Caregiver Perspectives on Integrating Spirtuality Into Health Care

This submission has been approved by the above IRB for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

Study Description:
This research examines client (homeless persons) and nurse perspectives on interactions between clients and nurses to examine how spritually-based nursing care may differ from traditional health care.

Investigator's Responsibilities:
Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

Stamped copies of approved consent forms and other documents will arrive under a separate email. You must use the stamped forms with subjects unless you have approval to do otherwise.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented. Any adverse event or unanticipated problem involving risks to subjects or others should be reported to the Office of Research Compliance and Ethics.

This study was reviewed in accordance with federal regulations governing human subjects research, including those found at 45 CFR 46 (Common Rule), 45 CFR 164 (HIPAA), 21 CFR 50 & 56 (FDA), and 40 CFR 26 (EPA), where applicable.

CC: Elizabeth Barber, Leadership Studies

NORTH CAROLINA AGRICULTURAL AND TECHNICAL STATE UNIVERSITY

INFORMED CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Responsible Investigator: Antonia Monk Reaves
Faculty Advisor: Dr. Forrest Toms, Associate Professor
Dissertation Chairperson: Dr. Elizabeth Barber, Associate Professor
Title: Documenting the Role of Spirituality in Improving Healthcare Outcomes for Vulnerable Populations

Purpose of the Research
You have been asked to participate in a research study, "Documenting the Role of Spirituality in Improving Healthcare Outcomes for Vulnerable Populations." Information obtained from this study will be compiled, analyzed and used in my doctoral dissertation.

Procedures
If you agree to participate, you will be asked to complete a paper-pencil questionnaire or electronic survey, and a 60-minute, face-to-face interview in the Interactive Resource Center, the Salvation Army Center of Hope, local faith institution, or a location of your choice, between July 1, 2013 and July 31, 2013. I will provide forms and materials needed. You are being asked to allow me to audiotape the interview, but if you prefer I can take written notes instead.

Risks and Discomforts
This study involves minimal risk and discomfort. The probability of harm and discomfort is not greater than your daily life encounters. Risks may include emotional discomfort from answering questionnaire or interview questions. Recalling traumatic or distressing events may cause some short-term suffering or distress. While the questionnaire will focus primarily on the care received by the patient and its effectiveness, there will potentially be questions during the interview that will center on homelessness.

Benefits
You will not directly benefit from participating in this study; however, the information you share can be used to help other people receive effective healthcare service and ultimately achieve better health outcomes.

Audio/Video Recording
If you allow it, I will use an audio recorder to accurately capture what is said. The recordings will be transcribed, but your name will not be used in written documents. Audio recordings and transcription will be kept on a password-protected computer. Reports of study findings will not include any identifying information.

□ Yes, I agree to be audiotaped and/or videotaped as a part of this study.

□ No, I do not agree to be audiotaped and/or videotaped as a part of this study.

Printed Name__________________________ Signature__________________________

Approved: 7/12/13
Expires: 7/11/14

Confidentiality
All information collected in this study will be kept confidential to the extent permitted by law.

At no time will your name be revealed in any written reports. The information you have given will be used for my dissertation research and may be used as a basis for articles or presentations in the future. I will not use your name in audio recordings, publications or presentations.

Your email address is requested so that I may follow up if needed. However, it will be stored separately from any data collected. Although the findings of this study may be published, no information that can identify you will be included.

Questions about the Study
If you have any questions about your involvement in this project, you may contact me, Antonia Monk Reaves, at 336-471-7178 or by email at antonia.monkreaves9@gmail.com. If you have any study-related concerns or any questions about your rights as a research study participant, you may contact the Office of Research Compliance and Ethics at North Carolina A&T State University at 336-334-7995.

Voluntary Participation/Withdrawal
Your participation is voluntary, and you may end your participation at any time. Refusing to participate or leaving the study will not result in any penalty or loss of benefits to which you are entitled. Not participating in this study will not affect your access to care or affect your relationship with ___________________ (site name). Your consent is being given voluntarily. You may refuse to participate in the entire study or any part of the study. If you choose to participate, you are free to withdraw at any time without any negative effect on your relations with North Carolina Agriculture and Technical State University or any other participating institutions or agencies.

You will receive a copy of this consent form for your records, signed and dated by the investigator.

Statement of Consent
I have read the above information and have received answers to any questions I had. I am at least 18 years of age or older and voluntarily consent to take part in this research study.

Participant's Name (Print) __________________________________

______________________________________ ______________
Participant Signature Date

______________________________________ ______________
Investigator's Signature Date

Name of facility_______________________________________