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SPIRITUALITY AND HEALTH: IMPLICATIONS FOR POLICY AND PRACTICE

A Dissertation Submitted in Partial Fulfillment of the
Requirements for the Degree
Doctor of Education
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Organizational Leadership

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College of Education and Organizational Leadership

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ABSTRACT

Spirituality and Health: Implications for Policy and Practice

Dara Vazin, EdD

Purpose. The purpose of this study was to establish among health educators a consensus in the definition of spirituality and health that would ultimately guide effective development of a curriculum or program in spirituality and health for undergraduate programs in college health science departments.

Methodology. This mixed-methods research study relied on qualitative data collected from interviews of a sample of leaders from national health organizations using broad, general interview questions. Survey data were collected from a broader set of educators employed within the CSU system who teach personal health courses at the undergraduate level.

Findings. After multiple interviews, consensus was reached by health experts/leaders on the definition of spirituality as it relates to health at the undergraduate level. Experts agreed there is a connection and that spirituality is a connective link that ties the different dimensions of health together; however, how they described the relationship varied. The CSU health educators viewed all of these elements of spirituality as important definitions of spirituality. Both experts and CSU educators agreed that spirituality is an important component to include in the health curriculum. How it should be included varies. Additionally, experts and CSU educators agreed that one of the most important objectives was to identify and explain how spirituality relates to the other dimensions of health.

Conclusions. The study data support the conclusions: (a) from the perspective of leaders, it is important to have a clear definition of the spiritual dimension of health to guide curriculum; (b) from the CSU health educator perspective, barriers to teaching spirituality are minimal and can be overcome; (c) the leaders and CSU educators agreed that spiritual health should be integrated into the health education curriculum for health science majors and minors.

Recommendations. It is recommended that this study be replicated with larger secular and nonsecular populations and universities. Further research should be conducted on the opinions of university administrators/policymakers about the inclusion of the spiritual dimension of health for all university students, and finally, professional preparation and training in graduate programs for future health educators.

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CONTENTS

ABSTRACT iv

FIGURES xi

TABLES xiii

ACKNOWLEDGEMENTS xv

Chapter

I. INTRODUCTION 1

Background 1

The Dimensions of Health 2

The Emotional Dimension of Health 2

The Intellectual Dimension of Health 3

The Interpersonal/Social Dimension of Health 3

The Environmental Dimension of Health 3

The Physical Dimension of Health 4

The Spiritual Dimension of Health 4

Research Problem 6

Purpose of the Study 8

Research Questions 9

Significance of the Study 9

Definitions of Terms 11

Delimitations 12

Summary 13

المنارة للاستشارات

www.manaraa.com

Organization of the Study 14

II. REVIEW OF THE LITERATURE 15

Dimensions of Wellness and Health 15

Understanding Spirituality as an Integral Component of Health and Health Instruction 19

Barriers to Integrating Spirituality into Health Instruction at Institutions of Higher Learning 21

Spirituality Versus Religion 23

Competing Definitions of Spirituality 25

Competing Definitions of Spiritual Health Introduced 27

Teaching Spiritual Health 29

Spirituality Courses in the CSU System 30

Summary 31

III. RESEARCH DESIGN AND METHODS 35

Purpose of the Study 35

Research Questions 36

Research Methodology and Design 37

Research Design Elements 38

Survey Research Design 39

Telephone or Semipersonal Focused Interviews 39

Schedule-Structured Interview or Survey 40

Population and Sample 41

Population 41

للاستشارات المنارة

www.manaraa.com

Sampling 42

Instrumentation 44

Pilot Testing 47

Theoretical Model 48

Data Collection Procedures 50

Phase 1.Qualitative Telephone or Semipersonal Focused Interview. 51

Phase 2.Quantitative Surveys, Schedule-Structured Interviews 52

Phase 3. Qualitative Semistructured Follow-Up Interviews 52

Instrument Reliability and Validity 53

Validation by Consensus Building 53

External Validity: Generalizing Conclusions 55

Data Analysis 56

Qualitative Data Analysis: Phases 1 and 3 56

Qualitative Data Analysis: Phase 2 57

Limitations 58

Summary 60

IV. ANALYSIS OF THE DATA 61

Purpose of the Study 61

Research Questions 62

Research Design, Methodology, and Selection of Subjects 63

Health Education Leader Participant Sample 64

California State University (CSU) Health Educator Participant Sample 65

المنارة للاستشارات
www.manaraa.com

Health Education Leader Participation Validation 66
Presentation of the Data by Research Question 66
Research Question 1 66
Research Question 2 76
Research Question 3 81
Research Question 4 91
Research Question 5 93
Summary of the Findings 100
Summary of the Findings for Research Question 1 101
Summary of the Findings for Research Question 2 102
Summary of the Findings for Research Question 3 102
Summary of the Findings for Research Question 4 103
Summary of the Findings for Research Question 5 103
V. SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS 105
Summary of the Study 105
Overview of the Problem 105
Purpose of the Study 108
Research Questions 108
Summary of Methodology 109
Population and Sample 110
Overview of Data Collection 110

المنارة للاستشارات
www.manaraa.com

Overview of Data Analysis 111

Major Findings and Conclusions 112

Findings for Research Question 1 112

Conclusions for Research Question 1 117

Findings for Research Question 2 118

Conclusion for Research Question 2 119

Findings for Research Question 3 119

Conclusions for Research Question 3 121

Findings for Research Question 4 121

Findings for Research Question 5 122

Conclusion for Research Question 5 122

Findings Related to the Literature 124

Summary of Results 126

Implementation or Policy Change Implications of the Study 126

Recommendations for Future Research 128

Summary Recommendation for Implementing Spirituality at CSU 128

Concluding Remarks 129

REFERENCES 132

APPENDICES 141

A. INFORMED CONSENT FORM: GROUP 1 142

B. INFORMED CONSENT FORM: GROUP 2 147

C. RECRUITMENT LETTER—GROUP 1 152

D. RECRUITMENT LETTER—GROUP 2 155

المنارة للاستشارات
www.manaraa.com

E. GROUP 1 INTERVIEW QUESTIONS (PHASE 1) 158
F. GROUP 2 E-MAIL SURVEY (PHASE 2) 161
G. GROUP 1: RE-INTERVIEW QUESTIONS (PHASE 3) 165
H. LETTER OF SUPPORT TO DEPARTMENT CHAIR 167
I. IRB APPROVAL LETTER 169

المنارة للاستشارات
www.manaraa.com

FIGURES

Figure | Page

1. Causal chain of variables linking classroom instruction regarding spiritual aspects of health to improved health 50

2. Visual representation of the method of the study 59

3. Frequency of responses to quantitative Survey Question1, "Selected health experts have identified elements of the term Spirituality as it relates to health education at the undergraduate university level. These ELEMENTS of the spiritual dimension of health are listed below. Please mark the terms below as being either RELEVANT or IRRELEVANT." 72

4. Frequency of responses to quantitative survey question, "Listed below are common THEMES of the spiritual dimension of health recognized by selected health experts. Please mark if you AGREE or DISAGREE with each theme listed." 75
.... 116

5. Frequency of responses to quantitative Survey Question3,"To what degree do you believe spirituality to be an important component of the health curriculum at the undergraduate university level?" 87

6. Frequency of responses to quantitative Survey Question 4, "How confident are you in teaching the spiritual dimension of health?" 88

7. Frequency of responses to quantitative Survey Question 5, "Selected health experts have established student learning objectives for undergraduate students as it relates to the spiritual dimension of health. Potential student learning objectives are listed below. Please mark as Relevant or Irrelevant." 90
.... 123

8. Frequency of responses to quantitative Survey Question 6, "Some barriers to teaching spiritual health have been identified as those listed below. For each one, evaluate how it applies to you or not." 92

المنارة للاستشارات
www.manaraa.com

9. Frequency of responses to quantitative Survey Question 3, "In your perception, how important is it that university leaders promote the inclusion of the spiritual dimension of health as it relates to an undergraduate level course in the university curriculum?" 99

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TABLES

Table Page

1. Harmony of Definitions of Spirituality Extracted From the Literature 28

2. Review of Spirituality Courses Offered in CSU Programs 32

3. Research Question Correlation 45

4. CSU Health Educator Population and Sample Details 66

5. Responses to Interview Question 1. Expressed Elements of a Definition for Spirituality as it Relates to Health Instruction 68

6. Expressed Elements of a Definition for Spirituality as it Relates to Health Instruction 71
.... 114

7. Degree of Agreement of CSU Health Educators With Each of Four Spiritual Dimensions of Health Recognized by Health Experts 74
.... 115

8. Response to Interview Question 2. Expressed Description of Connection or Relationship of Spirituality to Improved or Sustained Health 77
.... 118

9. Interview Question 3: Stated Causes of the Relationship of Spirituality to Improved Sustained Health 80

10. Rationale in Support of Conclusion That Spiritual Health Should Be Included in Undergraduate Level Courses 82
.... 120

11. Responses to Whether Spirituality Should Be Taught as an Individual Course or as a Single Unit of a More Comprehensive Course 84

12. Relative Levels of Confidence Teaching the Spiritual Dimension of Health 88

13. Degree to Which Proposed Learning Objectives Are Perceived to Be Relevant by CSU Health Educators 89

المنارة للاستشارات
www.manaraa.com

14. Degree to Which Potential Barriers to Teaching Spiritual Health Have Applied to CSU Health Educators 92

15. Spearman Rho Correlations (Confidence vs. Barriers) 94

16. Learning Objectives Proposed to be Included in a Single Unit or Course Entitled Spirituality and Health 95

17. Recommendations to Leaders of Universities Regarding Instruction of the Spiritual Dimension of Health in the Undergraduate Curriculum 97

للاستشارات المنارة
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CHAPTER I

INTRODUCTION

Background

Many institutions of higher learning are tackling student issues, such as stress, financial difficulties, diseases, suicide, and learning disabilities, as well as balancing school, work, and family (Insel & Roth, 2009). Finding balance in routine segments of their lives is a challenge for most people, especially college-aged students (Lipworth, Hooker, & Carter, 2011). The college years have a major impact in shaping the direction of an individual's life. Colleges and universities are ideal environments in which to provide students with the necessary tools to make good decisions that will impact their lifelong personal health practices. The concept of health and wellness is recognized as multifaceted and comprises six dimensions: spiritual, emotional, intellectual, social, environmental, and physical (Hawks, Hull, Thalman, & Richins, 1995). Of these six dimensions of health, the spiritual dimension is believed to be the center or core in which all other dimensions operate and interact. The spiritual dimension plays an important role in influencing one's overall health and well-being (Eberst, 1984; Hawks, 1994; Scandurra, 1999).

The literature makes a strong case for the inclusion of spiritual health in the college curriculum as it relates to health and living a balanced life. Research shows that

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individuals with a strong sense of spirituality make better decisions and live more satisfying lives. The transitional college years can present numerous challenges for students trying to balance school, work, and relationships. Therefore, the university is an ideal place to introduce or reemphasize the importance of spiritual health and its influence on leading a balanced, healthy life (Case-Smith, 2012).

The Joint Committee on Health Education and Promotion (2012) report on terminology for health education emphasized the importance of well-defined and widely accepted terms to guide health education professionals' communication with both colleagues and noncolleagues. The literature shows that scholars recognize the spiritual dimension as important to individuals' health. However, this has yet to be defined within the health education profession.

The Dimensions of Health

The ever-changing concept of health and wellness encompasses six dimensions: spiritual, emotional, intellectual, interpersonal/social, environmental, and physical (Strout & Howard, 2012). Within this widely accepted definition of health, spiritual health is one of the dimensions for which there is no consensus definition.

The Emotional Dimension of Health

The emotional dimension of health relates to mental health and reflects one's ability to understand and deal with feelings. Emotional/mental health involves the capacity to live a full life, and to be flexible to address life's challenges. Emotional health indicators/characteristics include sense of worth, self-control, personal beliefs,

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emotional awareness, productively coping with stress, problem solving, creativity, and cultural identity. Qualities and behaviors associated with emotional health include optimism, trust, self-esteem, self-acceptance, self-confidence, the ability to understand and accept one's feelings, and the ability to share feelings with others.

The Intellectual Dimension of Health

The intellectual dimension of health addresses the need to maintain an active mind, to learn new things throughout one's lifetime, and to seek and embrace new experiences and challenges. Qualities and behaviors associated with intellectual health include openness to new ideas, capacity to question, ability to think critically, motivation to master new skills, sense of humor, creativity, curiosity, and lifelong learning.

The Interpersonal/Social Dimension of Health

The interpersonal or social dimension of health includes the ability to develop and maintain satisfying and supportive relationships essential to physical and emotional health. Social health encourages participation in and contributions to community and society. Qualities and behaviors associated with the interpersonal/social dimension of health include communication skills, capacity for intimacy, and the ability to cultivate support systems of friends and family (Insel & Roth, 2009).

The Environmental Dimension of Health

The environmental dimension of health is based on the livability of one's surroundings, including safety, clean air, water, food, and freedom from violence. A

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healthy environment is dependent on having abundant, clean natural resources, maintaining sustainable development, recycling, and reducing pollution and waste (Insel & Roth, 2009).

The Physical Dimension of Health

The physical dimension of health is based on the overall condition of one's body, the absence of disease, and the fitness level and ability to care for oneself. To achieve optimal physical health requires making good choices to prevent illness or injury. Qualities and behaviors associated with physical health include eating well and ensuring proper nutrition, exercising, practicing safe sex, receiving regular checkups, avoiding injuries, and making good overall health choices (Strout & Howard, 2012).

Within each of the six dimensions, health educators recognize that spirituality holds some profound implications for disease prevention and overall health and wellness (Fisher, 2009). Kolander and Chandler (1991) asserted that "spirituality represents the umbrella under which all other dimensions of wellness unites . . . the essence of who we are as humans" (p. 32). These dimensions are fluid, and the condition of one dimension of health can often influence another dimension. The primary goal of health education is to improve the health, knowledge, attitudes, and behaviors of an individual that will ultimately lead to a balance in all dimensions of health.

The Spiritual Dimension of Health

Addressing the multiple dimensions of health, Hahn, Payne, and Mauer (2005) explained that college students who are transitioning into more complex aspects of their

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lives are particularly susceptible to emotional vulnerability, thereby experiencing feelings that may lead to rejection and failure, reducing their opportunity to be productive and satisfied with life. A number of studies have concluded specifically that including the spiritual dimension of health in college instruction positively impacts, for example, cardiovascular health (Williams et al., 1999), recovery from addictions and reduced teen sexual activity (Holder et al., 2000), overall depression (Nelson, Rosenfeld, Breitbart, & Galietta, 2002), eating disorders (Hawks, 2004), breast cancer (Feher & Malay, 1999), improved survival rates associated with AIDS (Ironson et al., 2011), and a number of other health behaviors (Waite, Hawks, & Gast, 1999).

Various studies have concluded that individuals who report higher levels of spirituality live healthier lifestyles, have better levels of satisfaction and self-esteem, have lower levels of hopelessness and loneliness (Fisher, 2009), are less inclined to participate in behaviors that compromise health (Turner-Musa & Lipscomb, 2007), experience lower levels of depression, and report lower levels of alcohol and tobacco abuse (Larson, Wood, & Larson, 1993).

While spirituality is an accepted dimension of a balanced health strategy, college and university departments of health sciences have not generally assimilated spirituality as a distinct topic area or as a course in the health curriculum. The university is an important place to educate students on the role spirituality can play in their overall health, not only while they are attending the university, but also long after they leave. Spirituality is a vehicle by which to address current life issues and experiences.

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However, the decision to include spirituality in the university classroom by health educators appears to be much more complex.

The majority of colleges and universities offer students the opportunity to take a course designed to provide them with the tools to prevent and/or reduce health concerns such as a Personal Health 101 class. An introductory lower division general education course has the potential to reach a large number of college students. The main goal of this type of health course, for example, is to encourage students to make good decisions about their overall health (Insel & Roth, 2009). Developing a unit, sequence, or course on spirituality and health would provide college students with the tools to productively cope with life's challenges and lead a more balanced life. Banks (1980) found that the majority (80%) of health educators at the college level believe there is a spiritual dimension of health and this dimension should be included in health education preparation programs.

Research Problem

Spirituality plays a vital role in the overall health and well-being of an individual (Larson et al., 1993). As described by Kolander and Chandler (1991), "Spirituality represents the umbrella under which all other dimensions of wellness unites . . . the essence of who we are as humans" (p. 32). Health educators recognize that spirituality seems to hold profound implications for disease prevention (Banks, 1980). College health educators recognize the important link between spirituality and student health practices, not only while they are attending the university, but also once they leave.

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Studies indicate a growing need to more fully integrate spirituality education into the university curriculum (McKenzie & Smeltzer, 2001). As a major and integrated dimension of health, spirituality has not been adequately defined, researched, or integrated into the health education curriculum (Hawks, 2004). Colleges and universities are ideal settings in which to provide students with the necessary awareness, knowledge, and skills to make good decisions that will positively impact their lifelong personal health practices and well-being.

During October of 2012, this researcher conducted a review of the course offerings at California State University (CSU) campuses and concluded that of all the spirituality courses offered in the CSU system, not one is offered as a spirituality and health course within a department of health sciences. One course is offered in public health at Fresno. Fullerton, Channel Island, and Chico offer an elective alternative/ holistic course. One course is offered in the public health department at Fresno. Sacramento offers a course in social work. All other courses offered on the subject of spirituality are in programs devoted to religious, ethnic, or gender studies. The lack of course offerings in spiritual health within the CSU health science departments reflects a lack of consensus in this topic.

Despite a renewed interest and growing literature on spirituality, there is no consensus on a definition that readily captures the depth and breadth of spirituality among college/university health educators. A number of studies along with a review of the CSU course offerings confirmed that spirituality is discussed on a limited basis. Introductory and lower level personal health courses offer the student the opportunity to

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take a course designed to provide him or her with skills to prevent and/or reduce health concerns in themselves and others. This type of introductory lower division general education class has the potential to reach a large number of college students. More time devoted to teaching spirituality in these types of courses can be beneficial to students and would contribute to a more rigorous health program.

Purpose of the Study

The purpose of this study was to establish a definition of spirituality containing all characteristics essential to the development of optimum health, a definition capable of effectively guiding the development of a curriculum or program in spirituality and health for undergraduate programs in college health science departments. Specifically, the first aim of this study was to gain consensus on such a definition among a select group of national health organization leaders and among university health educators within the California State University (CSU) system. For purposes of this study, this was described as a consensus definition. The second purpose of this study was to identify which aspects of spiritual health objectives/learning outcomes should be taught/included in a college health education curriculum (unit, sequence, or course) and why. The knowledge gained by this study was intended to provide valuable policy guidance to college health programs on CSU and college campuses and other academic institutions, for development of a full range of health courses to meet the needs of college-aged students.

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Research Questions

The following research questions were developed for this study:

1. What is the degree and nature of agreement/disagreement on the definitions of spirituality among the health leaders and educators as it relates to health instruction at the university level?
2. What is the relationship between spirituality and health as perceived by university health educators and key leaders within national health organizations?
3. What are the perceptions among health educators and key leaders within national health organizations pertaining to the importance of spirituality in the health curriculum at the undergraduate level?
4. What are the perceptions among health educators regarding the barriers to teaching spiritual health at the undergraduate college level?
5. What learning objectives do university health educators and key leaders of national health organizations believe spirituality as it relates to health should be included at the undergraduate college level?

Significance of the Study

A review of the literature established the need for more research addressing spiritual health instruction of college-aged students (Banks, 1980; Hawks, 1994; McGee, 2006). Banks (1980) surveyed health educators about the inclusion of spirituality in the college-level curriculum, and found that while spirituality is discussed on a limited basis in a large number of college general education health courses, health educators

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experienced barriers to teaching spirituality. Some objected to the inclusion of spirituality in health courses because of cultural and personal beliefs of students. Other health educators expressed discomfort teaching the material or that they lacked the requisite training or experience to effectively teach this topic. Another barrier cited in the literature was lack of adequate time to offer spirituality education. However, the primary barrier to teaching spiritual health cited in the literature was the lack of consensus among health educators on the definition of spirituality. Even though it is established within the health profession that spirituality is a key dimension of health, and though a provisional definition has been offered above, there is ambiguity about how the related concepts should be incorporated into a college-level health curriculum (Hawks, 1994; Hawks et al., 2007). If health educators do not know what spirituality is, or how to teach it, they will not feel competent to instruct students on the important role spirituality plays in health and life. The challenge for health educators is to address all of the six dimensions of health and provide a more comprehensive approach with at least equal time devoted to teaching spirituality (Neely & Minford, 2008). Several studies cited that the main barrier to addressing spirituality and health within the university classroom is the lack of consensus of a definition of spirituality (e.g., Hawks et al., 2007).

Based upon the literature review it seems a natural fit for health educators to use their expertise to develop and implement spirituality as an integral aspect of health and wellness. Further exploration of these areas of spirituality could fill the gap in the literature by offering an accepted definition of spirituality from the viewpoint of leaders in the field as well as insight into the types of training, education, and/or support

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necessary for college health educators to be encouraged to teach spirituality in the classroom. Such a definition, if accompanied with strategies for removing barriers to teaching, and if supported with a fully developed curriculum, can guide health educators within the CSU system and throughout the world to develop policies, procedures, and practices to enhance the health instruction offered to future generations of students. Finally, this study should help to expand the current body of literature in spiritual health in California college/university settings. The conclusions drawn from this study can foster policy changes in the health education curriculum.

Definitions of Terms

Consensus definition of spirituality as it relates to health. A statement on which a select group of national health organization leaders university health educators within the CSU system have reached agreement that said statement (a) adequately describes all characteristics of spirituality essential to the development of optimum health, and (b) is capable of effectively guide the development of a curriculum or program in spirituality and health for undergraduate programs in college health science departments.

Curriculum. A group of related courses, often in a special field of study; a defined set of studies, which students must fulfill to pass a certain level of education.

College health. A coordinated and planned set of policies, procedures, activities, programs, and services designed to enhance, protect, promote, and improve the health and well-being of students, faculty, and staff in institutions of postsecondary education.

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Health education. Any combination of planned learning experiences using evidence-based practices and/or sound theories that provide the opportunity to acquire knowledge, attitudes, and skills needed to adopt and maintain healthy behaviors (Green & Kreuter, 2005).

Learning objectives. The knowledge, skills, and abilities that students have attained as a result of their involvement in a particular set of educational experiences (McKenzie, Neiger, & Thackeray, 2013).

Health promotion program. According to the *American Journal of Wellness*, "Health Promotion is the science and art of assisting people change their lifestyle to move toward a state of optimal health—a balance of physical, emotional, social, spiritual, and intellectual health" (as cited in O'Donnell, 1986, pp. 4-5).

Delimitations

This study was conducted in three distinct phases. Delimitations narrowing the scope of the study existed in each of the three phases. The first phase consisted of telephone interviews with four experts from national health organizations. The second phase consisted of an online survey of all CSU health educators teaching a personal health course during spring of 2013. The third phase involved the same national health experts interviewed in Phase 1. Purposive sampling was used in this study. According to Creswell (2008), "Purposeful sampling is a qualitative sampling procedure in which researchers intentionally select individuals and sites to learn or understand the central phenomenon" (p. 214). Lastly, the population in Phase 2 was from nonsecular

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institutions of higher learning in California. Therefore, the findings of this study might not generalize to all other institutions of higher learning.

Summary

This chapter briefly summarized the history of the study of health education and the role spirituality plays in the college-level health curriculum. Institutions of higher learning can be pivotal to the growth and development of healthy young adults. Based upon the review of the literature, spirituality plays a vital role in the overall health and well-being of an individual (Larson et al., 1993). One of the biggest challenges among educators has been that there are no clear definition statements on spiritual health. There is a lack of professional preparation on how to teach and what needs to be included. As described by Kolander and Chandler (1991), “Spirituality represents the umbrella under which all other dimensions of wellness unites . . . the essence of who we are as humans” (p. 32). Health educators recognize that spirituality seems to hold profound implications for disease prevention (Banks, 1980). Studies indicate a growing need to more fully integrate spirituality education into the university curriculum (McKenzie & Smeltzer, 2001). As a major and integrated dimension of health, spirituality has not been adequately defined, researched, or integrated into the health education curriculum (Hawks, 2004). Colleges and universities are ideal settings in which to provide students with the necessary tools to make good decisions that will impact their lifelong personal health.

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Organization of the Study

This study is organized into five chapters, references, and appendices. Chapter I, the introduction of the study, provided the background of the study, the dimensions of health, the research problem, purpose of the study, research questions, significance of study, definitions of terms, delimitations, and summary. Chapter II presents a review of the literature related to the study. Chapter III describes the methods used in this study, the research and study design, population, procedures for data collection and analysis, as well as limitations of the study. Chapter IV provides a synthesis of the analyzed data obtained in the study. Finally, Chapter V concludes with a summary of the findings, implications for action, recommendations for future research, and final remarks.

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CHAPTER II

REVIEW OF THE LITERATURE

A literature review "involves locating, analyzing, synthesizing, and interpreting previous research and documents" with a goal of obtaining detailed knowledge of the topic, focusing the purpose of the study, uncovering previous research similar to the current study, identifying valid measures used in previous research, and linking findings to previous studies (Roberts, 2010, p. 73). This literature review focused on the emerging research surrounding spirituality as an integral part of health education in institutions of higher learning and included a summary and analysis of the following topics: the six established dimensions of health, a pioneer study by Banks (1980), spirituality and various competing definitions of what it is, the importance of defining spirituality and health, and, finally, a brief review of health education and what makes health education unique to this area of study.

Dimensions of Wellness and Health

The literature defines health as multidimensional and requires balance between the six elements: physical health, emotional health, intellectual health, social health, environmental, and spiritual health (Cottrell, Girvan, & McKenzie, 2002). These dimensions are fluid, and the condition of one dimension of health can often influence

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another dimension. The primary goal of health education is to improve the health, knowledge, attitudes, and behaviors of an individual student that will ultimately lead to a balance in all dimensions of health. Life balance is a subjective, dynamic concept that relates to health. When unbalanced in work, family, and daily life activities, the result can be reduced health and performance issues for individuals, families, communities, and organizations (Wagman, 2012). Matuska (2012) proposed that life balance congruence as measured by the agreement between what a person wants to do and what he or she actually does relates to health outcomes (Case-Smith, 2012). Her research revealed that a person's satisfaction with how he or she spends time relates to stress levels and overall well-being. Case-Smith (2012) concluded that balanced participation in life activities is important to the health and well-being of an individual. This relationship, she concluded, is most critical when a person or family must cope with a health problem (Case-Smith, 2012).

In health education practice, the spiritual dimension of health is often ignored or omitted. For example, most published health education objectives include physical health variables as primary outcomes (Healthy People, 2020). Within the educational setting, personal health courses are offered, and no argument has been offered to disregard any of the six elements of health. It is presumed that each of the six, including the spiritual dimension of health, is intended to be taught. However, there is limited research on spiritual health dimension with specific outcome/learning objectives. Research conducted by Williams et al. (1999) concluded that the emotional dimension of health exerts a profound influence on cardiovascular health, and often researchers do not

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consider emotional health variables as outcomes including various types of cancer and cardiovascular prevention programs.

Because college students are in a transitional stage of life, they are particularly sensitive to environmental and contextual influences, including family, peer group, school, neighborhood, and society. Each of these influences can either support or challenge the health and well-being of young people. Addressing the positive development of young people facilitates their adoption of healthy behaviors and helps to ensure a healthy and productive future adult population. According to the U.S. Census Bureau (2008, as cited in "Overview of the Uninsured," 2011), the percentage of uninsured citizens is highest among 19- through 24-year-olds. In other words, college-age students are more likely to be at risk of experiencing health concerns for which they are not prepared to respond.

The majority of colleges and universities offer students the opportunity to take a course designed to provide them with the tools to prevent and/or reduce health concerns such as a Personal Health 101 class. An introductory lower division general education course has the potential to reach a large number of college students. The main goal of this type of health course, for example, is to encourage students to take responsibility and make good decisions about their overall health (Insel & Roth, 2009). Developing a unit, sequence, or course on spirituality and health would provide college students the tools to deal with the daily chaos and lead a more balanced life. Banks (1980) found that the majority of health educators at the college level believe there is a spiritual dimension of health and this dimension should be included in health education preparation programs.

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Spiritual health influences such diverse outcomes as recovery from addiction and reduction of teen sexual activity (Holder et al., 2000), depression (Nelson, Rosenfeld, Breitbart, & Galietta, 2002), eating disorders (Hawks, 2004), breast cancer (Feher & Malay, 1999), improved survival rates associated with AIDS (Ironson et al., 2011), and a number of health behaviors (Waite et al., 1999). Addressing the multiple dimensions of health, Payne et al. (2005) explained that college students are particularly susceptible to emotional vulnerability, thereby experiencing feelings that may lead to rejection and failure, reducing their opportunity to be productive and satisfied with life. Turner-Musa and Lipscomb (2007) determined that individuals who have reported higher levels of spirituality are less inclined to participate in "health-compromising behaviors" (p. 495). Nelms, Hutchins, Hutchins, and Pursley (2007) examined the relationship between spirituality and health risks of college students, and concluded that there is a statistically significant relationship between spirituality and the self-reported health of college students in a university setting. Other researchers have focused on positive connections between spirituality and lower depression rates for college-aged students. In a study by Fisher (2009), students reported higher life satisfaction and healthier lifestyles. Fisher also found that those with high spiritual well-being had higher levels of self-esteem and lower levels of hopelessness and loneliness than their peers. Additional research suggested that there was a positive relationship/link between spirituality and decreased use of alcohol and cigarettes among college students aged 18 to 25 (Larson et al., 1993).

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Health educators recognize the importance of spiritual health. Therefore, it logically follows that spirituality and health would be taught in a course or part of other health courses.

Understanding Spirituality as an Integral Component of Health and Health Instruction

Health education is a lifelong process of educating people about their health so they can make informed decisions about their health. It has been taught in American institutions of higher learning for more than a century (Chang, 2001). According to Green and Kreuter (2005), health is a combination of learning experiences designed to facilitate voluntary actions conducive to health. These educational experiences facilitate gaining new knowledge, acquiring and practicing skills, and developing habitual behaviors to change or improve health status. The Joint Committee on Health Education and Promotion (2012) defined health education as "any combination of planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions" (p. 3). The World Health Organization (2012) described health education as comprising "consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health" (p. 58). Health education as a discipline has a distinct body of knowledge, a code of ethics, skill-based competencies, and distinct criteria for credentialing health education professionals (Livingood & Auld, 2001). There is a vast amount of research and literature regarding

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the history of health education and the primary roles of a health educator. Health educators have a responsibility to transmit up-to-date, accurate health information to the populations they serve, specifically, college-aged students. Healthy People 2020 provides clear goals and objectives for the health of this nation (Reigelman & Garr, 2011). This solid framework serves as a behavior change blueprint for health education and health promotion programs. This framework recognizes the need to develop the whole self, including spiritual health into one's daily life.

Because college students are in a transitional stage of life, they are particularly sensitive to environmental and contextual influences, including family, peer group, school, neighborhood, and society. Each of these influences can either support or challenge the health and well-being of young people. Addressing the positive development of young people facilitates their adoption of healthy behaviors and helps to ensure a healthy and productive future adult population. According to the U.S. Census Bureau (2008, as cited in "Overview of the Uninsured," 2011), the percentage of uninsured citizens is highest among 19- through 24-year-olds. In other words, college-aged students are more likely to be at risk of experiencing health concerns for which they are not prepared to respond.

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Barriers to Integrating Spirituality Into Health Instruction at Institutions of Higher Learning

Despite a renewed interest and growing literature on spirituality, there is no consensus on a definition that readily captures the breadth and depth of spirituality among college/university health educators. Within each of the six dimensions, health educators recognize that spirituality holds profound implications for disease prevention and overall wellness (Fisher, 2009). The literature shows that health professionals agree that it is important to address spirituality in the university classroom (Banks, 1980; McGee, 2006). In a study conducted in a university setting, McGee (2006) asserted that spirituality is viewed as important and influential in the health and well-being of individuals. McGee also reported that decisions to include spirituality in the curriculum appear to be much more complex. In another study by Banks (1980), health educators were surveyed about the inclusion of this topic in the college-level curriculum. Results showed that spirituality is discussed on a limited basis in a large number of college general education health classes (for example, Personal Health 101). These types of courses offer the student the opportunity to take a course designed to provide him or her with tools to prevent and/or reduce health concerns. This type of introductory lower

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division general education class has the potential to reach a large number of college students.

Several studies reported that the primary barrier is the ambiguity of dealing with dimensions of health that have not achieved a consensus definition in the health profession. For example, a definition of the spiritual dimension of health in a Personal Health 101 course textbook offers that spiritual health must be left to the individual (Cottrell et al., 2002). There are several other barriers that hinder a health education practice that genuinely promotes a multidimensional health and wellness perspective. For example, some dimensions are more readily accepted and embraced due to the nature of the dimension. By way of example, the physical health dimension is tangible, understandable, measurable, and objective. Therefore, it is relatively easy to discuss in the classroom. Another barrier to implementing spiritual health in the college classroom has to do with the political nature of this sensitive topic, which leaves the health education profession hesitant to act on its own definition of health. Based upon the literature, spirituality can be promoted without violating the separation of church/ religion/state (Weaver & Cottrell, 1996).

The field of health education is constantly evolving due to the increase in technology between 2000 and 2011 as well as the recognition of the importance of disease prevention and health promotion through health education efforts. To that end, every 10 years, leaders of professional health education associations come together to define key terms that are essential to helping them communicate with each other and those outside of the health field. Over the past 80 years, seven terminology reports have

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been developed for the profession. The most recent report demonstrated the significance professionals place on terminology used within the profession. While the report provides valuable revisions and new terminology, it does not include a definition of the spiritual dimension of health. However, the term holistic health is addressed and defined as "a perception of the individual as an integrated system rather than one or more separate parts including physical, mental, spiritual, and emotional" (*Mosby Medical Dictionary*, 2009, n.p.). This is evidence there is no consensus on the definition of spirituality. In order for health educators to embrace and teach the spiritual dimension of health, this dimension needs to be defined so that it can become a legitimate, measurable outcome for health education programs.

Spirituality Versus Religion

The importance and value of spirituality as it relates to overall health status of an individual is cited repeatedly in the literature. Scholars make the case that spiritual well-being is the core of human health and that in order to improve health in the other dimensions—physical, emotional, social, or intellectual dimensions—individuals need to concentrate on enhancing the spiritual dimension of health. Because of its confusion with religion, discussion of spiritual issues or implementation of spiritual health curriculum in a health or classroom setting was avoided. It is only within the last 30 years that spiritual health has begun to reemerge in the health field as a recognized and important facet of health (McGee, Nagel, & Moore, 2003).

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Spirituality and religion are terms that are often used interchangeably, but the two concepts are different. Therefore, it is important to address the differences: Spirituality, although not religion, may be a dimension of the religious life. Fairholm (1997) asserted that spirituality may possess religious versus secular overtones, but spirituality primarily deals with one's inner, private "life force" and may not be viewed in religious terms (p. 78). According to Russell's model of well-being, spiritual health forms the overall umbrella under which all other dimensions are united. In this model, spirituality is not necessarily religious dogma, but rather, an individual's philosophy, value, and meaning of life (Mullen, McDermott, Gold, & Belcastro, 1996; Russell, 1981).

Banks (1980) suggested that spirituality involves the search by humans for meaning in their lives, while religion involves an organized institution with rituals and practices about a higher power or God. Baker (2003) asserted that spirituality is more than simply a religion or belief or affiliation.

Spirituality is described by Bellamy et al. (2007) as the central way of life that guides people's conduct and is the essence of individuals' existence that integrates and transcends the physical, emotional, intellectual, volitional, and social dimension (Chidarikire, 2012). Religion, on the other hand, is the organized outward expression of that connection and meaning, or simply the external expression of one's faith (Yuen, Skibinski, & Pardeck, 2003). As Koenig (2009) stated, spirituality is considered more personal, while religion is more organized and often includes rituals and attendance within a social group.

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Competing Definitions of Spirituality

Although spiritual health is recognized as an important element for optimal well-being within health education, it appears to be the most complex health dimension to define, measure, and validate (Eberst, 1984). Scholars from various academic disciplines have attempted to define spirituality and the spiritual dimension of health with varying degrees of similarities and differences.

According to Muller and Dennis (2007), spirituality is believed to be a direct dimensional "driver" of health within all dimensions (physical, mental, emotional, and social). Hoyman (1966) was one of the first individuals to address the spiritual dimension of health in the health education literature. Banks (1980) conducted focus group interviews in which participants reflected on their perception of the relationship between their spirituality and their health belief values. The results yielded the following four spiritual health definitions:

> (a) a unifying force within individuals which integrates all the other dimensions (physical, mental, emotional, and social) and therefore, plays a vital role in determining the state of well-being of the individual; (b) a meaning and purpose in life; (c) a common bond between individuals; and (d) individual perceptions of faith. (p. 199)

Bensley (1991) identified six different perspectives related to spiritual health: (a) sense of fulfillment, (b) values and beliefs of community and self, (c) wholeness in life, (d) well-being, (e) God or a controlling power, and (f) human-spiritual interaction. Kass, Friedman, Leserman, Zuttermeister, and Benson (1991) observed that spirituality may be defined as both a personal conviction for and an internalized connection with the existence of God or another higher power. Green and Ottoson (1999) considered the

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spiritual dimension to enhance an individual's health, when spirituality includes (a) personal belief or faith that extends beyond one's self and provides a sense of belonging, (b) a locus of control and empowerment for self-realization, (c) a system of unconditional meaningfulness that provides a personal sense of positive direction and fulfillment, and (d) peace and tranquility in the face of stressful situations.

Chandler, Holden, and Kolander (1992) asserted that the six dimensions of health are interrelated and interactive and offered the dimension of spirituality as the core of this multidimensional model. These researchers suggested that spirituality is a part of being human and it needs to be cultivated as much as the other dimensions of wellness and health. Spirituality offers a path through which an individual can create a new and more whole or complete self. The literature contends that spirituality exists as a conceptual construct, and within the spirituality, there exists an element known as spiritual health, one of six essential components of a related construct known as health. Within spiritual health, there exists another set of elemental constructs.

According to Hawks (1994), "Spirituality is an intrinsic component of being human, and is a multidimensional construct that includes characteristics of life purpose, love, selflessness, connection to a higher power, and service to others" (p. 8).

Chapman (1986) stated,

> Optimal health can be considered as the ability to develop our spiritual nature to its fullest potential. This could include our ability to discover and articulate our own basic purpose in life, learn how to experience love, joy, peace, fulfillment, and to help ourselves and others achieve their full potential. (p. 38)

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Maslow (1970) believed that "the spiritual life is the essence of what makes us human and that an appreciation for the spiritual is needed for optimal human development and well-being" (p. 325). Aldridge (1993) presented 13 definitions primarily focused on spirituality and healing. According to a more recent definition by Hawks (2008),

> Spirituality is . . . a high level of faith, hope, commitment in relation to a well-defined worldview or belief system that provides a sense of meaning and purpose to existence in general, and that offers an ethical path to personal fulfillment which includes connectedness with self, others, and a higher power or larger reality. (p. 11)

Other researchers mention or allude to a need to transcend or rise above everyday material or sensory experience, one's relationship to God or some other higher universal power; a force or energy; a search for greater meaning, an ultimate purpose, and/or direction in living; and an ability to heal by means of nonphysical kinds of interventions such as prayer and/or meditation (Hawks, 1994; Jose, 1997; Thoresen, 1999; Thoresen & Harris, 2002). McGinn (1993) identified 35 different definitions of spirituality. Zinnbauer and Pargament (2005) reported nine definitions of spirituality. Scott (as cited by Piedmont, 2005, 2007) identified 40 different definitions of spirituality with nine content areas (Lodhi, 2011).

Competing Definitions of Spiritual Health Introduced

Table 1 summarizes the definitions of spirituality extracted from the literature. The literature emphasized different themes: (a) fulfillment, self-actualization, and achieving potential; (b) developing an ability to heal by nonphysical interventions; (c) a

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search for an ultimate purpose or meaning in life; (d) achieving a sense of transcendence; (e) achieving connections with a higher universal power; (f) association with a unifying force or energy within individuals; (g) the sensation and development of love; (h) a common bond between individuals, experienced as *selflessness*; (i) a common bond between individuals experienced as *service to others*.

Table 1

Harmony of Definitions of Spirituality Extracted From the Literature

Author	Unifying force/energy unites all other dimensions of health	Individuals meaning and purpose in life	Transcends the individual God/ultimate; cosmic force; selflessness	Set of principles that govern our conduct	Recognition/perceptions of powers beyond the natural or rational	Fulfillment, self-actualization, achieving potential	An ability to heal by non-physical interventions	Search for an ultimate purpose or meaning in life	Connection with a higher universal power	Hope/love/compassion for others	A common bond between individuals, or selflessness
Banks (1980)	X	X	X	X	X		X	X			X
Chandler, Holden, & Lolander (1992)						X				X	
Aldridge (1993)							X				
Hawks (1994)						X			X	X	X
Jose (1997)											
Reed (1987)		X		X				X			
Thoresen & Harris (2002)		X								X	
Hawks (2004)								X		X	
Lodhi (2011)	X		X						X		

Despite numerous efforts to define the spiritual dimension of health, the possible role of spirituality continues to be misunderstood due to the lack of consensus in the

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definition. Articles on this topic over the past 20 years may be an indication that college health professionals are ready to address and to teach the spiritual dimension of health. Lemmer (2012) discussed the importance of teaching spirituality to future professionals in the healthcare industry and argued that the two most challenging aspects of developing a curriculum were (a) defining spirituality and (b) having to teach to students at different "spirituality maturity" levels.

Teaching Spiritual Health

The field of health education has changed dramatically in the past 2 decades. One of the essential underpinnings of any profession is a body of well-defined terms used to enable members to communicate with the clarity necessary for understanding among themselves and with others. In a 2012 terminology report by the Joint Commission on Health Education and Promotion, common terms frequently used by health educators in a variety of settings were defined for use by the professional health educator as well as by other individuals and groups. In this report, the committee recognized that other health professionals (e.g., physicians, nurses, etc.) are concerned with and involved in health education as a part of their professional role and that they may have a different orientation. The terms included reflect trends, concepts, and practices.

In addition to a lack of a clear definition of spiritual health among university health educators, there is ambiguity about how this concept should be incorporated into the health curriculum (Hawks, 1994). An article by Lantz (2007) offered considerations for teaching spirituality in higher education. This included legal considerations,

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accreditation and spiritual care standards, and ethical principles of spirituality. Since 2000 there has been a significant increase in formal education in spirituality and health in the healthcare professions. According to Pulchaski et al. (2010), over 85% of medical and osteopathic schools have topics related to spirituality integrated into their curriculum. For example, nursing programs have integrated spirituality into baccalaureate education. Social work programs have spirituality integrated into their undergraduate and master's programs. Psychology programs include coursework on spirituality at the bachelor's, master's, and doctoral levels. The Marie Curie Cancer Center in London has developed a set of competencies for healthcare providers for spiritual care (Pulchaski et al., 2010). Health researchers recognize that those college students are more apt to change their level of spiritual dimension of health. Pulchaski et al. concluded that increasing students' health can come from an increase in spiritual health education activities (e.g., a learning environment which questions life's purpose requires self-examination, etc.).

Spirituality Courses in the CSU System

CSU is a public university system in the state of California. The CSU system is composed of 23 campuses, has almost 437,000 students, and is supported by more than 44,000 faculty members and staff. It is the largest, most diverse, and most affordable university system in the United States (CSU, 2013). While spirituality is an accepted dimension of a balanced health strategy, college and university departments of health sciences have not generally assimilated spirituality courses into the health curriculum.

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In October of 2012, a preliminary study was conducted to identify how many CSU campuses offer a course in spirituality and health. An investigation of all 23 CSU campuses online was done and queried the terms “spiritual,” “spirituality,” and/or “spiritual health.” Additionally, the health terms “alternative” and “holistic” were queried as possible terms used in the health profession to address spiritual health. Table 2 lists member colleges and universities of the CSU system and the spirituality courses offered in various departments.

Of all the spirituality courses offered in the CSU system, not one is offered as spirituality and health course within a department of health sciences. One course is offered in public health at Fresno. Fullerton, Channel Island, and Chico offer an elective alternative/holistic course. Sacramento offers a course in social work. All other courses offered on the subject of spirituality are in programs devoted to religious, ethnic, or gender studies. As a profession, health educators have a responsibility to relay comprehensive health information to the populations they serve, including college-aged students.

Summary

This chapter considered the elements implementing spirituality as a component of health instruction in institutions of higher learning. A history of health instruction was presented and the concept of spirituality was fully developed. A framework for understanding spirituality within the context of health instruction was introduced.

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Table 2

Review of Spirituality Courses Offered in CSU Programs

CSU	Course title	Department	GE	Level-300-400
Bakersfield	1.Spirituality and Mysticism 2.Spiritual Autobiography	Religious Studies (RS)	Y	370, 371
Channel Islands	Complimentary, Alternative Health	PSY	Y	342
Chico	Complimentary, Alternative Medicine	Hesc	Y	365
Dominguez Hills	N/A			
East Bay	N/A			
Fresno	Holistic Health and Alternative Medicine	Public Health (PH)	T	128
Fullerton	Holistic Health	Hesc/AFRO/CPRL	Y	325
	African American Religions and Spirituality			
Humboldt	1.Consumerism & (Eco) spirituality 2.Spiritual Traditions of India	Religious Studies (RS)	Y	361, 341
Long Beach	Women, Religion and Spirituality	Religious Studies (RS)	N Pre	410
Los Angeles	Spiritual Experiences and Mysticism in World Religions	RELS	Y	430
Maritime Academy	N/A			
Monterey Bay	N/A			
Northridge	N/A			
Pomona	N/A			
Sacramento	1. Social Work and Spirituality 2. Spirit and Nature 3. Feminism and the Spirit.	Social Work (SWRK) HRS Human & Religious Studies Women Studies (WOMS)	Y	132/232 & 155 & 234//145
San Bernardino	MA Education—Holistic & Integrative Program			

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Table 2 (*continued*)

CSU	Course title	Department	GE	Level-300-400
San Diego	1. Black Religions and Spirituality 2. Nature, Spirituality, Ecology	Religious Studies (REL)	Y	351 xlisted//376
San Francisco	1. Science & Spirituality in Ancient Africa 2. Caribbean Culture & Spirituality OTHER: Holistic Health Center-Minor	African Studies (AFRS) Latina/o Studies (LTNS)	Y	213
San Jose	N/A		Y	440
Polytechnic, San Luis Obispo	Spiritual Extremism: Asceticism, Mysticism, and GE C4 Madness	Religious Studies (RELS)		372
San Marcos	N/A			
Sonoma	N/A			
Stanislaus	Women's Spirituality	Gender	Y	4304

Note. Green highlighted courses fulfill the following criteria: (a) spiritual or spirituality in course title; (b) GE; (c) undergraduate course at the 300-400 level. Some departments offer holistic health, and/or the course is graduate level rather than at the undergrad 300-400 level course. Holistic, Alternative Health, Complementary and Alternative Medicine (CAM).

This literature examined effective strategies and barriers associated with implementing the spiritual dimension of health. The potential variables were introduced; those included a definition of the spiritual dimension of health, the perceptions of the relationship between spirituality and health, and the importance of what learning objectives should be included in a course on spirituality and health. The literature was reviewed as a means to implement spirituality as a component of health instruction as a means for institutions of higher learning to achieve goals related to the overall well-being of an individual.

Chapter II presented a review of the literature pertinent to the purpose and research questions stated in this study. The review of the literature was intended to frame

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the study, and in doing so, a careful review of professional journals, books, academic and government reports, and dissertations was done.

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CHAPTER III

RESEARCH DESIGN AND METHODS

This chapter presents the method of the study, beginning with a restatement of the purpose of the study and the research questions, followed by a description of the type of research, the design, the population and sample, the sampling procedures, the instrumentation, the steps taken to ensure validity and reliability, and the data collection procedures taken to analyze the data. Finally, Chapter III describes the statistical methods used to analyze the data, identifies the limitations of the study, and concludes with a brief summary of the method.

Purpose of the Study

The purpose of this study was to establish a definition of spirituality containing all characteristics essential to the development of optimum health, a definition capable of effectively guiding the development of a curriculum or program in spirituality and health for undergraduate programs in college health science departments. Specifically, the first aim of this study was to gain consensus on such a definition among a select group of national health organization leaders and among university health educators within the California State University (CSU) system. For purposes of this study, this was described as a consensus definition. The second purpose of this study was to identify which aspects of spiritual health objectives/learning outcomes should be taught/included in a college

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health education curriculum (unit, sequence, or course) and why. The knowledge gained by this study was intended to provide valuable policy guidance to college health programs on CSU and college campuses and other academic institutions, for development of a full range of health courses to meet the needs of college-aged students.

Research Questions

The following research questions were developed for this study:

1. What is the degree and nature of agreement/disagreement on the definitions of spirituality as it relates to health instruction at the university level?
2. What is the relationship between spirituality and health as perceived by university health educators and key leaders within national health organizations?
3. What are the perceptions among health educators and key leaders within national health organizations pertaining to the importance of spirituality in the health curriculum at the undergraduate level?
4. What are the perceptions among health educators regarding the barriers to teaching spiritual health at the undergraduate college level?
5. What learning objectives do university health educators and key leaders of national health organizations believe spirituality as it relates to health should be included at the undergraduate college level?

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Research Methodology and Design

This study was designed to use mixed methods. The first and third phases of research conducted in this study relied on qualitative data collected from a sample of leaders from national health organizations using broad, general interview questions in which the detailed views of participants were collected and analyzed. The qualitative research perspective captured the intricate details about the participants' feelings, thoughts, emotions, and processes, all of which were viewed as critical to this study. Creswell (2008) described a mixed-methods research design as one in which a set of "procedures for collecting both quantitative and qualitative data" is used within a single study, and in which the resulting data are analyzed and reported (p. 642). Krathwohl (2004) defined qualitative research as "research that describes phenomena in words instead of numbers or measures and usually uses induction to ascertain what is important in phenomena" (p. 15). Creswell (2008) further defined qualitative research as

> an inquiry approach useful for exploring and understanding a central phenomenon. To learn about this phenomenon, the inquirer asks participants broad general questions, collects the detailed views of participants in the form of words or images, and analyzes the information, drawing on personal reflections and past research. The final structure of the final report is flexible, and it displays the researcher's biases and thoughts. (p. 645)

The second phase of research relied on quantitative data collected from a broader set of educators employed within the CSU system who teach personal health courses at the undergraduate level. The data collected from expert interviews of the first phase of the study were used to develop an online survey, which was administered to the second group of participants. These data were collected using interviews composed of narrow questions generated from the results of the first phase of the study.

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Contrasted with the qualitative research approach, Krathwohl (2004) defined quantitative research as "research that describes phenomena in numbers and measures instead of words; the focus of the research is usually predetermined and deduced from prior research" (p. 690). Quantitative research is a tightly designed approach often used to further explore phenomena, but also to validate, confirm, or test results generated from earlier qualitative methods. Creswell (2008) further described quantitative research as that in which

> the investigator specifies narrow questions, locates or develops instruments to gather data to answer the questions, and analyzes numbers from the instruments, using statistics. From the results of these analyses, the researcher interprets the data using prior predictions and research studies. The final report, presented in a standard format, displays researcher objectivity and lack of bias. (p. 645)

Research Design Elements

Creswell (2008) recommended the use of a mixed-methods design when

> the combination of both forms of data provides a better understanding of a research problem than either quantitative or qualitative data by itself. Mixed methods designs are procedures for collecting, analyzing, and mixing both quantitative and qualitative data in a single study or in a multiphase series of studies. (pp. 61-62)

While Creswell (2008) delineated the broadest division of research designs as the choice between a qualitative and a quantitative approach and the option of mixing the methods when it is beneficial to do so, he identified a number of specific research designs that comprise quantitative or qualitative methods. Recommended quantitative designs include experimental research, correlational research, and survey research. Qualitative designs include grounded theory research, ethnographic research, and narrative research.

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Creswell categorized interviews as a tool for conducting survey, grounded theory, ethnographic, or narrative research.

Survey Research Design

This study utilized telephone or semipersonal focused interviews in Phase 1 and Phase 3, as well as mail- or e-mail-based surveys in Phase 2. Data were collected for the two of the three stages of research with personal focused interviews with a small number of leaders of national healthcare organizations thought to have expert knowledge about the essential components of health and health instruction. Frankfort-Nachmias and Nachmias (1996) firmly considered interview designs as a form of survey research. They noted that "social science researchers can choose from among three methods of gathering data with surveys: Mail questionnaires, personal interviews, and telephone interviews" (p. 224).

Telephone or Semipersonal Focused Interviews

Other than technological differences and concerns of bias, should a respondent not have access to a communication device, Frankfort-Nachmias and Nachmias (1996) made few distinctions between a telephone interview and a personal focused interview. They described the personal focused interview as an interview with four characteristics:

1. It takes place with respondents known to have been involved in a particular experience.
2. It refers to situations that have been analyzed prior to the interview.
3. It proceeds on the basis of an interview guide specifying topics related to the research hypotheses.
4. It is focused on the subjects' experiences regarding the situations under study. (p. 234)

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The questions are "malleable enough to follow emergent leads and standardized enough to register strong patterns" (Frankfort-Nachmias & Nachmias, 1996, p. 234).

Schedule-Structured Interview or Survey

Data were collected for the first phase of research with schedule-structured interviews with a narrow set of health educators/leaders within national health organizations. These data were collected using interviews in which the number and wording of questions were identical for all of the respondents, and which were comprised of questions constructed from a vocabulary sufficiently common to the respondents to have the same meaning for each of them.

Creswell (2008) described a survey design as a quantitative approach in which the researcher administers "a survey or questionnaire to a small group of people (called a *sample*) to identify trends in attitudes, opinions, behaviors, or characteristics of a large group of people (called the population)" (p. 61). Given that an interview is a form of survey, Frankfort-Nachmias and Nachmias (1996) described the schedule-structured interview as "the least flexible personal interview form" and the form in which "the number of questions and the wording of the questions are identical for all the respondents" (p. 232).

Researchers use the schedule-structured interview to make sure that any variations between responses can be attributed to the actual differences between the respondents and not to variations in the interview. The schedule-structured interview is based on "three critical assumptions" (Frankfort-Nachmias & Nachmias, 1996, p. 187):

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1. That for any research objective "the respondents have a sufficiently common vocabulary so that it is possible to formulate questions which have the same meaning for each of them" (Frankfort-Nachmias & Nachmias, 1996, p. 187).
2. That it is possible to phrase all questions in a form that is equally meaningful to each respondent.
3. That if the "meaning of each question is to be identical for each respondent, its context must be identical and, since all preceding questions constitute part of the contexts, the sequence of questions must be identical" (Frankfort-Nachmias & Nachmias, 1996, p. 187).

A third phase of research relied on qualitative re-interviews with the four national health experts. Experts were presented with a definition of spiritual health based upon their initial collective responses to this question and they were asked to agree or disagree with the definition and tell why. The interviews were conducted in the same manner as the first round of interview questions; consent to participate was verbal, and the responses were audio recorded using an electronic recorder. Of the experts, all but one responded to this round of interview questions. Attempts were made to contact this one expert by e-mails, telephone, and with a personal letter of re-invitation mailed to a home address.

Population and Sample

Population

The population for this study consisted of two related target populations. Group 1 participants were key health education leaders from national health organizations. Group

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2 participants consisted of health educators who teach within the CSU system. Purposive sampling was used to identify the key leaders as well as health professors within the population who met the specific criteria. The criteria for selection for each group were as follows:

1. The Group 1 population consisted of key health leaders from national health organizations within the health education profession. Examples are American Association of Health Education (AAHE), American Public Health Association (APHA), and National Commission for Health Education Credentialing (NCHEC). These organizations are widely recognized accrediting bodies/organizations within the health education profession.
2. The Group 2 population consisted of health educators who teach a personal health course at the undergraduate level at one of the 23 CSUs that have such departments.

Creswell (2008) defined a target population as “a group of individuals (or a group of organizations) with some common defining characteristic that the researcher can identify and study” (p. 152), and explained that “survey researchers typically select and study a sample from a population and generalize results from the sample to the population” (p. 358).

Sampling

Group 1. Participants from the expert leader population were chosen based upon their key role within the organization—president and/or CEO—and experience working in the field of health education. Patton (1990) suggested that a standard for selecting

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participants is whether they are "information rich" (p. 169). The population for this study was a set of highly respected experts within the health profession. Specifically, four experts were chosen based upon their leadership in a national health organization; for example, AAHE, NCHEC, and APHA. These are widely accepted national organizations within the health education profession.

Group 2. Participants for the CSU educators group were selected from health education/science, or public health departments that teach a personal health course at the undergraduate level within one of the 23 CSUs that have such departments. Krathwohl (2004) introduced the concept and importance of carefully selecting a sample from a larger population, allowing a researcher to generalize findings from the sample to the entire population. He explained,

> The inference of generality is derived from the relationship between what is studied, the sample, and the piece of the world of which it is a component and of which it is therefore representative. The piece of the world to which we wish to generalize, in sampling, we refer to as population or universe. Populations and universes are made up of units—usually in social science research the units are people or behaviors—and it is these we sample. Because we can interact only with small parts of our world at any given time, we are continually sampling it and, on the basis of what we can see or otherwise sense, making judgments about the rest, which we cannot sense directly. (p. 160)

The concept of generalizability, which is based on inferential statistics, is often important in a study because it allows one to apply the results from a small number of individuals to all members of a population (Creswell, 2008). This study was designed to protect the concept of generalizability by including participants from each of the CSU programs who might be impacted by the results of this study, health educators who teach undergraduate personal health courses. The CSU system includes teaching universities

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with large numbers of student enrollment and represents diverse faculty and students. There are a total of 23 CSUs; the campuses offer programs and/or departments of health science/education.

Of the 23 CSU campuses, 15 offer programs and/or departments of health science/education. Each of these departments is represented by a department chair. The health sciences department chair at CSU Fullerton was petitioned to contact each of these 15 department chairs and to request three specific things:

1. That they authorize the researcher to contact all subordinates who match the requirements of the Group 2 sample.
2. That they provide the researcher with e-mail addresses of each of the subordinates identified above.
3. That they contact each of the subordinates identified above, and request that they respond to the brief survey.

Instrumentation

The researcher used a mixed-method design for data collection. This method began with qualitative component to gather in-depth explanations of the research problem from a small sample of national health organization leaders. This was followed by a quantitative component to obtain a general idea of the research problem. The researcher first conducted the telephone interview questions. Next, the online survey questions were administered. A matrix was developed to correlate the interview questions and online survey questions with the research questions (see correlation Table 3). The reliability for

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these methods had been tested in a field-test for readability, clarity, and comprehension of each question. The validity of the instrument was confirmed through expert review.

Table 3

Research Question Correlation

Research question	Telephone interview question	Quantitative survey question
1. What is the degree and nature of agreement/disagreement on the definitions of spirituality as it relates to health instruction at the university level?	1	1, 2
2. What is the relationship between spirituality and health as perceived by university health educators and key leaders within national health organizations?	2, 3	
3. What are the perceptions among health educators and key leaders within national health organizations pertaining to the importance of spirituality in the health curriculum at the undergraduate level?	4, 5	4, 5
4. What are the perceptions among health educators regarding the barriers to teaching spiritual health at the undergraduate college level?	1	6
5. What learning objectives do university health educators and key leaders of national health organizations believe spirituality as it relates to health should be included at the undergraduate college level?	6, 7	3, 7

Telephone interview questions administered to a sample of four health education leader/expert participants. The following eight telephone interview questions were developed to solicit qualitative responses from the health education leader participant sample. Responses were collected using a digital voice and audio recording.

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Interview Questions as Sources of Qualitative Data

1. Given definitions proposed in the literature, what definition would you propose for the term *Spirituality* as it relates to health instruction at the undergraduate university level?
2. Is there a connection or relationship of spirituality to improved or sustained health? If so, what is the relationship?
3. What do you believe is the cause of the relationship described in response to question 2 (the connection or relationship of spirituality to improved or sustained health)?
4. To what degree do you believe Spirituality, as you have defined it, to be an important dimension of the health curriculum at the undergraduate college level?
5. In your opinion, should spirituality be taught as an individual course or as a single unit of a more comprehensive course?
6. What learning objectives do you believe should be included in a single unit, or course entitled Spirituality and Health?
7. Are there any recommendations you would make to leaders of universities to promote instruction of the spiritual dimension of health in the undergraduate curriculum?
8. Is there anything else you would like to add?

The researcher isolated relevant portions of the data from the interview transcripts of each participant, using as guidelines the purpose and research questions of the study. The objective was to search for patterns, emerging themes, and ideas that fit into the participants' experiences regarding the spiritual dimension of health. As the interviews progressed, the participants further delved into their understanding and experience of the spiritual dimension of health. A few distinctions emerged in the data regarding the definition of spirituality.

Quantitative survey instrument distributed to CSU health educator participant sample. To validate the initial qualitative responses, a round of quantitative data collection was employed with the CSU health educator participant sample. The survey was administered online, and questions were developed based upon themes that were extracted from the qualitative responses. Quantitative Survey Questions 1 through

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7 included a multiple-point Likert-type scale. Questions 1 and 2 also included an option for participants to include open-ended comments in response to the question: "[Are there] any other elements of the spiritual dimension of health you would like to add?" or "[Are there] any other themes of the spiritual dimension of health you would like to add?" A similar unstructured question was asked at the end of the quantitative assessment to allow respondents to share additional thoughts that were not asked in the quantitative questions.

Answers to the eight survey questions were informed by responses from both the telephone interview questions and the quantitative survey questions. Quantitative data obtained from the survey instrument were intended both as a method of validating the responses gained during the telephone interviews and as a method to broaden the sample from which information was gathered, thus allowing the researcher to generalize the results to the population of all health CSU health educators. Table 3 identifies each interview question with the research question for which it was designed to solicit data.

Pilot Testing

Roberts (2004) recommended that "any time you create your own instrument or modify an existing one, it must be field tested" (p. 138). She recommended a procedure in which five to 10 people are selected "to test the instrument and to make judgments about its validity. The people should not be involved in the study but should be like those in the study" (p. 138). She recommended that the researcher and the participants in the field-test pay particular attention to understandable instructions, clear wording, sufficient detail, difficult sections, irrelevant questions, appropriate length, and convenience. In

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addition, the researcher should ensure that the field-test results in adequate answers. If the instrument is deemed inadequate in any of these recommended characteristics, the instrument should be improved and retested.

Pilot testing was conducted on both sets of participants. To test the interview questions in Phase 1, a department chair within the CSU system was interviewed and responses were recorded and minor adjustments to the interview questions were made. In Phase 2, the survey was initially pilot tested on two CSU instructors who taught personal health courses at the undergraduate level.

Interview Questions 1 and 2 focused on the relevance or irrelevance of the data gained in Phase 1 of the study, as well as placing values to competing definitions of spirituality. Survey Question 8 was an attempt to determine the breadth of opinion among college instructors employed in health education/science departments within the CSU system, and who teach personal health courses at the undergraduate level, of the degree to which they believe spirituality is an important component of the health curriculum at the undergraduate college level.

Theoretical Model

Variables of interest for this study included spirituality, the perceptions of the relationship between spirituality and health, the importance of spiritual health, and what learning objectives should be included. The primary independent variable for this study was spirituality, and the dependent variable was health. One might say then that spirituality is thought to be a cause of health, that spirituality is antecedent to health, or

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rather that improved health results from or is subsequent to spirituality. Researchers often use the terms *independent* and *dependent* to describe different types of variables. Creswell (2008) defined an independent variable as "an attribute or characteristic that influences or affects an outcome or dependent variable" (p. 640). Likewise, Creswell defined a dependent variable as "an attribute or characteristic that is influenced by the independent variable. Dependent variables are dependent or influenced by independent variables" (p. 638).

The causal chain represented in Figure 1 reflects two possible patterns of causation. At the simplest level, the study is based on an assumption that classroom instruction regarding spiritual aspects of health cause (or contribute to) improved health through causal link *a*. A more likely set of relationships is represented by the causal chain *b*→*c*→*d*→*e* in which moderating variables: *(b)* classroom instruction regarding spiritual aspects of health causes or contributes to awareness; (*c*) awareness resulting from instruction results in knowledge; (*d*) knowledge results in healthy behaviors; (*e*) healthy behaviors cause overall good health. Of course, this causal chain presupposes the links also expressed as *f*, *g*, *h*, *i*, and *j*.

This more complex relationship of variables is not implicitly stated in the research questions; however, the questions are general enough to allow for complex responses that may address any or all of these variables, and validate the causal chain represented in Figure 1, or may result in modifications.

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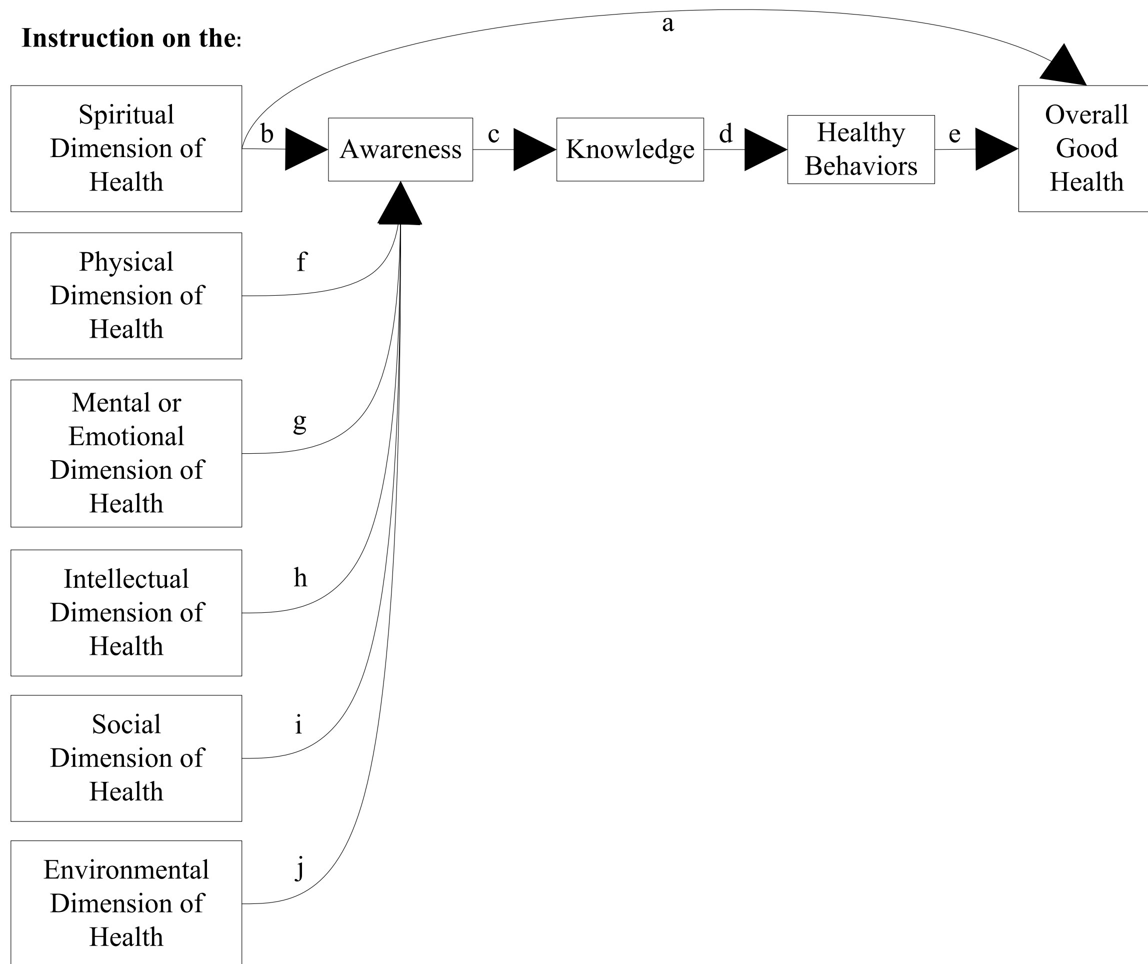

Figure 1. Causal chain of variables linking classroom instruction regarding spiritual aspects of health to improved health.

Data Collection Procedures

The Institutional Review Board (IRB) process for the University of La Verne and the National Institute of Health (NIH) was followed. Following the IRB approval, participants were sent a copy of the consent forms (Appendix A—leaders; Appendix B—CSU educators) along with a letter of invitation (see Appendix C and D) and the

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interview questions (see Appendix E), which were sent to each participant in advance of the interviews. The interview times were jointly agreed upon by the participant and the researcher. All participants were interviewed via telephone in the confines of their offices and/or home.

The interviews begin with an explanation of the purpose of the research, the research methods, and the nature of the participant involvement in the study. Prior to the start of the interview, participants were assured that their identity would be kept confidential, and as required by the IRB for the University of La Verne, they were invited to sign a consent form and/or give verbal consent prior to participation and be audio recorded.

Phase 1. Qualitative Telephone or Semipersonal Focused Interviews

Initial data collection consisted of three recorded telephone interviews, conducted by the researcher on March 11, 2013, March 14, 2013, and March 26, 2013. Each interview was conducted with a leader from each of the four national health organizations, labeled Group 1 participants. At least 1 week in advance of the telephone interview, each participant was provided by e-mail a brief description of the purpose of the research, a set of various definitions (Appendix E) of spirituality previously proposed in the literature. The e-mail also included a copy of the consent form (Appendix A), and confirmed the date and time scheduled for the telephone interview with each leader participant. Participants were assured that neither their personal identity nor the identity of their organization would be released in the dissertation. Participants were asked to

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consider the previously proposed definitions of spirituality, the research questions, and the purpose of the study, and be prepared to provide informed and thoughtful answers to the interview questions. Because of the qualitative nature of the study, the interview was not limited to the specific questions listed in Appendix E but also included questions that emerged during the interview.

Phase 2. Quantitative Surveys, Schedule-Structured Interviews

The data collected from Phase 1 interviews were compiled; themes and patterns were identified and then generated into a question for the second phase of research. Phase 2, a quantitative approach, was used to complement the qualitative approach. A separate set of interview questions was submitted to instructors employed in health education/science departments within the CSU system, who taught personal health courses at the undergraduate level. See Appendix F for survey questions.

Phase 3. Qualitative Semistructured Follow-Up Interviews

A third phase of research relied on qualitative re-interviews with the four national health experts to gain consensus on the definition of spirituality as it relates to health; these were administered June 28, 2013, and June 30, 2013. Experts were presented with three follow-up questions (Appendix G) and asked to reflect on their initial collective responses to agree or disagree with the definition and why. The interviews were conducted in the same manner as the first round of interview questions; consent to participate was verbal, and the responses were audio recorded using an electronic

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recorder. Of the experts, all but one responded to this round of interview questions. Attempts were made to contact this one expert by e-mail and telephone, along with a personal letter of re-invitation mailed to a home address, but the attempts were unsuccessful. See Appendix G for follow-up interview questions.

Instrument Reliability and Validity

According to Krathwohl (2004), "Reliability refers to the consistency of an instrument in measuring whatever it measures" (p. 435). Reliability was tested in this study for its readability and clarity by conducting a field-test of the two data collection survey instruments; this was described earlier. However, reliability is enhanced by "providing evidence of adequate validity and by determining that the resulting measures are consistent" (p. 435).

Validation by Consensus Building

This study is based on the supposition that instruction on the spiritual dimension of health causes or contributes to overall good health. This study did face validity using the expert review. The researcher asked committee members if these interview and survey questions were the right questions. In a sense, every aspect of this study is one of validation. The CSU system has already established that instruction concerning each of the six dimensions of health causes or contributes to overall good health. The study consisted of two phases. In Phase 1, telephone interviews were conducted to formalize the research questions for Phase 2. In Phase 2 of the study, CSU professors teaching

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undergraduate course in personal health responded to a structured survey instrument based on the some of the results of the interviews conducted in Phase 1.

The first phase of the study incorporated a number of interviews with health experts to determine if they judged that supposition to be credible and whether the variables were believed to be related as presupposed. The second phase of the study included those college professors most likely to teach an introductory level health course in the CSU system. Both groups were asked to validate the presumed relationships of the variables. Because the spiritual dimension of health was not taught in introductory level health courses, it was not possible to collect or measure empirical evidence of the effects of the presumed cause. Therefore, those validation steps based on empirical demonstrations that the presumed cause precedes the presumed effect were not possible.

No rival explanations of instruction and overall good health were suggested in the literature, but the general nature of the survey questions in the first phase of the study allowed for rival explanations to surface.

The first phase of the study allowed a small group of experts to consider evidence from the literature and from their own experiences to make judgments of the totality of the presumed cause-and-effect relationship. The second phase of the study allowed a broad group of participants to make a final judgment of the totality of that conceptual evidence.

Krathwohl (2004) explained that the “evidence that permits the inference of whether,” that the supposed cause leads to the expected effect, “is described by a concept called internal validity” or “linking power,” otherwise described as “the capacity

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provided by a research study for readers to link cause to effect" (p. 137). Yet, he also described a second type of validity, external validity, "the capacity provided by a research study for readers to generalize the [causal] relationship beyond the study's particular constellation of circumstances" (Krathwohl, 2004, p. 137).

External Validity:
Generalizing Conclusions

The second phase of this study included the entire population of teachers likely to teach undergraduate courses in personal health, thus eradicating the potential that any racial, social, geographical, age, gender, or personality groups were underrepresented in the responses. Participants were solicited from all California colleges and universities that offer undergraduate courses in personal health, thus eradicating the potential that any setting of interest was underrepresented in the responses.

Responses were collected from participants during one limited time range during the spring of 2013. Therefore, the study did not consider threats to external validity that might result over time. However, because the way that students learn is not thought to vary with seasons or over relatively short periods of time, it is not likely that this limitation would result in a threat to the validity of the study.

Creswell (2008) explained that there are three major problems that "threaten our ability to draw correct inferences from the sample data to other persons, settings, and past and future situations" (p. 310). These threats include the following:

1. Limitations of the sample to include an adequately broad range of "racial, social, geographical, age, gender, or personality groups" (p. 310).

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2. Limitations of the sample to include an adequately broad range of “settings” where the study was conducted or from which the data were collected (p. 310).
3. Limitations of the sample to include and adequately broad range of times at which the data were collected.

Data Analysis

Research Question 1 focused on the degree and nature of agreement/disagreement on the definitions of spirituality as it relates to health instruction at the university level. Research Question 2 focused on the perceived relationship between spirituality and health. Research Question 3 focused on perceptions of the importance of spirituality in the health curriculum at the undergraduate level. Research Question 4 focused on perceptions of how best to teach spirituality at the undergraduate college level.

Qualitative Data Analysis: Phases 1 and 3

The telephone interviews conducted in Phase 1 of the study asked broad general questions (Appendix E) to collect detailed views of four highly respected expert leaders of organizations in the field of health education. The interviews resulted in four sets of transcripts.

Denzin and Lincoln (2000) recommended a method for analyzing textual evidence obtained from qualitative approaches. The researcher focused on key words in context, word counts, and textual coding. After the four recorded interviews were transcribed, the researcher reviewed all of the data twice before developing a preliminary

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list of key words. A variety of colored highlighters were used during the preliminary reviews to identify similar key words. Subsequently, the four transcripts were merged into a single common document, and the researcher conducted a search for each of the key words identified earlier and marked with an identifying color. The researcher then compiled a list and frequency count of the key words, sorted and grouped by respondent and by research question. (The list was used to find patterns from the interview responses from the four participants to the open-ended questions.) Before adopting the resulting themes, the researcher compared them with major themes identified in the literature to determine which were supported in the literature and which were not.

Once the qualitative data were coded and analyzed, the initial results were compiled into a single composite document, sorted by research question and by key themes. If necessary, the data were redacted to ensure that the identity of the respondents was protected. Respondents were identified as being Participant 1, Participant 2, Participant 3, and Participant 4. After, the responses to the initial interviews were transcribed, they were coded, summarized, and organized into themes.

Quantitative Data Analysis: Phase 2

Data from Phase 2 of the study, those which were gained from quantitative Interview Questions 1-7 (Appendix F), were generated from responses from university professors/instructors employed in health education/science or public health departments within the CSU system, and who taught personal health courses at the undergraduate level. In addition to the quantitative data requested, the survey also allowed for

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qualitative responses. The qualitative surveys resulted in 14 response documents, a 70% response rate.

Data from the quantitative results were analyzed with descriptive statistics. Qualitative responses gained from Phase 2 of the study were analyzed using the same procedures identified Phase 1 (see Figure 2).

Limitations

Roberts (2004) described limitations as features of a study the researcher knows in advance "may negatively affect the results" or limit the "ability to generalize" the results to a broad population (p. 146). The major limitation of this study was the relatively small sample size of highly respected experts in the field of health education. In addition, the sample of participants in the quantitative section of the study was limited to nonsecular institutions of higher learning in California. The descriptive component of this study was limited to participants' self-reported perceptions of spirituality and health. Also, since there were only four national health leaders, the findings may not be generalized to other professions or organizations.

The interpretation between responses may differ with each individual answering the question. This study was limited to the openness/receptiveness of the individuals answering the questions about spirituality.

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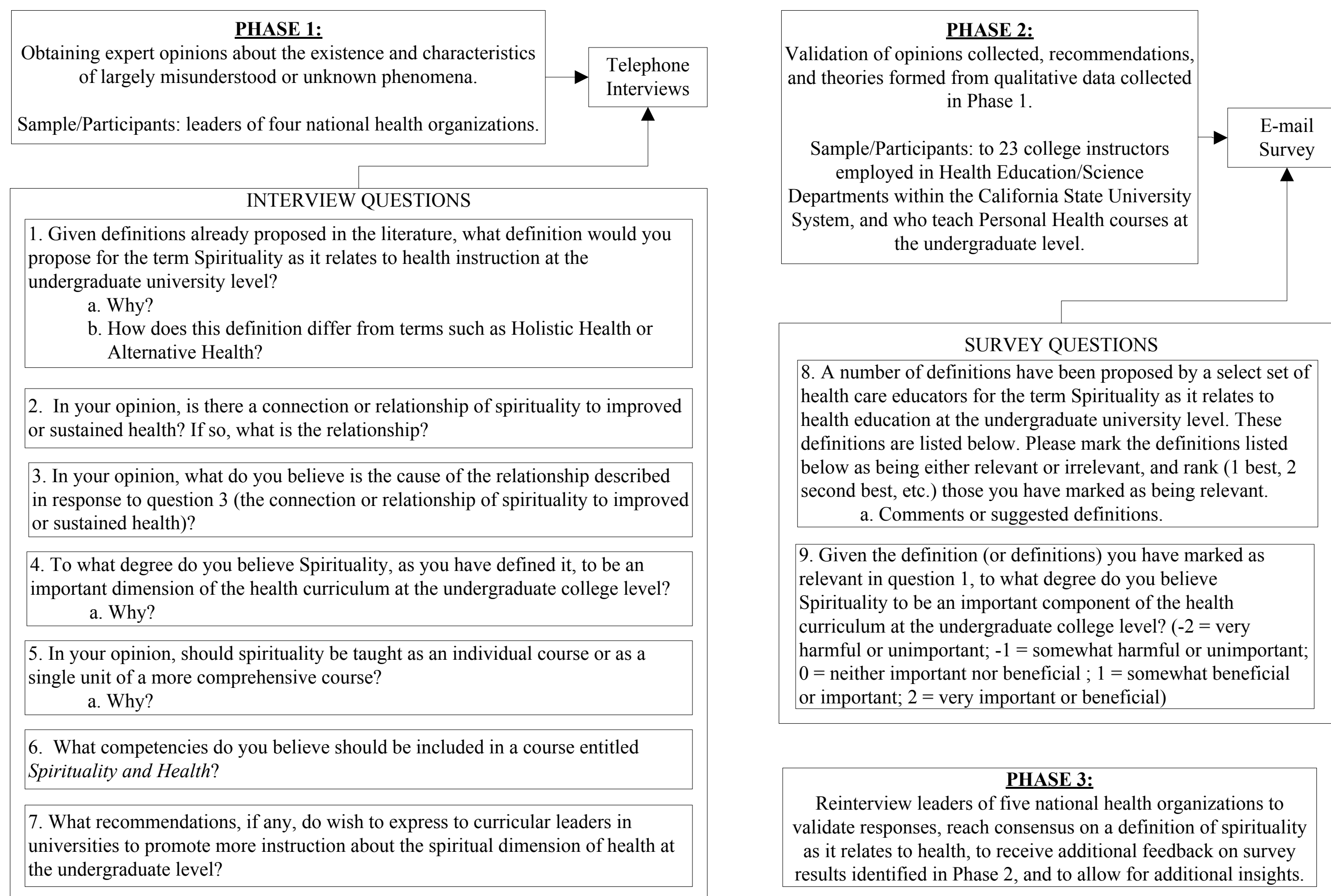

Figure 2. Visual representation of the method of the study.

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Summary

The purpose of this chapter was to describe the research design and methods for the study. This study explored the participants' thoughts and beliefs regarding a definition for the spiritual dimension of health, and the potential competencies that should be included in a college class, unit, or sequence on spiritual health. The chapter restated the purpose and research questions, the sample population interviewed, data collection procedures, and methods of analyzing the data. The next chapter presents the findings of this study.

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CHAPTER IV

ANALYSIS OF THE DATA

Chapter IV presents the purpose of the study, the research questions, a review of the methodology used and a description of the subjects who provided data for the study, and an analysis of the data as they pertain to the five research questions. The chapter provides a description of the qualitative data obtained from interviews with acknowledged experts, and quantitative data obtained from current practitioners. This chapter is divided into the following sections: (a) purpose of the study; (b) the research questions; (c) research design, methodology, and selection of subjects; (d) data collection; (e) presentation of the data by research question; and (f) summary of the findings.

Purpose of the Study

The purpose of this study was to establish a definition of spirituality containing all characteristics essential to the development of optimum health, a definition capable of effectively guiding the development of a curriculum or program in spirituality and health for undergraduate programs in college health science departments. Specifically, the first aim of this study was to gain consensus on such a definition among a select group of

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national health organization leaders and among university health educators within the California State University (CSU) system. For purposes of this study, this was described as a consensus definition. The second purpose of this study was to identify which aspects of spiritual health objectives/learning outcomes should be taught/included in a college health education curriculum (unit, sequence, or course) and why. The knowledge gained by this study was intended to provide valuable policy guidance to college health programs on CSU and college campuses and other academic institutions, for development of a full range of health courses to meet the needs of college-aged students.

Research Questions

The following research questions were developed for this study:

1. What is the degree and nature of agreement/disagreement on the definitions of spirituality as it relates to health instruction at the university level?
2. What is the relationship between spirituality and health as perceived by university health educators and key leaders within national health organizations?
3. What are the perceptions among health educators and key leaders within national health organizations pertaining to the importance of spirituality in the health curriculum at the undergraduate level?
4. What are the perceptions among health educators regarding the barriers to teaching spiritual health at the undergraduate college level?

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5. What learning objectives do university health educators and key leaders of national health organizations believe spirituality as it relates to health should be included at the undergraduate college level?

Research Design, Methodology,
and Selection of Subjects

This study was designed to use mixed methods. The first phase of research conducted in this study relied on qualitative data collected from a sample of leaders from national health organizations using broad, general interview questions in which the detailed views of participants were collected and analyzed. The qualitative research perspective captured the intricate details about the participants' feelings, thoughts, emotions, and processes, all of which were viewed as critical to this study. The second phase of research relied on quantitative data collected from a broader set of educators employed within the CSU system who teach personal health courses at the undergraduate level. The data collected from expert interviews of the first phase of the study were used to develop an online survey, which was administered to the second group of participants.

The researcher used the following criteria to select the target population for this study. The population for this study consisted of two related populations. The first sample population was health education leaders from national health organizations. The second sample population consisted of health educators who teach within a CSU system. Purposive sampling was used to identify the key leaders as well as health professors within the population that met the specific criteria. The criteria for selection for each sample population were as follows:

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Health Education Leader
Participant Sample

The first sample was chosen based upon their (current or former) leadership role in a national health organization within the health education profession, for example, American Association of Health Education (AAHE), American Public Health Association (APHA), National Commission for Health Education Credentialing (NCHEC), and American Public Health Association (ASHA). These organizations are widely recognized accrediting bodies/organizations within the health education profession. Four participants, all of whom met the desired criteria, were identified to participate in the first part of the study. All four of the identified subjects agreed to participate and ultimately completed the interview process.

All four participants served in a leadership role with AAHE and APHA at one time during their career. Additionally, three of the four served as leaders of the ASHA, two served on the Joint Commission on Health Education and Promotion (2012) terminology report, and two of the four expert leaders consulted/served with NCHEC on developing professional health education standards. Finally, all four participants were former professors who taught a personal health course or similar course during their tenure as faculty. One of the four key leaders actually taught a course on spiritual health at a major university.

The researcher contacted each leader via e-mail with a letter of invitation to participate. If the leader agreed to participate, a copy of the interview questions and a consent form was e-mailed. The researcher conducted telephone interviews with four

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health leaders from March 4, 2013, to March 22, 2013. Each participant was asked seven interview questions. Each interview lasted approximately 30 minutes. At the beginning of each telephone interview, participants gave verbal consent to being audio recorded (see IRB, Consent form; see Appendices A and I). Audio tapes of each interview were downloaded onto the researcher's secure computer and then transcribed. Main themes, patterns, and ideas were logged in a Word document. The *Handbook of Qualitative Research*, edited by Denzin and Lincoln (2000), suggested analyzing text by looking at key words in context lists (KWIC), key words, and coding. Denzin and Lincoln offered suggestions and deeper interpretations of qualitative data that can assist researchers with forming more comprehensive conclusions.

California State University (CSU)
Health Educator Participant Sample

The second sample consisted of health educators who teach a personal health course at the undergraduate level within a health education, health science, and/or public health department at one of the 23 campuses within the CSU system. Of the 23 CSU campuses, only 15 have a health education, health science, or public health department (Table 4). From those 15 campuses, a population of 20 potential participants was identified, 14 of whom responded to the survey, for a 70% response rate. Follow-up e-mails and personal telephone calls were made to each of the remaining CSU educators inviting them to participate in this study.

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Table 4

CSU Health Educator Population and Sample Details

Category	*n*	%
Total identified respondents	20	100%
Total responded	14	70%
Total who failed to respond	7	35%

Health Education Leader Participant Validation

To validate the findings and conclusions reached in the first two rounds of data collection and analysis, a third round of data collection was employed in which the original four health educator leader experts were re-interviewed and asked to review and reflect on the findings gained from the original interviews (qualitative data) and the online surveys (quantitative data), and to share their insights and express agreement or disagreement with the results.

Presentation of the Data by Research Question

Research Question 1

What is the degree and nature of agreement/disagreement on the definitions of spirituality as it relates to health instruction at the university level?

Responses were categorized and analyzed in two different stages. First, responses solicited from telephone interviews with the sample of four highly respected health education leaders were analyzed in accordance with the methods described in Chapter III.

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Responses to qualitative telephone Interview Question 1: Definition of spirituality. Interview Question 1 asked, "Given definitions proposed in the literature, what definition would you propose for the term *Spirituality* as it relates to health instruction at the undergraduate university level?"

After the four recorded interviews were transcribed, the researcher reviewed all of the data twice before developing a preliminary list of key words. A variety of colored highlighters were used during the preliminary reviews to identify similar key words. Subsequently, the four transcripts were merged into a single common document and the researcher conducted a search for each of the key words identified earlier and marked with an identifying color. The researcher then compiled a list and frequency count of the key words, sorted and grouped by respondent and by research question (Appendix E). The list was used to find patterns from the interview responses from the four participants to the open-ended questions. The key words, phrases, and themes were collected into a codebook. Finally, the researcher created a theme tree to map the recurring themes in the data. Before adopting the resulting themes, the researcher compared them with major themes identified in the literature to determine which themes were supported in the literature and which were not. Once the qualitative data were coded and analyzed, the initial results were compiled into a single composite document, sorted by research question and by key themes. If necessary, the data were redacted to ensure that the identity of the respondents was protected. Respondents were identified as being Participant 1, Participant 2, Participant 3, and Participant 4.

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The data indicated very little agreement among the four highly respected health education leaders on the essential elements of the definition/purpose of spirituality. Table 5 illustrates that, while the four health education leaders cumulatively proposed 10 different important elements of a definition of spirituality as it relates to health education at the university level, there was no single theme identified by all four participants.

Table 5

Responses to Interview Question 1. Expressed Elements of a Definition for Spirituality as it Relates to Health Instruction

	Experts			
Initial responses	P1	P2	P3	P4
Essential animating life force, source of will, determination, loyalty, dedication				X
Source of well-being, inner calm, peace, or transcendence	X		X	X
Source of purpose, significance, quest for a personal or universal meaning in life		X		X
Source of inspiration	X			X
Source of satisfaction w/life		X		
Source of emotional confidence	X			
Source of mentorship of well-being	X			
Integral element of optimal health, in combination w/other dimensions of health	X			
Supports individual efforts to support health improvement of others	X			
Subjective and personal			X	

Note. Initial responses from experts show little agreement on definition.

There was consensus by three of the four participants (Participants 1, 3, and 4) that a definition should express that spirituality is a “source of well-being, inner calm,

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peace, or transcendence." Two participants (Participants 2 and 4) agreed that spirituality is a "source of purpose, significance, quest for a personal or universal meaning in life." Two participants (Participants 1 and 4) agreed that spirituality is a "source of inspiration." Each of the remaining elements was expressed by only a single participant.

Participant 1 identified six of the 10 different themes as being important elements to a definition, stating,

> Spirituality is a source of inspiration for an individual to have confidence in achieving well-being and helping others do so. The spiritual dimension of health, in combination with the physical, social, emotional and environmental dimensions, provides the potential for the individual to achieve optimal health status. Also, it provides the potential for the individual to help others, individually or collectively, improve their health status.

Participant 4 identified four themes, claiming that spirituality is "the quality of the functioning of the vital principle(s) and animating force(s) within people." It is "the essential and activating principle(s) of a person . . . the will, loyalty or dedication . . . the real sense of significance of a person." A definition of spirituality also includes

> the advancement of an aspect of self as part of a personal quest for understanding answers to ultimate questions about life, about meaning and about relationship to the entire universe and becoming transcendent of the world we see, touch, sense and feel. Some individuals and cultures may develop and utilize religious rituals to seek this transcendence and others may develop and practice other forms of individual or community interactions to reach these levels.

Participant 4 also added,

> I see spirituality as a health dimension, which allows a person or communities to experience a more transcendent meaning in life. Here people have the ability to override the mere physical realities of their life can express a relationship with all aspects of the university with a level that goes beyond the sense of self as merely their body and their mind. This may be a "god" figure for some people, but it can also be about nature, art, music, family, or community for others. It depends upon

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> whatever beliefs and values give a person has adopted as a sense of meaning and purpose in their life.

Participants 2 and 3 each identified two important themes. Participant 2 stated, simply, that “spirituality relates to purpose and meaning in life. It is important that you/people/individual live your life with purpose and people who do are more satisfied with their lives.”

Participant 3 expressed that spiritual health is

> much more than religion, it is whatever brings a person to a calmness within. Many would characterize it. I really get into it when I do yoga, or listen to calming music, or feel that inner calmness or piece when read the Bible, or going to a concert. Very subjective and very individual and very personal. A lot of different things can get you to that moment. Calmness, what it boils down to . . . people looking for that calmness transcended to someplace else.

The themes identified from responses to Interview Question 1 were used to formulate online quantitative Survey Question 1. The responses appeared overly broad. Therefore, the researcher sorted through the major themes and identified common elements such as the concept of connection to and compassion for others as spirituality relates to the definition of spirituality, or the concept that spirituality relates to purpose and meaning in life. The following key elements emerged from Interview Question 1: (a) compassion for others; (b) purpose and meaning in life; (c) collective, connected to and with other people; (d) calmness and inner peace.

Response to online quantitative Survey Question 1: **Definition of spirituality.** Table 6 and Figure 3 illustrate the responses from 14 CSU health educators to online quantitative Survey Question 1: “Selected health experts have identified elements of the term Spirituality as it relates to health education at the undergraduate university level.

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These ELEMENTS of the spiritual dimension of health are listed below. Please mark the terms below as being either RELEVANT or IRRELEVANT."

Responses were collected on a 5-point Likert-type scale, and response options included 1 (*irrelevant*), 2 (*somewhat irrelevant*), 3 (*neither irrelevant nor relevant*), 4 (*somewhat relevant*), and 5 (*relevant*). Table 6 presents the mean and standard deviations of responses.

General consensus was evident for each of the four proposed definitional elements of the term spirituality as it relates to health education at the undergraduate university level.

Table 6

Expressed Elements of a Definition for Spirituality as it Relates to Health Instruction

Proposed definitional element	*n*	%	Mean	*SD*
Purpose and meaning in life	13	92%	4.50	1.09
Compassion for others	12	85%	4.21	1.42
Collective, connected to and with other people	12	85%	4.43	1.16
Calmness/inner peace	11	80%	4.07	1.38

The mean response from CSU health educators was greater than 4.0 for each of the proposed elements, indicating that, in general, respondents perceived each of the proposed elements to be *relevant* or *somewhat relevant*. Of the proposed elements, responses to *purpose and meaning of life* resulted in the highest mean score, 4.50, and the lowest standard deviation, 1.09 (therefore the greatest agreement). The lowest mean

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score resulted from responses to *calmness and inner peace*, with a mean of 4.07 and a standard deviation of 1.38.

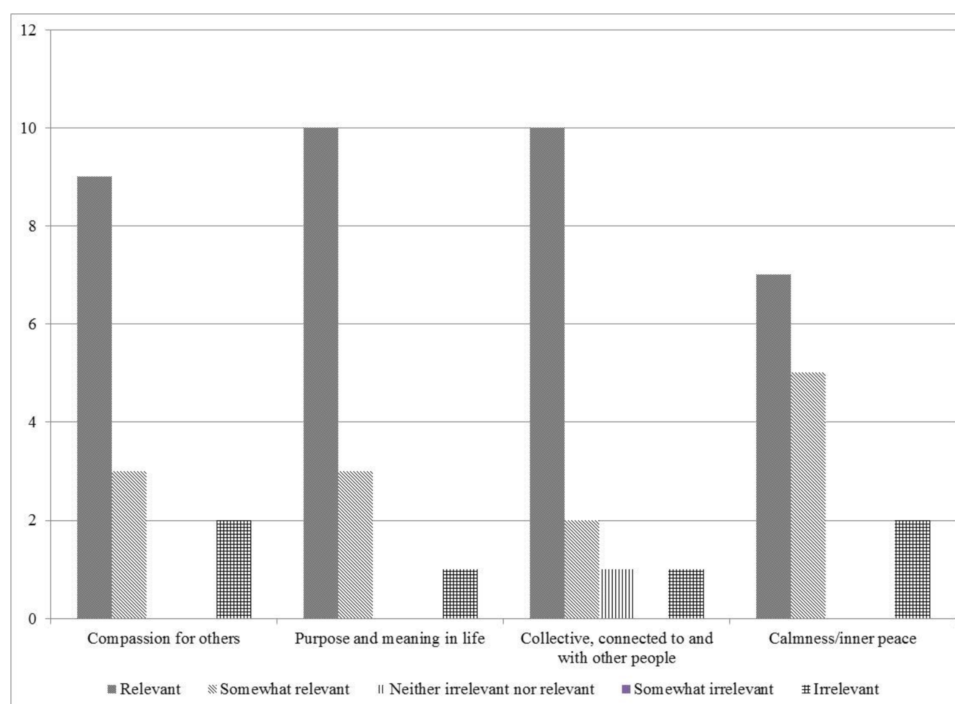

Figure 3. Frequency of responses to quantitative Survey Question 1, "Selected health experts have identified elements of the term Spirituality as it relates to health education at the undergraduate university level. These ELEMENTS of the spiritual dimension of health are listed below. Please mark the terms below as being either RELEVANT or IRRELEVANT."

The frequency of responses to each of the four themes is displayed in Figure 3. Notice that at least one respondent for each element indicated that element to be irrelevant to health education at the undergraduate university level.

In response to an open-ended question that asked for other missing elements, one respondent recommended adding an element to the definition entitled *cultural humility*.

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Another respondent recommended adding an element described as "consideration of self in relation to the universe at large as well as the day-to-day environment: people, nature, weather, etc."

Response to online quantitative Survey Question 2. Table 7 and Figure 4 illustrate the responses from 14 CSU health educators to online quantitative Survey Question 2: "Listed below are common THEMES of the spiritual dimension of health recognized by selected health experts. Please mark if you AGREE or DISAGREE with each theme listed."

Responses were collected on a 5-point Likert-type scale, and response options included 1 (*strongly disagree*), 2 (*somewhat disagree*), 3 (*neither agree nor disagree*), 4 (*somewhat agree*), and 5 (*strongly agree*). Agreement was weaker for this survey question than for Survey Question 1. Table 7 presents the mean and standard deviations of responses describing the perceived degree of agreement with four proposed elements identified by health experts.

The mean response from CSU health educators was greater than 4.0, *somewhat agree* or *strongly agree*, for only one of the proposed themes, *Spiritual health is individual, subjective, and very personal*, with a mean response of 4.36 and a standard deviation of 1.15. The mean response for the theme, *Spiritual health is connected to and is the driving force to all other dimensions of health*, was 4.00, for an average response of *somewhat agree*, and with a standard deviation of 0.78. Mean responses between 3.00 and 4.00, *neither agree nor disagree* to *somewhat agree*, resulted from responses to the remaining two questions. Responses to the theme, *Spiritual health can transcend an*

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individual, resulted in a mean score of 3.86 with a standard deviation of 0.95. Responses to the theme, *Spiritual health leads to optimal health*, resulted in a mean score of 3.64, with a standard deviation of 1.15. The frequency of responses to each of the four themes is displayed in Figure 4.

Table 7

Degree of Agreement of CSU Health Educators With Each of Four Spiritual Dimensions of Health Recognized by Health Experts

Proposed theme	Mean	*SD*
Spiritual health is individual, subjective, and very personal	4.36	1.15
Spiritual health is connected to and is the driving force to all other dimensions of health	4.00	0.78
Spiritual health can transcend an individual	3.86	0.95
Spiritual health leads to optimal health	3.64	1.15

In response to the question regarding spiritual health leads to optimal health, one respondent warned that “Spiritual over-doing, like any other dimension, can lead to imbalance and therefore less-than-optimal health overall. It is important, yes, and it must be balanced as reasonably and practically.”

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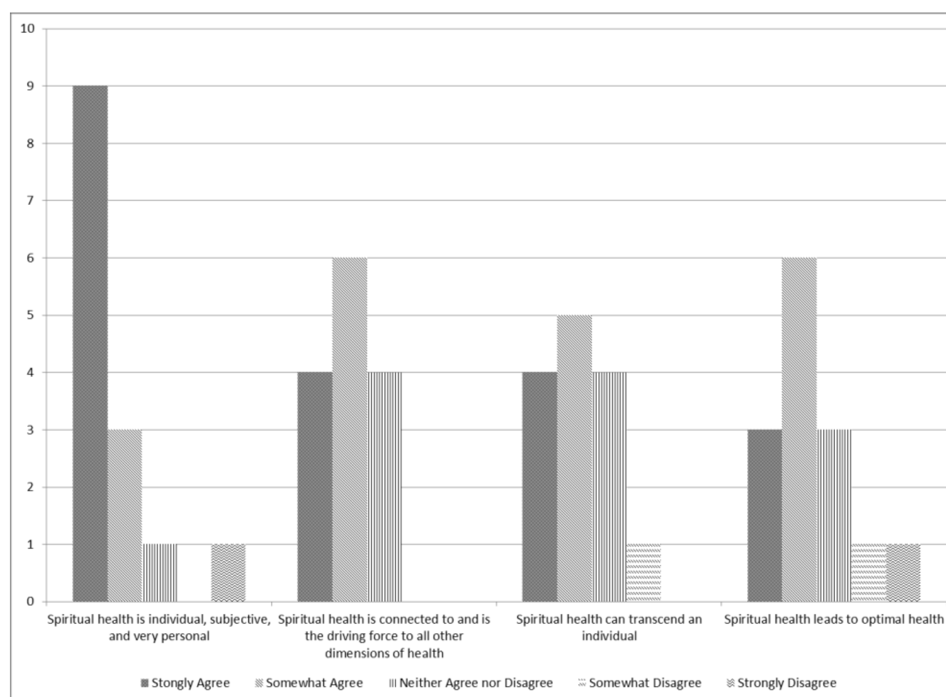

Figure 4. Frequency of responses to quantitative survey question, “Listed below are common THEMES of the spiritual dimension of health recognized by selected health experts. Please mark if you AGREE or DISAGREE with each theme listed.”

Responses to qualitative Re-interview Question 1. After the initial data were compiled and analyzed, and after college health instructors responded to related questions, a second round of semistructured interviews was conducted with the four health experts as a means to gain consensus on the definition of spiritual health. Consensus was defined as three of the four who responded to the follow-up questions all agreed. Each of the experts was asked to reflect on their initial responses to the spiritual dimension of health, the responses of the three other experts, to confirm that the analysis accurately reflected their initial response, and to comment on the information offered by all other respondents. The experts agreed on the following definition:

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> *Spirituality*, as it relates to health education at the university level, is one of the six major dimensions of human health. It is comprised of subelements that, when functioning well, supports the animating aspects of life. Healthy spirituality supports the four major types of essential intertwined aspects of a balanced life:
> 1. **Purpose and meaning in life:** consisting of inspiration, a sense of personal significance, and satisfaction with life.
> 2. **Will**: consisting of determination, dedication, and emotional confidence.
> 3. **Selflessness:** consisting of loyalty, mentorship, and compassion for others.
> 4. **Calmness or inner peace:** consisting of transcendence, inner calm, a sense of peace and well-being, and motivation for quest for a universal meaning of life.

Participant 4 agreed with all of the above definition and proposed a fifth item: **Vision:** consisting of a clear sense of one's place in the human existence. Participant 3 agreed with the proposed definition and recommended the definition be simplified further, to become:

> *Spirituality*, as it relates to health education at the university level, is the synergistic dimension of health that, when functioning well, supports the animating aspects of life and the other five dimensions of a balanced life:
> 1. **Purpose and meaning in life:** consisting of inspiration, a sense of personal significance, and satisfaction with life.
> 2. **Will:** consisting of determination, dedication, and emotional confidence.
> 3. **Selflessness:** consisting of loyalty, mentorship, and compassion for others.

Research Question 2

What is the relationship between spirituality and health as perceived by university health educators and key leaders within national health organizations?

Responses were solicited in telephone Interview Questions 2 and 3 from the sample of four highly respected health education leaders were analyzed in accordance with the method described in Chapter III.

Response to Interview Question 2: Connection—spirituality and health. Interview Question 2 asked, "Is there a connection or relationship of spirituality to

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improved or sustained health? If so, what is the relationship?" As with the responses to Interview Question 1, there was little agreement among the four highly respected health education leaders on the essential elements of the Research Question 2, which asked participants about the relationship that exists between spirituality and improved health. The four participants agreed there is a connection/relationship and that spirituality is a connective link that ties the different dimensions of health together; however, how they described the relationship varied. The results are displayed in Table 8.

Table 8

Response to Interview Question 2. Expressed Description of Connection or Relationship of Spirituality to Improved or Sustained Health

	Expert			
Response category	P1	P2	P3	P4
Source of inspiration to achieve well-being	X			
Source of inspiration to help others achieve well-being	X			
Synergistic element, along with other six dimensions of overall optimal health	X			X
Spiritual core is mechanism by which all six dimensions of health interact				X
Purpose in life drives decisions and leads to satisfaction with life		X		
Increased spirituality leads to improved physical health			X	

Note. There was little consensus among experts.

Two participants agreed there was a synergistic element, along with the other six dimensions of overall optimal health. There was no agreement on any of the other identified elements. Participant 1 identified three of the themes, commenting,

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> Yes, there is a connection or relationship of spirituality to improved or sustained health. Spirituality serves as a source of inspiration for the individual, group, or population to work toward an optimal level of physical, social, emotional, and environmental well-being, which increases the potential for optimal overall well-being.

Participant 2 stated,

> I think there is a connection between having a purpose in life is what drives the decisions you make in life. So, it becomes important that you live your life with purpose and people who do tend to be more satisfied with their life so that's my connection. And, this ties in with definition of spirituality.

Participant 3 claimed,

> Yes, sure that's been shown a lot with cancer and laughter as the best medicine. When one has that inner feeling, for example Valerie Harper . . . she knows she isn't going to beat this, but will live life to the fullest. A lot of branches missing, don't see it [spiritual health] across board. If you look at curricula, of maybe 300 programs in Health Ed across the U.S., maybe five have history of health education. We stand on the shoulders of others . . . people who have dealt with the spiritual dimension and what can happen and know the cause of the relationship.

Participant 4 identified two of the key themes,

> There are of course many ways all six of dimensions synergistically interact such as the nervous systems, circulatory system, the endocrine system, the lymphatic system. However, I propose that there is also a spiritual "core" that also provides a significant level of inter-relatedness among the dimensions.

Participant 4 described a personal model of health in which

> all six of the dimensions are connected to one another through in many ways but I also include what I call the spiritual core. Thus, the spiritual dimension is more than just a major facet of health, it provides another mechanism by which all six of the dimensions communicate and interact.

Response to follow-up Interview Question 2: Connection-spirituality and health. The health experts were asked to reflect on their initial responses to Interview Question 2, specifically, to agree or disagree with the identified themes as legitimate and

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important answers to the question regarding a connection or relationship of spirituality to sustained health. There was general consensus that there is a connection of spirituality to sustained or improved health and that the themes were all legitimate. Participants 2 and 3 believed that spirituality is the synergistic element or core of all other dimensions.

Participant 3 stated, “The key item on this list is synergistic element/core. You can tie all other items on this list such as source of inspiration back to the core element.” Participant 4 clarified the relationship,

> Items 1 [source of inspiration to achieve well-being], 2 [source of inspiration to help others achieve well-being], 5 [purpose in life drives decisions and leads to satisfaction with life], and 6 [increased spirituality leads to improved physical health] are dependent upon spirituality being in good to very good condition. In the same way, physical health can have positive or negative impact on spiritual or social health. What happens if spiritual health is weak or really sick? I agree with Item 3, synergistic element, along with the other five dimensions of overall optimal health

Response to Interview Question 3: Cause of relationship. Interview Question 3 asked, “What do you believe is the cause of the relationship described in response to question 2 (the connection or relationship of spirituality to improved or sustained health)?” There was considerable agreement on one causal factor, that spirituality is the synergistic mechanism by which all six dimensions of health interrelate. A summary of the responses is displayed in Table 9.

Three of the four respondents, 75%, indicated they believe spirituality is the synergistic mechanism by which all six dimensions of health interrelate. Two of the four, 50% of the sample, agreed that spirituality is a synergistic element of overall optimal health.

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Table 9

Interview Question 3: Stated Causes of the Relationship of Spirituality to Improved Sustained Health

Causes	Experts			
	P1	P2	P3	P4
Spirituality is the synergistic mechanism by which all six dimensions of health interrelate	X		X	X
Spirituality makes life meaningful and leads to a sense of fulfillment & purpose (Erickson)		X		
Synergistic element, along with other six elements, of overall optimal health			X	X
Humans are hardwired with interconnected dimensions of health, but to be effective it must be developed				X

Note. There was some agreement.

Participant 1 commented that "spirituality, when harnessed properly, serves as the source of positive inspiration for the individual, group or population to act in the manner necessary to harness the benefits of the other dimensions of health." Participant 2 referred to Erickson's (1950) last stage of development, stating,

> It's the question of "has or does my life have meaning?" Too many people live their life without meaning. From a health perspective, doing things that are meaningful in life is what gives us fulfillment. Yes, it is very subjective, up to each individual to find what gives [his or her] life meaning and purpose.

Participant 3 identified two of the key themes, that not only is spirituality an important element in the synergistic relationship among the six elements of health, but that spirituality is the mechanism by which the elements interrelate: "These ideas are all tied together. Yes, the research supports this and anyone who has dealt with change, crisis, [or] illness in their life can better understand the connection."

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Participant 4 identified three of the four key themes in a metaphor of a behavior of which people are all familiar.

> The cause would have to be related to the fact that we are all "hardwired" that way. There are many aspects of life that we do not have an on-going awareness of on a day-to-day basis. For example, when we first get dressed in our clothing we can all "feel" the fact that we now have clothing on our bodies. However, in a few seconds your senses adjust to these sensations and for the rest of the day we may "know" we have clothing on but we do not sense it or feel it. In fact, we do not pay much attention to the clothing of others unless they have NO clothing on their bodies. In the same fashion, we all have the interconnectedness of the dimensions of health but over our lives we need to learn how to sense, recognize, and utilize these relationships. Unfortunately, we have not developed the skills necessary to do this and, for the most part, very few of our predecessors have learned how to do this and thus we have no educators to help us learn the needed abilities.

Research Question 3

What are the perceptions among health educators and key leaders within national health organizations pertaining to the importance of spirituality in the health curriculum at the undergraduate level?

As in Research Question 1, the responses were categorized and analyzed in two different stages. First, responses to Interview Questions 4 and 5 were solicited from telephone interviews with the sample of four highly respected health education leaders and were analyzed in accordance with the method described in Chapter III. Then quantitative data were collected from 14 CSU health educators in response to Survey Questions 4, 5, and 6.

Response to telephone Interview Question 4: Spirituality in health curriculum. Interview Question 4 asked, "To what degree do you believe Spirituality, as

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you have defined it, to be an important dimension of the health curriculum at the undergraduate college level?"

There was overall general agreement on this question. All four participants agreed that spirituality is important and should be in the health curriculum at the undergraduate level. Each of six key themes was expressed by two of the participants. Two participants believed spirituality can be at least a unit within a health course. Two other participants agreed that spirituality should be a separate elective course in the minor curriculum and a required course within the major (health) curriculum. Participant 3 suggested, "Spirituality should receive the same level of focus and study as all the other dimensions (of health)." Participant 4 stated, "We need to build many more resources, teaching methods and techniques, and assessment instruments for spirituality to match those that we have for most of the other dimensions." A summary of the responses is displayed in Table 10.

Table 10

Rationale in Support of Conclusion That Spiritual Health Should Be Included in Undergraduate Level Courses

	Experts			
Rationale	P1	P2	P3	P4
Important to overall health, therefore should be included	X		X	
Essential element of being a good person and living a meaningful life		X		
Spirituality should definitely be incorporated . . . not from a religious standpoint, but from health education			X	
Spirituality should receive as much attention as other dimensions . . . possibly more because it is ignored				X

Note. There was some agreement.

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Participant 1 commented,

> Spirituality is an important dimension of health and, therefore, must be addressed in the health curriculum. It should be a unit in a personal health course, which serves as a general education course requirement or a foundation course in a major or minor curriculum. It should be an elective course in the minor curriculum and a required course in the major curriculum. It should be addressed as a key dimension of health in the capstone course of the major curriculum.

Participant 2 reflected on classroom experiences and noted,

> Spiritual health has been often neglected. When I taught, I really tried to get my students to be good people . . . teach them about good values, morals, ethics, and to do good, meaningful things with their lives. If they wait until they are 80 to do meaningful, good things with their life, it is too late. If they are 20 and asking that question, they can figure it out and do meaningful things with their life.

When asked if the students were responsive to this guidance, Participant 2 believed that possibly half of the students were responsive, and half were not:

> They thought I was crazy anyway. One time I asked them to go home and call their parents and tell them they love them. In the next class I learned the dialogue with the parents was receptive for students. I tried to bring real life experience into the classroom as it relates to the spiritual dimension.

Participant 3 stated, simply, that "Yes," spirituality should "definitely be incorporated . . . not from a religious standpoint, but from a health education or calmness standpoint." Participant 4 stated,

> Spirituality should receive the same level of focus and study as all the other dimensions. In fact, we may need to initially dedicate more time to spirituality since, for the most part, we have been focusing on the physical, emotional, and mental dimensions to a greater extent that the social, vocational, and spiritual dimensions. We need to build many more resources, teaching methods and techniques, and assessment instruments for spirituality to match those that we have for most of the other dimensions. With these resources more comprehensive and effective approaches to health in whole and spirituality in specific can come to fruition.

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Responses to qualitative telephone Interview Question 5: Individual or single unit course. Interview Question 5 asked, "In your opinion, should spirituality be taught as an individual course or as a single unit of a more comprehensive course?" Three of the respondents believed spiritual health should be taught as a single unit in a more comprehensive course. However, Participant 1 suggested a more comprehensive course for students with a major or minor in health. Participant 3 suggested that spirituality be taught neither in a single unit, nor as an individual course, but should be integrated into the entire curriculum (see Table 11).

Table 11

Responses to Whether Spirituality Should Be Taught as an Individual Course or as a Single Unit of a More Comprehensive Course

Responses	Experts			
	P1	P2	P3	P4
Spirituality should be taught as an individual course	X			
Spirituality should be taught as a single unit in a more comprehensive course	X	X		X
Spirituality should be integrated into other courses and units			X	

Note. There was considerable agreement.

Participant 1 identified two different approaches, depending on the goals of the student.

> Spirituality is an important dimension of health and, therefore, must be addressed in the health curriculum. It should be a unit in a personal health course, which serves as a general education course requirement or a foundation course in a major or minor curriculum. It should be an elective course in the minor

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> curriculum and a required course in the major curriculum. It should be addressed as a key dimension of health in the capstone course of the major curriculum.

Participant 2 believed spirituality is best taught as a single unit in a more comprehensive course, arguing, “It is a component of health. We talk about physical, emotional, mental, social, it is good to have the spiritual dimension of health in there—it touches all of those things.” One problem Participant 2 identified with teaching spirituality is that it is “often neglected and there is nothing in the books. So if you teach it, it’s often on your own.” Because so little was available in instructional materials, Participant 2 “used to tell students, I do not care where you find your spirituality (for me it is a walk in nature), it doesn’t matter where you find it, as long as you take some time to search for it (volunteer, walk in nature, religion).”

Participant 3 took a different approach, arguing that spirituality is best taught, not as a single unit nor as an individual course, but as an integrated element in the curriculum, claiming,

> The expanded concept [spirituality] is part of the services component in the K-12 Health Education instruction and is included in the school health system. Instruction on Health Education always included the Spiritual Health side. Services included psychological counseling which is a spiritual health component.

Participant 4 replied to Interview Question 5 by simply stating, “Yes, it should be taught as part of a more comprehensive course.”

Response to follow-up Interview Question 5: Individual or single unit course. As a means of gaining consensus on this question, expert leaders were asked to reflect on the most concrete ideas regarding instruction of the spiritual dimension of health in the undergraduate curriculum.

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> Spirituality is an important dimension of health and, therefore, must be addressed in the health curriculum. It should be a unit in a personal health course which serves as a general education course requirement or a foundation course in a major or minor curriculum. It should be an elective course in the minor curriculum and a required course in the major curriculum. It should be addressed as a key dimension of health in the capstone course of the major curriculum.

Leaders were asked to agree or disagree, and to explain why or why not. There was general agreement with the statement, and, all three added to this claim that spirituality should be integrated into other courses.

Response to quantitative online Survey Question 3. Figure 5 illustrates the responses from 14 CSU health educators to online quantitative Survey Question 3, "To what degree do you believe spirituality to be an important component of the health curriculum at the undergraduate university level?" Responses were collected on a 5-point Likert-type scale, and responses included 1 (*unimportant*), 2 (*somewhat unimportant*), 3 (*neither unimportant nor important*), 4 (*somewhat important*), and 5 (*very important*). The mean score was 4.43 with a standard deviation of 0.65. Thirteen of 14 or 92.8% of respondents believed spirituality to be a *somewhat important* or *very important* component of the health curriculum at the undergraduate university level.

A correlation coefficient was administered on Survey Questions 3, "To what degree you believe spirituality to be an important component of health curriculum?" and Survey Question 7, "How important is it that university leaders promote the inclusion of the spiritual dimension of health as it relates to an undergraduate level course in the university curriculum?" The finding of .63, with a *p*-value of .02, is a positive correlation, suggesting that as one score goes up, so does the other. According to these findings, if health educators get the *vibe* that the university (or at least the department)

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thinks it is important to teach spiritual health, the instructor him or herself will feel like it is important too.

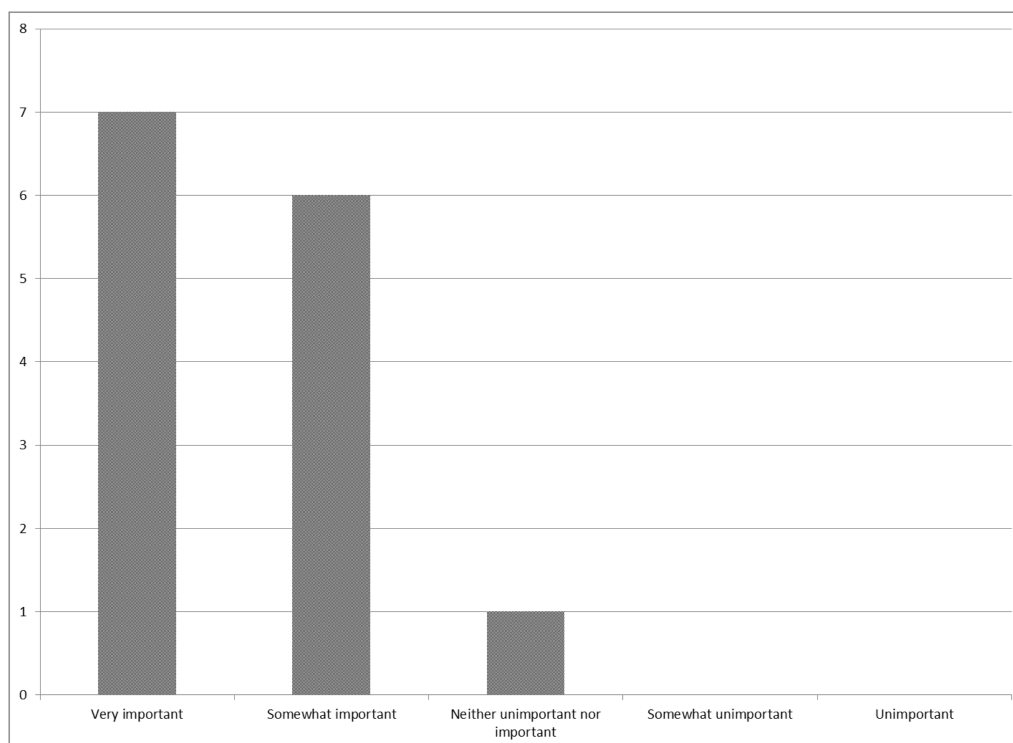

Figure 5. Frequency of responses to quantitative Survey Question3,"To what degree do you believe spirituality to be an important component of the health curriculum at the undergraduate university level?"

Response to quantitative online Survey Question 4. Figure 6 illustrates the responses from 14 CSU health educators to online quantitative Survey Question 4, "How confident are you in teaching the spiritual dimension of health?" Responses were collected on an 11-point scale, and response options ranged from 0 (*not confident at all*) to 10 (*very confident*). The mean response was 7.57, with a standard deviation of 2.56. The frequency of responses for which each score was assigned is displayed in Figure 6.

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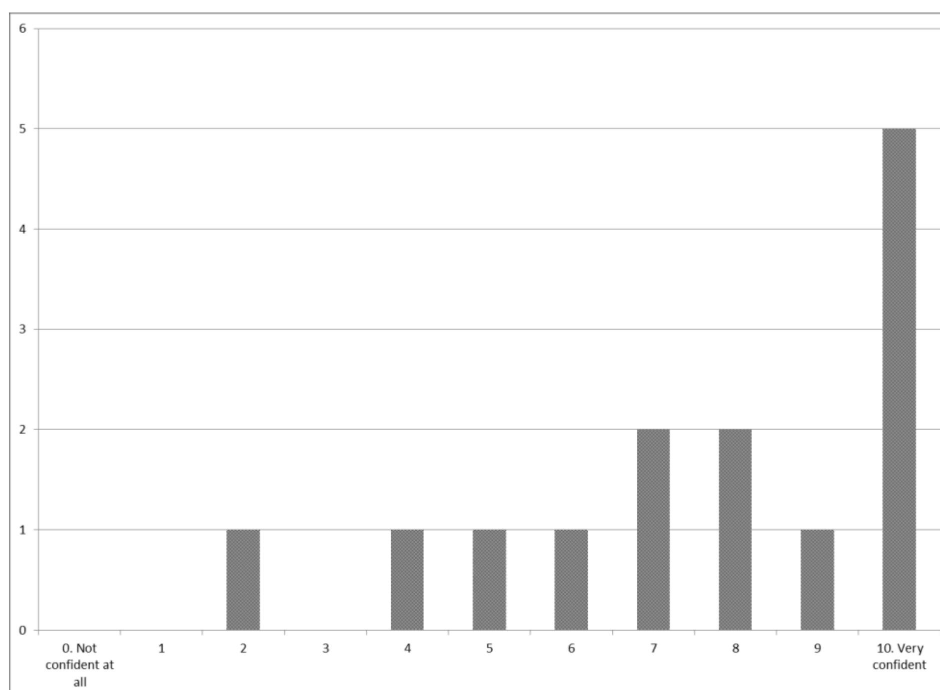

Figure 6. Frequency of responses to quantitative Survey Question 4, "How confident are you in teaching the spiritual dimension of health?"

Table 12 shows the frequency of respondents by levels of teaching confidence in accordance with a conventional method of competency categorization: 3 or less representing lack of confidence and 7 or more having confidence.

Table 12

Relative Levels of Confidence Teaching the Spiritual Dimension of Health

Level of confidence	Frequency of responses	Percentage of response
Not confident	1	7.2%
Moderately confident	3	21.4%
Confident	10	71.4%
Total	14	100.0%

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While four of the 14 respondents expressed relatively low or moderate confidence teaching the spiritual dimension of health, more than 70% of respondents were confident teaching the material.

Response to online quantitative Survey Question 5. Table 13 and Figure 7 illustrate the responses from 14 CSU health educators to online quantitative Survey Question 5, "Selected health experts have established student learning objectives for undergraduate students as it relates to the spiritual dimension of health. Potential student learning objectives are listed below. Please mark as Relevant or Irrelevant." Responses were collected on a 5-point Likert-type scale, and response options included 1 (*irrelevant*), 2 (*somewhat relevant*), 3 (*neither irrelevant nor relevant*), 4 (*somewhat relevant*), and 5 (*relevant*).

Table 13

Degree to Which Proposed Learning Objectives Are Perceived to Be Relevant by CSU Health Educators

Proposed learning objectives	Mean	*SD*
Explain how spirituality relates to the other dimensions of health	4.64	0.63
Use a case study to illustrate how spirituality impacts health status	4.43	0.65
Establish their own personal definition of spirituality	4.29	1.14
Develop specific actions/behaviors they will take to improve elements of spirituality to improve during their time as a college student	4.29	0.61
Identify elements of their own spirituality they would like to assess	4.07	1.14
Identify spirituality elements they would like to improve five years after their graduation or departure from college	3.57	1.34

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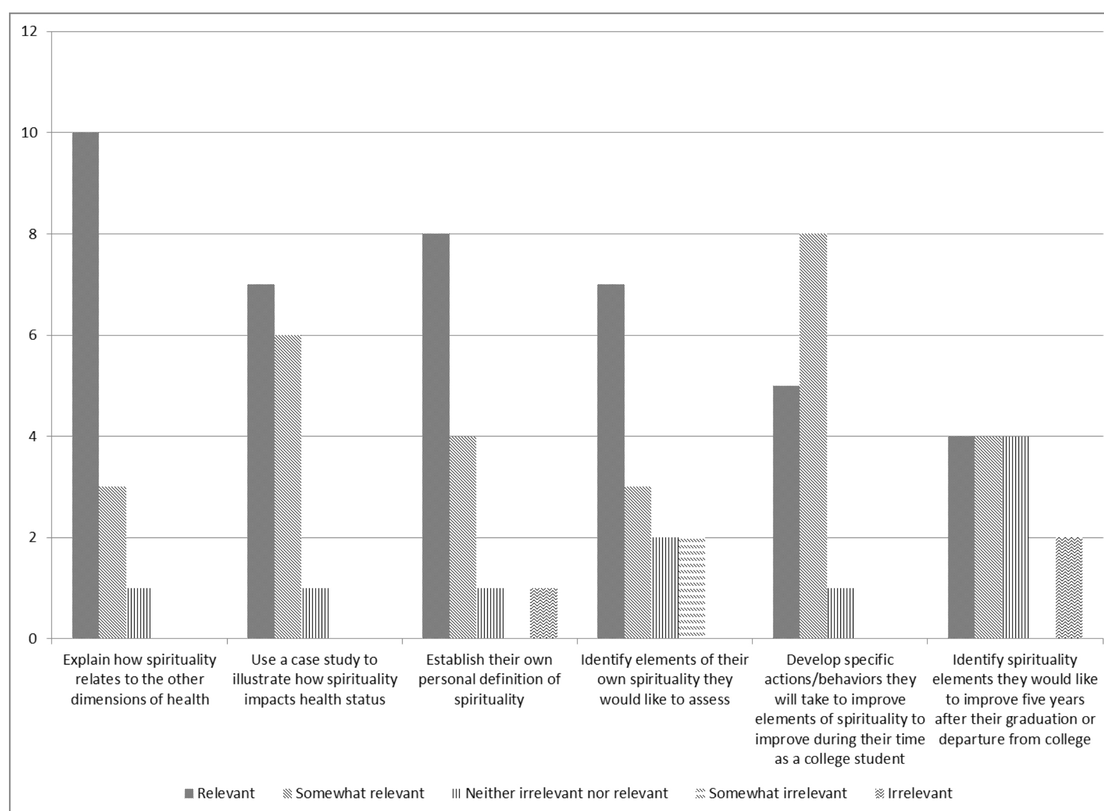

Figure 7. Frequency of responses to quantitative Survey Question 5, “Selected health experts have established student learning objectives for undergraduate students as it relates to the spiritual dimension of health. Potential student learning objectives are listed below. Please mark as Relevant or Irrelevant.”

There was relative agreement among CSU health educators that five of the six proposed themes are relevant components of a health curriculum at the undergraduate level. Explaining how spirituality relates to the other dimensions of health, with a mean response of 4.64 and a standard deviation of 0.63, was rated with the highest level of relevance of the proposed objectives with 13 of 14 participants, or 92.9%, who rated this objective as *somewhat relevant* or *relevant*. Four additional objectives received mean response ratings greater than 4.0. Of the proposed objectives, only identify spirituality

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elements they would like to improve 5 years after their graduation or departure from college received a mean ranking lower than 4.0. The frequency of responses displayed in Figure 7 confirms the stated levels of support of each of the five proposed themes. Only eight of 14 participants, or 57%, ranked identify spirituality elements they would like to improve 5 years after their graduation of departure from college as being *somewhat relevant* or *relevant*.

Research Question 4

What are the perceptions among health educators regarding the barriers to teaching spiritual health at the undergraduate college level?

Response to online quantitative Survey Question 6. Table 14 and Figure 8 illustrate the responses from 14 CSU health educators to online quantitative Survey Question 6, "Some barriers to teaching spiritual health have been identified as those listed below. For each one, evaluate how it applies to you or not." Responses were collected on a 5-point Likert-type scale, and response options included 1 (*does not apply*), 2 (*weak application*), 3 (*moderate application*), 4 (*strong application*), and 5 (*very powerful application*). Table 14 presents the means and standard deviations of responses describing the degree to which CSU health educators perceived four potential barriers to teaching spiritual health have applied to them personally.

The mean scores for all of the suggested barriers were 3.00 or lower. Health educators reported the political nature of the topic to be the weakest barrier, followed by difficulty to assess the spiritual dimension of health and lack of training on how to teach

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Table 14

Degree to Which Potential Barriers to Teaching Spiritual Health Have Applied to CSU Health Educators

Identified barriers	Mean	*SD*
Ambiguity of the term spirituality	3.00	1.24
Lack of training on how to teach spiritual health	2.93	1.27
Political nature of the topic	2.43	1.50
Difficulty to assess spiritual dimension of health	2.64	1.01

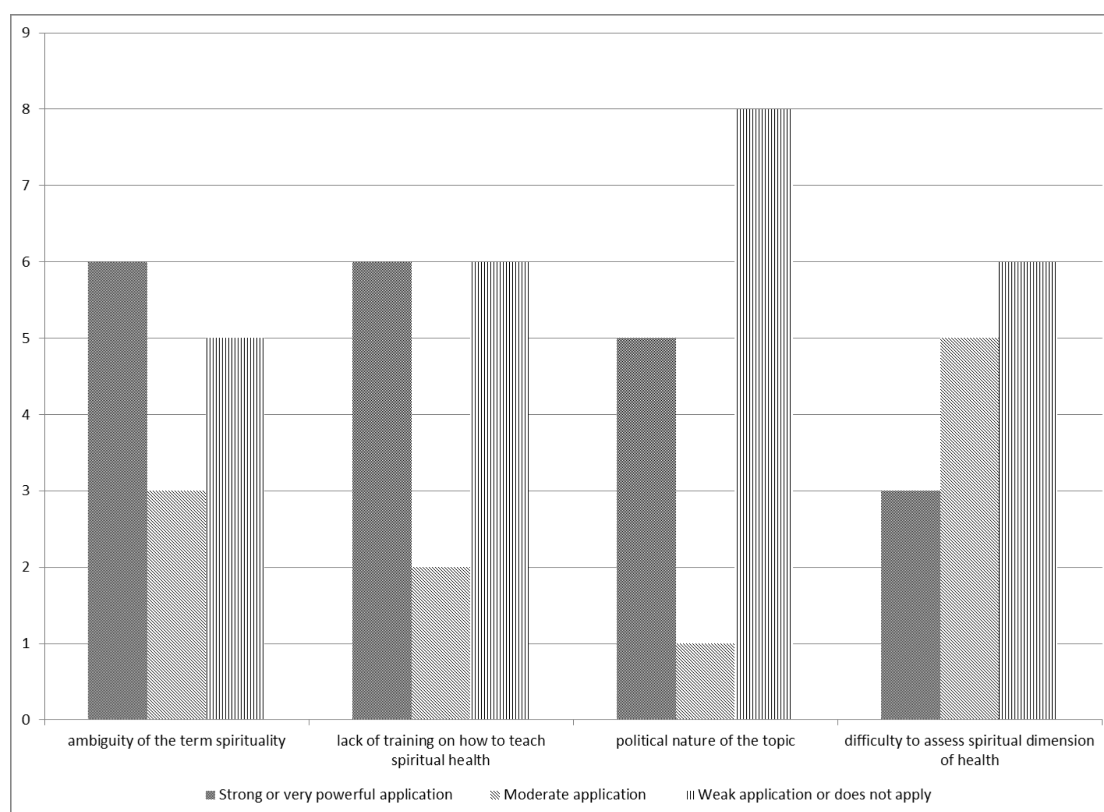

Figure 8. Frequency of responses to quantitative Survey Question 6, “Some barriers to teaching spiritual health have been identified as those listed below. For each one, evaluate how it applies to you or not.”

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spiritual health. Figure 8 displays the frequency of responses to each of the four proposed barriers. Ambiguity of the term spirituality was reported as the highest barrier; however, it was rated only as a moderately applicable barrier.

Responses to three out of the four barrier questions are found in bimodal distributions. There was an equal split between those who perceived lack of training to be a strong barrier and those who perceived it to be a weak barrier (six and six respondents, respectively), for example. A split of bimodal distribution for the barrier of ambiguity leaned slightly toward the strong direction (six and five, respectively), while for that of political nature toward the weak direction (five and eight, respectively).

Correlation of Survey Questions 4 and 6. The data from this survey question, "How confident are you in teaching the spiritual dimension of health?" was correlated with Survey Question 6, barriers to teaching spiritual health. Table 15 shows that one of the subscales was very strongly correlated with Survey Question 6, and the other two were so close to being significant (with a *p*-value of .055). The negative correlation suggests that the more barriers there are to teaching spiritual health, the less confidence.

Research Question 5

What learning objectives do university health educators and key leaders of national health organizations believe spirituality as it relates to health should be included at the undergraduate college level?

Responses were solicited in telephone Interview Questions 6 and 7 from the sample of four highly respected health education leaders, and in online quantitative

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Table 15

Spearman Rho Correlations (Confidence vs. Barriers)

Barriers		Confidence
Ambiguity	Correlation coefficient	-.524
	Sig. (2-tailed)	.055
	n	14
Lacks training	Correlation coefficient	-.889**
	Sig. (2-tailed)	.000
	n	14
Politics	Correlation coefficient	-.335
	Sig. (2-tailed)	.242
	n	14
Difficult to assess	Correlation coefficient	-.523
	Sig. (2-tailed)	.055
	n	14

Note. All of these correlations are negative; however, one barrier—lack of training—is statistically significant, while the others were not at the .05 level.
**Correlation is significant at the 0.01 level (2-tailed).

Survey Questions 3 and 7. The results of each question were analyzed in accordance with the method described in Chapter III.

Responses to telephone Interview Question 6: Learning objectives. Interview Question 6 asked, “What learning objectives do you believe should be included in a single unit, or course entitled Spirituality and Health?”

Table 16 reflects the objectives proposed in response to Interview Question 6. There was some degree of consensus that students in a health course should learn to define spirituality as a dimension of health, and to identify and explain how it relates to the other dimensions of health. However, an extensive list of proposed objectives was proposed on which there was no consensus.

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Table 16

Learning Objectives Proposed to Be Included in a Single Unit or Course Entitled Spirituality and Health

Learning objectives	Experts			
	P1	P2	P3	P4
The learner will define spirituality as a dimension of health.	X		X	
The learner will identify and explain how spirituality relates to the other dimensions of health.	X	X	X	
The learner will use a case study to illustrate how spirituality impacts health status.	X			
The learner will establish his/her own personal definition of spirituality.				X
The learner will list at least nine subelements of the spiritual dimension of health.				X
The learner will identify at least five subelements of their own spirituality they would like to assess.				X
The learner will successfully complete at least five assessments of their spirituality.				X
The learner will develop five specific actions/behaviors they will take to improve the five subelements of spirituality the want to advance during their time as a college student.				X
The learner will identify at least five other spirituality subelements they would like to advance over the next 10 years after their graduation or departure from college.				X

Note. There was no consensus among experts.

Participant 2 argued that the primary goal in developing a set of objectives is that they "should help students to see the connection between spiritual health and having quality of life." Further, Participant 2 described the importance of students' taking "time to explore their spirituality," noting that "oftentimes they don't."

> Students feel religion is crammed down their throats. I try to teach them there is more to spirituality than just religion . . . it's about how you treat people, how you respect people, basically compassion for others. As health educators, we need to

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> be sensitive that not everyone sees the world you do. If you expect that, you are going to run into frustration.

Participant 3 struggled with this question and reflected that all of the earlier questions posed in the interview should "formulate the basis for objectives that would be in a course on spiritual health."

Participant 4, who has embraced this topic as a professional, enumerated a very concrete set of six proposed experiential objectives that could potentially serve as a guide to development of a course or unit on spiritual health:

> At the completion of this course, 80% of the students will be able to
> a. Establish their own personal definition of spirituality;
> b. List at least nine subelements of the spiritual dimension of health;
> c. Identify at least five subelements of their own spirituality they would like to assess;
> d. Successfully complete at least five assessments of their spirituality;
> e. Develop five specific actions/behaviors they will take to improve the five sub-elements of spirituality the want to advance during their time as a college student;
> f. Identify at least five other spirituality subelements they would like to advance over the next 10 years after their graduation or departure from college.

Responses to Interview Question 6 were sorted and used to formulate the ideas and concepts from which the online quantitative Survey Question 6 was formed. The following key constructs resulted from this process:

1. Explain how spirituality relates to the other dimensions of health.
2. Use a case study to illustrate how spirituality impacts health status.
3. Identify elements of their own spirituality they (students) would like to address.
4. Establish their own personal definition of spirituality.
5. Develop specific actions/behaviors they will take to improve elements of spirituality during their time in college.

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6. Identify elements of spirituality they would like to improve 5 years after their graduation or departure from college.

Response to Interview Question 7. Interview Question 7 asked, "Are there any recommendations you would make to leaders of universities to promote instruction of the spiritual dimension of health in the undergraduate curriculum?" Table 17 summarizes the recommendations made in response to Interview Question 7.

Table 17

Recommendations to Leaders of Universities Regarding Instruction of the Spiritual Dimension of Health in the Undergraduate Curriculum

Recommendations	Experts			
	P1	P2	P3	P4
Include instruction on spiritual health in the general education health course	X			
Include instruction on spiritual health in the foundation course for the minor and major in health	X			
Ensure a course on spirituality is offered among electives in the health minor curriculum and among required courses for health majors	X			
Address spirituality in capstone course of the health major	X			
Spirituality should be integrated into all other health courses and units		X	X	
Support more research into the spiritual aspects of health and well-being				X

Note. There was no consensus.

Participant 2 argued that the spiritual dimension of health is "one of those threads that runs through everything we talk about as a profession" and recommended that

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discussions of spiritual health be considered a "thread in almost every course we teach." Participant 2 claimed further that "there are certain things in life that have to tie everything together, and spiritual health is one of those things that does it nicely," but warned that

> I think that it's important when we teach it not to push our own spiritual agenda and to respect everybody. [For example], do you typically define religion versus spiritual. No, I keep it in the spiritual domain. Sometimes you get spirituality through religion or through things you do with your life, (i.e., volunteering). It's very simple, do good things and life will be good for you.

Participant 3 expressed an observation that may be key to understanding why instruction in spiritual health is not more evident in health courses at the college level.

> If you look at the Framework National Center for Health Education, you won't find spirituality mentioned in skills as what health educators do across the board. But, you will find the underlying principles of spirituality in all of those skills. The separation of church and state, the word spirituality, has kept people a little bit shy. But, in the area of health education, this feeling of inner peace and calmness *is* spirituality. Whatever floats your boat. I think leaders do embrace this level of spirituality in the curriculum, but not in a separate course.

Participant 4 expressed a plea for more research into the spiritual aspects of health and well-being, recommending eight specific research projects that may be fruitful:

- Create guidelines that will avoid any focus on a specific religious focus.
- Support interdisciplinary research and scholarship on spirituality.
- Establish effective training programs for professors teaching within spirituality topics.
- Establish a health education core course that has laboratories that allow students to assess their health in all dimensions of health.
- Generate a summary of all possible services on campus and in the community, which students can assess to advance their health in all six dimensions.
- Establish a long-term program to track graduates and other students' lives and the status of their health in all six dimensions.
- Articulate this process with alumni affairs so as to keep graduates and other students connected with the campus as their health is followed long-term.
- Build a collection of resources related to spirituality and health.

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An overall organizational thought for which there was general agreement from participants was to start building and promoting spiritual health courses starting from the bottom up (100 level to 500 or undergraduate to graduate), to compile resources for people seeking spiritual health, and to train professors/faculty on topic of spiritual health.

Response to online Survey Question 7. Figure 9 illustrates the responses from 14 CSU health educators to online quantitative Survey Question 7, "In your perception, how important is it that university leaders promote the inclusion of the spiritual

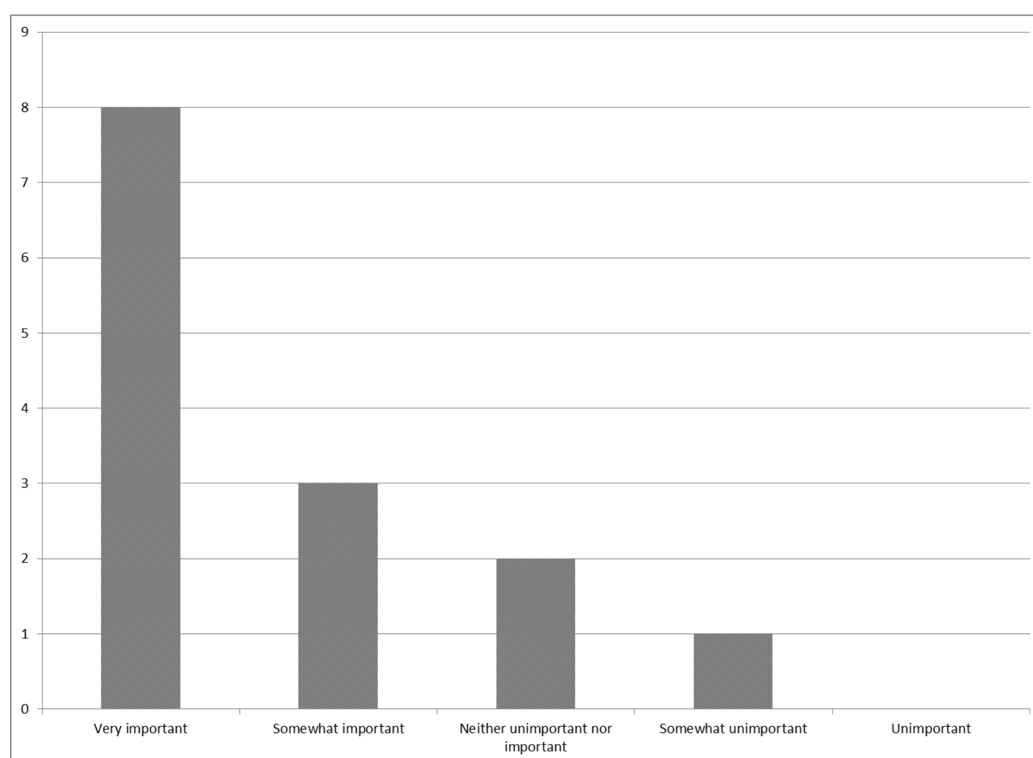

Figure 9. Frequency of responses to quantitative Survey Question 3, "In your perception, how important is it that university leaders promote the inclusion of the spiritual dimension of health as it relates to an undergraduate level course in the university curriculum?"

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dimension of health as it relates to an undergraduate level course in the university curriculum?" Responses were collected on a 5-point Likert-type scale, and responses included 1 (*unimportant*), 2 (*somewhat unimportant*), 3 (*neither unimportant nor important*), 4 (*somewhat important*), and 5 (*very important*). The mean score was 4.29 with a standard deviation of 0.99. Thirteen of 14 or 92% of respondents believed spirituality to be somewhat important or very important component of the health curriculum at the undergraduate level.

Response to telephone Interview Question 8. Telephone Interview Question 8 asked the four health education leaders, "Is there anything else you would like to add?" The four participants expressed their interest in the topic and their willingness to provide additional assistance, if necessary. Participant 1 shared, "When I taught a course titled Spirituality and Health as a special topics course during the 1990s, it was a very popular course that drew students from across several majors and minors on campus."

Response to online Survey Question 8. Online quantitative Survey Question 8 asked, "Is there anything else you would like to add regarding this topic?" One respondent expressed, "Wow this made me uncomfortable! Thank you for the food for thought." Another reiterated what had been expressed by others, "The importance of spiritual health cannot be ignored, and it must be distinguished from religion."

Summary of the Findings

This study utilized telephone interviews to assess perceptions of four national health organization leaders to establish a definition of spirituality and health, and to

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develop from their expertise recommendations for developing a curriculum or program in spirituality and health for undergraduate students in college health science departments. The results of these telephone interviews were used to develop an online survey instrument distributed to CSU health educators with the intent to broaden input to the study and to validate the results of the interviews. This chapter presented the purpose of the study, the research questions, the research design, methodology, and details about the selection of subjects, both those for the health education leader interview group and for the CSU health educator survey group, data collection, and a presentation of the results.

Summary of Findings for Research Question 1

What is the degree and nature of agreement/disagreement on the definitions of spirituality as it relates to health instruction at the university level? Among the health leaders/experts in the first round of interviews, it appeared there was little agreement on the precise elements of the definition or purpose of spirituality. However, there was agreement by three of the four experts that a definition should express that spirituality is a "source of well-being, inner calm, peace, or transcendence." Two of the experts agreed spirituality is a "source of purpose, significance, quest for a personal or universal meaning in life." Finally, two participants agreed that spirituality is a "source of inspiration."

Among the CSU health educators, there was a general consensus for each of the proposed elements of the definition of spirituality. In general, respondents perceived each of the proposed elements of spirituality—compassion for others, purpose and

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meaning, collective/connected to and with other people, calmness and inner peace—as an important part of the definition of spirituality. Of the four elements, purpose and meaning of life was reported as the most relevant or important among the participants.

Summary of Findings for Research Question 2

What is the relationship between spirituality and health as perceived by university health educators and key leaders within national health organizations? The four participants agreed that there is a connection/relationship and that spirituality is a connective link that ties the different dimensions of health together; however, how they described the relationship varied. Experts offered that spirituality is a source of inspiration to achieve well-being, a source of inspiration to help others achieve well-being, a synergistic element, a spiritual core, and that purpose in life drives decisions and leads to satisfaction in life.

Summary of Findings for Research Question 3

What are the perceptions among health educators and key leaders within national health organizations pertaining to the importance of spirituality in the health curriculum at the undergraduate level? Among the health experts, there was overall general agreement on this question in both the initial and second round of interviews. All four participants agreed that spirituality is important and should be in the health curriculum at the undergraduate level. One expert suggested that "spirituality should receive the same level of focus and study as all the other dimensions [of health]." The experts offered

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their rationale in support of conclusion that spiritual health should be included in the undergraduate level courses as well as integrated into other courses.

CSU health educators were specifically asked, “To what degree do you believe spirituality to be an important component of the health curriculum at the undergraduate university level?” Of the health educators, 13 out of 14 (92%) responded that spirituality is an important component to include in the health curriculum.

Summary of Findings for Research Question 4

What are the perceptions among health educators regarding the barriers to teaching spiritual health at the undergraduate college level? Survey Question 6 asked CSU educators to evaluate how the barriers (ambiguity of term, lack of training, political nature, difficult to assess) to teaching spiritual health applied to them personally. On this question alone, ambiguity of the term was moderately higher than the other barriers. When Question 4—confidence in teaching—was correlated with Question 6—barriers, lack of training was reported as the a highest barrier. The other barriers were moderately significant.

Summary of Findings for Research Question 5

What learning objectives do university health educators and key leaders of national health organizations believe spirituality as it relates to health should be included at the undergraduate college level? There was some degree of consensus that

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students in a health course should learn to define spirituality as a dimension of health, and that they should identify and explain how it relates to the other dimensions of health.

Among the CSU health educators, there was consensus on the importance/ relevance on five out of the six objectives proposed. The most important objective was "explain how spirituality relates to the other dimensions of health" and the weakest consensus was "identify spirituality elements they would like to improve 5 years after their graduation or departure from college."

Chapter V contains the summary of the study and provides conclusions from research based upon the data. Conclusions and implications of the findings are presented in relation to the research questions of this study. Recommendations along with suggestions for future research in the area of spirituality and health are offered.

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CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS,
AND RECOMMENDATIONS

This chapter includes information about the purpose of the study, research questions, summary of methodology, and important conclusions of the study, including the relationship of the findings to the literature and previous studies. Finally, this chapter provides a discussion on the implications for use and recommendations for future research studies.

Summary of the Study

Overview of the Problem

The concept of health and wellness is recognized as multifaceted and comprises six dimensions: spiritual, emotional, intellectual, social, environmental, and physical (Hawks et al., 1995). Of these six dimensions of health, the spiritual dimension is believed to be the center or core in which all other dimensions operate and interact. The spiritual dimension plays an important role in influencing one's overall health and well-being (Eberst, 1984; Hawks, 1994; Scandurra, 1999). The literature makes a strong case for the inclusion of spiritual health in the college curriculum as it relates to health and living a balanced life. In support of this conclusion, the California State University

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(CSU) system of schools has adopted all six of the dimensions of health, including spirituality, as the conceptual framework within which college health programs are expected to operate (Riegelman & Garr, 2011). Research shows that individuals with a strong sense of spirituality make better decisions and live more satisfying lives. Although spiritual health is recognized as an important element for optimal well-being within health education, it appears to be the most complex health dimension to define, measure, and validate (Eberst, 1984).

Lack of a consensus definition of spirituality as it relates to health instruction at the college level. The majority of health educators at the college level believe there is a spiritual dimension of health, and this dimension should be included in health education preparation programs (Banks, 1980). Yet, no definition of spirituality has been adopted by which the concept of spirituality can be clearly understood and communicated. In order for health educators to embrace and teach the spiritual dimension of health, this dimension needs to be defined so that it can become a legitimate, measurable outcome for health education programs. The importance and value of spirituality as it relates to overall health status of an individual is cited repeatedly in the literature. Scholars make the case that spiritual well-being is the core of human health and that in order to improve or sustain health in the other dimensions—physical, emotional, social, or intellectual—individuals need to concentrate on enhancing the spiritual dimension of health.

Prevalence of spirituality in current health instruction. In October 2012, a preliminary study was conducted to determine the prevalence of courses in spirituality or spiritual health offered within health science departments at schools in the CSU. The

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researcher reviewed websites and online course catalogs for each CSU campus. Of all the spirituality courses offered in the CSU system, not a single course was identified as a spirituality and health course within a department of health sciences. One course was offered in public health at CSU Fresno. CSU Fullerton, Channel Island, and Chico offered an elective alternative/holistic course. CSU Sacramento offered a course in social work. All other courses offered on the subject of spirituality were in programs devoted to religion, ethnicity, or gender.

Theoretical barriers to integrating spirituality into college-level health programs or courses. Several studies have reported that the primary barrier to integrate spirituality into college-level health programs or courses is the lack of a consensus definition and a lack of terminology with which to comfortably offer instruction. The literature emphasized a number of different themes: fulfillment, self-actualization, and achieving potential; developing an ability to heal by nonphysical interventions; a search for an ultimate purpose or meaning in life; achieving a sense of transcendence; achieving connections with a higher universal power; association with a unifying force or energy within individuals; the sensation and development of love; a common bond between individuals experienced as *selflessness*; and a common bond between individuals experienced as *service to others*. In contrast, the physical dimension of health, and to some degree the other dimensions, is much more tangible, understandable, measurable, and objective, and therefore easier to discuss in the classroom (Aldridge, 1993; Banks, 1980; Chandler et al., 1992; Cottrell, 2002; Hawks, 1994, 2008; Jose, 1997; Lodhi, 2011; McGinn, 1993; Reed, 1987; Scott, 2005; Thoreson, 1999; Thoreson & Harris, 2002).

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A second identified barrier was the sensitive political nature of the subject, which has been thought to contribute to a hesitance in instructor-developed course materials based on personal definitions and conceptions (Weaver & Cottrell, 1996).

Purpose of the Study

The purpose of this study was to establish a definition of spirituality containing all characteristics essential to the development of optimum health, a definition capable of effectively guiding the development of a curriculum or program in spirituality and health for undergraduate programs in college health science departments. Specifically, the first aim of this study was to gain consensus on such a definition among a select group of national health organization leaders and among university health educators within the California State University (CSU) system. For purposes of this study, this was described as a consensus definition. The second purpose of this study was to identify which aspects of spiritual health objectives/learning outcomes should be taught/included in a college health education curriculum (unit, sequence, or course) and why. The knowledge gained by this study was intended to provide valuable policy guidance to college health programs on CSU and college campuses and other academic institutions, for development of a full range of health courses to meet the needs of college-aged students.

Research Questions

1. What is the degree and nature of agreement/disagreement on the definitions of spirituality as it relates to health instruction at the university level?

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2. What is the relationship between spirituality and health as perceived by university health educators and key leaders within national health organizations?
3. What are the perceptions among health educators and key leaders within national health organizations pertaining to the importance of spirituality in the health curriculum at the undergraduate level?
4. What are the perceptions among health educators regarding the barriers to teaching spiritual health at the undergraduate college level?
5. What learning objectives do university health educators and key leaders of national health organizations believe spirituality as it relates to health should be included at the undergraduate college level?

Summary of Methodology

This study was designed to use mixed methods. The first and third phases of research conducted in this study relied on qualitative data collected from a sample of leaders from national health organizations using broad, general interview questions in which the detailed views of participants were collected and analyzed. The second phase of research relied on quantitative data collected from a broader set of educators employed within the CSU system who teach personal health courses at the undergraduate level. The data collected from expert interviews of the first phase of the study were used to develop an online survey, which was administered to the second group of participants.

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Population and Sample

While it could be said that the population of this study was all health education leaders, the study focused on two related but different groups within that population. The first population sampled was health education leaders from national health organizations. Purposive sampling was used to identify participants from this first population. The intent was to identify extremely knowledgeable and influential leaders in the field. The second related population consisted of all health educators who teach a personal health course at the undergraduate level with a health education, health science, and/or public health department at one of the 23 campuses within the CSU system. An effort was made to include in the second part of the study all health professors within the CSU population who met those specific criteria. Therefore, for this second group there is no distinction of the entire population and the sample.

Overview of Data Collection

The researcher contacted each leader via e-mail with a letter of invitation to participate. If the leader agreed to participate, a copy of the interview questions and consent form was e-mailed. The researcher conducted telephone interviews with four health leaders from March 4, 2013, to March 22, 2013. There were eight questions. After the qualitative and quantitative data were analyzed, the researcher invited the experts to participate in a second round of re-interview questions consisting of three follow-up questions.

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The second sample consisted of all health educators who taught a personal health course at the undergraduate level with a health education, health science, and/or public health department at one of the 23 campuses within the CSU system. Of the 23 CSU campuses, only 15 had a health education, health science, or public health department (Table 1). From those 15 campuses, a population of 20 potential participants was identified, 14 of whom responded to the survey, for a 70% response rate.

Overview of Data Analysis

One risk associated with qualitative data is the potential for inaccurate interpretation, which may lead to invalid conclusions. Krathwohl (2004) noted that in "qualitative research, the observer is the instrument. We have to wonder how, over the period of the study, the observer changes in the perception of the observed, and how that affects the observations" (p. 318). Therefore, particular attention must be paid to the procedures for collecting, analyzing, and interpreting data to protect against faulty interpretation.

The data for this study were collected using two different methods. Recorded telephone interviews were conducted to collect qualitative data from four highly respected expert leaders of organizations in the field of health education. The interviews resulted in four sets of transcripts, which were combined and reviewed and coded to identify key themes, both those themes consistent with the literature and those newly emergent. To validate the collection and analysis of the initial responses, a second round of interviews was conducted with three of the four experts. This second round of

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interviews also allowed for each expert to reflect on the results from the other experts and for consensus conclusions to be reached.

An electronic survey instrument was used to collect quantitative data from 14 of the 20 college instructors employed in health education/science departments within the CSU system, and who taught personal health courses at the undergraduate level. The instrument was developed to reflect themes identified in the earlier qualitative phase of data collection. In addition to highly structured qualitative questions, the instrument also allowed respondents to offer broad qualitative responses. Qualitative responses focused on the relevance or irrelevance of the data gained in the earlier phase of the study, the value each respondent placed on competing definitions of spirituality, and the degree to which respondents believe spirituality is an important component of the health curriculum at the undergraduate college level. Data from the quantitative results were analyzed with descriptive statistics.

Major Findings and Conclusions

Findings for Research Question 1

What is the degree and nature of agreement/disagreement on the definitions of spirituality as it relates to health instruction at the university level?

Finding 1. In the initial round of interviews with health experts, there was little agreement among the four highly respected health education leaders on the essential elements of the definition/purpose of spirituality. As displayed in Table 5, the four health

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experts cumulatively proposed 10 different important elements of a definition of spirituality as it relates to health education at the university level.

Additionally, there was no single theme identified by all four participants. There was consensus by three of the four experts that a definition should express that spirituality is a "source of well-being, inner calm, peace, or transcendence." Two experts agreed that spirituality is a "source of purpose, significance, quest for a personal or universal meaning in life." And two experts agreed that spirituality is a "source of inspiration."

After the initial data were compiled and analyzed, and after college health instructors responded to related questions, a second round of semistructured interviews was conducted with the four health experts. Each of the four experts was asked to reflect on their initial responses to the spiritual dimension of health, the responses of the three other experts, and to confirm that the analysis accurately reflected their initial response, and to comment on the information offered by all other respondents. The experts agreed on the following definition:

> *Spirituality*, as it relates to health education at the university level, is one of the six major dimensions of human health. It is comprised of subelements that, when functioning well, support the animating aspects of life. Healthy spirituality supports the four major types of essential intertwined aspects of a balanced life:
> 1. **Purpose and meaning in life:** consisting of inspiration, a sense of personal significance, and satisfaction with life.
> 2. **Will:** consisting of determination, dedication, and emotional confidence.
> 3. **Selflessness:** consisting of loyalty, mentorship, and compassion for others.
> 4. **Calmness or inner peace:** consisting of transcendence, inner calm, a sense of peace and well-being, and motivation for quest for a universal meaning of life.

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Participant 4 proposed a fifth item: **Vision:** consisting of a clear sense of one's place in the human existence. Participant 3 recommended the definition be simplified further, to become:

> *Spirituality*, as it relates to health education at the university level, is the synergistic dimension of health that, when functioning well, supports the animating aspects of life and the other five dimensions of a balanced life:
> 1. **Purpose and meaning in life:** consisting of inspiration, a sense of personal significance, and satisfaction with life.
> 2. **Will:** consisting of determination, dedication, and emotional confidence.
> 3. **Selflessness:** consisting of loyalty, mentorship, and compassion for others.

Finding 2. As evidenced in Table 6 (repeated here for easy reference), general consensus was evident among CSU health educators for each of the four proposed definitional elements of the term spirituality as it relates to health education at the undergraduate university level.

Table 6

Expressed Elements of a Definition for Spirituality as it Relates to Health Instruction

Proposed definitional element	*n*	%	Mean	*SD*
Purpose and meaning in life	13	92%	4.50	1.09
Compassion for others	12	85%	4.21	1.42
Collective, connected to and with other people	12	85%	4.43	1.16
Calmness/inner peace	11	80%	4.07	1.38

The mean response from CSU health educators was greater than 4.0 for each of the proposed elements, indicating that, in general, respondents perceived each of the proposed elements to be *relevant* or *somewhat relevant*. Of the four proposed elements (purpose and meaning in life; compassion for others; collective, connected to other

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people; calmness/inner peace), responses to *purpose and meaning of life* resulted in the highest mean score, 4.50, and the lowest standard deviation, 1.09 (therefore the greatest agreement). The mean score for *compassion for others* was 4.21, with a standard deviation of 1.42, the greatest standard deviation of the four themes (and thus the least agreement).

Finding 3. Table 7 (repeated here for easy reference) summarizes the responses of health educators to survey questions regarding the themes of the spiritual dimension of health.

Table 7

Degree of Agreement of CSU Health Educators With Each of Four Spiritual Dimensions of Health Recognized by Health Experts

Proposed theme	Mean	*SD*
Spiritual health is individual, subjective, and very personal	4.36	1.15
Spiritual health is connected to and is the driving force to all other dimensions of health	4.00	0.78
Spiritual health can transcend an individual	3.86	0.95
Spiritual health leads to optimal health	3.64	1.15

The mean for health educators was greater than 4.0, *somewhat agree* or *strongly agree*, for only one of the proposed themes, *spiritual health is individual, subjective, and very personal*, with a mean response of 4.36 and a standard deviation of 1.15. The mean response for the theme *Spiritual health is connected to and is the driving force to all*

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other dimensions of health was 4.00, for an average response of *somewhat agree*, with a standard deviation of 0.78. Mean responses between 3.00 and 4.00, *neither agree nor disagree* to *somewhat agree*, resulted from responses to the remaining two questions. Responses to the theme *Spiritual health can transcend an individual* resulted in a mean score of 3.86 with a standard deviation of 0.95. Responses to the theme *Spiritual health leads to optimal health*~~,~~ resulted in a mean score of 3.64, with a standard deviation of 1.15. Figure 4 (repeated here for easy reference) manifests an overwhelming sense that CSU health educator participants perceive the spiritual dimension of health be individual, subjective, and very personal.

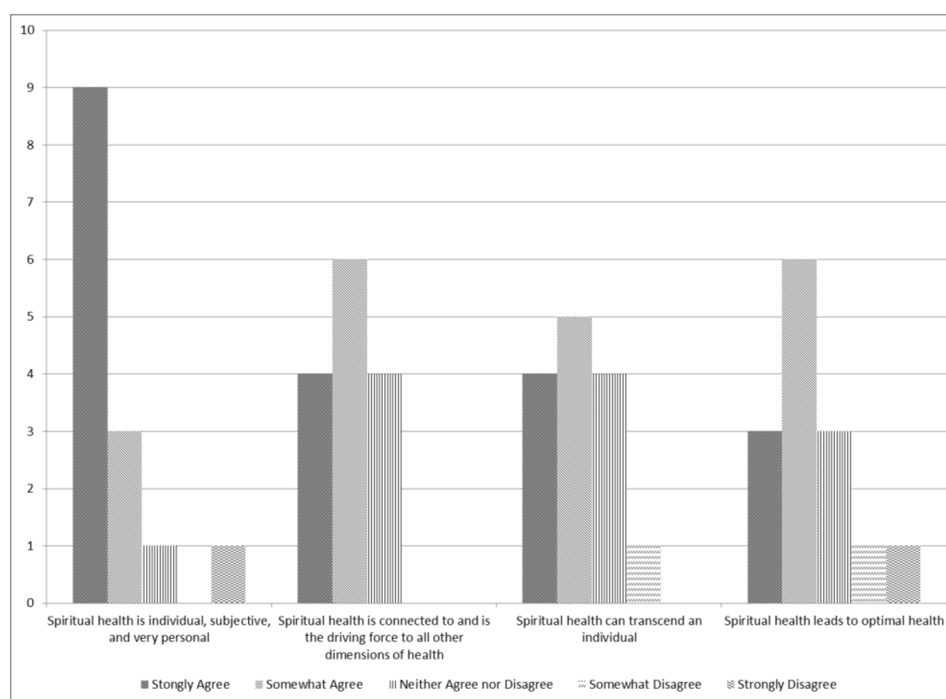

*Figure 4.*Frequency of responses to quantitative survey question, “Listed below are common THEMES of the spiritual dimension of health recognized by selected health experts. Please mark if you AGREE or DISAGREE with each theme listed.”

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Conclusions for Research Question 1

Conclusion 1: Consensus on a definition of spirituality. While a consensus definition of spirituality as it relates to health instruction at the college level did not become evident from initial interviews with expert respondents, consensus was reached when the experts reflected on their own initial responses and to those of other experts and CSU health educators.

Conclusion 2: A proposed definition of spirituality. After reflecting on their own initial responses and to those of other experts and CSU health educators, the consensus definition of spiritualty as it relates to health instruction at the college level is the following:

> *Spirituality*, as it relates to health education at the university level, is the synergistic dimension of health that, when functioning well, supports the animating aspects of life and the other five dimensions of a balanced life:
> 1. **Purpose and meaning in life:** consisting of inspiration, a sense of personal significance, and satisfaction with life.
> 2. **Will:** consisting of determination, dedication, and emotional confidence.
> 3. **Selflessness:** consisting of loyalty, mentorship, and compassion for others.

Conclusion 3. While a level of consensus was achieved with the three health experts, full consensus on a definition of spirituality cannot be claimed until a broader base of participants is allowed to offer opinions on a final definition.

Conclusion 4. CSU health educators overwhelmingly perceived that the spiritual dimension of health be individual, subjective, and very personal, and perhaps beyond the constraints of a consensus definition. Further work must be done to determine if a consensus can be reached among all health educators on a definition of health as it relates to health courses at the undergraduate college level.

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Findings for Research Question 2

What is the relationship between spirituality and health as perceived by university health educators and key leaders within national health organizations?

Finding 4. The four experts agreed there is a connection/relationship and that spirituality is a connective link that ties the different dimensions of health together; however, Table 8 (repeated here for easy reference) reflects multiple themes used to describe those relationships.

Table 8

Responses to Interview Question 2. Expressed Description of Connection or Relationship of Spirituality to Improved or Sustained Health

Responses	Expert			
	P1	P2	P3	P4
Source of inspiration to achieve well-being	X			
Source of inspiration to help others achieve well-being	X			
Synergistic element, along with other six dimensions of overall optimal health	X			X
Spiritual core is mechanism by which all six dimensions of health interact				X
Purpose in life drives decisions and leads to satisfaction with life		X		
Increased spirituality leads to improved physical health			X	

Upon reflection, the health experts agreed that the synergistic element of spirituality describes the fundamental role spirituality plays in connecting all elements of health. Participant 3 stated, "The key item on this list is 'synergistic element.' It is core, the main legitimate theme here. You can tie all other items on the list (i.e., source of

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inspiration) back to the core element of synergy." Participant 4 clarified the relationship, explaining that

> Items 1 [source of inspiration to achieve well-being], 2 [source of inspiration to help others achieve well-being], 5 [purpose in life drives decisions and leads to satisfaction with life], and 6 [increased spirituality leads to improved physical health] are dependent upon spirituality being in good to very good condition.

Finding 5. There was general consensus of CSU educators to survey question, "In your perception, how important is it that University leaders promote the inclusion of the spiritual dimension of health as it relates to an undergraduate level course in the university curriculum?" Eleven of 14 or 78% of respondents believed it to be somewhat important to very important that university leaders promote the inclusion of the spiritual dimension of health, undergraduate level curriculum

Conclusion for Research Question 2

Conclusion 5. The four health experts reached agreement that spirituality is the synergistic connective link that ties the different dimensions of health together. This basic conceptual element of spiritual health was an integral part of the definition on which the experts ultimately reached consensus.

Findings for Research Question 3

What are the perceptions among health educators and key leaders within national health organizations pertaining to the importance of spirituality in the health curriculum at the undergraduate level?

Finding 6. There was overall general agreement among the four health professionals that spirituality is important and should be included as part of the health

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curriculum at the undergraduate level. For example, Participant 3 suggested, “Spirituality should receive the same level of focus and study as all the other dimensions (of health),” and Participant 1 commented that

> Spirituality is an important dimension of health and, therefore, must be addressed in the health curriculum. It should be a unit in a personal health course which serves as a general education course requirement or a foundation course in a major or minor curriculum. It should be an elective course in the minor curriculum and a required course in the major curriculum. It should be addressed as a key dimension of health in the capstone course of the major curriculum.

Participant 4 added,

> I am not sure that in the long term spirituality needs to be an entire course in and of itself. It is not philosophically defensible to separate out each dimension into a separate course. However, as we begin to more fully address spirituality, there may be a need for a separate course since most people are not aware of this aspect of their health/life and its influence on overall health.

A summary of responses from health professionals is displayed in Table 10 (repeated here for easy reference).

Table 10

Rationale in Support of Conclusion That Spiritual Health Should Be Included in Undergraduate Level Courses

	Experts			
Rationale	P1	P2	P3	P4
Important to overall health, therefore should be included	X		X	
Essential element of being a good person and living a meaningful life		X		
Spirituality should definitely be incorporated . . . not from a religious standpoint, but from health education			X	
Spirituality should receive as much attention as other dimensions . . . possibly more because it is ignored				X

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Finding 7. Responses to the inclusion of spiritual health in the undergraduate level were in alignment with the experts. The majority of participants (90%) agreed this dimension of health is important and should be included in a course or courses at the undergraduate level. Additionally, experts agreed the spiritual dimension of health should be integrated into all other courses (within the health curriculum).

Conclusions for Research Question 3

Conclusion 6. There was broad agreement across all participants that spirituality is an important element of health instruction at the college level. The researcher concluded that this broad agreement likely exists beyond the CSU system into all state-operated universities in California and across the nation.

Conclusion 7. There was broad agreement across all participants that spirituality should be included as a unit in introductory health courses, and could productively be taught as an individual course at more advanced and graduate levels.

Findings for Research Question 4

What are the perceptions among health educators regarding the barriers to teaching spiritual health at the undergraduate college level?

Finding 8. Of the barriers, ambiguity of the term spirituality was reported as the highest barrier by the CSU educators. When confidence in teaching spiritual health was correlated with barriers to teaching, lack of training had a strong significant correlation meaning the highest barrier. The other barriers, difficult to assess, political nature of topic, and lack of training were reported as moderately significant.

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Conclusion 8. If these barriers are resolved, health educators will know what to teach, how to teach spirituality, and are more likely to teach it and teach it effectively.

Findings for Research Question 5

What learning objectives do university health educators and key leaders of national health organizations believe spirituality as it relates to health should be included at the undergraduate college level?

Finding 9. There was general consensus across all participants that prior to effectively teaching students about the spiritual aspects of health, it is essential that a working definition of spirituality be established among health educators.

Finding 10. Figure 7 (repeated here for easy reference) displays a general consensus that students in a health course should learn to explain how spirituality relates to the other dimensions of health, establish their own definition of spirituality (which should presumably be related to the consensus definition obtained from this study), and identify elements of their own spirituality they would like to assess.

Conclusions for Research Question 5

Conclusion 9. The spiritual dimension is viewed as an integral part of overall health of a human being, yet if faculty members do not know what the term means, they cannot effectively teach it. The working definition offered by this study removes the most rudimentary barrier to teaching spirituality in college health courses. In addition, a spirituality unit offered within a college-level health course should, at the very least,

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require that students learn to explain how spirituality relates to the other dimensions of health; reflect on the consensus definition and, if necessary, establish their own definition

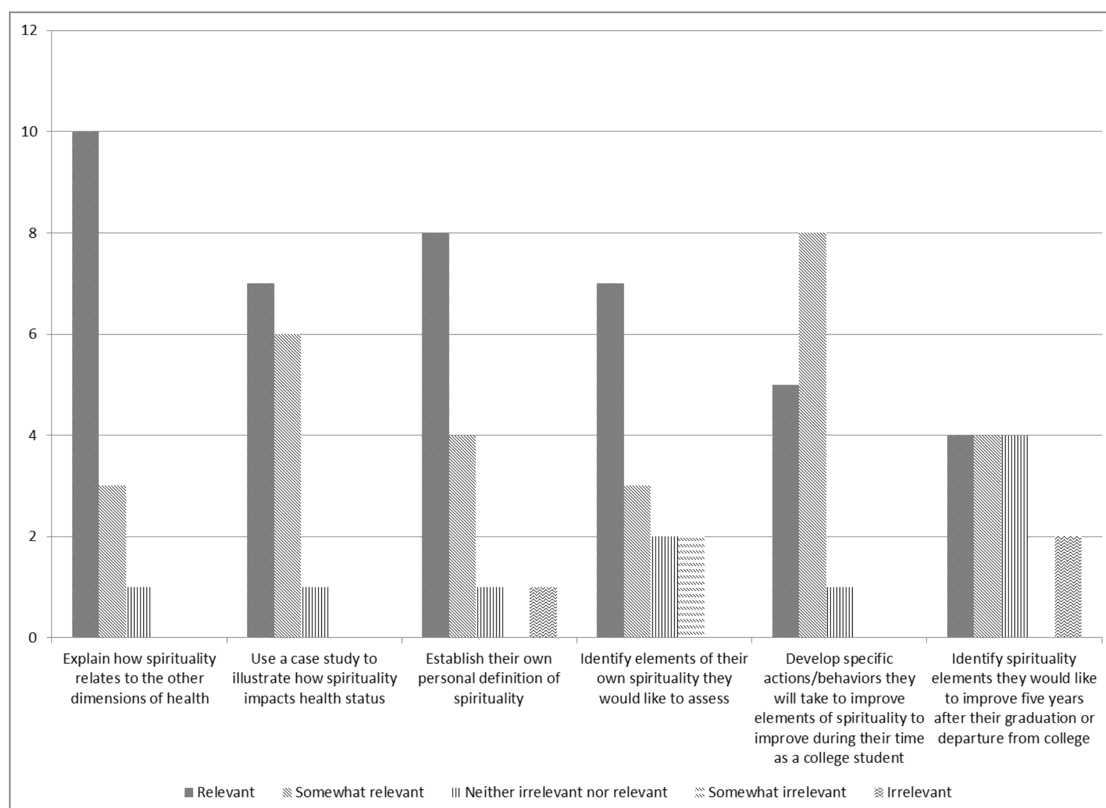

Figure 7. Frequency of responses to quantitative Survey Question 5, "Selected health experts have established student learning objectives for undergraduate students as it relates to the spiritual dimension of health. Potential student learning objectives are listed below. Please mark as Relevant or Irrelevant."

of spirituality; and identify elements of their own spirituality they would like to assess and develop.

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Findings Related to the Literature

The review of the literature and this study found that it is important to have a clear definition of the spiritual dimension of health. It is only within the last 30 years that spiritual health has begun to reemerge in the health field as a recognized and important facet of health (McGee et al., 2003). There are several barriers that hinder a health education practice that genuinely promotes a multidimensional health and wellness perspective. For example, some dimensions are more readily accepted and embraced due to the nature of the dimension. Findings from each claim in the literature are listed below.

Claim 1 from the literature. Barriers to teaching the spiritual dimension of health: Several studies reported that the primary barrier is the ambiguity of dealing with dimensions of health that have not achieved a consensus definition in the health profession.

Finding 11. The results obtained from CSU health educators supported the claim that this barrier exists, and that it is the greatest barrier to teaching spirituality in college health courses. Without a clear definition of spiritual health, it is difficult if not impossible to teach.

Claim 2 from the literature. Another barrier to implementing spiritual health in the college classroom has to do with the political nature of this sensitive topic. Because of its confusion with religion, discussion of spiritual issues, or implementation of spiritual health curriculum in a health or classroom setting was avoided.

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Finding 12. This researcher was surprised to find that politics was not a barrier for the CSU faculty who teach this dimension of health. Participants in this study did not view politics as a barrier to implementing instruction on the spiritual dimension of health.

Claim 3 from the literature. The literature emphasized different themes as they relate to the definition of spirituality: (a) fulfillment, self-actualization, and achieving potential; (b) developing an ability to heal by nonphysical interventions; (c) a search for an ultimate purpose or meaning in life; (d) achieving a sense of transcendence; (e) achieving connections with a higher universal power; (f) association with a unifying force or energy within individuals; (g) the sensation and development of love; (h) a common bond between individuals, experienced as *selflessness*; and (i) a common bond between individuals experienced as *service to others*.

Finding 13. The health experts agreed upon the following themes, which mirror some of the themes cited in the literature: purpose and meaning in life; calmness/inner peace consisting of transcendence; and selflessness, including compassion for others.

Claim 4 from the literature. Health as a "driver" or core element of health. According to Muller and Dennis (2007), spirituality is believed to be a direct dimensional "driver" of health within all dimensions (physical, mental, emotional, and social).

Finding 14. Three of four experts corroborated this claim, stating that spirituality is the core dimension of health with which all other dimensions interact.

Claim 5 from the literature. In addition to a lack of a clear definition of spiritual health among university health educators, there is ambiguity about how this concept

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should be incorporated into the health curriculum due to the difficulty with measuring and assessing/evaluating spiritual health of an individual (Hawks, 1994).

Finding 15. After multiple interviews, the four health experts agreed that spirituality should be integrated into other health courses unless it is offered as a specialized course at more advanced levels.

Finding 16. Both the health expert leaders and CSU educators agreed that support from university leaders is an important factor in the incorporation of this topic into the curriculum.

Summary of Results

The highly respected experts and the CSU educators agree that the greatest barrier to teaching spirituality is lack of definition. CSU educators agree that spiritual dimension is important to teach; however, they are unclear how to teach and implement it into their courses. Findings indicate that the support of university leaders for the inclusion of the spiritual dimension of health is an important factor for CSU educators.

Implementation of Policy Change Implications of the Study:

1. **Implications for health departments in the CSU system.** An opportunity exists to capitalize on the broad consensus expressed in findings from the experts and CSU educators that spirituality is an important element of health instruction, and that it "should receive the same level of focus and study as all other dimensions (of health)." The results of this study should be shared with department heads of all CSU health

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departments, who should form a committee to develop a policy to implement this dimension into the major and minor health curriculum at the undergraduate level.

2. **Implications for other health-related organizations and health professionals.** To advance the aims of health education theory and practice, leaders of national health organizations, and allied health professionals should consider developing standards of practice to be implemented on a national level.
3. **Implications for publishers of college-level health textbooks.** To work with health professionals to develop a textbook specifically designed to address the spiritual dimension of health for use by undergraduate students.
4. **Implications for CSU.** CSU should offer courses on the spiritual dimension of health in the health major and minor. If experts (e) and faculty (p) teaching personal health courses agree that spirituality is an important dimension to be taught, then why aren't we doing this? Recommend to ask college administrators why this is not being done.
5. **Implications for integrating and applying spiritual health teachings or courses**. Spiritual health teachings or courses should be applied to other disciplines such as kinesiology, aging, and even to athletic teams. For instance, the spiritual elements such as the goal to obtain higher purpose are descriptive that can apply to athletes or sports/teams.
6. **Implications for involvement of those who have an impact on student success.** If a definition of spiritual health is to be fully developed and utilized by faculty, need to involve and invite all of those who have an impact and investment in student success

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to include health and well-being. Examples of potential invitees are faculty, administrators, community churches, and other disciplines within the campus.

7. **Implications for professional preparation**. Develop a training manual for professional preparation on how to teach the spiritual dimension of health.

Recommendations for Future Research

The following recommendations are based on the findings and conclusions of this study:

1. This researcher agrees with and recommends the suggested set of important quantitative study questions proposed by Participant 4:

   > I would also like to know what, if any, are the measurable aspects (subelements) of spirituality that we might be able to assess and track. Also, how are these subelements of spiritual health related or inter-related to each of the subelements of the other five dimensions of health? Are some more closely "related" than other? Can we "reach" to one subdimension that is not very accessible by focusing on its "related" subelements in other dimensions?

2. Replicate this study with larger, secular and nonsecular populations/universities across the nation to increase generalizability.
3. Conduct a survey on college administrators and curriculum teams to determine policy and implementation of a spiritual health courses and training of graduate students.
4. Recommend that there be more exploration regarding the barriers to teaching spirituality given the data and the definition of spirituality established in the consensus building process.

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Summary Recommendation for Implementing Spirituality at CSU

The curriculum in college health programs is well established. Textbooks are in print and instructors depend on learning objectives that may have been unchanged for years. Methods of observing or measuring elements of health have been tested and confirmed. Therefore, attempts to change attitudes about adding greater coverage to spirituality in the health curriculum represent change to a firmly established system. Lewin and others before him recognized that change efforts generally encounter resistance. Though such resistance was not identified in this study, attempts to introduce additional elements of spiritual health into the system will likely be met with such resistance. Lewin proposed a force-field model of change in which resistance to change can be overcome (as cited in Yukl, 1998). Therefore, organizational development concepts related to change management must be considered with future steps to realize desired changes.

Concluding Remarks

This study explored barriers to teaching the spiritual dimension of health at the undergraduate level. The main barrier this study focused on was the lack of definition of what spirituality is all about as well as a way of teaching this topic. When I went through this process, after two rounds of interviews with the leaders, the experts did come to consensus on a definition of spiritual health. In essence, through this research, there is now a definition that eliminates this barrier to teaching this topic. I recommend conveying this expert definition to university leaders to discuss the potential there is to

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implement this dimension into the major and minor health curriculum at the undergraduate level. The curriculum currently being used to teach health is deficient in that it does not adequately address all six dimensions of health. It appears that CSU educators are enthusiastic about teaching spirituality, but they need the tools to better understand what to teach and how to teach the spiritual dimension of health. Per the experts interviewed in this study, spiritual health is the core that ties all other dimensions together. When educators teach health, it is addressed on a continuum from high to low. Like health, I believe spirituality should be addressed from high to low with the goal to achieve balance on all dimensions. I believe it is important that along with the proposed definition, and a balance on all dimensions, there need to be measurable learning objectives. I believe health educators need to reexamine how they approach teaching health in general, allowing equal time devoted to all six dimensions. I propose that future studies should consider the amount of time devoted to teaching spiritual health in the classroom. Another consideration is that other health-related professions have started to integrate spiritual health into their curriculums; somehow health education departments have not. Within the six dimensions, health educators rely on other experts, for example, physical health—kinesiology, social health—sociology, social psychology; however, for the spiritual dimension, they do not. I recommend that as a profession, health educators closely examine how they look at health and perhaps invite religious studies and other related disciplines to look at and provide their insights. I recommend that public health professionals form a task force to create a working, viable definition of spirituality and health to be the standard for the profession. This task force can include university

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educators, administrators and others vested in students' health, well-being, and life success. In health education, there has not been enough done in terms of a literature review on spiritual health to make it digestible for college-aged students. Therefore, a final product—a textbook or training manuals for health educators—needs to be in a format or language that appeals to college students. Finally, the results of this study provide important information to the existing body of literature on this emerging life topic. I believe continued research into spirituality and health is vital to every individual, and health professionals, as a viable topic to explore and expand.

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APPENDICES

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APPENDIX A

INFORMED CONSENT FORM: GROUP 1

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CONSENT TO PARTICIPATE IN RESEARCH

The Spiritual Dimension of Health: Implications for policy and practice.

Four Leaders of National Health Organizations

You are being asked to participate in a research study conducted by Dara Vazin, a doctoral student in the Organizational Leadership program at the University of La Verne, California. The results from this study will be contributed to a dissertation on the spiritual dimension of health. You were selected as a possible participant in this study because of your leadership role within an established national health organization.

- **PURPOSE OF THE STUDY**

The main purpose of this study is to establish a consensus definition among health educators of the spiritual dimension of health. The second purpose of this study is to identify which aspects of spiritual health learning objectives should be included in a college health education curriculum (unit, sequence, or course) and why.

- **PROCEDURES**

If you decide to participate in this study, I will ask you to do the following things:

You have been selected to participate in this study because of your leadership role in a national health organization. You are being asked to participate in a telephone interview which contains eight questions and should take approximately 25 minutes. The interviews will be recorded using a voice recording device. Your identity will be kept confidential. At the start of the interview you will be asked to give your verbal consent to participate in this study.

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Your identity and information will be protected. Collected data will be stored in a locked cabinet at the researcher's home office.

Participation is strictly voluntary and you can choose to answer some or all of the questions and/or withdraw from the study at any time without penalty.

- **POTENTIAL RISKS AND DISCOMFORTS**

Risks are no greater than those found in everyday university activities. While there is a varying degree of ideas about this topic, the details are mundane and should not cause any emotional reaction. You do not have to answer any interview question that makes you feel uncomfortable.

- **POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY**

There are no direct benefits to participants. Potential benefits of this study can provide college/university health programs in California and other academic institutions for development of a curriculum or program in spirituality and health for undergraduate studies to meet the needs of college aged students.

- **PAYMENT FOR PARTICIPATION**

None

- **CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means removing the names of participants.

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Data will be protected on a secure computer that is password protected. Only the researcher will have access.

The telephone interviews will be audio taped and you can request to review the transcripts which will be written without any identifying information. Only the researcher will have access to the audio tapes which will be used educational purposes only and will be erased upon completion of the study.

- **PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

- **IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact the researcher Dara Vazin at (XXX) XXX-XXXX or dvazin@fullerton.eduor the Dissertation Chair Dr. Casey Goodall at (XXX) XXX-XXXX or cgoodall@tusd@edu.

- **RIGHTS OF RESEARCH PARTICIPANTS**

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Marcia L. Godwin, Ph.D., IRB Director, at

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909-593-3511, extension 4103, (mgodwin@laverne.edu). University of La Verne, Institutional Review Board, 1950 Third Street, CBPM 123, La Verne, CA 91750.

SIGNATURE OF RESEARCH PARTICIPANT OR LEGAL REPRESENTATIVE

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

____

Printed Name of Participant

____

Printed Name of Legal Representative (if applicable)

____ ______________

Signature of Participant or Legal Representative Date

SIGNATURE OF INVESTIGATOR (If required by the IRB)

In my judgment the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

____ ______________

Signature of Investigator Date

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APPENDIX B

INFORMED CONSENT FORM: GROUP 2

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CONSENT TO PARTICIPATE IN RESEARCH

The Spiritual Dimension of Health: Implications for policy and practice.

Approximately 15-20 Health Educators who teach an undergraduate health course within the California State University system.

You are being asked to participate in a research study conducted by Dara Vazin, doctoral student in the Organizational Leadership program at the University of La Verne, California. The results from this study will be contributed to a dissertation on the spiritual dimension of health. You were selected as a possible participant in this study because of you teach an undergraduate level course in Personal Health (or similar) within the California State University System (CSU).

- **PURPOSE OF THE STUDY**

The main purpose of this study is to establish a consensus definition among health educators of the spiritual dimension of health. The second purpose of this study is to identify which aspects of spiritual health learning objectives should be included in a college health education curriculum (unit, sequence, or course) and why.

- **PROCEDURES**

If you decide to participate in this study, I will ask you to do the following things: You have been selected to participate in this study because of your teaching experience of an undergraduate personal health course (or similar) within the California State University System (CSU). You are being asked to participate in

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an electronic survey which contains five questions and should take approximately 15 minutes.

Your identity will be kept confidential. At the start of the electronic survey you will be asked to give your consent to participate in this study. If you agree, you will click the yes/I agree button and it will take you directly to the survey. If you do not agree, click no and it will take you out of the survey.

Your identity and information will be protected. Collected data will be stored in a locked cabinet at the researcher's home office.

Participation is strictly voluntary and you can choose to answer some or all of the questions and/or withdraw from the study at any time without penalty.

- **POTENTIAL RISKS AND DISCOMFORTS**

Risks are no greater than those found in everyday university activities. While there is a varying degree of ideas about this topic, the details are mundane and should not cause any emotional reaction. You do not have to answer any interview question that makes you feel uncomfortable.

- **POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY**

There are no direct benefits to participants. Potential benefits of this study can provide college/university health programs in California and other academic institutions for development of a curriculum or program in spirituality and health for undergraduate studies to meet the needs of college aged students.

- **PAYMENT FOR PARTICIPATION**

None

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- **CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means removing the names of participants.

Data will be protected on a secure computer that is password protected. Only the researcher will have access.

- **PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

- **IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact the researcher Dara Vazin at (XXX) XXX-XXXX or dvazin@fullerton.edu. or the Dissertation Chair Dr. Casey Goodall at (XXX) XXX-XXXX or cgoodall@tusd@edu.

- **RIGHTS OF RESEARCH PARTICIPANTS**

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your

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rights as a research participant, contact Marcia L. Godwin, Ph.D., IRB Director, at 909-593-3511, extension 4103, (mgodwin@laverne.edu). University of La Verne, Institutional Review Board, 1950 Third Street, CBPM 123, La Verne, CA 91750.

SIGNATURE OF RESEARCH PARTICIPANT OR LEGAL REPRESENTATIVE

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

____
Printed Name of Participant

____
Printed Name of Legal Representative (if applicable)

______________________________________ ______________
Signature of Participant or Legal Representative Date

SIGNATURE OF INVESTIGATOR (If required by the IRB)

In my judgment the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

______________________________________ ______________
Signature of Investigator Date

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APPENDIX C

RECRUITMENT LETTER—GROUP 1

المنارة للاستشارات

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[Date]

Dear [Expert],

I am a doctoral student in Organizational Leadership program at the University of La Verne, California, and I am conducting my dissertation study on the spiritual dimension of health. You were selected to participate because of the expertise gained by leadership in a national health organization. According to research, the concept of health and wellness is recognized as multifaceted and comprised of six dimensions: spiritual, emotional, intellectual, social, environmental, and physical (Hawks, Hull, Thalman, & Richins, 1995). Of these six dimensions of health, the spiritual dimension is the central component, which all other dimensions interact and plays a key role in influencing one's overall health and well-being.

The two goals of my study are (a) to establish a consensus definition of the spiritual dimension of health from a select group of national health organization leaders and from university health educators within the California State University (CSU) system; and (b) to identify which spiritual health learning objectives should be included in a college health education curriculum (unit, sequence, or course) and why. My ultimate goal is to establish a consensus definition of spirituality among health educators that would ultimately guide an effective development of a curriculum or program on spirituality and health for undergraduate programs. Further, I want to determine if it is feasible to increase the likelihood that all the dimensions of health will be appropriately represented in the California college health curriculum.

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This letter is to confirm that you are willing to serve as an expert participant in my study. As a participant of the study, you will be asked to participate in a 25-minute telephone interview. The interviews will be audio recorded using an electronic recording device. Your identity will be kept confidential. At the start of the interview, I will ask you to give your verbal consent to participate in this study. Participation in this study is voluntary, and you may withdraw at any time without penalty. There are no foreseeable risks in participating in this study. Your identity and information will be protected. Collected data will be stored in a locked cabinet at the researcher's home office. The attached consent form contains detailed information regarding the process and procedures of this study. I ask that you review the consent form prior to our telephone interview.

This study is being supervised by Dr. Casey Goodall, dissertation chair for this research study. He can be reached at (XXX) XXX-XXXX or cgoodall@tusd.edu. If you have any questions regarding the researcher or wish to schedule an interview, you may contact the researcher at (XXX) XXX-XXXX or dvazin@fullerton.edu.

Sincerely,

Dara Vazin- EdD Candidate

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APPENDIX D

RECRUITMENT LETTER—GROUP 2

المنارة للاستشارات

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[Date]

Dear [Health Educator],

I am a doctoral student in Organizational Leadership program at the University of La Verne, California and I am conducting my dissertation study on the spiritual dimension of health. You were selected to participate because of your Health Education experience teaching an undergraduate level course in Personal Health (or similar) within the California State University System.

The two goals of my study are (a) to establish a consensus definition of the spiritual dimension of health from a select group of national health organization leaders and from university health educators within the California State University (CSU) system; and (b) to identify which spiritual health learning objectives should be included in a college health education curriculum (unit, sequence, or course) and why. My ultimate goal is to establish a consensus definition of spirituality among health educators that would ultimately guide an effective development of a curriculum or program on spirituality and health for undergraduate programs. Further, I want to determine if it is feasible to increase the likelihood that all the dimensions of health will be appropriately represented in the California college health curriculum.

This letter is to confirm that you are willing to serve as a participant in my study. As a participant of this study, you will be asked to participate in an electronic survey containing four questions. The survey is confidential and will take approximately 10-15 minutes to complete. At the start of the electronic survey, you will be asked to give

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consent to agree to participate in this study. If you click the agree button, it will take you directly to the survey. Participation in this study is voluntary, and you may withdraw at any time without penalty. There are no foreseeable risks in participating in this study. Your identity and information will be protected. Collected data will be stored in a locked cabinet at the researcher's office. The attached consent form contains detailed information regarding the process and procedures of this study.

This study is being supervised by Dr. Casey Goodall, dissertation chair for this research study. He can be reached at (XXX) XXX-XXXX or cgoodall@tusd.edu. If you have any questions regarding the research you may contact the researcher at (XXX) XXX-XXXX or dvazin@fullerton.edu.

I would greatly appreciate your assistance. If you are not interested in taking part of this study, I ask that you please forward this recruitment letter to other health science professors who teach an undergraduate level course in personal health within the CSU system.

Sincerely,

Dara Vazin- EdD Candidate

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APPENDIX E

GROUP 1 INTERVIEW QUESTIONS (PHASE 1)

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Thank you for agreeing to participate in this study. Your participation in this study is voluntary. This study should take approximately 25 minutes to respond to 7 questions. Your responses will be kept confidential. The interview will be audio recorded and if you choose to participate in this study, you will be asked to give your verbal consent prior to the interview. Thank you.

A number of definitions of spirituality have been proposed by the literature. Some main themes that have been identified include: Unifying force/energy; Individual meaning and purpose in life; Transcends the individual. God or ultimate; Set of principles that govern conduct; Perceptions of powers beyond the natural; Fulfillment, achieving highest potential; An ability to heal by nonphysical interventions; Connection with a higher universal power; Hope, love, compassion ; A common bond between individuals; selflessness

Questions:

1. Given definitions proposed in the literature, what definition would you propose for the term *Spirituality* as it relates to health instruction at the undergraduate university level?

2. Is there a connection or relationship of spirituality to improved or sustained health? If so, what is the relationship?

3. What do you believe is the cause of the relationship described in response to question 2 (the connection or relationship of spirituality to improved or sustained health)?

4. To what degree do you believe Spirituality, as you have defined it, to be an important dimension of the health curriculum at the undergraduate college level?

5. In your opinion, should spirituality be taught as an individual course or as a single unit of a more comprehensive course?

6. What learning objectives do you believe should be included in a single unit, or course entitled *Spirituality and Health*?

7. Are there any recommendations you would make to leaders of universities to promote instruction of the spiritual dimension of health in the undergraduate curriculum?

Is there anything else you would like to add?

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Thank you for your participation in this study. May I contact you via e-mail if I have any questions regarding your responses?

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APPENDIX F

GROUP 2 E-MAIL SURVEY (PHASE 2)

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Thank you for agreeing to participate in this study. Your participation in this study is voluntary. This study should take approximately 15 minutes. Your responses will be kept confidential. At the start of the survey you will be asked to give your consent to participate in this study. If you agree, click the yes/I agree button and it will take you directly to the survey. Thank you.

1. Selected health experts have identified elements of the term Spirituality as it relates to health education at the undergraduate university level. These ELEMENTS of the spiritual dimension of health are listed below. Please mark the terms below as being either RELEVANT or IRRELEVANT.
2. Listed below are common THEMES of the spiritual dimension of health recognized by selected health experts. Please mark if you AGREE or DISAGREE with each theme listed.
    a. Spiritual health is individual, subjective, and very personal
    b. Spiritual health is connected to and is the driving force to all other dimensions of health
    c. Spiritual health can transcend an individual
    d. Spiritual health leads to optimal health
    e. Any other themes of the spiritual dimension of health you would like to add
3. To what degree do you believe spirituality to be an important component of the health curriculum at the undergraduate university level?

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4. How confident are you in teaching the spiritual dimension of health? Please rate your confidence level on the scale below where 0 means "not at all confident" and 10 means "very confident."
5. Selected health experts have established student learning objectives for undergraduate students as it relates to the spiritual dimension of health. Potential student learning objectives are listed below. Please mark as Relevant or Irrelevant.
    a. Explain how spirituality relates to the other dimensions of health
    b. Use a case study to illustrate how spirituality impacts health status
    c. Establish their own personal definition of spirituality
    d. Identify elements of their own spirituality they would like to assess
    e. Develop specific actions/behaviors they will take to improve elements of spirituality to improve during their time as a college student
    f. Identify spirituality elements they would like to improve five years after their graduation or departure from college
6. Some barriers to teaching spiritual health have been identified as those listed below. For each one, evaluate how it applies to you or not.
    a. ambiguity of the term spirituality
    b. lack of training on how to teach spiritual health
    c. political nature of the topic
    d. difficulty to assess spiritual dimension of health

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7. In your perception, how important is it that university leaders promote the inclusion of the spiritual dimension of health as it relates to an undergraduate level course in the university curriculum?
8. Is there anything else you would like to add regarding this topic?

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APPENDIX G

GROUP 1: RE-INTERVIEW QUESTIONS (PHASE 3)

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Re-interview Q1: Based on the input (Table 1 RE-Interview Q's), please tell me whether you agree or disagree with the following definition of spirituality and why.

Spirituality, as it relates to health instruction at the university level, is one of six dimensions of optimal health. It is the animating force of life, and the source from which we four different types of essential motivations in life:

1. Purpose and meaning in life: consisting of inspiration, a sense of personal significance, and satisfaction with life.
2. Will: consisting of determination, dedication, and emotional confidence.
3. Selflessness: consisting of loyalty and compassion for others.
4. Calmness or inner peace: consisting of transcendence, inner calm, a sense of peace and well-being, and motivation for quest for a universal meaning of life.

Re-Interview Q 2:

Table 6.Response to interview question 2. Expressed description of connection or relationship of spirituality to improved or sustained health. Based on the input from those health education leaders, please tell me if you agree or disagree that all of the identified themes are legitimate and important answers to the question. Why or why not?

Re-Interview Q3: The most concrete ideas regarding instruction of the spiritual dimension of health in the undergraduate curriculum was expressed by one expert leader as

> Spirituality is an important dimension of health and, therefore, must be addressed in the health curriculum. It should be a unit in a personal health course, which serves as a general education course requirement or a foundation course in a major or minor curriculum. It should be an elective course in the minor curriculum and a required course in the major curriculum. It should be addressed as a key dimension of health in the capstone course of the major curriculum.

Do you agree or disagree with that comment? Why or why not?

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APPENDIX H

LETTER OF SUPPORTTO DEPARTMENT CHAIR

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[Date]

Dear [Department Chair],

As you know, I am a doctoral student in Organizational Leadership program at the University of La Verne, California and I am conducting my dissertation study on the spiritual dimension of health. The purpose of my study is to establish a consensus definition of spirituality among CSU Health Educators that would ultimately guide an effective development of a curriculum or program on spirituality and health for undergraduate programs. The second purpose of this study is to identify which spiritual health learning objectives should be included in a college health education curriculum (unit, sequence, or course) and why.

Faculty who teach an undergraduate level course in Personal Health (or similar) within the CSU system will be asked to participate in an electronic survey. The survey is confidential and will take approximately 10 minutes. For your convenience, I have attached a copy of the consent form, which outlines the procedures of the study.

I am writing to request your support to forward this message to other Health Education/Science Department Chairs from California State Universities asking them to encourage their faculty's participation in my study. If there are any questions regarding this study, please feel free to contact Dara Vazin directly at 714-318-8312 or email dvazin@fullerton.edu.

Thank you for your support.

Sincerely,

DaraVazin –EdD Candidate

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APPENDIX I

IRB APPROVAL LETTER

المنارة للاستشارات
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University of La Verne
Institutional Review Board

TO: Dara Vazin, Doctor of Education Candidate

FROM: University of La Verne, Institutional Review Board

RE: 2013-CEOL-17-Vazin- The Spiritual Dimension of Health: Implications for Policy and Practice

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The research project, cited above, was reviewed by the College of Education and Organizational IRB Committee. The college review determined that the research activity has minimal risk to human participants, and the application received an Expedited review. The application was approved with one additional conditions:

- Please delete the sentence "No information will be released to any other party for any reason" from the informed consent forms.

A copy of this approval letter is required to be included as an appendix to your completed dissertation. The project may proceed to completion, or until the **date of expiration of IRB approval, February 28, 2014.** Please note the following conditions applied to all IRB submissions:

No new participants may be enrolled beyond the expiration date without IRB approval of an extension.

The IRB expects to receive notification of the completion of this project, or a request for extension within two weeks of the approval expiration date, whichever date comes earlier.

The IRB expects to receive prompt notice of any proposed changes to the protocol, informed consent forms, or participant recruitment materials. No additional participants may be enrolled in the research without approval of the amended items.

The IRB expects to receive prompt notice of any adverse event involving human participants in this research.

There are no further conditions placed on this approval.

The IRB wishes to extend to you its best wishes for a successful research endeavor. If you have any questions, please do not hesitate to contact me.

Marcia Godwin (signature) — Marcia L. Godwin, Ph.D. — February 28, 2013

Approval Signature — IRB Director/Chair — Date

For the Protection of Human Participants in Research

mgodwin@laverne.edu
(909) 593-3511, ext. 4103

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