Anusandhanvallari
Vol 2026, No.1
August 2026
ISSN 2229-3388

An Analysis of Perspective-Practice Gap in Spiritual Care Among Nurses in Kerala

[1]Kannan S, [2]Dr. Anand Sadasivan

[1]Research Scholar (Corresponding Author), Amrita School of Spiritual and Cultural Studies, Amrita Vishwa Vidyapeetham, Amritapuri, Kerala, India, Email:drkannansuresh@gmail.com

[2]Assistant Professor Amrita School of Spiritual and Cultural Studies, Amrita Vishwa Vidyapeetham, Amritapuri, Kerala, India

Abstract: Background: While spiritual care is recognized as a fundamental component of holistic nursing, operationalizing it remains challenging, particularly in pluralistic societies like India. Previous assumptions suggest nurses may possess high personal spiritual perspectives but struggle to translate them into clinical practice due to systemic barriers. **Objective:** This study aimed to quantitatively analyse the "perspective-practice gap" among nurses in Kerala and assess the relationships between their practical spiritual care delivery, philosophical perspective, and religious attitudes. **Methods:** A descriptive, correlational cross-sectional design was utilized. A cohort of nurses (N = 165) in Kerala, India, completed the Indian-validated 15-item Spirituality and Spiritual Care Rating Scale (SSCRS). Data were analysed using paired-samples t-tests and Pearson correlations across the scale's three validated factors: Spiritual Care (Factor 1), Spirituality Perspective (Factor 2), and Spirituality Attitude (Factor 3). **Results:** Contrary to the hypothesized gap, participants scored significantly higher in practical Spiritual Care ($M = 4.10$, $SD = 0.76$) than in philosophical Spirituality Perspective ($M = 3.73$, $SD = 0.92$), $t(164) = 6.99$, $p < .001$. A strong positive correlation existed between practical care and perspective ($r = .689$, $p < .001$). Notably, rigid Spirituality Attitudes showed no significant correlation with the ability to provide Spiritual Care ($r = .016$, $p = .839$). **Conclusion:** Nurses in Kerala demonstrate an "inverse" perspective-practice gap, excelling in operationalized spiritual care despite lower abstract philosophical perspectives. Furthermore, rigid religious attitudes do not influence clinical spiritual care competence, suggesting that nursing education should prioritize broad humanistic perspectives over specific religious frameworks.

Keywords: Spiritual care, Spirituality, Cross-sectional study, Holistic nursing, SSCRS, Nursing education, Kerala, India, Caring science.

1. Introduction

The 21st-century paradigm of healthcare has shifted significantly from a rigid biomedical model to a holistic framework, emphasizing the interconnectedness of the biological, psychological, social, and spiritual dimensions of the human experience. The roots of this holistic approach in nursing can be traced back to Florence Nightingale, who viewed spirituality as an intrinsic aspect of human healing, and later to theorists like Jean Watson, whose Theory of Human Caring posits that the spiritual dimension is central to the transpersonal caring relationship (Watson, 2008). Within this framework, nursing is uniquely positioned to address the spiritual needs of patients. Nurses, by virtue of their continuous bedside presence, often serve as the primary source of "spiritual comfort" and meaning-making during severe illness, navigating the existential crises that frequently accompany physical suffering (McSherry et al., 2002; Puchalski, 2001).

However, the operationalization of spiritual care remains a persistent clinical challenge. While international nursing bodies—such as the International Council of Nurses (ICN)—mandate spiritual care as an ethical obligation, the practical competence to deliver it varies significantly. Empirical evidence indicates that integrating spiritual care into routine practice yields measurable benefits, including reduced patient anxiety, enhanced coping mechanisms, and improved overall quality of life (Balboni et al., 2007). Furthermore, the translation of personal

spiritual beliefs into professional care is often hindered by systemic barriers, including severe time constraints, high patient-to-nurse ratios, and a profound lack of specific, actionable training in nursing curricula (Cone & Giske, 2018).

This study examines the practical operationalization of spiritual care within the specific cultural context of India. Unlike the highly secularized West, India is a pluralistic society where spirituality, religion, and daily life are inextricably linked. The Indian socio-cultural fabric is woven with diverse theological traditions—including Hinduism, Islam, Christianity, and Sikhism—each offering distinct paradigms of illness, suffering, and healing (Narayanasamy, 2006). By utilizing a newly validated, culture-specific instrument, this research aims to investigate the "perspective-practice gap"—the potential dissociation between a nurse's internal philosophical view of spirituality and their practical, bedside delivery of spiritual care.

2. Literature Review

2.1 The Construct of Spiritual Care in Nursing

Spiritual care is fundamentally defined as an altruistic, interpersonal, intuitive, and integrative process. McSherry et al. (2002) argue that it transcends mere religious ritual; it is the process of enabling patients to find meaning, hope, and purpose during health crises. It involves operationalized skills such as active listening, demonstrating empathy, establishing a therapeutic presence, and recognizing subtle signs of spiritual distress.

Modern holistic nursing theories assert that spiritual care is not a specialized task relegated to chaplains, but a foundational element of nursing practice. For instance, Watson's (2008) "caritas processes" explicitly require nurses to be sensitive to the self and others, nurturing faith and hope. Despite its acknowledged importance, Ross (2006) notes that the concept remains abstract in clinical settings (Ross, 2006). Nurses frequently report feeling incompetent or underprepared in addressing these needs, often citing a fear of imposing their own beliefs or a lack of vocabulary to initiate spiritual conversations (Cone & Giske, 2018).

2.2 Measurement Challenges and the SSCRS

To quantitatively measure this construct, the Spirituality and Spiritual Care Rating Scale (SSCRS) was originally developed in the United Kingdom and has been utilized in over 42 studies globally (Harrad et al., 2019). The tool was designed to capture a broad, highly individualized, and largely secularized understanding of spirituality common in Western healthcare models.

However, scholars note that perceptions of spirituality differ vastly in Asian contexts compared to Western contexts, necessitating rigorous cross-cultural validation (Mok et al., 2010; Tiew & Creedy, 2012). Western tools often implicitly favour individualistic paradigms of meaning-making, whereas Eastern constructs are frequently collectivistic, deeply embedded in family structures, and explicitly religious. Koenig and Al Zaben (2021) emphasize that psychometric validation is crucial to ensure culturally congruent measurement, warning that deploying Western instruments in Eastern populations can yield fundamentally flawed data (Koenig & Al Zaben, 2021).

2.3 The Indian Context: Divergence from the West

A pivotal study by Pais et al. (2023) tested the SSCRS in an Indian tertiary care setting, fundamentally challenging the applicability of the original Western scale (Pais et al., 2023). They found that Indian spirituality is often inextricable from a Supreme Being (a "God-centric" model).

Consequently, the original 17-item Western model did not fit the Indian cohort. Instead, a 15-item, 3-factor model emerged as psychometrically robust for Indian nurses:

- **Factor 1 (Spiritual Care):** The practical application of care (e.g., listening, kindness, allowing time to explore fears).
- **Factor 2 (Spirituality Perspective):** The nurse's philosophical view of life, morals, meaning, and a unifying life force.
- **Factor 3 (Spirituality Attitude):** The nurse's beliefs regarding rigid concepts like forgiveness, atheism, and restrictive religious observance.

2.4 Identifying the Perspective-Practice Gap

Despite the validation of this new scale, critical gaps in the literature remain. Specifically, there is a lack of empirical data on whether Indian nurses possess a high internal "Spirituality Perspective" (Factor 2) but fail to translate it into operationalized "Spiritual Care" (Factor 1) at the bedside due to systemic constraints like task-oriented care models and understaffing. Previous literature suggests an assumption that strong internal spirituality naturally equates to strong spiritual care, yet the "implementation gap" is frequently observed in clinical audits. Understanding this potential dissociation is crucial for healthcare management and curriculum reform, providing targeted insights into where the breakdown between theory and practice occurs.

3. Methodology

3.1 Research Design and Setting

This study utilized a quantitative descriptive and correlational cross-sectional design. This approach allows for an intra-cohort analysis of nursing competencies across different spiritual domains, capturing a snapshot of current clinical realities. The study was conducted in healthcare settings in Kerala, India. Kerala presents a highly relevant setting for this research; it boasts the highest literacy rate in India, a robust, globally exported nursing workforce, and a unique 'Kerala Model' of development that prioritizes social welfare and public health. Furthermore, the state's pluralistic society, characterized by the harmonious coexistence of diverse religious and spiritual traditions, provides a rich sociocultural backdrop for exploring how nurses integrate spiritual care into their clinical practice amidst varying belief systems.

3.2 Sample Size and Selection

A purposive sample of 165 nursing professionals was recruited from hospitals in Kerala, India. The optimal sample size was determined *a priori* using the power analysis formula for a paired-samples t-test, ensuring the robust detection of a conservative effect size while minimizing Type II errors.

The mathematical calculation to achieve 80% statistical power ($1 - \beta = 0.80$) at a 5% significance level ($\alpha = 0.05$, two-tailed) is given by the standard approximation formula:

$$N = \left(\frac{Z_{1-\alpha/2} + Z_{1-\beta}}{d} \right)^2$$

Where:

N = Required sample size

$Z_{1-\alpha/2} = 1.96$ (the critical value for 95% confidence level)

$Z_{1-\beta} = 0.842$ (the critical value for 80% statistical power)

$d = 0.22$ (a conservative estimation for a medium-to-small standardized effect size)

Applying these values into the equation:

$$N = \left(\frac{1.96 + 0.842}{0.22} \right)^2$$

$$N \approx 162.2$$

Rounding up to ensure adequate statistical power, a minimum of 163 participants was required. The final recruited sample of N=165 comfortably satisfies this mathematical threshold.

Furthermore, this sample size aligns perfectly with established methodological guidelines for scale validation and deployment in healthcare research (Boateng et al., 2018; Pais et al., 2023). For a 15-item instrument like the modified SSCRS, maintaining an ideal subject-to-item ratio of 10:1 requires a baseline sample calculated as:

$$N \geq (\text{Number of Items}) \times 10$$

$$N \geq 15 \times 10 = 150$$

Thus, the recruited sample size of 165 accommodates both the required psychometric ratio criteria (N > 150) and the mathematical power requirements for paired quantitative analysis.

The study was conducted within healthcare facilities in the state of Kerala, India. The target population comprised registered nurses currently engaged in direct clinical practice. Nurses working in administrative or non-clinical roles were excluded. The demographic profile of the participants revealed a predominantly female workforce (n = 160, 97.0%), with only a small minority of male nurses (n = 5, 3.0%). The age of the participants ranged from 22 to 55 years, with a mean age of 37.0 years (SD = 8.5).

Regarding religious affiliation, the cohort reflected the pluralistic nature of the Indian context, predominantly comprising Hindu practitioners (n = 112, 67.9%), followed by Christian (n = 42, 25.5%) and Muslim (n = 11, 6.7%) nurses. The questionnaire was self-administered in English after obtaining written informed consent.

3.3 Data Collection Procedure

An electronic flyer was created to provide a brief overview of the study, its objectives, required participant characteristics, and a link to the self-administered digital questionnaire (Modified SSCRS). To recruit the purposive sample of nursing professionals from hospitals in Kerala, the e-flyer was distributed through professional healthcare networks and social media platforms, primarily utilizing targeted hospital staff WhatsApp groups. Although online surveys possess inherent methodological limitations—such as the inability to strictly control the distribution population and the potential for self-selection bias (Andrade, 2020) —robust measures were implemented to mitigate these issues.

The first page of the digital survey was designed as a strict screening mechanism to ensure respondents met the required inclusion criteria. Specifically, participants had to verify they were registered nurses within Kerala. If

respondents provided answers aligning with the exclusion criteria (e.g., working in administrative or non-clinical roles), the survey was immediately terminated. Eligible participants were then provided with a detailed research information sheet and required to provide digital informed consent before accessing the survey items. If individuals chose not to consent, the survey page automatically closed. Data collection occurred between February and April 2025.

3.4 Instrument

Data were collected using the Modified SSCRS, validated specifically for the Indian Context by Pais et al. (2023). The instrument contains 15 items scored on a 5-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).

- **Spiritual Care (7 items):** Assesses practical bedside behaviours and interpersonal interventions.
- **Spirituality Perspective (4 items):** Assesses broad philosophical views regarding peace, meaning, and morality.
- **Spirituality Attitude (4 items):** Assesses specific religious/dogmatic attitudes (negatively worded items were reverse-scored prior to analysis to ensure directional consistency).

3.5 Data Analysis

To account for the unequal number of items across factors, cumulative scores were transformed into mean scores (ranging from 1 to 5) to allow for direct comparison. Data analysis was conducted using Python (version 3.10) executed within the Google Gemini Advanced Data Analysis environment. Data management and descriptive statistics were performed using the pandas library (version 2.0). Inferential statistical analyses—specifically paired-samples t-tests to investigate the "Perspective-Practice Gap" and Pearson product-moment correlations to examine associative relationships—were calculated using the scipy.stats module (version 1.10). Data visualizations, including boxplots and correlation heatmaps, were generated using the matplotlib (version 3.7) and seaborn (version 0.12) libraries. The alpha level for statistical significance was set *a priori* at .05

.3.5 Ethical Considerations

This study received ethical approval from the Institutional Ethics Committee of Amrita Vishwa Vidyapeetham, Amritapuri, Kerala, India (Ref No.: IHEC/2026/005). Written informed consent was obtained from all participants after they were provided with a detailed information sheet explaining the study's purpose, voluntary nature, and right to withdraw at any time. Confidentiality and anonymity were strictly maintained throughout data collection and analysis. The research was conducted in accordance with the Declaration of Helsinki.

4. Results

4.1 Descriptive Statistics

The descriptive analysis revealed that the highest aggregate scores within the cohort were observed in Factor 1: Spiritual Care (M = 4.10, SD = 0.76). This indicates a generally high level of self-reported practical engagement with patients. This was followed by Factor 2: Spirituality Perspective (M = 3.73, SD = 0.92) and Factor 3: Spirituality Attitude (M = 3.37, SD = 0.72). A summary of the descriptive statistics is presented in Table 1.

Table 1. Descriptive Statistics of Modified SSCRS Factors (N = 165)

Domain	Mean	Std. Deviation (SD)	Minimum	Maximum
Factor 1: Spiritual Care (Practice)	**4.10**	**0.76**	**1.00**	**5.00**
Factor 2: Spirituality Perspective	**3.73**	**0.92**	**1.00**	**5.00**
Factor 3: Spirituality Attitude	**3.37**	**0.72**	**2.00**	**5.00**

4.2 Intra-Factor Comparison: The Inverse Perspective-Practice Gap

To investigate the hypothesized gap between perspective and practice, a series of paired-samples t-tests were conducted. The analysis revealed a statistically significant difference between Factor 1 and Factor 2, $t(164) = 6.99$, $p < .001$.

Contrary to the initial hypothesis—which suggested nurses might possess high abstract perspectives but struggle with practical implementation due to heavy workloads or lack of training—the cohort scored significantly higher on the practical delivery of spiritual care than on their philosophical perspective. Furthermore, Factor 1 scores were significantly higher than Factor 3 scores ($t = 9.01$, $p < .001$), and Factor 2 scores were significantly higher than Factor 3 scores ($t = 3.75$, $p < .001$).

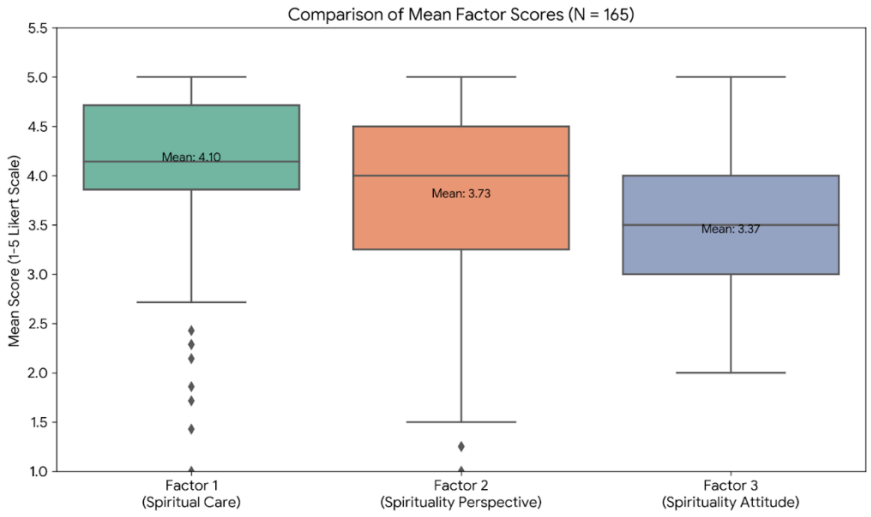

Figure 1. Boxplot comparing the distribution and means of the three SSCRS Factors, illustrating the significantly higher proficiency in practical Spiritual Care compared to Perspective and Attitude.

4.3 Correlational Analysis

A Pearson correlation matrix was computed to assess the relationships between a nurse's practical care, philosophical perspective, and specific religious attitudes (see Table 2).

Table 2. Pearson Correlation Matrix of SSCRS Factors

	Factor 1 (Practice)	Factor 2 (Perspective)	Factor 3 (Attitude)
Factor 1 (Practice)	-		
Factor 2 (Perspective)	.689*	-	
Factor 3 (Attitude)	.016	-.114	-

*Note. *p < .001*

A strong, positive correlation was found between Factor 1 and Factor 2, r (163) = .689, p < .001. This indicates that increases in a nurse's internal, philosophical understanding of spirituality are robustly associated with an increase in their ability to deliver practical spiritual care.

Crucially, the analysis demonstrated no statistically significant correlation between Factor 3 (Spirituality Attitude) and practical Spiritual Care (r = .016, p = .839) or Spirituality Perspective (r = -.114, p = .146).

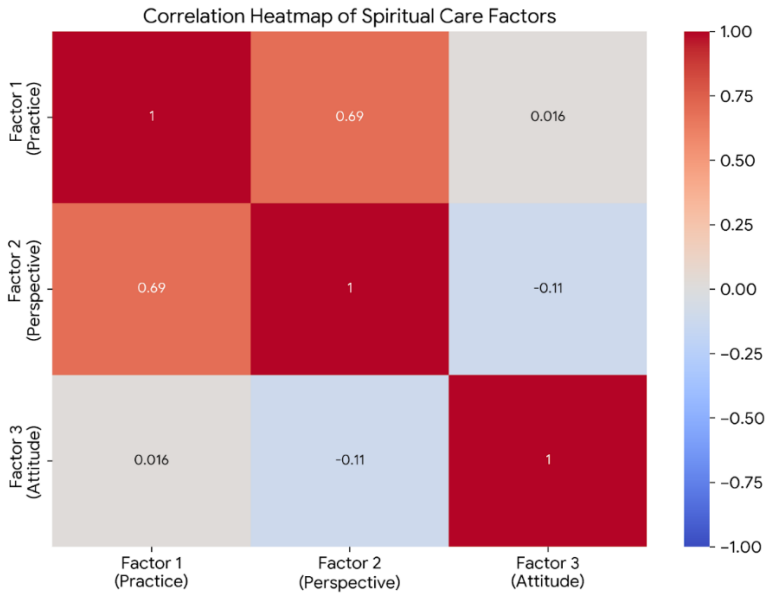

Figure 2. Correlation Heatmap demonstrating the strong positive relationship between Perspective and Practice, and the isolation of Attitude.

5. Discussion

This study yielded three critical findings that significantly advance the understanding of spiritual care operationalization in the Indian nursing context, challenging Western-centric assumptions and offering targeted pathways for educational reform.

First, the data revealed a statistically profound **"Inverse" Perspective-Practice Gap**. Originally, it was hypothesized that nurses might harbour a profound internal spiritual perspective but face institutional barriers in translating it to bedside care. Instead, participants demonstrated exceptional proficiency in the practical acts of spiritual care—such as listening, showing kindness, and making time for patients' anxieties—even when their abstract philosophical perspective of spirituality scored lower. This phenomenon suggests that in the Indian cultural context, these practical behaviours are deeply ingrained as foundational "good nursing care". Consequently, therapeutic presence and hospitality are operationalized organically, rather than being strictly dependent on advanced theological or philosophical conceptualizations of spirituality.

Second, despite practical scores outperforming perspective scores, the correlational analysis proved that **Perspective and Practice are deeply linked** ($r = .689$). The two domains move synchronously. Nurses who possess a broader, more cohesive philosophical view of life, meaning, and unity (Factor 2) are significantly more likely to provide high-quality, operationalized spiritual care (Factor 1). This aligns with Jean Watson's theory, emphasizing that a nurse's intentionality and internal spiritual maturity directly dictate the quality of the transpersonal caring moment.

Third, and perhaps most importantly for nursing ethics and education, the study proved the **Irrelevance of Rigid Religious Attitudes**. Factor 3, which measures restrictive beliefs regarding atheism, forgiveness, and exclusive places of worship, had absolutely no statistical bearing on a nurse's ability to provide spiritual care ($r = .016$). This is a vital validation of professional nursing ethics. It proves that a nurse holding strict, dogmatic religious views and a nurse holding liberal, secular views are equally capable of providing excellent spiritual comfort to patients. Professional duty successfully overrides personal dogma.

Limitations

Several limitations should be acknowledged. First, the study relied on self-reported data via the SSCRS; therefore, the findings reflect perceived rather than observed spiritual care practices. Second, the purposive sampling conducted in Kerala limits generalizability to other regions in India. Third, the cross-sectional design precludes causal inferences regarding the directionality of the relationship between Spirituality Perspective and Spiritual Care. Finally, although anonymity was assured, social desirability bias may have influenced responses, particularly on items related to professional competence. Future studies employing observational methods or mixed-methods designs would strengthen these findings.

Implications for Nursing and Policy

These findings have direct, actionable implications for nursing administration and curriculum design.

1.**Re-evaluating Curriculum:** Hospital administrators and educators do not need to alter a nurse's specific religious attitudes (Factor 3) to improve patient outcomes. Interventions targeting religious dogma are statistically unwarranted.

2.**Fostering Perspective:** Training interventions should focus exclusively on broadening a nurse's humanistic and philosophical perspective (Factor 2). Because of the strong correlation with practice, incorporating reflective journaling, mindfulness, and existential discussions into core clinical modules will likely yield direct improvements in bedside spiritual care (Factor 1).

3.**Recognizing Existing Strengths:** Institutions should formally recognize and document the "basic" relational tasks (listening, kindness) as valid spiritual care interventions, validating the intrinsic strengths of the Indian nursing workforce.

6. Conclusion

Spiritual care is a vital component of holistic nursing that can be successfully operationalized regardless of a practitioner's specific religious dogmas. Kerala nurses demonstrate a remarkable capacity for translating spirituality into practical, bedside comfort, prioritizing human connection, empathy, and listening over abstract theology. The presence of an "inverse" perspective-practice gap highlights a workforce that acts spiritually before it philosophizes spiritually. Future qualitative research—particularly phenomenological inquiries—should explore the lived experiences of these nurses to understand the intrinsic, cultural motivations that drive this high level of practical care, further bridging the gap between holistic theory and clinical reality.

7. Acknowledgment

The authors would like to express their sincere gratitude to Sri Mata Amritanandamayi Devi, Chancellor of Amrita Vishwa Vidyapeetham, for her blessings, inspiration, and enduring support toward our research endeavors.

8. References:

[1] Andrade, C. (2020). The Limitations of Online Surveys. *Indian Journal of Psychological Medicine*, *42*(6), 575–576. https://doi.org/10.1177/0253717620957496

[2] Balboni, T. A., Vanderwerker, L. C., Block, S. D., Paulk, M. E., Lathan, C. S., Peteet, J. R., & Prigerson, H. G. (2007). Religiousness and Spiritual Support Among Advanced Cancer Patients and Associations With End-of-Life Treatment Preferences and Quality of Life. *Journal of Clinical Oncology*, *25*(5), 555–560. https://doi.org/10.1200/JCO.2006.07.9046

[3] Cone, P. H., & Giske, T. (2018). Integrating spiritual care into nursing education and practice: Strategies utilizing Open Journey Theory. *Nurse Education Today*, *71*, 22–25. https://doi.org/10.1016/j.nedt.2018.08.015

[4] Harrad, R., Cosentino, C., Keasley, R., & Sulla, F. (2019). Spiritual care in nursing: An overview of the measures used to assess spiritual care provision and related factors amongst nurses. *Acta Bio Medica Atenei Parmensis*, *90*(4-S), 44–55. https://doi.org/10.23750/abm.v90i4-S.8300

[5] Koenig, H. G., & Al Zaben, F. (2021). Psychometric Validation and Translation of Religious and Spiritual Measures. *Journal of Religion and Health*, *60*(5), 3467–3483. https://doi.org/10.1007/s10943-021-01373-9

[6] McSherry, W., Draper, P., & Kendrick, D. (2002). The construct validity of a rating scale designed to assess spirituality and spiritual care. *International Journal of Nursing Studies*, *39*(7), 723–734. https://doi.org/10.1016/S0020-7489(02)00014-7

[7] Mok, E., Wong, F., & Wong, D. (2010). The meaning of spirituality and spiritual care among the Hong Kong Chinese terminally ill. *Journal of Advanced Nursing*, *66*(2), 360–370. https://doi.org/10.1111/j.1365-2648.2009.05193.x

[8] Narayanasamy, A. (2006). *Spiritual Care and Transcultural Care Research*. Quay.

[9] Pais, N. D., Suresh, S., & DCunha, S. (2023). Spirituality and Spiritual Care in Nursing: Validity of the Spirituality and Spiritual Care Rating Scale in an Indian Context. *Journal of Religion and Health*, *62*(3), 2131–2143. https://doi.org/10.1007/s10943-022-01634-1

[10] Puchalski, C. M. (2001). The Role of Spirituality in Health Care. *Baylor University Medical Center Proceedings*, *14*(4), 352–357. https://doi.org/10.1080/08998280.2001.11927788

[11] Ross, L. (2006). Spiritual care in nursing: An overview of the research to date. *Journal of Clinical Nursing*, *15*(7), 852–862. https://doi.org/10.1111/j.1365-2702.2006.01617.x

[12] Tiew, L. H., & Creedy, D. K. (2012). Development and preliminary validation of a composite Spiritual Care-Giving Scale. *International Journal of Nursing Studies*, *49*(6), 682–690. https://doi.org/10.1016/j.ijnurstu.2011.11.014

[13] Watson, J. (2008). *Nursing: The Philosophy and Science of Caring, Revised Edition*. University Press of Colorado.