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# Patterns Under Construction: Nurses' Lived Experiences Shaping Spiritual Care

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Patterns Under Construction:  
Nurses' Lived Experiences Shaping Spiritual Care

A DISSERTATION SUBMITTED TO THE FACULTY OF THE  
SCHOOL OF EDUCATION OF THE UNIVERSITY OF ST. THOMAS  
ST. PAUL, MINNESOTA

By

Renee Kumpula

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS  
FOR THE DEGREE OF  
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Patterns Under Construction:  
Nurses' Lived Experiences Shaping Spiritual Care

We certify that we have read this dissertation and approved it as meeting departmental criteria for graduating with honors in scope and quality.

We have found that it is complete and satisfactory in all respects, and that any and all revisions required by the final examining committee have been made.

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## ABSTRACT

*“How do nurses form their patterns for practice of spiritual care?”* Developmental theory provided a framework for conceptualizing and analyzing how nurses integrate patterns into practice and shape spiritual care. Registered Nurses ( $n=12$ ), as alumni of a faith-based liberal arts institution, participated in phenomenological research with individual interviews, focus group interviews, and follow-up interviews. Participants described their lived experience and how they approach spiritual assessment as required by the Joint Commission standard for US nurses. Demographic characteristics included: 2 males and 10 females, diploma and associate degree prepared RNs, and completion of RN to baccalaureate degree programs in the last four years. Participants reported a variety of clinical practice settings with patients of diversity in hospital systems. Participants emphasized the importance of identifying role models, first time experiences in providing spiritual care, offering supportive services, participating in prayer and religious practices, personal constructions of spirituality, nuances in spiritual assessment, holistic spiritual interventions, cultural considerations, and spiritual care in varied practice settings. The following patterns emerged regarding development and practice in spiritual care: trusting intuition, sensing, and awareness; connecting through caring and comforting; surveying and offering spiritual support; and affirming affiliation or accommodating religious/spiritual practices. Findings suggest nurses incorporated holistic care concepts from dialogue through innovative strategies or alternative pedagogies in nursing education and nurses who grow in personal faith development integrate and shape patterns in providing spiritual care.

*Key words: spiritual care, Registered Nurse, RN, associate degree, baccalaureate degree, RN to baccalaureate programs, nursing education, Joint Commission standard, holistic care, phenomenology, spiritual assessment, patterns in providing spiritual care, competency, nurse preparation, innovative strategies, lived experience, practice settings, hospital systems, dialogue-based education, alternative pedagogies, cultural considerations, diversity, US nurses*

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## INTRODUCTION

Among the health professions, nurses compose the most trusted profession in our society. Nurses establish interactions, conduct ongoing assessments, and provide many hands-on interventions in inpatient and outpatient venues. Health professionals often work for institutions, organization, or agencies with operational units (Heller, Oros, & Durney-Crowley, 2000; Magnussen, 1998). Within inpatient units, health professionals deliver care in clusters of patient rooms or exam rooms, clinic areas, and offices.

In inpatient settings, an individual using health services becomes a “patient” because he or she is admitted for episodic care related to an emerging concern, a chronic condition, or an acute disease process. In outpatient settings, an individual becomes a “client” because he or she is seen, assessed, and treated in a clinic, treatment center, office, or agency in the community or in his or her home (Clark, 2008). The reality in contemporary health care involves multiple disciplines which deliver holistic health services (Koenig, 2007). Whether in inpatient or outpatient settings, nurses often assess individuals during the intake or admission process. Nurses spend the most time at the bedside in hospitals or inpatient settings or with clients in outpatient settings like homes or clinics in the community (Clark, 2008).

In the profession of nursing, research informs evidence-based practice (EBP), which currently advises nursing knowledge in education and practice. Establishing EBP from holistic care research comprises a current emphasis in the profession (LoBiondo-Wood & Haber, 2010). Spiritual care constitutes part of the spectrum of holistic needs. Nurses demonstrate an ability to take abstract concepts concerning the spiritual dimension and conduct assessment (O’Brien, 2008). Rather than gaining an explicit

understanding of knowledge through nurse preparation, how nurses provide spiritual care may involve implicit understandings from life experience. Implicit understandings necessarily involve individually constructed perceptions by interpreting phenomena throughout the lifespan (Bogdan & Biklen, 2007).

The focus of spiritual care, though centuries old, bears new scrutiny. Honored in ancient religious traditions, the spiritual dimension attained renewed relevance due to the complexities of current health care delivery (Koenig, 2007). A result of the modern hospice movement and a push toward holistic care, today's health care includes consideration of spiritual health and well-being. Spiritual health contributes to the strengths promoting the health and wellness of the individual and groups (Clark, 2008).

In a pluralistic society, increasing diversity necessitates the ability to identify factors influencing health and healing, including spiritual care (Koenig, 2007). The spiritual dimension influences the human being's capacity to hear bad news, to endure marvels of technological treatments, to cope with problematic outcomes, and to heal through prescribed treatments and interventions and/or unconventional means (Koenig, 2007). In rising aging and vulnerable populations, spiritual well-being requires attention.

### **Problem Statement**

Research affects nursing practice. Defining what constitutes effective practice continues to be a focus of nursing. In nursing practice, the nurse works to discover unmet needs and brings them to the fore. Renewed interest surfaced in promoting spiritual well-being (Koenig, 2007). Assessing spiritual need forms one aspect of nursing assessment. The Joint Commission, a national non-profit organization which accredits and certifies health care services, mandated nurse documentation of spiritual assessment and care upon

admission to health care systems (Joint Commission, 2011). Assessment encompasses how nurses process and interpret the life experience, impressions, and actual expressions about health, well-being, and spiritual care from the patient and family (O'Brien, 2008). Considering how nurses construct their reality and interpret phenomena in daily occurrences may impact how they view holistic care and the spiritual dimension of the human being (Taylor, 2002). To understand practice better, looking at the lived experience of nurses and the phenomenon of spiritual care provided merit. In this study, I explored how some nurses understand and make meaning of their life experience in their delivery of spiritual care, including how they interpreted these experiences and developed patterns for providing spiritual care.

### **Significance of the Problem**

This issue presents relevance for nursing and other professions involved in health care, education, and psychosocial supports in society due to broad implications for addressing spirituality as part of an individual's support systems. With the amount of time spent at the bedside, nurses possess the greatest opportunity among interdisciplinary team members to approach spiritual care and spirituality (Taylor, 2002). As part of accreditation in health care systems, nurses document spiritual needs assessment upon admission to inpatient care settings (Joint Commission, 2011). Despite the standard, how nurses actually assess spiritual status varies widely. Although research substantiates the need for spiritual care, delivery of spiritual care continues to confuse and confound nurses in practice (Cavendish, Luise, Russo, Mitzelotis, Bauer, Bajo, Calvino, Horne, & Medefint, 2004). This confusion presents broad implications for education and nursing practice. Some might argue nurses should implement similar patterns of spiritual care. If

nurses vary patterns significantly, how nurses transfer knowledge from nurse preparation to practice may be in question.

Moreover, the Joint Commission mandate implies a practice standard with legal ramifications (Joint Commission, 2011). Despite the importance of the standard, some nurses acknowledge inability to assess or support spiritual care. Nursing skills occupy focused attention in nursing education. Therefore, if nurses value all other skills and seek best practice, one questions why spiritual care receives so little attention or emphasis in nurse preparation. While Tippett (2010), author and public radio host, and guests discuss the importance of spirituality in relation to health and healing in society at-large, nurses flounder in delivering consistent spiritual care across settings. When health and healing matter most, wide variances continue in how nurses provide spiritual care. Either spiritual care may exist in curricula and be glossed over/ignored, or faculty exclude it because of misconceptions. Historically, religious overtones muddy this practice issue.

Every human being possesses spiritual needs. Even those who do not value what is spiritual or religious remain spiritual beings. Swinton and McSherry (2006) posed failing to provide support for spiritual care results in a significant breach of human rights. If nurses do not provide care that meets EBP in spiritual care, human rights violations may exist. According to the American Nurses Association (ANA) Code of Ethics, failure to provide spiritual care also violates the dignity of human persons (American Nurses Association, 2001). If spiritual care exists in theory without implementation in practice across settings, then nurses may become complicit in ethical and legal violations (Joint Commission, 2011). If nurses do not uniformly practice spiritual care, a gap between knowledge and practice remains. Providing spiritual care may involve developmental

growth in the life of the nurse in order to make human connection and relate to dimensions of the body, mind, and spirit (Cavendish, et al., 2004; Taylor, 2002). All nurses, not just those who claim to be spiritual or religious, need to provide relevant spiritual care. Regardless of religious persuasion or spiritual stance, all nurses need to demonstrate the ability to provide spiritual care and support which matters to the patient and family. This charge for practice requires further understanding of how nurses develop patterns in providing spiritual care. A nurse of any persuasion, religion, doctrine, or creed ought to be able to deliver thoughtful spiritual care—to hold a hand, shed a tear, or offer relevant support (O'Brien, 2008, Taylor, 2005).

### **Purpose of the Study**

Many suggest nurse preparation in higher education should provide nurses with knowledge and skills for best practice (Benner, 1984; Cavendish, et al., 2004; Dossey, Selanders, Beck, & Attewell, 2005; Highfield, Taylor, & Amenta, 2000; O'Brien, 2008; Taylor, 2005). However, in providing holistic care, nurses may vary how they apply their knowledge and respond to cues in the clinical environment. Responding to spiritual cues proves to be important in relation to expectations of practice. This study explored how nurses think about providing spiritual care and how they learned to approach the spiritual dimension of the human being. Phenomenology provided the means to examine both a whole phenomenon and its parts or components.

This study involved uncovering and examining the lived experience of nurses who provide spiritual care. The study focused on nurses who completed similar educational requirements and who practice with similar standards and expectations in a variety of clinical settings. The purpose of this study was to understand: first, what



influences, both spiritual and general, may impact nurses' conceptualization and formation of patterns for practice; and second, how nurses internalize and operationalize those patterns in providing spiritual care.

### **Research Question**

This study's formulated research questions explored the process of delineating nursing practice and derived meaning from individual lived experiences. Looking at individual perspectives included religious beliefs, bias, and assumptions. A person's "situatedness" in a particular location and time may affect the construction of their spiritual reality (Taylor, 2002). Nurses' lived experience and perspective of their own spiritual reality affect their understanding and ability to assess another human being's spiritual reality. This individual reality influences how individual nurses deliver spiritual care (Taylor, 2002). Looking at both the "how" and "why" beyond what constitutes spiritual care practice is the focus of the study. The focused research question was: How do nurses form their patterns for practice of spiritual care?

The broader questions in a phenomenological study include: What is it like to be a nurse who provides spiritual care? What comprises spiritual care? What does this mean to the individual nurse?

### **Definition of Terms**

For this study, the following terms were defined as:

- Nurses:* Registered Nurses (RNs) who have practiced nursing with associate degree or diploma credentials and completed baccalaureate credentials within the last ten years.
- Form:* To shape or develop as in a habit or prescribed way of doing something.
- Patterns:* Gradually shaped and repeated customs and behaviors.

- Practice:* Integrated and applied skill as a caregiver in the nursing profession.
- Providing:* Implementation of independent nursing interventions which meet identified needs through assessment.
- Spiritual:* Relating to or affecting the spirit, as in the spiritual dimension of the human being.
- Care:* A nurturing way of relating to another valued human for whom one feels responsible and personally committed (Swanson, 1993).
- Spiritual care:* Integrated, purposeful nursing care of the whole person including the body, mind, and spirit which is focused on spiritual needs as the client defines and understands them (O'Brien, 2008).

### **Researcher's Perspective**

Early in life, I developed a unique perspective of spiritual care. Growing up in a family of nurses and teachers, I wanted to find an alternative career to that of my relatives and parents. On the fast track to becoming a journalist under the mentorship of a high school teacher, I changed direction during my junior year. I assessed my core values and the abilities others acknowledged within me; I identified a central concern for others and the unique life experience I acquired for holistic and spiritual care.

I spent my childhood surrounded by professionals from multiple disciplines, many inspired by faith and a mission to serve. Mealtimes, even with extended family or friends, consisted of substantive spiritual conversation. My parents served as leaders in the school, church, and community, providing my four siblings and me with access to role models and various perspectives. My parents entertained church and community leaders; I frequently served coffee and listened to rich conversations replete with ideas about education, mission, and spiritual themes.

Being an active part of an intergenerational system in the community, I listened intently, asked questions, and participated in adult discussions and activities. I heard

foreign dignitaries and leaders in education who discussed faith-based ideas for service initiatives in the community and abroad. I learned from adults who routinely demonstrated spiritual care of others, regardless of their career path or religious persuasion. This upbringing afforded me a privilege to integrate both an organic understanding and an intellectual knowledge of spiritual concepts. Having exposure to multiple professionals who modeled spiritual care and intervention—from nurses, to teachers, to social workers, to clergy, I developed a comfort level in assisting others in a spiritual way. This sense of purpose led me to choose nursing for my career path.

Upon graduation with a baccalaureate degree in nursing, I took further classes to understand spiritual care in more depth. As a new RN, my clergy assigned parishioners for me to visit even before I completed my orientation in a major metropolitan hospital. Thus began my service in parish or faith community nursing, an aspect of nursing practice I continue. Due to my life experience and undergraduate education in holistic nursing, I routinely provided spiritual care. I considered a spiritual conversation with someone to be an honor. I learned how to have dialogue at a level where the other person was comfortable and how to use whatever terms the other person chose in order to express his or her spiritual view or ambivalence.

Spiritual care continued to be a focus of my practice as I worked in public health, home care, and hospice settings. When considering the lifespan and the human experience, I came to understand the individual desires to make meaning of this fragile pilgrimage through life. When considering meaning-making, I think about the spiritual nature of every human being. Making meaning springs forth from hope within the human heart to reach out to the eternal, the divine, and the omnipotent (O'Brien, 2008).

Spiritual longing comes from deep within, a desire to be fulfilled even in the midst of the mundane. This deep longing for fulfillment within the human being, even fulfillment of the human spirit, imparted particular relevance for my nursing practice (O'Brien, 2008).

Ever since I completed research about end-of-life nursing education for my master's program, one comment in the literature kept coming back to me. Frommelt (1991) reported spiritual care in the context of end-of-life care remained without intentional study and without much attention in research. As I continually researched spiritual care due to my ongoing parish nursing contacts with congregants and families, I found spiritual care lacked purposeful attention among other evidence-based practice within the profession. This permeated my consciousness as I pursued doctoral studies.

My present interest stems from current practice in teaching associate degree and baccalaureate degree nursing in various levels and programs of study at a liberal arts university. In developing clinical sites with community partners, several undergraduate baccalaureate nursing students, including multicultural students, recently identified their interest in learning how to provide effective spiritual care for elders. Other students, as practicing RNs who are completing baccalaureate credentials, identified their interest in providing holistic, spiritual care. Their interest stemmed from parish nursing visits to diverse clients in community settings, home visits with public health nurses, and hospice home care. I see curiosity and openness among my students, both novice and experienced nurses, to explore meanings of spiritual care and spirituality. This capacity for spontaneously questioning what is known and unknown about the human soul and spirit further stimulated my interest in the topic.

In the middle of data collection during this study, I experienced being the spouse of someone needing lifesaving surgery and heroic measures. My husband and I sat in the receiving posture of spiritual care in a hospital intensive care and a specialty unit. Subsequently, I lived out the experience of the study by receiving spiritual support before I completed analysis and derived this study's eventual findings.

When faced with health crisis, my husband and I appreciated how simple spiritual care really became. The singular human vessel who offered spiritual care did not matter; he or she did not need to provide specific religious care for us to feel spiritually supported. The religious affiliation, doctrinal stance, or spiritual understanding of nurses and the health care team did not matter. Their developmental stage, personal faith, maturity, intellect, or station in life did not matter. What mattered was each caring individual who sensed our need, expressed compassion, and reached out—simply holding a hand, extending support, or offering a prayer.

### **Importance of the Study**

This study provides both information and insights into how nurses experience professional practice and reflect upon their practice. Findings of this study inform nursing education and practice because little qualitative research has been done across practice settings or to evaluate spiritual practice among nurses who care for the entire lifespan. To date, I identified several qualitative studies with similar design yet limited samples to oncology, hospice, or parish nurse settings (Van Dover & Bacon, Pfeiffer, 2006; Van Dover & Pfeiffer, 2001; Zerwekh, 1993). I found one qualitative study previously conducted across practice settings (Narayanasamy & Owens, 2001). Other studies done with nurses in the United States used mixed methods (Boutzell & Bozett,

1990; Highfield & Cason, 1983; Stranahan, 2001; Taylor, Amenta & Highfield, 1995). Across disciplines, the findings of the study will have relevance for any professional practice dealing with forming or informing patterns of spiritual assessment, spiritual interaction, and spiritual care.

### **Overview of the Dissertation**

In this chapter, I provided background to frame the issue and posed a purpose statement. I described the significance of the study to the profession of nursing, which may provide instructive findings for other disciplines as well. I identified my own philosophical orientation toward spiritual care along with describing my background and interest in the topic of spiritual care.

In Chapter Two, I examined pertinent literature for both nursing education and practice in regard to spiritual care. I established the prevailing content knowledge for how nurses may provide spiritual care. In examining research, I described content and pedagogical threads which bear on nurses' provision of spiritual care. This review includes relevant literature for understanding how nurses integrate and form practice patterns.

In Chapter Three, I described the methods I employed for data gathering and analysis in this study. In Chapters Four and Five, I reported data findings with analysis including description of participants with demographic information, identification of significant themes and threads, and analysis with connections to theory. In Chapter Six, I provided conclusions and implications for theory, research, and practice.

In summary, identifying how nurses form patterns of spiritual care contains significance for nursing practice and nursing education. A problem in nursing exists

where nurses provide spiritual assessment and care without consistency. The purpose of this study was to understand what influences may impact nurses' conceptualization and formation of patterns for practice and how nurses internalize and operationalize those patterns in providing spiritual care.

## CHAPTER TWO: REVIEW OF THE LITERATURE

Persons who enter the health care system in an inpatient environment require spiritual assessment as part of care for the whole person. According to a Gallop poll in 2006, 57% of Americans said religion is very important to them personally, a percentage which increased to 72% for older Americans over 65 years of age (Koenig, 2007). In the United States, individuals who experience episodic care in response to a health care concern may expect services such as spiritual care during their hospital stay (Koenig, 2007). Growing attention on holistic needs in American culture raised awareness about spirituality and increased public interest on the topic.

### **Spiritual Care: The Issue**

The issue of spiritual care emerges from a new commitment to holistic care in contemporary health care. A shift from the curative model of disease of the twentieth century to a holistic model of health for the twenty-first century continues to unfold (Dossey et al., 2005). This holistic perspective implies a state of harmony among mind, body, and spirit. Although the spiritual dimension was previously addressed by other entities, the World Health Organization (1998) recently instituted the spiritual dimension into the official definition of health with four domains of well-being: physical, mental, social, and spiritual. This definition informs global health and a number of health initiatives in the United States including Healthy People 2020 and other national programs (Healthy People, 2011). The goal of holistic health care is to achieve and maintain a state of well-being whereby the healing processes within the mind, body, and spirit continue unimpeded (Benner Carson & Koenig, 2008; Leathard & Cook, 2009).



Public health entities and the health professions promote this newer paradigm for disease prevention and health promotion (Clark, 2008).

Presently, nursing remains the only health profession mandated to document holistic care of the entire human being including spiritual care in health care settings (Joint Commission, 2011). Due to their contact with patients at the bedside, nurses must provide documentation about spiritual assessment and care with every hospital admission. This requirement from the Joint Commission set the standards for hospitals and providers of health care (Joint Commission, 2011). The spiritual care criterion requirements include: guidelines for inclusion of spiritual assessment and documentation on hospital admission assessment forms, provision of pastoral care for patients who request it, and the hospital's provision for spiritual needs of dying patients and their families (Cavendish, et al., 2004; Gray, Garner, Snow & Wright, 2004; Meyer, 2005). Some believe the criteria meet the bare minimum and spiritual assessment should also delineate more about the patient's beliefs, denomination, and spiritual practices that are meaningful or necessary for the well-being of the patient (Benner Carson & Koenig, 2008; Koenig, 2007). Moreover, the Patient Bill of Rights calls attention to essential holistic needs (US Health and Human Services, 2011).

Currently, renewed interest in spiritual well-being permeates society at-large. Spiritual health adds a renewed consideration for holistic health care and focuses attention on the individual life experience, impressions, and expressions about spiritual care (Koenig, 2007; O'Brien, 2008). Religious coping became widespread among patients who experience an increasing number of common chronic health conditions. With religious coping, patients utilize their religious beliefs or spiritual practices in order

to deal with emotional distress brought on by change or loss (Koenig, 2007). Believing in God or a Higher Power allows them a way to release such problems by turning these concerns over to God, alleviating suffering, and finding meaning in difficult circumstances. This gives patients a locus of control and an ability to reduce anxiety or embrace hope during a health crisis (Benner Carson & Koenig, 2008; Koenig, 2007).

Individual perspectives may include religious beliefs, bias, and assumptions. How each person situates himself or herself in a particular time and place affects his or her spiritual reality (Taylor, 2002, 2005). The frame of potential conversations about the reality of the individual varies from person to person, both professionals and patients alike. This becomes essential in understanding the dynamics behind identifying patients' religious preferences or broader beliefs (O'Brien, 2008). Nurses' lived experience and perspective of spiritual reality affects their understanding and ability to do adequate spiritual assessment and ultimately deliver relevant and meaningful spiritual care. An overview of spiritual care provides background to understand the issue and the relevant literature.

### **Overview of Spiritual Care**

Among the professions, nursing may be more advanced and forward thinking about addressing spirituality issues (Swinton, 2006). Florence Nightingale conceptualized nursing as a vocation or divine calling, delineated the importance of the character and moral development of nurses, and identified the imperative of giving spiritual care (Dossey, 2000). Bradshaw (1994) proposed Nightingale shaped nursing as covenantal practice. Nightingale's vision included nursing as ministry among the ill and infirmed (Webb, 2002). She established nursing as a modern profession for respectable

women in society. Over time, nursing gradually institutionalized and secularized practice. The acuity and complexity of care displaced time for spiritual care and the profession increasingly ignored the spiritual aspect of nursing care.

In the nursing profession, nurses must understand and recognize various characteristics and tensions of the spiritual dimension. How nurses comprehend and document this understanding remains vital in order to conduct appropriate assessment of spiritual needs and provide appropriate referrals and resources (Dossey et al., 2005). Within the context of providing holistic care of the biophysical, psychosocial, cultural, and spiritual dimensions, nurses need a broader understanding of the spiritual dimension, including what some term as *spirituality* (Van Leeuwen & Cusveller, 2004). Spirituality impacts how human beings think and function, “to transgress and transcend” their objective condition (Rys, 2009, p. 54). Although the various dimensions of the human being are separate yet interrelated, nurses may not perceive spiritual care as being distinct from providing physical, psychological, social, or religious care (Carroll, 2001; Nussbaum, 2003). With changing demographics and increasing complexity of health conditions, nurses need to identify each individual’s expression of spiritual need and provide appropriate support (Bash, 2004). When major religions are no longer points of spiritual reference within society, nurses need to understand there may be no one narrative for spiritual care, but rather an individual’s boundaries define the spiritual experience (Bash, 2004; Dossey et al., 2005; Koenig, 2007).

Both a lack of unity about agreed-upon definitions of spiritual care and spirituality for nursing, along with variations in a nurse’s own spiritual and cultural beliefs, may influence spiritual care (Carroll, 2001; MacLaren, 2004; McManus, 2006). Belf’s (2002)

suggestions for coaching with spirit provided noble goals for nurse educators including being of service, finding purpose, identifying whose spirituality is in question, finding the action for the common good, and determining the best way to connect in relationship. Determining what has an impact on nurse perception about spirituality and spiritual care is essential for effective practice (Taylor, 2002). Historical background provides context to understand what spiritual care and spirituality entail.

### **Historical Context of Nursing and Spiritual Care**

Historical context frames the current issue of providing spiritual care. During the Crimean War, Florence Nightingale formed a new nursing paradigm and envisioned a positive image for nursing as a respectable women's profession among the middle class. Previously, sisters of charity, religious women, and women of ill repute worked as nurses (Dossey et al., 2005). Nightingale established spiritual care as a hallmark of practice and ensured character development of nurses in training (Dossey, 2000; Dossey et al., 2005).

Once organized under Nightingale, nurses cared for the ill, the wounded, and the infirmed in hospitals and institutions, which included attention to the spiritual dimension (Dossey, 2000). This tradition continued as other nurse leaders emerged. Clara Barton nursed soldiers during the Civil War. Lillian Wald began public health nursing in overcrowded tenement housing among new immigrants in New York City. Other lesser-known nurses advanced the profession (Clark, 2008). Starting as early as 1873 and over time, hospitals established nursing schools supported and/or staffed by religious orders, denominations, or benefactors along with some publicly supported hospital schools (Reverby, 1987). Around the beginning of the twentieth century, colleges implemented nursing curricula in order to improve the professional image of nursing and increase the

scientific rigor of nurse education. The first generic university education for nurses and a precursor of the baccalaureate nursing education model started at the University of Minnesota in 1909 (University of Minnesota, 2011). Along with changing modes of education, end-of-life customs changed public perception and norms (Copp, 1994; Reverby, 1987).

Changes in the twentieth century affected everyday life and impacted the perspective of society-at-large concerning life and death issues, including spiritual care. Technological advances changed health care and life expectancies as new medications, treatments, devices, machines, and surgeries changed the outcome of many medical conditions (Copp, 1994). Society embraced scientific ways to engineer avoidance of death, and perhaps avoidance of confronting the spiritual as well; the paradoxical attitude toward life and death in modern society produced evidence of this denial (Copp, 1994; Nussbaum, 2003; Rys, 2009). Health care advances changed the public's mentality about human ability to extend life beyond natural boundaries. Advances minimized the divine and transcendent, especially with technological treatments by making it possible to extend life (Rys, 2009). Societal attitudes reflected perceptions of man controlling his own destiny rather than God or the supernatural. Death became associated with acute episodes rather than a natural end to problems or old age (Copp, 1994; Nussbaum, 2003).

Societal advances also brought about a cultural shift for spiritual issues including the setting of the death scene. Early in the twentieth century, death occurred in community and family surroundings. Families cared for the dying and the dead in the home, mourned with community around members them, and participated in death rituals, in-home wakes, and burial rites (Copp, 1994). By the mid-twentieth century, the dying

experience and public forums for grief grew apart from community life. Consequently, illness, along with death and dying, became associated with the hospital or institutional settings. Death and its spiritual questions moved outside of everyday life in the community (Dossey, 2000). Rituals moved away from individuals and increasingly closer to separate funeral homes.

In the 1960s and 1970s, American conceptions of health began to shift again. Now, conceptions of health encompassed wellness, holistic health, health promotion, and “good death” or peaceful death as a natural event with special needs and attention (Copp, 1994; Hoffman, 2005; Leathard & Cook, 2009). End-of-life care evolved from the inception of hospice care in 1967 with Cicely Saunders at St. Christopher’s Hospice in England to more recent models of end-of-life care (Copp, 1994; Hoffman, 2005). Renewed focus on end-of-life care started conversations about holistic care across the lifespan including spiritual care with new emphasis on reciprocity and discourse with the client (Leathard & Cook, 2009). Along with attention to health promotion and end of life, the gradual changes within the nursing profession fostered public discourse.

Nursing in the United States gradually grew into a profession with established hospital schools of nursing that promoted nurses as caregivers by the middle of the twentieth century (Reverby, 1987). Over time, colleges and universities offered baccalaureate degrees as nursing visionaries saw the need for professional credentials.

After the American Nurses Association (1965) issued its position statement on nursing education in order to be recognized as a more worthy profession, a new emphasis on nursing within institutions of higher education became the new standard. Nurse scholars argued nurses needed a college degree to achieve professional recognition and

validate credentials similar to other disciplines (American Nurses Association, 1966). Over time, degreed nurses replaced some of their counterparts and attention to spiritual care diminished in practice (Magnussen, 1998). Community colleges introduced yet another model of nursing education. Suddenly, nursing provided three ways to acquire RN licensure and the same entry in professional practice: the hospital diploma school apprenticeship model (three year), college and university baccalaureate model (four year), and the community college associate degree model (two year). All pathways to RN credentials fulfilled requirements to qualify for the national professional licensure exam, the National Council on Licensure Exam for Nursing (NCLEX). The educational models varied in their approach and emphasis on the spiritual dimension (Nelson, 2002).

Recently, nurse scholars created an end-of-life curriculum for nursing in the United States, the End-of-Life Nursing Education Consortium (ELNEC), which includes spiritual care. The creation of ELNEC curriculum produced research about the national need for the end-of-life including spiritual considerations in collaboration of The City of Hope National Medical Center's partnership with the American Association of Colleges of Nursing (AACN), funded with the Robert Wood Johnson Foundation (AACN, 2001). Educational initiatives advanced nursing to new levels, but social conditions surrounding and within the profession remained. While added curricula improved nursing education, structural conditions continued to color nursing's ability to address spiritual care.

### **Nurse Socialization**

Although nursing steadily gained improved status in the public eye, nurses practiced as subordinates under physicians who both maintained power for prescriptive health needs and retained medicine as the dominant power in health care (Reverby,

1987). With formalized nursing education, some proposed schools followed a hierarchical structure, which reinforced patriarchy, subordination, and oppression (Dossey, et al., 2005; Reverby 1987). Hospital schools of modern nursing, often supported by religious orders, denominations, and philanthropists, offered training to young women in dualistic systems (Reverby, 1987). On one hand, nurses embraced a calling to advocacy and caring for humanity, while on the other hand, they worked in hierarchical systems which operated differently than their ideals (Dossey et al., 2005). Doctors conducted classroom teaching and ordered all treatments, procedures, and medications. Some posited nurses acted as glorified domestic laborers. Under supervision, nursing students provided bedside care, followed doctor's orders, and strived to perfect endless procedural skill (Dossey, et al., 2005; Reverby, 1987). Some proposed students in training worked long hours as free labor under the close supervision of nurses or sisters in religious orders who operated as assistants or handmaidens of the doctor (Dossey, et al., 2005).

Gradually, nurses gained status by transcribing doctors' orders and accompanying physicians on patient rounds (Reverby, 1987). As women took leadership roles in schools of nursing, head nurses and nursing instructors tended to follow similar male behavior patterns historically exhibited in traditional patriarchal relations (Dossey et al., 2005; Reverby, 1987). In health care, nursing remained the only health care profession billed as part of the hospital room charge. Healing and recovery, though often brought about by meticulous nursing care, was ascribed to the physicians who performed the surgeries and signed the orders (Heller et al., 2000; Reverby, 1987).



In the present, nurses collaborate with physicians yet lack empowerment despite unions. In labor structures, nurses continue to work as staff members rather than as autonomous professionals who bill for their services. Nurses often work under organizational power rather than their own (Dossey et al., 2005). Health care organizations continually offer less pay, longer hours, and increased work with fewer resources for nurses. Nurses care for clients with more complex conditions, complications, and technical modalities than in the past (Heller et al., 2000; Magnussen, 1998). The nursing profession experiences more stress, conflict, and burnout than ever before (Baltimore, 2006; Farrell, 1999; Meissner, 1999). This broadly documented experience among nurses impacts nurse advocacy for clients and provision of spiritual care (Dossey et al., 2005; Magnussen, 1998). In addition to conditions within nursing, expansion of health needs with globalization will have an impact on spiritual care.

### **Global and National Implications**

The future of nursing practice and nursing education remain affected by global changes and future challenges. With the magnitude of global health issues, such as the African and global HIV/AIDS epidemic to the shift in Western cultures of increasing chronicity, unprecedented health care needs may tax health care systems beyond the breaking point (Heller et al., 2000). Unparalleled future needs of rising aging and ailing populations include spiritual care and support (Taylor, 2002). Cultural stressors within health organizations result from increasing numbers of patients avoiding premature death, dying at older ages, and dying from a long series of chronic or terminal illnesses with multiple difficulties (Miller & Ryndes, 2005). Of all Medicare beneficiaries who died, 25% used hospice services prior to death; of Medicare managed care program

beneficiaries, 34% now utilize hospice care at the end-of-life. Estimates indicate about 43% of people dying from chronic disease conditions accessed hospice services since 2003 (Miller & Ryndes, 2005).

Spiritual care needs intersect with end-of-life issues and care. With decreasing financial and human resources for elder and end-of-life services, our culture explores a public health strategy to provide services for the future (Dossey et al., 2005). Quality of life issues pervade health care. As the understood “good quality of life” implicit in holistic practice extends the lifespan, more nursing interventions will occur in personal and community settings rather than in institutional settings (O’Brien, 2008).

The advent and growth of hospice services in the United States promotes a healthier societal perspective toward future end-of-life needs and services, including spiritual care. Through education and research, health care professionals teach the public about a more holistic and realistic view of living and dying with a good death as the natural end to a life (Hoffman, 2005; Norlander, 2001). Nurses find themselves and their profession bridging the gap between aggressive or invasive treatments and compassionate, holistic care for patients and their families including spiritual care (Hoffman, 2005; Scanlon, 1997).

Consequences may arise if holistic needs remain unaddressed in practice. The Joint Commission established guidelines with a requirement for addressing holistic needs in health care systems including the spiritual dimension of health care (Joint Commission, 2011). The guidelines even validated that clients without any religion or religious involvement possess spiritual needs as human beings (MacLaren, 2004). Swinton and McSherry (2006) posed that failing to provide support for spiritual care of

the whole person results in a significant breach of human rights. Moreover, failure to document spiritual assessment results in malpractice. Both the International Council for Nurses (2006) and the American Nurses Association (2001) established a separate code of ethics with similar statements about promoting a respectful environment for a patient's religion or spirituality during episodes of care (Cavendish, et al., 2004).

Nurses advocate for life's most meaningful experiences from birth to death (Walsh & Hogan, 2003). As leaders and educators, nurses, who are poised for reshaping and retooling society's view of care across the lifespan, can impact spiritual and end-of-life issues. Ethical and moral concerns currently burden health care environments where nurses see increased spiritual distress among clients and families. Although nurses must assess and document the spiritual status of patients upon admission to health care systems, a gap between theoretical understanding about spirituality and practice remains (Gray, et al., 2004; MacLaren, 2004; Mitchell, Bennett, & Manfrin-Ledet, 2006). Nurses simultaneously function as pliable spiritual beings themselves and providers of spiritual care as required by law in health care institutions (Joint Commission, 2011; Taylor, 2002). Therefore, nurse educators need to address spirituality intentionally with attention to both personal and system domains (Swinton, 2006). Nurses need to understand and identify variances between individual and collective spirituality along with determining when problems regarding spirituality comprise personal issues or barriers within systems (Heller et al., 2000).

From considering nursing practice settings in systems, changes in the role of nursing have an impact on how nurses relate to patients and those they teach. Whether providing information as power or teaching nurse preparation, these role changes require

contemplation. Assisting nurses to adjust from actively providing information to empowering patients and families in practice requires further attention.

### **Nursing Practice in Relation to Spiritual Care**

Spirituality and spiritual care affect nursing practice as the nurse's role shifted from care provider to facilitator and educator (Clark, 2008). Nurses empower patients to find information, utilize health care resources, and promote decision-making of holistic needs, including the spiritual dimension. Nursing remains challenged by future trends including an ongoing nursing shortage, growing shortages of nursing faculty, rising diversity among patients, more acutely ill patient populations, and increasing complexity in direct patient care (Heller et al., 2000). Nursing education struggles to accommodate incessant additive curricula due to newly developed evidence-based practice (EBP) and emerging technologies (Dossey et al., 2005). Because of increasingly complex practice environments, nurses need focused education and preparation for providing effective spiritual care in a practice model of holistic care (Taylor, 2002). Moreover, definition of the spiritual dimension of the human being needs to be addressed.

### **The Spiritual Dimension**

Definitions of the spiritual dimension, spirituality, and spiritual care vary. Interestingly, spirituality, though widely recognized, is a concept that is difficult to define. Some scholars say one should not limit its definition to mere words (Astin, 2004; Belf, 2002; Denton, 2004; Fluker, 2008). Finding life purpose in spirituality answers the questions: "Who am I?" and "Why do I exist?" (Belf, 2002, p. 16). Fluker (2008) suggested spirituality consists of "a way or ways of seeking or being in relationship with the other who is believed to be worthy of reverence and highest devotion" (p.1). Denton

(as cited in Denton & Ashton, 2004) described spirit as “a border crosser, a transgressor of linguistic and cultural boundaries” (p. 16).

Astin (2004) proposed spirituality:

. . . has to do with the values that we hold most dear, our sense of who we are and where we come from, our beliefs about why we are here, the meaning and purpose we see in our work and our life, and our sense of connectedness to each other and the world around us, incorporating both the intensely personal and the collective connection with community (p. 4).

Mahoney and Graci (1999) found spirituality appears to include charity, community, compassion, forgiveness, hope, learning opportunities, meaning or purpose, and morality.

Recent distinction between spirituality and religiosity emerged; whereas they were used as synonyms in the past, spirituality now denotes a more abstract and inclusive concept (Mahoney & Graci, 1999). Moreover, scholars proposed the meaning of spirituality changes. Milacci (2006) posited definitions of soul, spirit, and spirituality have become commodities and been co-opted to further various economic interests of those selling spiritual books and products with society’s renewed interest in the spiritual dimension.

Spirituality and religion may be used interchangeably but remain quite distinct. Whereas spirituality may be viewed to be broader and universal, religion results from social construction (Rex Smith, 2009). Young, Wiggins-Frame and Cashwell (2007) defined religion as a specific, codified, and organized form of spirituality. Religion may be more likely to have negative connotations than spirituality. In the same study, 82% of respondents said they strongly agree or agree with the statement, “I consider myself to be a spiritual person” (Young, et al., 2007, p. 51). Religion, from the Latin *religare* means to “tie together one of the organized systems of beliefs, practices, and worship of a person, group, or community” (Cavendish et al., 2004, p. 200). Cavendish et al. (2004)

suggested, although religion includes spirituality, spirituality may exclude any part of religion or religious practice.

From inter-disciplinary approaches, Murray and Zentner (1989) proposed spirituality comprises a quality exceeding any boundaries of religious affiliation and “strives for inspiration, reverence, awe, meaning and purpose even in those who do not believe in God” (p. 259). This spiritual dimension seeks harmony in the universe, longing for meaningful answers about the infinite, and guides individual focus in times of stress, illness, or death (Murray & Zentner, 1989). Bash (2004) asked, “What is spirituality?” and urged practitioners to be inclusive of many diverse explanations. He posited three approaches: (a) the *theistic* approach, the idea of believing in a Higher Power and having relationship with a transcendent being; (b) the *non-theistic* approach, the idea of life having meaning and value along with finding a sense of peace and personal fulfillment in life; and (c) the *via media* approach, the idea where one’s life is harmonious with the universe in allowing some measure of consciousness and purpose in times of stress, illness, and death (Bash, 2004, p. 11).

These correlate to the three perspectives postulated by Fluker (2008) including: the *formal* notion of spirituality, identified with recognized religions; the *informal* notion of spirituality, formed by the individual; and *philosophical or ethical* notions of spirituality, related to the positive attributes of human beings and shared values. Fluker (2008) proposed another aspect of spirituality involves an individual facing themselves and the other, implying one needs context within a communal experience, by facing the other in order to face oneself. The power of collective experiences shapes one’s idea of spirit or spirituality (Fluker, 2008). Currently, the literature supports broad conceptions

of a spiritual experience varying greatly with one's cultural background, education about spiritual beliefs, and personal choice about how to exercise and explore one's spirituality (Denton, as cited in Denton & Ashton, 2004). With society's increased interest in spiritual matters, spiritual intelligence is becoming a broader understanding (Hunt, 2009).

Delineating spiritual terms proposes to be an ongoing dilemma within nursing scholarship. Pesut, Fowler, Reimer-Kirkham, Taylor, and Sawatzky (2009) argued nursing's tension with spiritual care included the spiritual dimension of the human being, the claim that spirituality can be assessed, and the idea that spiritual assessment belongs to nursing exclusively; moreover, spiritual and religious pluralism in society and social justice contribute to the current discourse. Due to the broad spectrum of definitions and ongoing debate within nursing, McSherry and Cash (2004) proposed the development of a taxonomy for terms about spirituality and spiritual care within nursing due to the current scope of definitions and individual interpretations. Swinton (2006) posited spirituality in nursing remains broadly defined under three divisions: religious, non-religious, and amalgamist, which can apply to all people regardless of any religious persuasion. He suggested defining spirituality merits special care due to assumptions regarding religion. Reed (1992) upheld the spiritual dimension as one that contributes to health, but should not be the sole focus in nursing care. Salladay (2008) posed current use of spirituality replaced the previous terms of *faith*, *belief*, and *religion*. Despite a wide variance of worldviews and positions regarding what comprises spirituality in nursing, O'Brien (2008) claimed common elements of spirituality include "love and compassion; caring; transcendence; relationship with God; and the connection of body, mind, and spirit" (p. 6).

Nursing theorists and scholars proposed definitions of spiritual care that vary greatly. Among traditional nursing theories, three nurse theorists, Leininger (1995), Neuman (as cited in George, 2002), and Watson (as cited in Bevis & Watson, 1989), separately addressed spirituality as a major component in their nursing models. Other nurse scholars also addressed the spiritual dimension.

Dossey (1993) described spirituality as:

. . . a broad concept that encompasses values, meaning, and purpose; one turns inward to the human traits of honesty, love, caring, wisdom, imagination, and compassion; existence of a quality of a higher authority, guiding spirit or transcendence that is mystical; a flowing, dynamic balance that allows and creates healing of the body-mind-spirit; and may or may not involve organized religion (p. 24).

O'Brien (1982) defined spirituality as a basic human need: "that dimension of a person that is concerned with ultimate ends and values... Spirituality is that which inspires in one the desire to transcend the realm of the material" (p. 88). Leininger (1997), a nurse anthropologist, described spirituality as "a relationship with a supreme being that directs one's beliefs and practices" (p. 104).

Burkhardt (1989) proposed spirituality has three characteristics: "unfolding mystery," concerning one's attempt to find meaning and purpose in life; "harmonious interconnectedness," concerning an individual's relationship to God and other persons; and "inner strength," concerning one's "sense of the sacred" and personal spiritual resources (p. 72). Meraviglia (2004) described spirituality as the expressions and experiences of an individual's spirit in a "unique and dynamic process reflecting faith in God or a Supreme Being, connectedness with self, others, nature, or God; and integration of the dimensions of mind, body, and spirit" (p. 90). Narayanasamy and Owens (2001) defined spirituality as an individual's guiding principle, one that gives meaning and



purpose along with relating him or her to the world including aspects such as values, beliefs, and relationships which are specific and intrinsically personal.

Expanding definitions to include a multi-faith and multi-cultural society requires ongoing sensitivity. Misunderstanding may easily result with the gulf between religious beliefs and practices; what people identify as personal belief may not match their actual practice. However, during health crises or impending death, people often return to their initially held beliefs and practices (McManus, 2006). Implicit in most definitions remains the concept that the human spiritual dimension connects integrally with humanity (McSherry & Draper, 1997). With this process of forming individual spiritual identity, historical and cultural meanings infuse one's sense of spirituality. In understanding the fusion or intersection of individual spirituality with a sense of humanity, identifying components and concepts about spiritual care becomes necessary.

### **Identifying Spiritual Care**

Nurses provide spiritual care and care for all the other dimensions of the human being, including the biophysical, psychosocial, cultural, and spiritual in a model of holistic care (VanLeeuwen & Cusveller, 2004). Helping clients find comfort or peace in regard to spiritual care promotes health and healing. Nurses assist clients in finding their own spiritual place for health and healing regardless of any personal religious belief or acknowledgment of a Higher Being; therefore, a spiritual dialogue often results in a mutual spiritual experience (MacLaren, 2004; O'Brien, 2008; VanLeeuwen & Cusveller, 2004). Perhaps because of the power relations in hierarchies related to the nursing profession and nurse socialization, efforts to promote the empirical aspects of nursing

sometimes overshadow or minimize the spiritual dimension as one of importance (Catanzaro & McMullen, 2001).

Defining spiritual care, spiritual needs, spiritual assessment, spiritual interventions, and spiritual care practice provides focus for this review. As previously stated, spiritual care is defined as integrated nursing care of the whole person; the nurse meets the spiritual needs of the client through care for the whole person including the body, mind, and spirit (O'Brien, 2008; Shelly & Fish, 1988). Tjelta proposed an individual continues in ongoing interactions with others to achieve a quest for wholeness, simultaneously focusing on the spiritual, mental and physical aspects making up the whole person (as cited in Wessman, 1994). *Spiritual needs* often appear as evidence of problems, distress, sudden changes in practice or affect, sudden interest in spiritual matters, or sleep disturbances (Stoll, 1979; Taylor, 2002). *Spiritual assessment* requires attention to how these needs may change in relation to illness, stress, and vulnerability, and include four areas of concern for spiritual assessment of the individual: (a) his or her concept of God or deity; (b) source of hope and strength; (c) the value of or significance ascribed to religious practices and rituals; and (d) perception of the relationship between her or his state of health, and her or his spiritual beliefs (Stoll, 1979). *Spiritual interventions* include religious and spiritual practices or actions where the nurse ministers to the client's spiritual needs such as facilitating mutual spiritual conversations, reading or praying with or for the client, accommodating access to symbols and items for religious and spiritual practices, and referring the client to other human resources or facilitating access to other spiritual resources (O'Brien, 2008; Taylor, 2002).

In the past, during the hospital nurses' training era, student nurses learned spiritual interventions such as offering prayer or accommodating the use of objects, symbols, or rituals: the cross, a rosary, a prayer shawl, or other religious icons and objects. Nurses read scriptures or devotionals, which brought comfort and peace to clients in spiritual distress. They called the chaplain, the priest, the rabbi, or the clergy to provide spiritual counseling and spiritual intervention (Narayanasamy & Owens, 2001).

Specialized training included how Christian nurses provided communion or baptized clients in emergency situations. Within a rules-oriented, skills-focused paradigm, nursing students, by and large, did not question whether they should engage in prayer or reading at the bedside, nor did many question whether they should provide communion or baptize infants (Dossey, 2000; Narayanasamy & Owens, 2001). In the context of the times, they were primarily concerned with performing the procedure correctly so they could document the intervention accurately. This model of efficiency and accuracy affected nurse training in the hospital setting. Even though nurses did engage in active spiritual care in practice, technology eventually displaced nurses' presence and time spent at the bedside (Dossey, 2000). Taking care of increasingly sicker clients, nurses acquired heavier workloads, more patients to manage, and less time for interaction and spiritual care.

In present day practice, today's nurse exercises more personal choice about how he or she may provide spiritual care. The American Nurses Association (2001) drafted a policy to support nurses who wish to avoid practice situations causing them to violate their moral principles as a matter of conscience. Within a nurse's right to refuse to provide care, any nurse may remove herself or himself from situations causing him/her

moral distress; nurses may refuse to provide care conflicting with their moral and ethical beliefs, including strong spiritual convictions or prohibitions (American Nurses Association, 2001). As important as spiritual care is to every client, nurse educators need to include this controversial component of spiritual care provision in education. As subordinated staff in hierarchies, nurses may need permission from nurse leaders in the workplace in order to request being removed from caring for particular patients or being reassigned to other clients (Dossey et al., 2005). Nurse educators need to address these and other challenges in offering appropriate spiritual care.

### **Challenges in Providing Spiritual Care**

Factors that influence the nurse role in providing spiritual care require consideration. Nurses provide spiritual care in practice, sometimes without purposeful and thoughtful consideration to how they became spiritually situated themselves. Their historical conditions and experience shaped their perspective. Nurses' beliefs, biases, and assumptions about spirituality affect their practice in the workplace (MacLaren, 2004). Ambivalence, concern, or negativity regarding nurses' lived experience may cause discomfort in providing care for the spiritual dimension (Narayanasamy, 1999).

Challenges face the professional nurse as he or she prepares to provide effective spiritual care. Nurses may be subject to similar crises of meaning or spiritual crisis that their clients experience, such as clients experiencing advanced cancer and other life events that cause them to question their own previously held beliefs (O'Brien, 2008; Taylor, et al., 1999). Consequently, nurses may need to discover and acknowledge their own attitudes, beliefs, or level of comfort regarding their own spirituality and ability to provide spiritual care (McManus, 2006; Narayanasamy, 1993; Pesut, 2003; Stranahan,

2001; Van Leeuwen & Cusveller, 2004; Yang & Mao, 2007). Ideas of how a nurse's own spiritual and cultural beliefs may influence pedagogy or approach in providing spiritual care are relatively new (MacLaren, 2004; McSherry, 1998; Taylor, et al., 1999). Furthermore, several authors postulate nurses need to explore their own spirituality in order to recognize and provide optimal care for spiritual needs (Cusveller, 1998; O'Brien, 2008; Prail, 1995; Taylor, et al., 1999).

Nurse perception of their own spirituality affects how well they carry out spiritual care assessment, planning, and intervention (Cavendish et al., 2004). Ross (1994) posited nurses who were most sure of their own spirituality were able to respond at a deeper level in providing spiritual care: these nurses demonstrated being aware of their own spiritual dimension, experienced crises and life experience, gave of themselves, seemed to have spiritual awareness and life experience, and tended to be perceptive persons with sensitivity to others. Cavendish et al. (2004) reported congruence between nurses with religious affiliation and ability to provide for patients' spiritual needs.

Nurse preparation retains a deficit in developing nurse awareness of spiritual needs, including their own. Awareness of spiritual needs in practice may occur when nurses discover they share the client's religious or spiritual background: mutuality in experiences of faith or religious affiliation increased the level of spiritual care (Ross, 1997; Van Dover & Bacon Pfeiffer, 2006). Findings also showed nurses prompted spiritual interventions as a result of spiritually or religiously centered conversations. This correlated with nurses who fostered strong rapport in relationship with patients and provided spiritual interventions at a deeper level than nurses who made no such connection (Ross, 1997).

Although nurses seem more able to identify symbolic aspects of spirituality including religious artifacts, the cross, and the crucifix, they find it more difficult to delineate spiritual needs of a psychological or psychosocial nature (Narayanasamy, 1999; Narayanasamy & Owens, 2001; Ross, 1997). Extraneous factors interfered with therapeutic communication between the client and nurse such as changes in mental status or hearing and also hindered accurate identification of spiritual needs (Ross, 1994). Likewise, environmental conditions such as the lack of privacy, peace, or quiet prevented nurses from initiating spiritual assessment or care (Ross, 1994). Apart from identifying factors and visual clues that help identify spiritual need, nurses conduct spiritual assessment which can be articulated and understood.

### **Spiritual Assessment**

Assessment of spiritual needs begins the process of promoting spiritual care. Spiritual need assessment discovers the importance of “meaning and purpose related to life events, meaningful relationships and a need to give and receive love, a personal need for forgiveness, and hope” (Greenstreet, 1999, p. 653). Spiritual assessment requires communication about spiritual needs, evaluation of what spiritual interventions to offer, and determination of referrals for further spiritual care from chaplains, clergy, religious leaders, or elders in the community. A nurse’s own perception of his or her spirituality or his or her own level of comfort/discomfort affects ability in assessing all things which are spiritual and religious (VanLeeuwen & Cusveller, 2004; Yang & Mao, 2007).

Clients often approach nurses with questions and needs, often choosing the nurse as confidante rather than a religious leader or liaison. Whether a client believes in God or a Higher Being, belongs to a particular religion or religious group, believes in specific

dogma (a belief or set of beliefs, which a religion or group holds to be true) or doctrine (a body of ideas, particularly in religion, taught to people as being truthful or correct), nurses conduct spiritual assessment. Whether a client engages in particular spiritual practices, entertains spiritual ambivalence, acknowledges spiritual confusion, or rejects the need for spiritual care, nurses must thoroughly assess the client's need for spiritual care and support the client's choices with appropriate spiritual interventions (Gray, et al., 2004; O'Brien, 2008; VanLeeuwen & Cusveller, 2004). Understanding nurse responsibility for conducting assessment and the client's response to the nurse forms a basis for understanding common spiritual interventions.

### **Spiritual Interventions**

Analysis of ways to provide spiritual care informs caring for the spiritual dimension. Once a need for spiritual care is established, Narayanasamy and Owens (2001) identified four pathways in which nurses tended to approach spiritual needs: (a) *personal* approach, finding meaning through personal involvement and partnership, like counseling; (b) *procedural* approach, taking deliberate steps to provide for religious and spiritual needs, applying religious routines and practices without delineating actual needs, relying on team members such as chaplains and clergy to shield the nurse from spiritual care, and stereotyping patients' religious affiliation and sometimes colluding with families without the individual's knowledge; (c) *cultural* approach, ensuring cultural sensitivity and accommodation for specific spiritual practices while acknowledging ethical dilemmas and lack of support or resources; and (d) *evangelical* approach, connecting through similar religious affiliation or background, affirming the patient's faith and spiritual beliefs, and providing spiritual rituals such as baptism for critically ill

newborns and infants. These pathways provide terminology for development of spiritual care skills.

Regardless of the approach used, spiritual care contained ethical considerations for each particular approach yet yielded overall positive effects for patients, families, and nurses. Patients and families benefit from coming to terms with individual situations, finding coping abilities, and being comforted; nurses also benefit from being involved in rewarding experiences despite potential ethical dilemmas (Narayanasamy, 1999; Narayanasamy & Owens, 2001; Ross, 1997). Therefore, effective spiritual care results in well-being for all parties when provided appropriately.

A framework of holistic health provides context for spiritual care delivery. What comprises spiritual care may vary from assisting patients to sustain religious practices, prayer, and worship; assisting patients to find meaning or purpose in life, or helping patients transcend suffering and pain (Cavendish et al., 2004). First, nurses assist patients with their “customary” or “everyday” spiritual practices including prayer, meditation, reading scripture or worshipping. Nurses support patients in spiritual practice and expression as a professional responsibility (VanLeeuwen & Cusveller, 2004). Secondly, nurses support patients in spiritual distress or crisis; when experiencing illness or disease, clients become more vulnerable. Patients need more support to take care of more urgent and direct spiritual needs. Finally, nurses address persistent or severe spiritual distress with appropriate referrals to the multidisciplinary team and/or the patient’s religious leader, clergy, or spiritual advisor (VanLeeuwen & Cusveller, 2004).

Elements of spiritual care include physical touch, praying, reading devotionals or scriptures, or accommodating special requests for unique spiritual practices with dignity,



respect, equality, and equity, along with cultural sensitivity. Some spiritual practices require access and accommodation to particular objects or spaces. Objects enhancing a patient's spiritual practice include the cross, a crucifix, a rosary, scriptures, a prayer shawl, or other objects of significance (O'Brien, 2008). Sometimes environmental accommodation is needed for music or cultural practices such as rituals involving washing, special clothing, or kneeling. Referral to other human resources provides opportunity for further spiritual intervention. Even a nurse's presence comprises a strong component of providing spiritual care (Cavendish, et al., 2004; Rex Smith, 2007; Schaffer & Norlander, 2009).

Prayer, perhaps the most universal of spiritual practice forms, provides opportunity for caring as spiritual intervention. Dossey (1993) reported both personal and intercessory prayers improved health and healing, providing patient benefits. Whether professionals prayed with clients or patients were told others were praying for them, holistic benefits were realized (Beery, Baas, Fowler, & Allen, 2002; Cheung, Wyman, & Halcon, 2007; Taylor, 2003). Despite the evidence of prayer's effect on health and healing, prayer may not often be included in nursing curricula (Wright, 2009).

Taylor (2003) proposed requests for prayer should be understood as a segue to conversation and therapeutic communication. Her guiding points for offering prayer include: (a) supporting patient beliefs and practices regarding prayer, even if they differ from the nurse's beliefs and practices; (b) accommodating the patient's prayer and practices, which are neither helpful or harmful; and (c) providing alternatives for patient beliefs and practices that are harmful yet avoiding attempts to change the patient's belief system whenever possible (Taylor, 2003). Taylor (2003) posited nurse ethicists maintain

that prayer done as an act of love, even without patient consent, does not require mandatory consent; rather, the nurse may conduct spiritual assessment to determine whether prayer is wanted or expected and the nurse should use prayer only in a manner that is consistent with her/his personal beliefs. Schoonover-Shoffner (2005) cautioned about nurses imposing personal beliefs and advocated obtaining informed consent for performing religious practices for patients.

Spiritual distress indicates a deviation from spiritual integrity and requires attention. O'Brien (1982; 2008) proposed seven components of spiritual distress: (a) *spiritual pain*, a deep hurt from loss or separation from a person's primary spiritual sustenance, from God, or a life partner; (b) *spiritual anxiety*, a fear of potential loss of support; (c) *spiritual guilt*, a sense of personal inadequacy or guilt over sin; (d) *alienation*, a focus on materialistic concerns over the spiritual; (e) *spiritual anger*, blaming the source of support for allowing one to be ill or dying; (f) *spiritual loss*, a weakened or broken relationship with the person's source of support, and (g) *spiritual despair*, a loss of hope about losing or regaining love from a spiritual support and relationship (Greenstreet, 1999). Bradshaw (1994) claimed spiritual care involved covenantal nursing enacted by the art of nursing in relieving spiritual distress. Taylor and Mamier (2005) suggested spiritual distress also involves attending to spiritual "*eustress*," a positive stress requiring energy which may provide synergy for healing (p. 261).

Spiritual care befits the goal of spiritual care education. Competence in spiritual care involves the characteristics and attitudes of the nurse; the process of assessing, planning, and evaluating spiritual care; and the context of the care provided within an institution. VanLeewen and Cusveller (2004) found the following attributes that

correspond to competence: (a) nurse demonstrates an ability to collect and assess patient spirituality and spiritual needs; (b) nurse plans, provides, and documents spiritual care to the patient and the team; (c) nurse provides and evaluates effectiveness of spiritual care; (d) nurse separates her/his own beliefs, values, and feelings from the patient spiritual situation and choices; (e) nurse addresses transcultural spiritual needs in a caring manner; and (f) nurse contributes to improvement and quality assurance regarding spiritual care. Variations affect how patients present spiritual distress in different health conditions, therefore, different competencies may be needed across the lifespan and variations occur across different settings (VanLeeuwen & Cusveller, 2004). Unresponsive patients, such as those in critical care and at the end of life, require special consideration and sensitivity as nurses provide spiritual care to alleviate spiritual distress (Nussbaum, 2003).

When addressing the continuum of conscious to unconscious patients, nurses implement spiritual interventions to relieve spiritual stressors as Nightingale envisioned. As Americans explore the existential for answers and meaning of life, spirituality and the spiritual dimension enjoy a renewed interest (Dossey et al., 2005). When considering the existential in everyday living, Nightingale's contribution to nursing reveals further lessons for understanding spiritual care.

### **Modern Nursing's Spiritual Roots in Nightingale**

Acknowledging nursing's spiritual roots in Florence Nightingale's work becomes relevant when considering spirituality and the spiritual dimension. Nightingale established the provision of spiritual care within nursing and the credence of nursing being a spiritual practice (Dossey et al., 2005). In 1859, Nightingale wrote in *Notes on Nursing*, "And remember every nurse should be the one who is depended upon...she

must have a respect for her own calling, because God's precious gift of life is often literally placed in her hands" (as cited in O'Brien, 2008, p. 129). Webb (2002) contended Nightingale's theology involved faith through action: "God intended people to help themselves by discovering God's laws for improvement and acting on them" (p. 117).

Nightingale embraced a broad vision of spiritual care and vocation. She viewed God incarnate as being not only Jesus, but also believed Him present in His followers. Her idea of vocation included love of neighbor and generosity to serve humanity (Bradshaw, 1996). She believed every nurse was called to a purposeful life before God and freedom to choose ministering to others. This meant God could manifest Himself through each person, perhaps beyond Christianity's singular way to God (Webb, 2002).

Nightingale wrote about a desire to create the kingdom of heaven among humankind (Dossey et al., 2005; Smith, 1982). Near death, she stated her work as: (a) infusing the mystical religion among others, especially women and (b) to organize activity for training of "handmaids of the Lord," which referred to nurses as ministering spiritual care (Webb, 2002, p. 298). Her foundational writings in *Notes on Nursing* and *Notes for Hospitals* include references to spiritual care being a necessary and important part of caring for the whole patient (Dossey et al., 2005).

Analysis of Nightingale's views of nursing as a calling or vocation affects nursing today. Called a visionary, mystic, healer, existentialist, and theologian, Nightingale explored matters of faith which infused her writings on nursing and spirituality, categorized by some as heterodox or eclectic (Bullough et al., 1990; Hebert, 1981). With a background in the Unitarian Church and personal doubts about the Anglican Church, Nightingale valued prayer and the reading of scripture, both components of traditional

spiritual care. Her numerous writings on scripture passages number in the hundreds (Bostridge, 2008; Dossey et al., 2005). Nightingale read extensively about mystics within Catholicism and philosophers of the Enlightenment (Webb, 2002). Influenced by Lutheranism at Kaiserwerth Institute, she trained among nurse deaconesses despite the protests of her family. She witnessed Reformation ideals and communal nursing, which had an impact on how she eventually framed spiritual care (Smith, 1982).

Nightingale's views on the vocation of nursing may contain some peculiarities. Some critics upheld the idea that she entered into a mystical marriage with God while others maintained she took simple vows of chastity and purity (Bostridge, 2008; Dossey, 2000; Smith, 1982). Smith (1982) claimed, when she was infirmed at her home after the Crimean War, she "did not pray, did not attend divine worship, and only took the sacrament when Jowett [friend and confidante] brought it" and she used religiosity and ego, imagining herself as victim of persecution in reliving Christ's crucifixion (p. 183). Nightingale viewed mysticism as "...the attempt to draw near to God, not by rites or ceremonies, but by inward disposition..." (Webb, 2002, p. 169). She envisioned a broad range of acceptable practices and forms of worship within the Christian tradition. She looked to the Gospel of John about the reign of God within or the "indwelling of the spirit" (Webb, 2002, p. 211). Her writings reflect her belief that nurses represent God as ministers at the bedside, ministering in His name.

Analysis of Nightingale's vision of humanitarian service influenced the nursing profession. Nightingale's spirituality informed ideas of saving life in humanitarian service within nursing. Her second call, that of being a "savior," was viewed as a vocation or calling to nursing; she viewed herself as being singled out for a particular

purpose in a particular time and viewed all nurses as being called for the same purpose (Webb, 2002, p. 232). Viewing a “savior” as anyone (with God within them) who led others out of bad circumstances or error, Nightingale espoused humanitarian service as a type of social justice (Hebert, 1981; Webb, 2002, p. 232). She contemplated the role of God in evil and suffering yet dwelled on His positive attributes including being benevolent (Webb, 2002). Her dwelling on the positive attributes of God infused her reflection about how nurses should comfort the ill, the wounded, and the dying.

Analysis of Nightingale’s concept of holistic care informs contemporary nurses. Without imposing their religion on others, Nightingale invited nurses to practice holistic care by providing deliberate and intentional spiritual care yet avoiding preaching or proselytizing (Dossey et al., 2005). While in Scutari, present day Uskudar in Istanbul, Turkey, she insisted that patients of all races and cultures receive egalitarian care, and therefore, challenged military leaders in the theater of the Crimean War (Dossey et al., 2005). Promoting the primacy of love in healing and service to body, mind, and spirit, Nightingale appreciated the perspective of other world religions in her understanding of life and faith (Dossey et al., 2005; Hebert, 1981). She favored an ancient Persian prayer, “Four things, O God, I have to offer thee which Thou hast not in all Thy treasury; My nothingness, my sad necessity, my fatal sin, and earnest penitence. Receive these gifts and take the Giver hence” (Dossey, 2000, p. 342). Nightingale integrated Christian values and building community in nursing by honoring “unfolding mystery, holiness, and sacredness” in practice (Dossey et al., 2005, p. 36).

Some scholars suggest Nightingale’s schema of nursing was too narrow or limited by her reliance on Christian thought and the existence of God, and consequently, is

outdated for a postmodern application (McSherry & Cash, 2004). McSherry and Cash (2004) raised caution regarding confusion about the hidden and literal meanings of spirituality and a call for broader and more holistic conceptualizations for nursing.

Nightingale challenged the established policies and health care systems in her time. She advocated for care extending to the disenfranchised and the marginalized within her own culture and in a theater of war. Her broad view of nursing practice encouraged consideration of cultural implications for nursing practice when caring for patients of varied ethnic and cultural backgrounds. These lessons illustrate how contemporary nursing may approach spiritual care with patients of diversity.

### **Cultural Considerations**

Best practice for spiritual care includes cultural sensitivity when considering the demographic shifts in the new millennium. Nurses need to understand relevant spiritual concerns by first being aware of their own background, bias, and beliefs, thus acquiring a core of essential spiritual understandings (Gray, et al., 2004; Taylor, 2001; Yang & Mao, 2007). By accepting differences and recognizing diverse ways of daily living, nurses begin to understand how to promote spiritual wholeness (O'Brien, 2008). Knowing how to approach and discuss patient concerns and how to perform culturally sensitive spiritual assessments becomes paramount in nursing. Particularly in end-of-life nursing, this need rises to new prominence more than in other specialties. Birth and death, both binding and memorable events for families, focus unparalleled attention on the nurse's role. How nurses deliver culturally competent end-of-life care, including spiritual care, will be remembered and often impacts patients and families for years to come (Walsh & Hogan, 2003). These impressions profoundly affect multicultural clients concerning accurate

assessment of spiritual needs, the effectiveness and compliance with medical and nursing interventions including spiritual interventions, and possible outcomes of the healing process.

These variances in ethical, moral, and religious beliefs may alter how a nurse approaches spiritual care or advocacy issues regarding spirituality. Understanding these moral codes and ethical mores regarding spirituality become key in providing culturally sensitive care and making accommodation for clients (Felgen, 2004; Taylor, 2001). Ethical considerations include limitations of spirituality being a particular Christian phenomenon versus a broader existential form of spirituality (Narayanasamy, 1999).

Narayanasamy (1999) posited privatized spirituality connotes intensely powerful spiritual experiences and/or internalized awareness not readily shared. Spiritual integration within spiritual care includes restoration of meaning for one's life, of purpose and direction for the present situation, and of alleviating spiritual pain (Narayanasamy, 1999). With the current emphasis on health promotion and prevention in holistic care, it follows that becoming aware of individual variances while providing spiritual care comprises best practice. Although patients and families are the best resource, nurses need instruction about using resources like religious leaders, ethnic elders, or cultural community members. In this way, nurses help identify variances, along with finding specific ways to make accommodation for cultural and spiritual beliefs (Felgen, 2004).

Social factors impact how nurses provide culturally sensitive spiritual care. Factors of race, social class, cultural practices, and ethnic backgrounds potentially impact how a nurse approaches or carries out spiritual care. Specialized education regarding spiritual care includes how to explore these topics of concern with patients from various



faith traditions and cultures (Shirahama & Inoue, 2001; Yang & Mao, 2007).

Transcultural understanding includes focused nursing education to deal with potential divisive issues relating to factors perceived to be subject to discrimination or prejudice in society (Jenko & Moffitt, 2006). In providing spiritual care, such understanding should be intentionally cultivated to avoid negative experiences.

Nurses need to identify their own bias, assumptions, and beliefs affecting attitudes, behaviors, and ultimately, practice (Jenko & Moffitt, 2006). Identifying patterns within other cultural groups without stereotyping and acknowledging individual variations within the group is best practice (Chang & Taylor Harden, 2002). What nurses learned through their families, education, and socialization about spiritual development forms a foundation for providing cultural and spiritual assessment (Felgen, 2006).

### **Cultural Orientations**

Cultural differences include different orientations or conceptions of space, time, and surrounding environment. Because cultural variations exist among individuals, generalizations about cultural norms should always be assessed. The perception of comfortable personal space around a person's body varies among groups and individuals (Giger & Davidhizar, 2004). Some cultures use the intimate zone of close proximity where one experiences the other's heat, odor, and touch, including the Latino and Mediterranean cultures. For Western European and North American backgrounds, an arm's length from two to five feet is acceptable (Jenko & Moffitt, 2006). However, Eastern and African cultures may view such a range as being more intimate, typically reserved for spouses, family, and clan members. Some Asians and Africans add more distance to the acceptable comfort zone for space.

In addition, Muslim, Orthodox Jewish, and other traditions forbid touching the opposite sex outside of marriage (Jenko & Moffitt, 2006). Being aware of gender restraints with touch might affect the need to assign same-sex caregivers (Chang & Taylor Harden, 2002). Some individuals from the contact/spatial orientation tend to view non-contact people as being impersonal, impolite, shy, and uninteresting; whereas, individuals from the non-contact orientation view those with close contact as being pushy, impolite, and obnoxious (Jenko & Moffitt, 2006).

Awareness of time becomes weighted with values (Jenko & Moffitt, 2006). Many cultures hold a loose or fluid sense of time as opposed to days broken into segments and hours. This may affect the patient's ability to participate in treatments, regimens, and services. Using set reference points of mealtime for planning may not work in some cultures like the Hispanic cultures or other cultures with no set dinner time (Jenko & Moffitt, 2006). The tempo or the pace of daily life comprises another variation along with a cultural tendency to be oriented to the past, present or future. Past-oriented persons possess strong family and cultural ties, often showing honor for ancestors, elders, and traditions (Jenko & Moffitt, 2006). Present-oriented patients tend to live for today, purposing to live in harmony with one's surroundings without the constraints of set schedules. Future-oriented behaviors of patient involvement include planning for coming events such as preparing for end-of-life, recording advanced directives, and taking an active role in health care decisions (Jenko & Moffitt, 2006).

Environmental control includes the perception of a person's ability to change factors in his or her environment. Perception of this control varies, for patients either to believe situations are out of their control (as in the hands of fate) or to believe they

influence their surroundings through control as an act of personal responsibility and empowerment (Jenko & Moffitt, 2006). The physical environs in the care setting may contain unfamiliar or uncomfortable components for patient's cultural practices. Patients may be used to sleeping near the floor, in family beds, or at different set times during religious holidays or rituals. Currently, patient care settings are going through efforts to create family-friendly, holistic, comforting, and healing environments with natural and multicultural elements (Felgen, 2006).

Cultural differences exist in how patients experience and express basic biological processes of growth, nutrition, and pain. Dietary restrictions, religious holidays, and rituals may need accommodation such as Orthodox Jews keeping kosher or Muslims observing Ramadan (Chang & Taylor Harden, 2002; Jenko & Moffitt, 2006). Cultural concepts about the body's balance perpetuate perceptions; for instance, an imbalance of hot and cold results in an upset or illness. Consequently, Asian patients may have difficulty mixing hot and cold foods, thus violating their concept of balance through Yin/Yang (Jenko & Moffitt, 2006). Also for Asian, African, and Mexican cultures, ice water, the typical provision in American hospitals at the bedside is considered unhealthy, and hot drinks such as tea may be better received (Chang & Taylor Harden, 2002).

Biological and physiological variations exist in how different cultures respond to pain and how it is acceptable for patients or clients to acknowledge and describe their pain or distress (Chang & Taylor Harden, 2002). Perceptions and expressions of pain tend to be part of one's cultural and family experience. Some Asian patients believe they must be stoic and deny pain at all costs or they might lose face (Chang & Taylor Harden, 2002). An effective strategy to overcome this cultural dilemma is to give the patient

permission to be honest about pain or distress by asking him or her to be a model client, to follow the doctor's orders, and report pain accurately (Galanti, 2004).

### **Language and Communication Considerations**

Communication constitutes the means for nurse and client connection and understanding nuances of language. Listening carefully to particular words and use of language may prevent potential miscues and misunderstanding when appreciating a variety of other languages and heritage backgrounds (Jenko & Moffitt, 2006). Simple concepts like eye contact, tone of voice, nonverbal gestures, and particular words in a language of origin convey intended messages beyond the spoken response (Chang & Taylor Harden, 2002). Silence varies from showing respect in Asian cultures to agreement among Russian, Spanish, and French cultures; for Arabic or British cultures, silence might signal a need for privacy (Jenko & Moffitt, 2006). Learning to read cultural cues in verbal and nonverbal communication becomes essential in spiritual care.

With patients who are English Language Learners (ELL), a heavy accent does not mean the person cannot understand English. Patients may revert to their primary language and find stressful conditions hinder their ability to communicate in English (Chang & Taylor Harden, 2002). Talking effectively with ELL patients includes using clear and simple sentences, providing printed material to allow them time to process written language, and securing an official translator, instead of a family member or auxiliary staff to prevent communication glitches (Chang & Taylor Harden, 2002).

Nonverbal cues provide essential clues to understand patients of diversity. Eye contact, facial expressions, body posture, and touch hold multiple meanings (Jenko & Moffitt, 2006). With Asians, direct eye contact with an authority figure equals

disrespect, implying equality or peer status. To signify respect, Nigerians avoid eye contact (Jenko & Moffitt, 2006). Some gestures, like pointing or signaling with a finger, although common in English-speaking countries, comprise signs of disrespect in other cultures. Best practice avoids slang, gestures, and idioms (Galanti, 2004).

Touch provides therapeutic communication in nursing. Generally, shaking hands, deliberately touching the arm or hand, or checking the forehead with one's hand are appropriate and perceived to be reassuring or comforting uses of touch. Touch itself may denote specific meaning or cultural significance. Mediterranean, South American, Spanish, French, and Jewish cultures tend to use touch more frequently (Jenko & Moffitt, 2006). Nurses need to understand touch may imply intentionality and can be misunderstood. Southeast Asians consider the seat of the soul to be in the head; to pat the head equals an insult (Jenko & Moffitt, 2006). Some cultures consider parts of the body to be unclean or taboo. Using the left hand, reserved for toileting in some African and Middle Eastern cultures, offends. Showing the sole of the foot offends Southeast Asians and Arabs (Jenko & Moffitt, 2006). Appropriate and culturally sensitive use of touch becomes an important part of patient care and communication with patients and families.

### **Ethical Considerations**

Ethical problems in practice may be a product of the health care system itself (Dickinson, 2005). Spiritual care may involve ethical concerns about treatment options, alternative therapies, supporting patients in their cultural and religious practices, and advanced directives. Cultural practices about terminal diagnosis and impending death vary. Traditions range from keeping information from a patient if he or she is dying to informing a patient about the prognosis or impending death.

Generally, different cultures observe specific rituals about mourning. Patients and families require accommodation to grieve within the constructs of their tradition and cultural symbols when possible (Chang & Taylor Harden, 2002). Best practice includes asking patients how they wish to receive information and make decisions: whether they wish to handle this for themselves or prefer to have the family handle such news for them (Jenko & Moffitt, 2006; Schaffer & Norlander, 2009). Asians generally regard telling an elder about the diagnosis of terminal disease to be exceptionally cruel. Even so, ethnic Chinese families hold death to be one of life's most important issues (Shih, Gau, Lin, Pong, & Lin, 2006). The Chinese culture protects patients from harm and from bearing the burden of dying by keeping the patient out of the discussion due to respect and in order to reduce anxiety (Jenko & Moffitt, 2006). Some cultures believe to have any negative, audibly spoken words become self-fulfilling prophecy such as Filipino, Bosnian, and Native American cultures (Jenko & Moffitt, 2006).

Knowing who might be the center in decision-making for the patient becomes critical in assessing spiritual needs. Family constellations for making decisions include patient autonomy in decision-making in nuclear families, authority figure decision-making in extended families, and delegated community elder decision-making in cultural families including persons outside the biological family (American Nurses Association, 2000; Chang & Taylor Harden, 2002). Whereas Western European traditions promote independence in health care decisions, interdependence is encouraged in Hispanic, African, and Asian cultures. Hispanics share decision-making due to their mutual family responsibilities and may hesitate to appoint a single spokesperson in order to avoid offending other family members (Jenko & Moffitt, 2006). Among Latino cultures, a

woman might defer to her husband or father to make decisions or sign documents (Galanti, 2004). Middle Eastern cultures might refuse to receive care or treatment from female figures, since women are not assumed to be entrusted with critical matters in health care (Jenko & Moffitt, 2006). In Indian or Chinese cultures, dependence on family members to care for the one who is ill is more common (Chang & Taylor Harden, 2002). Another variation of decision-making is the tendency for matriarchal cultures to designate older women to act as health care guardians in some Native American and African American communities (Jenko & Moffitt, 2006).

Spiritual care influences how advance directives (ADs) may vary with the cultural background of the dying patient. ADs provide written instructions to guide others in making health care decisions according to the patient's wishes at the end of life. Ethical and legal implications involve Do Not Resuscitate (DNR) or Do Not Intubate (DNI) status, withdrawal of invasive therapies, and appropriate pain management (Scanlon, 1997). Living will and power-of-attorney documents ensure the quality of life will be preserved along with relieving suffering and possibly prolonging life (Browning, 2006). With terminal illness, some cultures consider the lack of a cure a punishment.

Other cultures might consider a terminal diagnosis to be evidence of the patient's wrongdoing in practicing sorcery or violating other mystical taboos. Due to the family's duty to care for its own, Arab families may appear to be overprotective of their loved one. Some cultures believe one defies the will of God to go ahead with future health care plans (Jenko & Moffitt, 2006). The Hmong tend to rely on oral traditions and avoid written directives. Consequently, even the idea of writing directives threatens some patients due to cultural beliefs. Many Asians believe in honoring the aged, therefore, for them, ADs

imply aggressive measures to preserve life at all costs. Hispanics might avoid issuing a directive so they might not offend relatives (Jenko & Moffitt, 2006). Other possibilities include cultural assumptions about ADs. Some groups, including Muslims, Jews, and Catholics, might see suffering as a channel for expressing one's faith or atoning for one's wrongdoing and therefore, might see removing life support as interfering with the hand of God (Jenko & Moffitt, 2006). Another cultural reaction to ADs might be African Americans perceiving DNR/DNI orders predispose patients to receive a substandard level of end-of-life care (Jenko & Moffitt, 2006). Considering the potential language and cultural barriers, having a translator or cultural community leader present is imperative to prevent misunderstandings (Browning, 2006).

Clearly, cultural barriers constitute consideration in caring for today's diverse patient populations when providing spiritual care. Language and cultural barriers potentially render spiritual care effective or ineffective without consideration in best practice. Because cultural knowing exists outside of an individual's lived experience, nursing education addresses relevant considerations for contemporary practice. To impart relevant education, addressing basic teaching and learning concepts requires pedagogical and curricular attention.

### **Nurse Education in Relation to Spiritual Care Practice**

Reestablishing spiritual care as intentional pedagogical and curricular work becomes critical in light of new emphasis on engaging students in critical discussion. Even though society grew more interested in spirituality, student development regarding spiritual care experienced recent neglect in nursing education (Gray, et al., 2004; Narayanasamy, 1993). Several studies revealed a lack of inclusion of spiritual care in



nursing programs (Carroll, 2001; Mitchell, et al., 2006; Narayanasamy, 1993). Spiritual content can be included in or excluded from curricula. Both state and private institutions may fail to provide deliberate and intentional educational preparation about spiritual care. Nurses must be prepared for spiritual care in order to provide holistic care. Individuals expect nurses to engage in spiritual conversations and assist them with their spiritual needs, or they seek alternatives such as talking with other patients when nurses fail to provide spiritual care (Koslander & Arvidsson, 2007; VanLeeuwen & Cusveller, 2004).

Nurses will not receive the preparation they need without faculty who value spiritual care and prepare to role-model and teach skills about providing spiritual care. Spiritual care involves understanding of different worldviews, the ways one views reality as “an interpretive lens on such things as the nature of man, the nature of the world, and the nature and/or existence of God” (Pesut, 2003, p. 291). Overt integration of spiritual care in nursing curricula includes acknowledgment of nursing’s spiritual roots, the language of spirituality, opportunities to connect religion and spirituality, exposure to literature on spirituality, and selection of conducive clinical sites for practice (Catanzaro & McMullen, 2001; McSherry & Draper, 1997; Purnell, Walsh, & Malone, 2004).

Critical reflection about learning experiences becomes essential for nurses to integrate the spiritual dimension in practice. Pesut (2003) encouraged opportunity for learners to engage in critical reflection of their own beliefs, attitudes, and behaviors; critical reflection includes discussion without debating issues such as the existence of God. By addressing the spiritual dimension with intentionality and purpose in nursing curricula, faculty can provide opportunity to address presumptions about spirituality that may hinder facilitation of spiritual care once nurses are in practice (Gray, et al., 2004;

MacLaren, 2004). By utilizing frameworks to assess strengths and gaps in curricula within programs, faculty can more definitively address concerns affecting spiritual care education (Kalb, Buethe, Harris, Maine, Martinson, & McDonald, 2008). Following critical reflection, intentionality, and effective assessment and evaluation of nursing curricula and programs, other considerations affect nurse ability in learning spiritual care.

### **Considerations for Learning about Spiritual Care**

Numerous considerations affect teaching and learning in spiritual care education including identifying key issues, the role of faculty, the role of the environment, and the role of the student or nurse in self-assessment. Finding strategies for accommodating learning about a domain with personal implications requires care. In addition, strategies that contribute to learning about spiritual care may prompt nurses toward the goal of providing optimal spiritual care in practice.

Along with common human fears regarding the unknown, nursing education may evoke particular fears or challenges due to its methodology and content. Moreover, learner perceptions of their spirituality and spiritual well-being impact learning (Wehmer, Quinn Griffin, White, & Fitzpatrick, 2010). Traditional nursing education tended to focus on perfection of technical skills or didactic teaching of complex content rather than allowing students to learn through mistakes or experiential learning (Dossey et al., 2005). When dealing with affective domains such as spiritual care, both students and practicing nurses articulate fears about letting down a fellow human being regarding existential matters or the unknown (Dossey, 2000).

Fear comprises a common factor affecting teaching and learning about spiritual care. Spiritual care education needs to address barriers in providing accurate spiritual

assessment and spiritual care (Mitchell, et al., 2006; Purnell, et al., 2004). Nurses reported three types of fears in relation to spirituality. They feared they were unable provide the right answers for spiritual questions, a spiritual discussion will produce discomfort for them and the client, and the nurse's role alone does not qualify them to provide spiritual care (Catanzaro & McMullen, 2001; Purnell, et al., 2004).

Catanzaro and McMullen (2001) suggested despite initial fears, learners who experienced focused teaching strategies in regard to providing spiritual care, including clinical assignments with opportunity for spiritual care practice, formed a connection with clients on a spiritual level. Finding clinical and community partners for field experience ensures that learners practice spiritual care as they explore and develop what spiritual care may entail. Elder care and other alternative community sites comprise living laboratories for the provision of spiritual care interventions without learners having to negotiate the complex client scenarios typical of hospital settings (O'Brien, 2008).

Faculty attitudes and experiences in provision of spiritual care affect learning by creating permission and opportunity for exploration of spiritual care. Fraser (2007) found faculty participants identified teaching about the spiritual dimension requires special sensitivity that is impossible to predict or prescribe; classroom situations progress in unexpected ways and faculty must be sensitive to slight nuances in the climate of the discussion over the planned curriculum. Adequate faculty experience, support, and willingness to teach spiritual content provided better nurse preparation about spiritual care. Gray et al. (2004) studied faculty ability to identify spiritual needs or provide spiritual care and whether teaching at a private or public institution affected these abilities: faculty perception regarding their own spiritual beliefs and practices proved

consistent among institutions. Faculty perception about engaging in spiritual dialogue differed for those, in secular or state institutions, who considered spiritual conversation to be invasive or offensive (Gray, et al. 2004). Cavendish et al. (2004) found a positive correlation between spiritual education and ability to provide spiritual care.

Educational environments may profoundly impact learning about spirituality and exposure to spiritual care (Gray et al., 2004). Groen (2008) created an open, yet bounded space in the learning environment by creating space for dialogue. Palmer (1998) delineated paradoxical tension in creating a hospitable yet charged space. Spaces promote learning when opening a dialogue for the voice of the group and the voice of the individual; a space for “little” stories about individuals and “big” stories about professions, a space supporting both community and solitude, and a space welcoming speech and silence (Palmer, 1998, p. 80).

Gillispie (2005) asserted the importance of building learner-teacher connections through dialogue including the importance of connecting through knowing the individual, extending mutual respect, forming trust, and offering mutuality to learners as valued and limited partners by acknowledging a mutually accepted inequality of knowledge and life skills. Creating a culture of caring within nursing education includes learner-centered dialogue. An effective educator places the learner perspective as the center of the dialogue, uses methodologies that promote learners finding an active voice, and encourages nurturing experiences in the process (Purnell et al., 2004; Schaffer & Juarez, 1996). Educators affect learner understanding about what caring means and motivation for caring for others by the role-modeling caring behaviors in both the classroom and clinical settings. Schaffer and Juarez (1996) found faculty-facilitated small group

dialogue about teaching and learning promoted learner awareness of caring behaviors among faculty and peers; the dialogue fostered egalitarian relationships and a community of caring.

Spiritual self-assessment comprised an essential inquiry to engage learning about spiritual care. Geroy (2005) proposed learners engage in *existential capacity building* in higher education, demonstrating willingness to engage in social and intellectual introspection and experimentation. Meyer (2003) found learner awareness of personal spirituality, a critical reflection component, was the greatest predictor of ability in the provision of spiritual care. Swinton and McSherry (2006) posited nurses “who deliver the best spiritual care are those who are themselves spiritually fulfilled” (p. 802). Mitchell et al. (2006) recommended using a non-graded self-assessment activity as either an oral or written assignment where participation is encouraged, yet learners could choose to talk privately with faculty after class.

In nursing practice, spiritual assessment enhances introspection and reflection, allowing spiritual healing. Some advocated learners need preparation for possible client responses during spiritual assessment such as confusion, discomfort, or upset (Mitchell, et al., 2006; O’Brien, 2008). In addition to spiritual problems or deficits, learners should assess for client coping abilities and strengths regarding spirituality (O’Brien, 2008). Although spiritual engagement becomes a necessary component of increasing spiritual awareness and spiritual self-assessment which transfers learning to spiritual assessment of others, Milacci (2006) posed spirituality and faith were loaded with meaning in general higher education research and therefore, may have application to nursing education

applications. Meanings, which are value-laden or loaded with personal knowing, invite special strategies for teaching and learning.

### **Teaching Strategies for Providing Spiritual Care**

Teaching strategies for spiritual nursing education include small group activities, innovative learning strategies, critical reflection and discussion, and clinical practicums. Several scholars discussed the importance of developing relevant strategies for improving learner understanding of spiritual care (Catanzaro & McMullen, 2001; Pimple, Schmidt, & Tidwell, 2003; Purnell et al., 2004). Pimple et al. (2003) suggested reflective discussion, case studies, role playing, and storytelling comprise effective learner-centered activities for promoting learner awareness in end-of-life education including spiritual care. Innovative strategies for dealing with end-of-life concerns and loss including spirituality considerations included: loss exercises, followed with discussion; case studies, which stimulate critical thinking; creative exercises such as storytelling, poetry, or personal testimonials; and other instructional alternatives (Matzo, Sherman, Lo, Grant, & Rhome, 2003).

Care mapping presented possibilities for engaging learners from various learning styles and preferences (Wilkes, Cooper, Lewin, & Batts, 1999). Hodge (2005) claimed spiritual life-maps for client-centered assessment provided usefulness in social work and may have application for nursing education. Based on Augustine's *Confessions* as autobiographical therapy, graphical representations of a life journey provided opportunity for participants to re-envision life circumstances through a spiritual lens (Hodge, 2005). Purnell et al. (2004) recommended semi-structured, learner-led spirituality seminars that promoted clinical inquiry. Nussbaum (2003) claimed special consideration for spiritual

distress care initiatives in critical care; similarly, end-of-life care protocols need attention and discussion in course activities. Such strategies need to be planned and implemented with sensitivity to opening rich dialogue without causing learners spiritual distress or feeling others are proselytizing them in discussions (Salladay, 2008). Providing learning experiences will increase spiritual competence (Nussbaum, 2003).

The impact of various factors merit analysis for spiritual care education. Intrinsic factors such as educational, social, economic, hierarchical, and political barriers impact the inclusion and integration of the spiritual dimension within nursing curricula (McSherry & Draper, 1997). Primary deterrents to curricular and pedagogical change for integration of spiritual care content in nursing education include economic constraints of human and monetary resources: human energy, time, and cost (McSherry & Draper, 1997). McSherry and Draper (1997) claimed extrinsic factors affect change and include assumptions of secular humanism and the separation of church and state along with modern secular and materialistic values, resisting integration of core spiritual values and the spiritual dimension into curricular change. Changing the structural conditions in the workplace to meet the mission comprises one component of implementing transformational nursing education.

Pesut (2003) delineated the goal of spiritual care education: to develop building intrapersonal connectedness and empowerment through pedagogy, thereby increasing learner-centered learning and critical reflection. Seeking to uncover learner abilities and experiences ensures involvement. Helping learners to develop their own philosophy of nursing regarding spirituality and spiritual care values builds connections (Pesut, 2003; Purnell, et al., 2004). Mitchell et al. (2006) claimed development of nurses includes

providing learning opportunities for learners to respond with spiritual competence and sensitivity. Spiritual competence promotes hope, purpose, and meaning within future nurses and among clients.

Strategies for education offer possibility for teaching about spiritual care in nurse preparation and continuing education for nurses. Although nursing education may exist in programs of nursing, further opportunities for nursing education remain unexplored. Nurse leaders may facilitate greater learning among learners if they become aware of the potential for higher or nursing education.

### **Leaders' Potential Impact in Higher and Nursing Education**

With a purpose of facilitating spiritual integration in nursing education, higher education provides lessons for nursing leadership. When thinking of pedagogy in regard to spirituality, Astin (2004) offered a template for transformative leadership among learners, faculty, and administration in higher education. This correlates with Senge's (1990) concept of leadership and spirituality intersecting, being both personal and collective in nature. Similarly, Wheatley's (1992) ideas of demonstrating personal awareness, practicing attentive listening, and releasing expectations also influence nurse educators in bringing about transformational growth and potential change in the way learning about spirituality is facilitated.

Astin (2004) suggested social change develop spontaneously and concurrently in many levels within the hierarchy of higher education. She cited the need for creating a supportive environment for learning, promoting sustainability and conservation within the surroundings, and creating shared responsibility and provision of care within the community. Group qualities include collaboration, shared purpose for proposed change,



respect for differences, cooperative division of labor, and knowledge creation and sustenance including skills and competencies in the learning environment (Astin, 2004).

Roles of leadership to impact transformational education are worthy of consideration. While contemplating practice and application for leadership, nurse leaders need holistic methods for facilitating transformation. Fluker (2008) proposed spirituality informs the internal and external lives of leaders who embrace ethics and morals. Furthermore, the spiritual dimension defines the core of worthy leaders. He postulated the interplay of the spiritual, ethics, and leadership continues to gain importance due to their utilization in organizational decision-making (Fluker, 2008).

Ward (2002) created a new paradigm for leadership including the intuitive and intrapersonal by emphasizing relationship. Individual qualities contribute to transformational leadership including knowledge and awareness of self, authenticity in beliefs and actions, commitment to collective work, empathy with others, and participation with competence (Astin, 2004; Ward, 2002). By assisting others with spiritual issues, leaders may benefit from looking at pathways for coaching with spirit (Belf, 2002). Identifying the path, pits/problems, patterns, polarization, and paradoxes precludes a leader to take opportunity to use spirituality in order to bring about transformational change (Belf, 2002).

Key features of spiritually-infused organizations include having a sense of purpose and vocation in one's work, promoting creativity and risk-taking, fostering outside commitments and family life, investing in wages and benefits which support the workforce, building community in day-to-day operations and decision-making, and infusing organizational values in the workplace (Groen, 2001). In considering

organizational culture, nursing faculty and educators wield power within educational systems. Using authority in evaluation and grading of student work requires using power. Thinking through the power dynamics in the learning relationship in the classroom offers opportunity to change the limitations of classroom models of the past.

**Relations of power.** Overcoming the challenges regarding spiritual care education involves a discussion about power dynamics in the classroom. Thinking through transformational education with alternative pedagogies implies a need to overcome a power gradient inherent in hierarchical institutions. In addition to schools of nursing being under the college or university hierarchy, religious ties associated with institutions of higher learning may impose added structural constraints (Bourdieu & Passeron, 1990). Those within hierarchical systems often equate power with their experiences in parochial schooling. No matter the religious persuasion, parochial systems have sometimes utilized religious workers, often from among religious orders or altruists, as cheap labor (Collins, 1994). Some maintained when the subjugated teach, they who are oppressed may also be perceived as the oppressor in the role as educator. This carryover to current academia contributes to hidden oppression and hegemony in systems (Apple, 2004; Kincheloe, 2007). Acknowledgment of educators perceived as oppressors within systems is important in adjusting the balance of power; alternative pedagogies offer ways to acknowledge the power gradient and share power with learners in decision-making in the classroom, providing a paradigm of learner-centered learning.

When thinking about how power perpetuates itself through reproduction in schooling per Bourdieu and Passeron (1990), the following questions affect potential transformational learning about spiritual care in nursing education: How does power

affect or limit one's capacity to deal with spiritual issues? How does subordination impact one's ability to consider religiously-loaded topics such as spirituality and spiritual care? How do power structures impact the perception of spirituality among individual nurse practitioners? How do power structures hinder the development of a transformational framework from which nurses may learn to provide spiritual care? How does patriarchy hinder liberation of those under its dominion?

Because spiritual care education involves transformative potential, further implications about hierarchical structures and the power gradient within them needs attention. When a faculty or educator is assigned the power to grade and/or evaluate another's performance or work, it validates the existence of an inequality of power between teacher and student, nurse and client, or leader and participant. Looking at how individuals view power differentials due to past interactions with Mead's (1938) symbolic interaction and within hierarchical relationship bears recognition.

**Implications of power and hierarchies.** Faculty in higher education should evaluate how they use their position to ensure they exercise power deliberately and appropriately rather than inadvertently and inappropriately. How one postures their professional credentials and position either enhances or hampers a learner's educational experience. Faculty often find themselves experiencing the duality of power, being both oppressed by the institution and perceived as being the oppressor over learners (Foucault, 1977; 1980). Consequently, faculty find themselves in a position to evaluate the interplay of freedom, the potential of choosing one's actions through individual liberty, and power in practice. Faculty may choose to exercise their professional and positional power over learners, thereby allowing those learners to become complicit

under a power differential or an asymmetrical power relationship (Bourdieu & Passeron, 1990).

Power, as conceptualized by Foucault (1977; 1980), functions in being both repressive and creative in relation to higher education. Discovering hidden histories and subordinate knowledges through qualitative methodology in research may yield new understandings of particular power relationships. Hierarchical or oppressive relationships, both before and during nurses' higher education experience, impact nurse ability to achieve academic success and meet the standards for professional performance. Foucault's genealogy (1980) provides a method to recover the nursing profession's subjugated knowledges and potentially form new knowledge. By understanding Foucault's (1980) archeology of knowledge, particularly when targeting local points affected by the exertion of power, nurses may conduct research and collect valuable yet hidden data through phenomenological or ethnological approaches.

With the dialectical relationship concerning power and knowledge, Foucault's (1980) notion of the exercise of power creating new knowledge, as well as forming new objects of knowledge, affects how nursing knowledge is created and how novice nurses may be formed as objects of that knowledge. This suggests nursing, as a profession, becomes doubly prone to abuses of power due to nurses being both the oppressed and the oppressor within hierarchical systems. Nursing, a predominantly female profession, embraces both a feminine knowledge and a subjugated knowledge. Common knowledge remains subjugated having been generally believed to be a lesser or inferior knowledge to medicine, the superior realm of doctors (Dossey et. al., 2005).

Although oppressed in a female profession with an inferior knowledge to doctors, nurse educators often exercise the power of the oppressor due to their zeal to provide quality education. Power exercised through language creates truth, which, in turn, changes social relations and structures, confirming Foucault's (1980) conception of knowledge production. Nursing education incorporates coded language by repeatedly creating new vocabulary. Those who decide what comprises knowledge ensure reproduction of the educational system. Language promotes a profession's legitimated knowledge and determines what will be taught in programs. Foucault's (1977, 1980) concern about power within a profession results in the ongoing creation of discourse.

With nursing knowledge constantly being evaluated and changed with curricular revision, nursing education continues in a code of normalization (Foucault, 1977). Once disciplinary power exacts its process, whereby norms and standards are formed and reinforced, nursing's specific discourse of truth becomes institutionalized. Beyond coded language and legitimated knowledge, nursing faculty and gatekeepers of licensure spend inordinate amounts of time classifying, tracking, and norming professional behaviors (Foucault, 1977; 1980). Nursing measures whether numerous required behavioral objectives are demonstrated in order to ensure learners become professional nurses (Dossey et. al., 2005). Who ultimately determines what comprises knowledge and truth for the profession of nursing may influence a query in qualitative research. With the affective nature of the spiritual dimension, care must be given to ensure nurse learning about a personal and emotionally-evocative domain of content remains valued, honored, and protected.

In teaching holistic and personal content or applications, personal transformation remains probable and possible. When using knowledge and truth to inform or transform, alternative pedagogies apply to individual or group learning sessions. Alternative pedagogies position the learner as the center of the teaching and learning process.

### **Alternative Pedagogy in Educational Practice**

Transformational learning toward competent spiritual care in practice may be developed through alternate pedagogies such as critical and narrative pedagogies. Through critical pedagogy, one can transform the self through the transformation of teaching and learning, changing the social relations in educational systems (Duarte, 2006). Critical pedagogy envelops a range of perspectives that challenge the status quo including critical theory via the Frankfurt School, social theory via the Chicago School, social construction of ideology and constructs, and critical reflection and critique (Darder, Baltodano, & Torres, 2009).

Apple (2004) cited the relationship of education to economic, political, and cultural power in society. Themes supporting his premises for nursing education include historical, social, and political control through hidden curriculum, ideological control through systems management, and reproduction through curricular development. According to Kincheloe (2004), hegemony remains a core concept of critical pedagogy and retains characteristics of the dominant power prevailing in educational systems; hegemony promotes inequality and marginalizes the potential success of the individual by favoring the dominant ideology in educational systems.

Bourdieu and Passeron (1990) claimed the acquisition of cultural capital, the necessary sociocultural knowledge and life experience for success in educational pursuits

as *habitus*, becomes essential in order for nurses to advance in an inequitable educational system. According to Bourdieu and Passeron (1990), those who achieve habitus and upward mobility share complicity in the system when they become professionals and perpetuate the system, becoming oppressed themselves within the hierarchy of the dominant power in society.

Critical pedagogues advocate pedagogy toward praxis which requires action. Critical pedagogy comprises transforming relations among education in the classroom, knowledge production, and the hierarchical structures of schooling, which relates to the material and social relation within community and society (Apple, 2004; Bruenig, 2005). Critical pedagogues work to empower those within asymmetrical power relations and transform inequities in social relations through praxis. In critical pedagogy, praxis involves both action and reflection, an ongoing process of being; “praxis is reflective, active, creative, contextual, purposeful, and socially constructed” (Bruenig, 2005, p. 111).

Developing praxis requires the investigation of the material and societal conditions which shaped an individual’s perception of their objective condition. Providing context for spirituality as lived experiences encourages nurses to critically reflect on their own experience and that of others they have encountered (Crisp, 2009). Moreover, belief in the value of others undergirds critical pedagogy; faith in people becomes an “*a priori* requirement for dialogue” (Freire, 2000, p. 113). Questioning various assumptions that surround sources of knowledge enhances dialogue. Bruenig (2005) claimed once nurses engage in dialogue, they discover knowledge remains partial, contextual, and socially constructed.

The role of the faculty towards praxis merits further consideration. Within critical pedagogy, the teacher acts as facilitator and collaborator, an agent of potential social change. Education is historical, cultural, social, and political in nature; therefore, teaching becomes intellectual, theoretical, and political in the classroom (Bruenig, 2005; Giroux & Simon, 1998). Asking, “How do I teach from the heart?” and aligning one’s spiritual practice with teaching practice along with viewing teaching as spiritual work becomes crucial (Ashton, as cited in Denton & Ashton, 2004, p. 58). Bruenig (2005) suggested faculty members start a course with experiential learning and situating their own experience as being the product of the educational system. She promoted self-disclosure of the faculty’s personal experience in schooling to put learners at ease about questioning assumptions regarding the role of learner and teacher or teaching and learning. However, the benefit of full faculty self-disclosure about their personal spirituality remains debatable and contains some risk (Crisp, 2009).

Moving from faculty as expert to a “guide on the side” posits a template for discussion-based learning strategies. By conversation and mutual engagement, dialogue replaces didactic methods with a learner-centered dialogue that involves the learner. Alternative pedagogies involve the learner in shared dialogue and decision-making.

**Learner-centered dialogue.** Critical pedagogues promote learning by listening to nurses’ perspectives, valuing their ways of knowing and life experience, promoting and role-modeling shared dialogue, and exercising shared decision-making in the learning environment (Bruenig, 2005). Hostetter (as cited in Denton & Ashton, 2004) posited attendance in activities should be highly encouraged because faculty cannot predict when rich narrative will occur. Empathy connects intellectual understanding with



heart connection and comprises a central component of effective dialogue, fostering compassion and questions such as: “How has this person suffered, Why is this person oppressed? What systems create or maintain this oppression? What can I do to change or transform this situation?” (Hostetter, as cited in Denton & Ashton, 2004, p. 37).

Denton (as cited in Denton & Ashton, 2004) proposed four areas for attention in teaching spirituality: first, spirituality represents many things from many perspectives; second, spirituality resides in the narrative where stories become vehicles of connection and then transformation; third, spirituality requires some instruction about particular religious traditions; and fourth, spirituality implies egalitarian risks of self-disclosure and dialogue for faculty and learners. Curricular practice involves incorporating nurse experience as “official” content (Giroux & Simon, 1998, p. 22). This presents potential contradictions to acknowledge and, thus make legitimate, nurse experience on one hand, and challenge it on the other. Affirming participant experience at the same time while educators promote learners to contest everything presents particular challenges (Giroux & Simon, 1998). From gerontological applications, Langer (2004) reported the phenomenon of “restorying” and developing elders’ shared stories in new directions; using a perspective based upon strengths and emphasizing positive attributes in shared dialogue promoted problem-solving, coping, and healing with possible transferable applications for nursing education.

Critical pedagogy cultivates action-oriented growth along with emancipation and empowerment. Duarte (2006) spoke of having an ontological “call to humanity” where “the educator must act and enjoin their students in action” (p. 108). Emancipatory work begins with identifying and “problematizing” the social conditions, ideologies, and social

relations which impact the oppressed (Giroux & Simon, 1998, p. 21). “Unpacking” values about education, religion, ethics, and spirituality may impact the nature of the dialogue and create discomfort or tension (Bruenig, 2005). Fear of freedom comprises a common obstacle to liberatory learning.

Empowerment among learners generates a major ethical concern; learners may be manipulated or controlled in the process (Freire, 2000). Perhaps the greatest obstacle to liberation concerns the oppressed experiencing internalization of the oppressor’s belief system; this results in education for domestication rather than education for emancipation (Freire, as cited in Chen, 2005). Some trapped in domestication may deny they are oppressed; this may complicate the faculty role in facilitating emancipation among some learners while understanding others remain trapped in situated objectification. Despite the influence of domestication, critical pedagogy fits liberatory work such as spirituality in education (Dillard et al., 2000).

Social justice underlies the goal of critical pedagogy (Chen, 2005). Taking risks in participant-centered dialogue through critical pedagogy includes risks (Bruenig, 2005). Finding previously unheard voices and uncovering previously hidden or subjugated knowledges uncovers contradiction; silenced voices reveal contradictions in structures and relations within the objective social condition (Foucault, 1980). Using critical pedagogy to actuate social justice serves as democratic education and social empowerment (Giroux & Simon, 1988). Through dialogical engagement, Chan and Chung (2004) found learners identified the spiritual well-being of the individual to be connected integrally to temporal and relational connections. Active engagement resulted in both intention and commitment to learn from the situation. Consequently, finding the

spiritual voice carries possibility for self-discovery and self-liberation (Chan & Chung, 2004; Crisp, 2009; Dillard, et al., 2000). Puett (2005) posited interfaith education advances possibility for transformation through dialogue among diverse traditions. Crisp (2009) proposed three worthy aspects of spiritual development can be fostered through critical pedagogy: belief and personal development, social development, and relating to others along with developing a sense of community.

Spirituality in action may be equated with social justice, a concern for human beings as God's creation (Smith, Sullivan, & Shortt, 2006). The concern for the love of neighbor transcends religious affiliation and traditions. Love of neighbor comprised a renewed construct in Catholic teaching and dogma after Vatican II in the 1960s; the Church reconstructed a new paradigm for Catholic social teaching whereby those in religious orders and parishioners at-large were to reach out to the greater community (Miller, 2009). Catholic social teaching rests on tenets of faith which underpin a respect for the sanctity and dignity of human life. Prior to Vatican II, most students interested in studies of spirituality in Catholic universities and seminaries came from religious orders; today, students from multiple religious backgrounds and affiliations seek spiritual content (Crisp, 2009). Along with Catholic education, Smith, Sullivan, and Shortt (2006) claimed Protestant leaders echo a biblical vision for shalom along with justice.

From a Jewish oral tradition, critical pedagogues may view their teaching responsibility as sacred, affecting students' knowledge, consciousness, and emotions (Schram, as cited in Denton & Ashton, 2004). In the biblical Jewish tradition, the "heart is the locus of reason and intelligence" of deliberation, planning, and decision making, therefore the heart becomes a repository of cognitive and affective domains, of wisdom

and emotions (Schram, as cited in Denton & Ashton, 2004, p. 77, 78). From the tradition of Judaism, Schram (as cited in Denton & Ashton, 2004) poses questions for the transformational classroom:

Who am I? Who are my people? By what values did they live? How should I live? How should I die? What are the legacies that I should transmit to the next generation? How do I become a *mensch*, a compassionate, resourceful, empathetic, ethical, reaching-out-to-others kind of human being? How do we interact with other people? (p. 83).

Consequently, justice comprises a noble goal for teaching in our global age.

Paulos (as cited in Denton & Ashton, 2004) proposed critical pedagogy, as pedagogy of the heart, results from compassion, empathy, and connection, and requires courage. Socrates, as an example of the model critical pedagogue, demonstrated his practice of teaching philosophy, the love of wisdom, which ultimately led to his death. Teaching others to learn carries inherent risk. Transformative pedagogy, despite the risk, encompasses possibility for students to apply learned beliefs about faith in action within practice, both strengthening commitment and transforming how they work (Wax, 2008).

Pedagogical alternatives such as critical pedagogy involve opportunity for dialogue and questioning to engage the learner. Using the Socratic method involves the learner in defining his or her view of spirituality further. Although classroom strategies may produce intellectual learning and knowledge, models for transformational learning potentially changes lives.

### **Transformational Learning Alternatives**

In connecting spiritual care and critical pedagogy, transformative action presents possibility for transformational change. Holistic nursing calls for a holistic pedagogy which alternative pedagogies and transformational learning theory may provide

(Mezirow, 1991). Transformational learning in higher education engages multiple dimensions of the human experience such as the sociocultural, rational, affective, imaginative, somatic, and spiritual domains; engaging learners in multiple ways will increase the likelihood where learning is “constructed and embodied, thus having the potential to be transformative” (Tolliver & Tisdell, 2006, p. 39).

Mezirow’s (1991) transformational learning theory corresponds to using alternative pedagogies in spiritual care education where discourse explores varied cultural paradigms concerning spirituality and uses critical reflection to facilitate transformational learning (Merriam & Caffarella, 1999; Merriam & Ntseane, 2008). Maxine Greene (as cited in Darder, et al., 2009) endorsed engaging students’ imagination in creative learning. Using literature, students’ stories, and client stories forms a plausible starting point for transformative learning. Cancer patients and others with other conditions in end-of-life care often view their diagnosis as a journey, once they become acclimated to it; learning about conditions of the suffering and oppressed may lead to transformational learning (Wright, 2008). Chan and Chung (2004) found learners identified the spiritual well being of the individual to be connected to temporal and relational connections. In considering common connotations of suffering, repentance is not usually equated with renewal; rather, it is commonly associated with being bad and asking God for forgiveness or avoiding God altogether. The Greek root for repentance, *metanoia*, means to “turn around” or “transform” and turn a painful experience into a transformational one (Wright, 2008, p. 25). By working through biases, assumptions, and beliefs with alternative pedagogies, nurses promote transformational learning for themselves and others.

A framework for developing spirituality as lived experience advances possibility for transformational alternatives from traditional pedagogy. Crisp (2009) developed a transformational framework for teaching spirituality with four dimensions: *life rituals*, both everyday events and life markers presented spiritual significance and meaning; *creativity*, using the aesthetic as spiritual expression and experience; *sense of place*, visualizing places of spiritual meaning and significance such as mountains, oceans, and forests; and *social action*, connecting action in the social sphere and social justice. By introducing students to broad themes, learners found affinity or affirmation through exploring spirituality (Crisp, 2009). Developing learner-centered dialogue and making meaning in reflection presents a viable alternative for exploring the spiritual dimension (Mezirow, 1991).

By viewing current issues, strategies, and methods for classroom engagement, nurses benefit from learning more about spiritual care. In reviewing the topical literature, potential gaps emerged in intentionally placing spiritual content in nursing curricula and in selecting teaching and learning strategies that successfully link knowledge to applications in practice. Moreover, topical research suggests that further research was needed in regard to delineating the link of nurses connecting knowledge to how they provide spiritual care in practice.

### **Conclusions from Topical Literature**

Overall, a survey of the literature produced a lack of nursing research about spiritual care concepts and practice among nurses. Ross's (2006) and Taylor's (2005) overviews of research on spiritual care each cited only two qualitative studies. Van Dover and Bacon (2001) reported qualitative findings regarding Christian nurses'

preferred spiritual interventions with patients. Zerwekh (1993) reported themes about what spiritual care involved through qualitative research with hospice nurses. Both studies rendered inclusive or non-generalizable findings. In addition, VanDover and Pfeiffer (2001) reported qualitative findings among parish nurses regarding spiritual care, which may not apply to other settings in the nursing profession. To date, I found no other qualitative studies with nurses across practice settings.

Other studies with nurses in the United States used quantitative or mixed methods studies. Highfield and Cason (1983) reported survey findings among surgical nurses regarding awareness of patient's spiritual needs. Boutzell and Bozett (1990) reported findings of a survey done among nurses in Oklahoma regarding assessment of patients' spiritual needs and perception of nurse preparation. Taylor et al. (1995) reported correlations about attitudes and spiritual care practice through quantitative measures among oncology nurses. Stranahan (2001) reported survey findings between perceptions and practice of spiritual care among licensed Nurse Practitioners (NPs), which may vary from RN practice. Cerra and Fitzpatrick (2008) found nurses who had a sense of spiritual well-being themselves and used their personal well-being to sense spiritual needs of patients; moreover, nurses who graduated from religiously affiliated institutions reported more positive existential well-being. To date, I found only several studies reporting qualitative findings with US nurses across practice settings in the profession.

In addition to considering research studies to date, relevant nursing theory emerged in the review of the literature. Several nursing theorists included the spiritual dimension in their models. However, the following theory informs how nurses formed their own view of the world, as if clients themselves, in relation to their own spirituality

through *modeling*. Secondly, they later learned to assess and evaluate the spirituality of another, the client, through *role-modeling*. This theory explained how nurses work through their own perceptions of spirituality in order to assess those of their clients including the need for spiritual care.

### **Nursing Theory: Modeling and Role-Modeling**

Erickson, Tomlin, and Swain's (1983) Modeling and Role-modeling (MRM) theory provides a paradigm for providing holistic assessment and care with seemingly simple concepts upon initial examination. *Modeling*, viewing the client's world from his or her model or perspective, implies understanding the way the client thinks, feels, believes, communicates, and behaves. *Role-modeling* involves the nurse using understanding of the client's world and working from within this model to help design effective interventions, which are perceived by the client to lead toward his or her optimal health (Erickson et al., 1983).

The paradigm includes components of (a) *holism*, implying the whole is greater than the sum of the parts, vs. *wholism*, implying the whole is equal to the sum of the parts, and addresses the genetic makeup and spiritual drive, which permeates the system; (b) *health*, well-being affected by dynamic interaction, which implies social subsystem interaction constituting the environment; and (c) the individual as *client* in relationship with the nurse as facilitator, nurturer, and provider of unconditional acceptance (Erickson et al., 1983). MRM blends common concepts with new applications specific to nursing with terms such as: modeling, role-modeling, affiliated-individuation, impoverishment, and self-care knowledge, self-care resources, and self-care actions, all with meaningful



implications for nursing practice (Erickson et al., 1983). The theory delineates a true partnership between nurse and client, emphasizing individualization of care.

Several concepts become critical for understanding the spiritual dimension. *Affiliated individuation* is defined as an instinctual, innate need to affiliate or connect, which is simultaneously dependent on support systems. Although the individual maintains a degree of separation or independence from those support systems, he or she perceives connection or affiliation, which provides meaning. Through affiliated individuation, the theory shows how people are alike (Erickson et al., 1983). *Inherited endowment* constitutes a mechanism of adaptation whereby the individual mobilizes both internal and external resources in response to stressors. These responses can be health-directed and goal-directed. This includes Selye's stress theory concerning biophysical insults and Engel's psychosocial theory. The theory contains semantic consistency in the detailed definition of significant terms and concepts (Chinn & Kramer, 2004) and is congruent with microinteractionism (Collins, 1994) and Fowler's (1981) stages of faith.

The theory's holistic, client-centered approach focuses on the total client. It explains dynamic interrelationships of biophysical, psychological, cognitive, and social subsystems along with the genetic base and spiritual drive which "permeate all aspects of the person" (Erickson et al., 1983, p. 45). This concept of an innate spiritual drive validates spirituality and holistic health (Frisch & Bowman, as cited in George, 2002). The theory contains the underlying belief that clients inherently know what they need to do to improve optimal health, to facilitate their own growth and development, and to improve their quality of life. With increased attention on holistic practices, MRM provides a venue to apply new methodologies in nursing practice (Erickson et al., 1983).

The client remains the focus and the client perspective starts the process of the nurse role-modeling the client's world before choosing appropriate nursing intervention. MRM supports the meeting of basic needs, which can only be satisfied "from within the framework of the individual" and, if left unmet, interfere with holistic health (Erickson et al., 1983, p. 58). MRM stipulates repeatedly met needs develop self-resources, which result in a client's tendency to pursue health-directed behavior. By the client being the center of care decisions, the central concept, *the client's perception is everything*, initiates action in this theory: nursing interventions occur only when the client perceives a need for action to be taken (Schultz, as cited in Peterson & Bredow, 2004).

This concept of the client being central proves valuable for nursing education due to being congruent with the movement toward personal autonomy, independence, responsibility for decision making, and cultural sensitivity (Erickson et al., 1983). It maintains consistency with Mead's (1938) symbolic interactionism and Fowler's (1981) faith development theory. Especially helpful for nursing education is the theorists' emphasis that the nurse is the only health care provider responsible for holistic care, thus giving nurses motivation and empowerment as caregivers (Erickson, et al., 1983).

The use of critical thinking illustrates potential application for the Adaptive Potential Assessment Model (APAM) within MRM; Erickson's own clinical observations and life experiences from psychoanalysis were integrated and synthesized with existing theoretical sources (Erickson et al., 1983). APAM includes assessment of the following: (a) the ability to cope, (b) arousal as a temporary state of stress, signifying unmet needs; and (c) a resulting need to establish equilibrium. When faced with the need to re-establish equilibrium, a good outcome results in adaptive equilibrium; the client's stress

would be relieved and demonstrate good potential for mobilizing both internal and external coping resources. A bad outcome results in maladaptive equilibrium whereby unmet needs continue and result in impoverishment, a deficit (Erickson et al., 1983). The APAM model approximates allowances for adaptive and maladaptive adjustments in Fowler's (1981) faith development theory and has an impact on spiritual care.

Impoverishment implies a stress state where diminished or depleted resources cannot be mobilized without direct nursing care or spiritual care in order to relieve unmet needs. This concept of MRM aligns with O'Brien's (2008) seven components of spiritual distress. An example of MRM concepts at work involves clients continually reworking residual issues (Erickson et al., 1983). The nurse role-models the client's world and mirrors back the client's perception in order to find new self-care initiatives or interventions for the client. This correlates with microinteractionism (Mead, 1938). Overall, MRM provides a logical framework from which to assess and plan spiritual care based upon the nurse's understanding of the client's view of the world and teaches the nurse to use reflective practice in action, a form of critical thinking (Frisch & Bowman, as cited in George, 2002). The nurse-patient interaction involved in MRM approximates the social interaction depicted in Mead's (1938) symbolic interactionism whereby the individual perceives their responses of the world in response to "the generalized other." (Collins, 1994).

Within MRM theory, delineating useful and meaningful nursing roles presents a strength, which is invaluable in nursing education. Nurse roles of facilitator and nurturer, along with expressing unconditional acceptance, provide the foundation of good nursing practice. Facilitating means to help, aid, and support, rather than *to do* for the client.

While MRM does not support standardized nursing interventions, its aims of individualized nursing interventions include building trust, affirming and promoting client strengths, promoting positive orientation, facilitating perceived client control, and setting mutual health-directed goals (Erickson et al., 1983). Developing reflective skills in action forms the key to MRM and nursing education; the nurse actively processes assessment, care, and interventions while engaging the client in ongoing interaction. Furthermore, the theory demonstrates both the art and science in nursing, enlightening nurses about the human psyche and how to role-model the client's world, which is especially valuable in teaching the aesthetic, the art of nursing (Schultz, as cited in Peterson & Bredow, 2004).

In addition to therapeutic interaction, the theory identifies the critical thinking skills used in the nurse's ongoing analysis of the client's world, his or her perception. Teaching nursing with MRM includes how to approach a client, how to communicate, and how to prioritize and meet the client's perceived biophysical, psychological, cognitive, social, and spiritual needs (Erickson et al., 1983). This critical thinking component aligns with Mead's (1938) symbolic interactionism and Fowler's (1981) faith development theory where the nurse-client dyad of interaction helps determine how individuals choose a course of action. In addition, the theory concepts, with aggregation and analysis of data, fulfill scientific principles for empirical knowledge and nursing as a science (Schultz, as cited in Peterson & Bredow, 2004). The theory became the theoretical basis for a growing number of schools of nursing.

Prescriptive or predictive qualities of the Adaptive Potential Assessment Model (APAM) provide a model for nursing practice. With the ability to anticipate and monitor

responses to basic needs and stressors, the nurse offers prescriptive interventions, which the client perceives need attention. The predictive quality of this adaptive response or ability to cope provides capacity for the nurse to predict health care needs, health deficits progressing from maladaptive equilibrium to impoverishment including the spiritual dimension, and even predict lengths of hospital stay (Erickson et al., 1983). With complementary application of Mead's (1938) symbolic interactionism and Fowler's (1981) stages of faith development, the individual selects adaptive or maladaptive courses of action of their own volition. This particularly relates to the provision of spiritual care for spiritual distress and other perceived spiritual stressors in O'Brien's (2008) schema and how nurses may assist clients in finding relief.

Some limitations of this theory emerged upon further study. The environment comprises a missing component in the paradigm of nursing, being implied as inherent in the client's social subsystems; biophysical stressors are included within the implied concept of environment. In nursing education, this means an incomplete paradigm from which to work (Shultz, as cited in Peterson & Bredow, 2004). For those dependent upon the Nightingale precept of the paramount importance of environment affecting the health and healing of patients, this theory may be seen as deficient (Chinn & Kramer, 2004).

Another limitation involves the theory's content and language which is dense and convoluted. To some, this may be perceived to be a benefit and to others regard it to be a deficit. The density of this theory becomes apparent due to the amount and complexity of synthesized theory and borrowed theory it encompasses (Schultz, as cited in Peterson & Bredow, 2004). This limitation would affect inexperienced nurses or nurses who have English as a second language (ESL) or English language learners (ELL). With MRM

being dependent upon having substantive, meaningful communication with clients, those with less proficient language comprehension, impaired ability in communicating accurately about subtle feelings and perceptions, or limited experience in exploring psychological processes with clients might have difficulty in fully using the theory.

A related limitation of this theory involves limited application in its purist sense with impaired clients who cannot communicate their perceptions, their own input, or their acknowledgement. Because MRM theory is based on the client's perception or model of the world, those who cannot share their perspective readily (i.e., pediatric, stroke, or unconscious patients) experience difficulty in using the theory. Since the client's perception remains integral to MRM, it would be difficult to ascertain client participation without direct communication. It should be noted the theorists attempted to address this contingency and suggested various strategies for applying their theory with clients who are not able to verbally communicate (Erickson et al., 1983).

With theoretical bases in the interdisciplinary work of Maslow, Erikson, Piaget, Engel, and Selye in Developmental Theory, many MRM concepts sound familiar. This foundation fulfilled structural consistency because of congruency with established psychological terminology and theory. This consistency within the theory demonstrates structural clarity, a logical progression from its assumptions and connections to its assertions (Schultz, as cited in Peterson & Bredow, 2004). Overall, MRM established concepts and interrelationships between nursing and psychology, initiated research, and provided a basis for holistic nursing, the current trend in health care.

In keeping with interdisciplinary theory, social cognitive theory informed a broader understanding of human interactions and relationships. With similarities to

MRM theory and its importance on the dyad between nurse and client, social cognitive theory's microinteractionism broadened theoretical foundations for analysis. Narrowing social relations to the essential dyad of a person and "the generalized other" informed a lens for analysis in the study (Mead, 1938).

### **Social Cognitive Theory: Microinteractionism**

The microinteractionist tradition, a distinctly American tradition, viewed the social world as consisting of human consciousness and human agency. Relying on the microinteractions between individuals or smaller groups rather than within large societal structures, the tradition explored how human relationships affected the individual. The tradition differs from other social cognitive theories like the macro-level structural components of society in Durkheimian tradition and the hard materialism in the conflict tradition of Marx (Collins, 1994).

As a tradition, microinteractionist theory started as an exercise of pragmatism in finding causes of emerging social problems in the late 1800s. With increased crime and waves of immigration affecting city life, American higher education changed its focus to science and scholarship rather than remaining as training institutions for clergy. Whereas English and continental universities turned to idealist philosophy, American institutions turned to pragmatic philosophy that identified the role of consciousness in interpreting one's social world (Collins, 1994; Kivisto, 2005).

Charles Sanders Pierce became the intellectual leader of pragmatism who established philosophy as science on the basis of developing the application of logic beyond deductive reasoning (Collins, 1994). Pierce went beyond deduction, which he considered to be an impairment to actual reasoning, to induction, a process of finding generalizations

based upon investigation, and a process of conjecture which he dubbed *abduction* (Collins 1994). Pierce established an expansion of logic to his new science, *semiotics*, a science of signs. In order for signs to be meaningful, both *semantics*, the words into which signs are translated, and *syntax*, the connection of words in relation to signs, were necessary (Collins, 1994). For all of this, Pierce determined thinking was not an independent function without meaning because signs were necessary and, without community, signs were without meaning. This implied labels and symbols are socially constructed and may vary in cultural interpretation (Kivisto, 2005). Therefore, thinking requires societal reference points and social relationships in order to occur (Collins, 1994).

As a form of sociology of thinking, yet another thread within the microinteractionist tradition involved the social behaviorist study of George Herbert Mead. Mead (1938) separated the self from the body, which led to the idea that self is a point of view; he claimed each individual cannot observe the whole self directly, even in a mirror. Therefore, one's reality of self is experienced only indirectly through others (Collins, 1994; Mead, 1938). Mead (1938) proposed one's self only develops through interaction with others, and symbolic interaction provides a basis for the reciprocating self (Balswick, King, & Reimer, 2005). Human communication relies upon symbols such as language that are directed both to self and others. *Reflexivity* is the quality of self where one can be distinguished from others yet can be an object either for others or self (Collins, 1994). Mead (1938) suggested thought is a conversation of gestures within self where one mentally plays out various responses before one responds with audible words within actual conversation. He also posed each individual had multiple selves—multiple roles or relationships with others, stages of make-believe as development of the self. Successive roles in rapid sequence



marked the developmental tasks of self: the organized self, the generalized self, and construction of self-image (Collins, 1994; Mead, 1938).

In *symbolic interactionism*, Blumer posited a fluidity of the social order that included negotiation skills consisting of three premises: (a) individual interaction is based on meaning; (b) meanings are derived from interaction with others; and (c) meanings are managed and changed or transformed by reflective and interpretative processes (Kivisto, 2005). Social situations create and recreate set of roles. Because they contain negotiation in the context of societal understanding, roles were socially constructed. Blumer's symbolic interactionism emphasized both spontaneity and indeterminateness, which allowed for change (Collins, 1994). Therefore, people transform objects in nature into symbols, which they interpret with cultural meaning (Kivisto, 2005).

The idea of looking at the social responses of the individual in relation to cognition and thinking fit the historical age. With advances in industry, technology, and domestic life, scientists had time to consider the human psyche and social relationships in a way that would not have been possible before people gathered in city centers during the industrial revolution (Kivisto, 2004). Furthermore, conflict and Durkheimian theorists hold the macro issues to be more important than the micro aspects of individual interaction, thus the name, microinteractionism. According to this theory, nurses' roles are socially constructed and they are negotiated in the context of societal understanding; both spontaneity and indeterminateness allow change (Collins, 1994). When multiple roles are in conflict, role incompatibility results (Kivisto, 2004).

Within microinteractionist tradition, the juxtaposition of *inner-direction*, internalization of one's values and roles, to *other-direction*, conformity to a group over self,

may have relevance for how nurses view their life experience (Kivisto, 2004). Mead's (1938) concept of "the generalized other" moved beyond microinteractionism toward interaction with others and presents a way to analyze nurse interactions. His theory centered upon the triad of meaning among the self, other, and perceptions about the *generalized other*, where meaning is derived from interaction with members of the same or a similar social group (Collins, 1994; Mead, 1938). When finding social meaning through symbols, "the generalized other" helps to determine one's own self concept; the meaning is either altered or reinforced by the interaction with "the generalized other," others who fit the same social group (Collins, 1994; Mead, 1938). This may apply to nurses where interactions are based upon previous bias and experience with others rather than on the present interaction.

Mead (1938) also posited each individual has multiple selves—multiple roles or relationships with others. When multiple roles are required, various methods reconcile roles; when multiple roles are in conflict, role incompatibility results (Kivisto, 2005). The implications of role incompatibility affect individual perception, and therefore, individual nurse ability to provide spiritual care.

The multiplicity of roles evolved further by Robert Merton where one person has many roles simultaneously with a number of people. For instance, a nurse might be a daughter, a sister, a friend, a mother, an employee, and a supervisor, all in relation to different people in her life (Collins, 1994). Multiplicity of roles is a concept that applies to the nursing profession, which allows for the potential for role conflict between the multiple roles one may have in a given situation.

From social cognitive theory and microinteractionism, developmental theory proved helpful in solidifying a theoretical foundation for analysis. Developmental theory spoke

directly to the research question and how nurses formed patterns in practice. Looking at professional development theory and faith development theory informed progression of patterns in providing spiritual care.

### **Developmental Theory**

In looking at nurses' lived experience related to interpretation of holistic nursing practice in a sphere like spiritual care, it seemed that theory about how adults adapt to change and develop would provide multiple perspectives for interpretation and analysis. The lens of psychological, sociocultural, theological, or other perspectives provided theoretical instruction for understanding the meaning of participant responses concerning spiritual care and spirituality. Viewing human development as ongoing and constant interaction with the environment undergirds particular models that attempt to explain the process of adult development (Merriam & Caffarella, 1999, p.135).

An integrative model by Magnusson (1995) may have relevance in determining how individuals construct and interpret meaning of life experience in relation to providing spiritual care. Magnusson (1995) outlined four assumptions including: (a) an individual functions and develops as an integrated, whole being; (b) the individual continues to develop through ongoing interaction with the environment that is reciprocal (meaning the individual continually adapts to feedback); (c) this interaction of biological, environmental, and cognitive factors also contains situational factors; and (d) the individual integrates changes and develops as a result of this ongoing feedback loop of interactions with holistic factors. Magnusson (1995) emphasized individuals respond as total integrated systems or beings rather than responding to singular variables during the lifespan. This model may have relevance due to its ability to offer explanation as to how

individuals frame problems at particular points in time, apply empirical reasoning to life happenings, and interpret meaning for life events (p.133).

Another developmental theoretical model by Perun and Bielby (as cited in Black, 1980) proposed adults view experiences as a multitude of “temporal progressions,” sequential life experiences of change that may appear to follow a time table such as: biophysical changes in early adulthood, sociocultural changes due to marriage or parenthood along with role reversal later in life due to death of a parent or spouse, and psychosocial or socioeconomic changes of roles in the workplace or family structure. Within this model, change may arise from two sources. First, basic change within the process of development is acknowledged to include both one’s deliberate choices of life decisions and unexpected life happenings or inevitabilities. Secondly, these changes may occur asynchronously and trigger other changes in response to an unexpected crisis such as major illness or disability of one’s self or a family member, or death of a nuclear family member (p. 134). This leads to an understanding of how adults process and interpret meaning of life events in varied time periods. Whereas adults may process some of the information concerning a basic life change, it may take time for them to process and incorporate meaning of other life changes.

Yet another model by Peters (1989) may provide interpretative value for analysis due to its focus on the biological, psychological, and sociological spheres of development in adults. Peters (1989) cites the changes in life structures occur throughout the lifespan in work, other, and self. Work includes all activities related to the workplace and one’s job. Furthermore, both internal forces such as biological or psychological factors and external forces such as social and economic factors impact how an individual negotiates

choices about their work, views expectations within social and family relationships, and shapes how they perceive themselves. (p. 135). An individual's life structure does not maintain stability but rather changes in response to individual choice in responding to both external and internal forces. Peters (1989) proposes one's "essence of development" evolves as an individual chooses his or her responses and reconfigures life structures.

Cognitive theory by Piaget provided a theory whereby human beings construct reality for themselves, incorporating ever increasingly complex cognitive capacities through the lifespan. Piaget's constructs of cognitive development and Mead's (1938) symbolic interactionism shared similarities with their mutual emphasis on the need for acquiring language and using language for development (Balswick et al., 2005). With planning future interactions in symbolic interactionism theory, becoming self in cognitive development theory approximates the learning through interaction in order to respond to "the generalized other." Symbolic interaction theory and cognitive development theory share the foundational assumption that human beings respond to their environment, react to their surroundings and interactions, and take action (Balswick et al., 2005).

Linking interdisciplinary theory with nursing professional development theory informed analysis of nurse characteristics and behavior. Utilizing a theory for general nursing practice informed how nurses learned skills in providing spiritual care. This explained, in part, how nurses negotiated skill development related to spiritual care.

### **Benner's Professional Development of Nurses**

Ideas about how a nurse progressed in nursing had relevance for examining how nurses navigate the profession and integrate spiritual care into practice. Development of young professionals affects the nursing profession. This was consistent with other

professional development theory in understanding how nurses progress in practice through building trust in the work environment, finding or exerting autonomy, exercising initiative, and maintaining a sense of industry in the workplace (Benner, 1984).

Benner (1984) proposed a model for nursing that followed the Dreyfus (as cited in Benner, 1984) model of skill acquisition, originally delineated when studying airline pilots and chess competitors. Benner's (1984) schema laid out the following sequential stages of nurse development: novice nurse, advanced beginner nurse, competent nurse, proficient nurse, and expert nurse. This became widely used in the nursing profession to describe how nurses grew in their role and developed professional skills and expertise.

In stage 1, the *novice nurse* learns contextual meaning for nursing knowledge, transfers theoretical understanding to real application, and adapts to clinical situations (Benner, 1984). It follows that novice or advanced beginner nurses first go through a period of orientation whereby he or she looks for mentors and exemplary nurses to help guide them in establishing abilities, which fulfill their professional role and responsibilities (Shirey, 2009). Once gaining experiential learning by coping with real situations, the novice moves to an advanced beginner (Benner, Tanner, & Chesla, 2009).

In stage 2, the *advanced beginner nurse* demonstrates acceptable, but marginal performance with frequent supervision and oversight. Nurses in this stage synthesize some but not all information within a clinical situation. Although they perform technical skills safely, they need ongoing support to set priorities, perceive emerging patterns, and validate patient needs which require nursing intervention(s) (Benner, 1984). Once acknowledging and utilizing more mature nurses as resources, nurses in the advanced beginner (stage 2) may view themselves as capable and competent some of the time, yet

seek other professionals for their own growth and development as needed. At this post-orientation phase, individual nurses may understand the standards for practice, policy and regulations impacting their work, and how to use their professional skills and obligations effectively (Benner et al., 2009).

In stage 3, the *competent nurse* delineates short-term and long-term implications of his or her actions, yet needs more time to demonstrate time management and agility in managing multiple patients. By working on intentional and deliberate planning, nurses achieve organization and efficiency in this level. The competent nurse begins to appreciate how to utilize an analytic principle such as a rule, protocol, guideline, or maxim in practice (Benner, 1984). It follows that competent nurses grow in exercising initiative as they move into independence and autonomy in their professional role. They exercise professional responsibility and accountability while finding rewards in testing their role (Benner et al., 2009).

In stage 4, the *proficient nurse* sees clinical situations within a larger context. Through experiential learning, the nurse learns from previous situations how he or she may modify actions in similar scenarios. Now recognizing whole situations, the nurse understands a basis for holistic nursing, how to adapt nursing actions for patient situations, and how to read patient situations for effective interventions (Benner, 1984). This stage provides particular relevance affecting teaching and learning; proficient nurses assess learner readiness for appropriate health teaching and appropriately apply analytic principles (rules, protocols, guidelines, or maxims) in practice (Benner, 1984). It follows that proficient nurses develop expertise and maintain a sense of industry. They constantly expand their own knowledge of nursing and demonstrate competence when

performing competently and independently. When acknowledged and recognized, proficient nurses may be tapped for team leading and other leadership roles (Benner, 1984; Benner et al., 2009).

In stage 5, the *expert nurse* practices without reliance on analytic principles for connecting his or her selected actions to understanding a clinical situation. An expert nurse utilizes intuition derived from processing previous situations and sometimes has difficulty delineating all the data inherent in his or her assessment (Benner, 1984). Often used as a consultant, nurse experts may require an interpretive or qualitative approach in order to assess their effectiveness and not all nurses are capable of reaching this stage. This stage includes flexibility and fluidity that requires systematic documentation for assertions and decisions since nurse experts often detect early clinical changes (Benner, 1984; Benner et al., 2009).

Having identified a nursing theory that informed how nurses acquired and integrated general skills in practice, another theory was needed to inform how nurses incorporated the spiritual background and influences in their own lives. Faith development theory proved helpful in delineating how nurses identified their own traditions of faith and reconciled those teachings. By working through stages of faith development, the theory explained how nurses incorporated their own faith development in providing spiritual care.

### **Fowler's Faith Development Theory**

In concert with professional development theory, Fowler's (1981) stages of faith theory has application for a study about how nurses understand and assess spiritual needs and provide spiritual care. The theory outlines a progression of faith development and



provides congruency with other developmental theorists such as Erikson, Piaget, Kohlberg, and Selman. Formed on a foundation of Kohlberg's moral development, faith developed as a natural construct once the moral conscience formed (Fowler, 1981). Developed from phenomenology, the theory offers a characterization of faith that provides a qualitative "account of what faith *does* and a conceptual model of what faith *is*" (Fowler, 2004, p. 412).

The theory includes how the individual processes social interaction in negotiating the following areas: logic, moral reasoning, perspective taking, world coherence, locus of authority, bounds of social awareness, and symbolic function (Fowler, 1981; Parker, 2009). Fowler (1981) posited faith was broader than any single structure within development and proposed the multifaceted aspect of faith. The theory applies either within or outside of organized religion (Balswick et al., 2005) and recognizes aspects of faith including the relational, cognitive, and affective aspects of human development.

Fowler's (1991) faith is both dynamic and generic, "a dynamic process of finding and making meaning in our lives" (p. 27). Becker (1968) called human beings *homo poeta* whose most distinguishing feature of "making meaning" separated us from other beings (Fowler, 1991, p. 27). Fowler (1981) qualified religious faith as the "personal appropriation of relationship to God through and by means of a religious tradition" (p. 36). Rather than constructing a religious or theologically based theory on relationship with God, Fowler based his theory on social relations. This allows for all human beings to be part of relations that cultivate trust and loyalty with others (Fowler, 1991, p. 31).

Fowler (1991) posited faith is "covenantal in structure" (p. 31). Covenant per Fowler includes a binding between persons or groups. His conception visualized social

structures as a covenantal triad of social relationships rather than as a covenantal relationship associated within the context of religion or between the individual and God or a Higher Power (Fowler, 1981). His conceptualization of a covenantal pattern of family is based upon the lateral relationship between self and others which forms selfhood; this social interaction makes possible the looking up to an apex of “shared center(s) of value and power” and forms one’s faith system (Fowler, 1981, p. 17). Therefore, the theory offers a framework for faith which may be uniquely Christian, faith based on another religion, or faith without affiliation with any religion (Fowler, 2004). Fowler’s (1981) concept of faith being covenantal correlates to Bradshaw’s (1994) representation of Nightingale’s covenantal practice in nursing. Due to Nightingale’s humanistic stance of nurses providing care for patients of all religions and creeds, she may have had a broader aspect of covenantal practice in mind than the Christian concept of covenant at the time (Dossey, 2000).

Seven stages of faith development over the lifespan include primal faith, intuitive-projective faith, mythic-literal faith, synthetic-conventional faith, individuative-reflective faith, conjunctive faith, and universalizing faith (Fowler, 1981). Fowler (1981; 2004) proposed two stages involve limited application: stage 1, primal faith, and stage 7, universalizing faith, apply to infants prior to language acquisition or to a few who achieve a level of faith later in life that is often ascribed to icons. Therefore, five stages of the theory, stages 2 through stage 6, are the most relevant for discussing faith development for this study’s purposes (Fowler, 2004).

Stage 1, *primal faith*, occurs from infancy to about two years of age. A pre-language phase, physical closeness stimulates emotional bonds whereby infants develop

successful attachment to others. This delineates a foundational stage in order to generalize the similar ability to trust others during the lifespan (Fowler & Dell, 2004).

Stage 2, *intuitive-projective faith*, from toddlerhood to early childhood, begins with language acquisition and progresses to the emergence of moral emotions and awakening of standards. This involves Erikson's struggle of autonomy and constraints (shame and doubt), and Piaget's sensorimotor solitary to associative play and shame along with knowledge of the sacred versus taboos (Fowler, 1981). Self-control and will-power emerge as an ordering of one's emotional and perceptive experiences. With concern of safety, security, and sensitivity to protective power, children relate to the symbolism of good and evil through stories and relationships (Fowler & Dell, 2004; Parker, 2009).

Stage 3, *mythic-literal faith*, from middle childhood and beyond, begins with Piaget's concrete operational thinking and moves to the conscious shaping and interpretation of meaning. Simple perspective-taking emerges where the person distinguishes his or her own perspective from that of others (Fowler, 1981). Construction of the larger order of things, including God and the universe, occurs along with emerging ideas of fairness and moral codes. A new term, *11-year old atheists*, refers to those who focus on moral retribution where the individual temporarily or permanently gives up their belief in God (Fowler & Dell, 2004). The beginnings of reflection about faith emerge and some, including girls, may progress more rapidly in their awareness of interpersonal relations and emotions. Fowler and Dell (2004) proposed this may yield either increased sensitivity or enhanced ability to manipulate or manage social relationships.

Stage 4, *synthetic-conventional faith*, from adolescence and beyond, includes tremendous strides in cognitive functioning through early formal operational thinking by Piaget. Individual thought and reasoning accelerate forward through abstract thinking, personal reflection, and synthesizing meaning (Fowler & Dell, 2004). Personal identity and the mutual interpersonal perspective form into a sense of personality and the self. Youth connect to values and beliefs which result in conforming to others like themselves; development of individual worldview or ideology is lived in this stage (Fowler, 1991).

Stage 5, *individuated-reflective faith*, from youth through adulthood, represents critical reflective thinking ability about one's beliefs and values. This re-examination involves investigating and questioning previously held beliefs, traditions, and religious ideas including creeds and symbols, along with those of other faith traditions. Fowler (1981) proposed the emergence of an *executive ego*, a distancing from the previously held values and ideals (p.179). What emerges is a developing sense of self-worth and self-identity that reflects independent judgment and choice (Fowler & Dell, 2004). With this new self-identity, comes a new ability for assuming responsibility for individual choices, beliefs, and lifestyle. Along with personal growth, there may be an overreliance on the use of reason or logic to negotiate discrepancies or questions (Parker, 2009).

Stage 6, *conjunctive faith*, in adulthood, represents an ability to balance the tensions of multiple perspectives through reflection and moves beyond binary perspectives to other alternatives (Parker, 2009). Often this includes dealing with the past in a process of reclamation or reworking of previous issues and other perspectives. Becoming aware of voices in the social influences that surrounded and constructed the self is part of this process (Parker, 2009). An openness and interest in other perspectives,

faith traditions, and cultures may lead to new understanding or insight. Individuals have an increased awareness of themselves and others, finding new ways to build relationships of relating to others (Fowler & Dell, 2004).

Stage 7, *universalizing faith*, occurs when very few reach a mature level of being totally surrendered with participation in universal regard for all humanity and global peace. Fowler (2004) proposed only individuals who broadly impact others, including world-renowned individuals such as Gandhi, Mother Teresa, and Dr. Martin Luther King, approach this level.

The faith development theory provides a framework to sort aggregate data and to understand faith orientations in phenomenology. Fowler (1981) posited the theory provides a way of understanding faith apart from analyzing the content of an individual's faith. Considering its origins, it seemed particularly relevant for interpreting a study about spiritual care and provided a framework for making correlations and interpreting phenomena. In addition to the structural characteristics, there are provisions for interpreting adaptive or maladaptive qualities of faith development inherent in the theory (Parker, 2009) that are congruent with nursing theory.

### **Conclusions from Analytic Literature**

Several theories informed the theoretical foundation for analysis in this study. The MRM nursing theory illustrated, first, how nurses as clients themselves learn modeling by facing their own stressors to adapt and achieve equilibrium in response to life stressors rather than maladapting and experiencing impoverishment, and secondly, how nurses later facilitate clients to work through a similar process by learning the client's view of the world through role-modeling (Erickson et al., 1983). Social cognitive

theory and microinteractionism informed how the individual developed a sense of self and future relationships through interactions (Collins, 1994). Benner's (1984) stages of professional development of nurses explained how nurses progressed in developing general skills and utilized others around them to negotiate nursing practice. Fowler's (1981) stages of faith elucidated how the individual viewed personal faith and engaged in reworking of personal spirituality throughout the lifespan.

### **Summary**

Examination of the literature helped to frame the issue and give context. History of the nursing profession provided background for current issues, nurse socialization, and both global and national implications for practice. An overview revealed varied definitions, concepts, and findings about spiritual care in nursing. Literature on the topic yielded knowledge of meanings of spirituality, components of spiritual care, spiritual interventions, and cultural considerations. Research of spiritual care in practice rendered studies with limited samples of hospice, oncology, and parish nurses. Few qualitative studies produced findings that explained how nurses interpret their life experiences and approach spiritual care. To date, I identified several qualitative studies that limited samples to oncology, hospice, or parish nurse settings in practice with similar design to this study (Van Dover & Bacon Pfeiffer; 2006; Van Dover & Bacon, 2001; Zerwekh, 1993). I found one qualitative study previously conducted across practice settings (Narayanasamy & Owens, 2001). Other studies conducted with nurses in the United States used mixed methods (Boutzell & Bozett, 1990; Stranahan, 2001; Taylor, Amenta & Highfield, 1995). Most nursing research about spiritual care utilized quantitative methods.

Review of nursing education constructs yielded considerations for teaching spiritual care, teaching and learning strategies, power relations which impact learning, and alternative pedagogies. Creating open spaces for learners to process spirituality concepts provides possibility for nurse preparation, higher education, and continuing education about spiritual care. Dialogue, innovative strategies, and group discussions promote educational value for learners, presenting potential for nurse training.

In examining theories for establishing the relevancy of the issue and laying a foundation for data analysis, a combination of social cognitive theory, developmental theory, and faith development theory provided a theoretical foundation for analysis. A convergence of these theoretical constructs supports the concept of the individual being shaped and nurtured within the context of interactions with others. Individuals construct interpretations of social interactions by actively responding to relationships in one's community (Balswick et al., 2005). Individual interpretation of social interaction transfers to future relationships, conferring social construction of self and the world (Collins, 1994; Mead, 1938). Both Benner's (1984) stages of professional development and MRM's Adaptive Potential Assessment Model (APAM) provide utility for defining characteristics and behaviors resulting from adaptive coping mechanisms. The process of personal and professional development becomes foundational to a study examining nurse practice of spiritual care. In reviewing the literature, the selected theories provide a relevant foundation and structural framework for analysis of the findings.

## CHAPTER THREE:

### METHOD

Old Jewish saying: *"Question: What is truer than the truth? Answer: The story."*

In this study, I sought participant description of lived experience through observation and phenomenology using open-ended interview questions. I actualized the following features of qualitative research: accessing settings or processes with the researcher as a key instrument, collecting descriptive data to substantiate or illuminate meaning, attending to identify the process whereby people form perspectives, allowing data to emerge and bubble up from participant responses to inductive questions and observations, and finding meaning by focusing on participant perspectives (Bogdan & Biklen, 2003; Creswell, 2007). I purposed to meticulously record, write about, and analyze data through multiple processes of interpretation and verification of participant meaning (Creswell, 2007). As researcher, I took particular care to ask questions in ways to discover what participants experienced, how they interpreted life experiences, and how they constructed their own world within the social sphere (Bogdan & Biklen, 2003).

Conceptual frameworks inform what the researcher thinks may be going on with a particular topic of interest. The conceptual framework for this qualitative research study included my own background as researcher in Chapter One, the theoretical foundation and analytical theory that explains what was studied in Chapter Two, the literature and what already has been done or discovered in Chapter Two, and my own lived experience, which may inform the internal logic of the query and the eventual design of the study in Chapter One (Maxwell, 2005). I correlated social cognitive theory, faith development



theory, and nursing theory to interpret what is happening and why it may be happening in regard to the phenomenon in Chapters Four and Five (Creswell, 2007).

I adjusted research design according to a number of factors as I considered the research questions and how they might be answered. Factors included: resources, research skills, potential problems, ethical considerations, the research setting, what type of data would be collected, and what results might be drawn from the data (Creswell, 2007; Maxwell, 2005). While considering a research question focused on lived experiences of participants, I chose an interactive design model. An interactive design allowed me, as the researcher, to learn about the research questions and develop more ideas as participants broadened the scope of description of shared information through self-disclosure (Maxwell, 2005). With interactive design, I entered into a learning process with participants and adjusted questions with myself as an instrument to accommodate learning more about the phenomenon through the self-reporting of participants (Creswell, 2007; Maxwell, 2005).

### **Theoretical Traditions for Methods**

Traditions supporting the relevancy of the method used in this study include phenomenology and microinteractionism approaches to qualitative research.

Phenomenology emerged as a strong method due to support from social theory.

Microinteractionism and symbolic interaction provided a social cognitive lens for understanding the formation of human behavior in society and among groups.

### **Phenomenological Theory**

A phenomenological approach considers the “situatedness” of participants, their vantage point in discerning a particular happening. Participant perspective determined

how the individual defined the experience and how it looked to them (Bogdan & Biklen, 2003). This point of view rested on a set of assumptions which framed an individual's view and how he or she made meaning of a phenomenon (Maxwell, 2005). This approach emphasized an interpretation of human interaction and utilized bracketing as a strategy to set apart an idea that participants assume or take for granted to be true (Bogdan & Biklen, 2003; Creswell, 2007). As researcher, I strived to enter the participant's conceptual world in order to understand his or her constructs around the happening or event. Bogdan and Biklen (2003) posited exploring the human lived experience asks: How do people make meaning? How do people come to use certain terminology and labels to describe their experience? How do some particularities emerge to be known as common experience? What comprises the natural progression and history concerning how the activity under study evolved?

One of the challenges I encountered in using a phenomenological approach involved the impossibility of fully understanding another's perspective (Creswell, 2007). Any inquiry intrudes into participants' lives and may not capture the essential understandings participants embraced (Marshall & Rossman, 2006). To offset limitations of language and interpretation, I planned how I might interpret phenomenological description. How I carried out data analysis with minimal personal bias or reactivity became critical to ensure I did not collect or interpret data based solely upon my own perspective (Bogdan & Biklen, 2003).

A phenomenological approach afforded me, as researcher, an ability to depend upon notes and memos to document observable cues, responses, voice inflections, gestures, body language, and physical reactions or responses which enhanced

interpretation of audio-recordings and transcriptions (Maxwell, 2005). Whatever I observed during my study about participants supported or enhanced their description of the phenomenon. Despite concerns about subjectivity, this approach rendered a valid interpretation of reality from a participant's perspective, which contributed to understanding the human condition (Bogdan & Biklen, 2003).

### **Symbolic Interaction Theory**

The microinteractionism tradition and symbolic interaction complemented a phenomenological approach due to its principal assumption where participant experience became mediated by interpretation (Marshall & Rossman, 2006). According to this theory, human beings interact with observable objects in the environment, which contain no inherent meaning without human interpretation; meaning was conferred by the human observer, in this case, my participants. This meaning became essential to interpretation; therefore, I sought to understand how the definitions and processes that created the meaning for the participant came to be (Bogdan & Biklen, 2003).

Through social interaction, individuals learn interpretation through interaction with others in their life pathway. These interactions constructed meaning for the particular individual. Sometimes participants share common experiences, but I, as researcher, could not assume the individual participants ascribed the same meaning to terminology and experiences they chose to self-report (Marshall & Rossman, 2006). Interpretation itself comprised the conceptual paradigm in this tradition. Participants conferred symbolic meaning to even overlooked or everyday experiences. As a researcher, I explored the meaning of these experiences and how behaviors developed in certain situations for individual participants (Bogdan & Biklen, 2003).

Furthermore, the construct of the self remains central in this theory. Each individual created their own sense of self, who they are, on the basis of interactive processes they encountered in life experience (Bogdan & Biklen, 2003; Mead, 1938). By constructing self based upon what each individual perceived others saw in them, a participant tended to place himself or herself in the other person's role. A participant began to see himself or herself as another person sees him or her; this constituted a social construction (Collins, 1994; Marshall & Rossman, 2006; Mead, 1938). Therefore, individuals first developed a perception of self and then developed a definition of self through the process of interaction (Bogdan & Biklen, 2003; Collins, 1994).

### **Data Collection Methods**

I selected methods for viability and ability to answer the research questions. When contemplating options for learning about nurse experience in providing spiritual care, I considered several strategies. By checking with key informants in parish, hospice, and end-of-life nursing, they confirmed observing spiritual care as a phenomenon could be difficult with data privacy. By checking with nurse managers in systems, they confirmed site observation where the researcher was not a current employee would take additional time and clearances. In addition, the ratio of the time needed to observe and capture the phenomena with data saturation would have been prohibitive. Although these may be appropriate strategies for observing technical skills, discharge planning, or other routine nurse-patient interactions, field observation presented difficulty in observing a personal, emotional, and sensitive area such as spiritual care. In the literature, I reviewed similar phenomenological studies done with interviews. By examining methods of

individual and focus group interviews, studies of similar design, and types of interview questions from the literature, I selected several types of interview as method.

When looking at a research question, several methods proved valuable: (a) individual interviews with semi-structured, inductive, and open-ended questions; (b) focus group interviews with inductive, open-ended questions; and (c) follow-up interviews to verify information, provide clarification, establish context, and achieve triangulation (Bogdan & Biklen, 2003 Creswell, 2007). To provide rigor in data collection, I employed memos and notes of participant observations (Maxwell, 2006). I used inter-rater reliability to provide opportunity to find themes and correlations among participant responses through data analysis (Bogdan & Biklen, 2003).

### **Study Sample**

I purposed to study RNs who completed baccalaureate program requirements within the last 10 years after practicing nursing as RNs upon finishing an associate degree or nursing diploma. I utilized convenience sampling of Unity University alumni. Unity University, a faith-based and religiously affiliated liberal arts university, provides a range of programs for traditional students and adult education alternatives. In a residential setting within a greater metropolitan area of the Midwest, Unity University maintains clinical partnerships with a variety of hospitals, clinics, and agencies in the region. Its nursing programs retain a presence and reputation in the greater Midwest.

### **Participant Recruitment**

Although I had originally planned to place announcements in local nursing publications and newsletters, the impending nurses' strike at metropolitan hospitals in June 2010 changed my approach. Leaders implemented strategic plans in health care

systems, affecting availability of potential participants. In the greater metropolitan area, staff nurses, unit managers, and nurse leaders expected to work longer hours leading up to and during the strike. With potential participants following nurse union directives or hospital policies, I realized getting volunteers for the study might be more difficult.

I secured institutional review board (IRB) approval from the University of St. Thomas (see Appendix A). I obtained IRB approval for inviting potential participants among both Unity University and Grace University alumni (see Appendix A). I met all clarifications or conditions for IRB approvals by amending the research proposal regarding location of interviews or the informed consent form.

Although I utilized access as a Unity University faculty to invite alumni to be potential participants, the study did not pose a conflict of interest. I visited another cohort of 24 students on Unity University campus where I teach as faculty. I invited the cohort to participate in my study upon completion of their program requirements. Four or five students approached me to express their personal interest in the study directly after the class session. After I explained they would need to contact me when their final transcript cleared the Unity University registrar's office, only one student contacted me after completing program requirements as a result of my classroom visit. Although I taught a similar cohort at a different location, I refrained from telling my students about the particulars of the study or research design while they were in the program to avoid any conflict of interest.

For recruitment of participants, I planned initially to secure email addresses for the RN to baccalaureate alumni from Unity University in order to invite potential participants to respond. I selected this population of nurses due to the proliferation of RN

to baccalaureate programs and the lack of research done with RNs who completed baccalaureate credentials. Later, I learned the alumni office secured few email contacts and retained mostly mailing addresses for alumni. Once I obtained IRB approval(s), I contacted the alumni office and obtained an electronic list of alumni mailing addresses for alumni within the last 10 years. I mailed a recruitment flyer (see Appendix B) and consent form (see Appendix C) to approximately 230 Unity University alumni from RN to baccalaureate program, 2000 to 2009, in the metropolitan and surrounding counties. The mailed information reached potential participants' home addresses within a week before a scheduled one day nurses' strike in June 2010.

After contacting another metropolitan liberal arts university to post the recruitment flyer with information about the study on their department bulletin board (see Appendix B), a Grace University colleague contacted me and urged me to secure IRB approval from the second institution in order for her to share recruitment information with their graduating RN to baccalaureate program cohort. I secured IRB approval (see Appendix A) from the second institution, Grace University. Then the same nursing faculty colleague requested my invitation be sent to the graduating cohort from their RN to baccalaureate program on my behalf. To my knowledge, I received no inquiries or responses from potential participants who graduated from Grace University.

I received voicemails and emails from eight to ten Unity University alumni within a week of sending the first mailing through the postal service. With a second nurses' strike in July 2010, area staff nurses and nurse leaders worked additional hours. Due to working increased hours, potential volunteers declined to participate in the study. About three months after the initial mailing, I contacted the alumni office at Unity University in

order to obtain an updated electronic list of mailing addresses for approximately another 45 alumni who completed their studies in spring of 2010 and who had not been previously cleared with the registrar at the time of the first mailing. I am not aware of any potential participants contacting me as a result of the second mailing.

With phone contacts, I used an intake form with some preliminary questions to determine whether individual participants were suitable for my study (see Appendix D). First, I reviewed the purpose of my study and criteria for participation, and I asked the potential participant if they had any questions or concerns, which eliminated no candidates. Secondly, I discussed the concept of self-reporting and the importance of participants using their own language in expressing their lived experience. I described the design of individual interviews and the projected length of the initial interview as 60 to 90 minutes. I described the sequence of data collection including individual interview, focus group interview, and a follow-up interview. I described the plan for the focus group to last around 55 minutes once focus group protocol was completed and participants provided assent. I described how the follow-up interview would occur after preliminary data analysis and require up to 50 minutes. I described how participants who completed all phases of the study would receive a gift card funded by two small grants. Thirdly, I reviewed the consent form and asked each participant for any questions or concerns. After the phone contact, I sent a follow-up email with the consent form as an attachment and directions to the interview location, a public or university library.

Over the following two months, I continually heard from potential participants who contacted me by phone or email. Although several early participants offered to send their former classmates the recruitment information as email attachments for a snowball



effect, no evidence emerged of any participants who responded to recruitment strategies by this method. About six to eight additional potential participants contacted me but did not respond when I attempted to return their phone calls and emails; later, several chose to decline participating in data collection due to time constraints.

### **Utilizing a Content Expert**

Due to my interest in promoting professional rigor and integrity at every level of the study, I secured a published content expert in spiritual care and parish nursing. I began consulting with this expert as I formed my research design, prepared semi-structured, inductive interview questions, and finalized the research proposal. I continued to meet and consult with this content expert throughout data collection, preliminary and ongoing analysis, and writing the findings for this report.

### **Piloting the Questions**

I piloted qualitative interview questions. In the fall of 2009, I utilized a survey method of the interview questions with nurses during an independent study in my doctoral coursework. Eight colleagues, ranging from newer graduates to veteran nurses, completed surveys with open-ended questions based on O'Brien's (2008) spiritual assessment questions. They offered feedback concerning the identification of important concepts, the development of meaningful questions, and how to get at underlying issues. A doctoral faculty expert on spirituality provided additional feedback about designing effective interview questions.

I conducted individual interviews for a data analysis class in spring 2010. The refined and tested pilot questions from O'Brien (2008) and other studies provided a template for the line of open-ended questions in order to explore how I might answer the

proposed research questions more effectively. I piloted open-ended questions in audio-recorded interviews of two faculty colleagues who taught the RN to baccalaureate programs and in other institutions, my targeted population and eventual sample for the study. I conducted, transcribed, coded, and analyzed four interviews, which included identifying themes and coding (Charmaz, 2006; Creswell, 2007; Marshall & Rossman, 2006; Maxwell, 2005). I gained the additional benefit of running these interviews through the rigor of collegial critique and feedback including identifying themes, verifying coding, and providing theoretical ties (Charmaz, 2006; Creswell, 2007).

I also benefitted from the doctoral faculty expert analyzing my transcripts, coding, and interpretation during the class. This, along with her ongoing feedback in the course, proved to be an essential element in understanding how to plan interviews along with designing effective questions in a way that would yield substantive results with actual participants. Finally, I met with a content expert in spiritual care who reviewed these artifacts, provided input in developing the research design, and advised further development or reordering of intentionally developed, open-ended questions.

### **Interviews**

In order to understand the phenomenon of providing spiritual care as a nurse better, the following underlying questions guided formation and development of the actual interview questions posed to participants: How did nurses incorporate or integrate life experience, beliefs, and knowledge into their spiritual care practice? What impacted the development of a nurse's conceptualization of spiritual practice? Does knowledge without lived experience eventually become a part of practice? What happened when life

experience and knowledge either intersected or conflicted with spiritual care? What interfered with or enhanced the formation of patterns in spiritual care practice?

I collected data in two ways: individual interviews and focus group interviews in three separate sessions (see Table 1). I selected the individual interview as a method for initial data collection from nurse's individual perspectives due to proven utility in research design for phenomenology (Bogdan & Biklen, 2003). I selected focus group interviews as a method for the second set of data collection due to proven effectiveness in promoting interaction among participants in order to enhance responses, allow for triangulation, and provide opportunity for additional information individuals may have been hesitant to share on their own (Creswell, 2007). I processed and analyzed the gathered data in the focus group interview as individual interview data. Focus group analysis will follow in post-doctorate work. The follow-up individual interview comprised a third data collection.

Table 1:

Sequence of Data Collection

Initial Individual Interview	Focus Group Interview	Follow-up Interview
Projected length: 90 minutes	Projected length: 55 minutes	Projected length: 50 minutes
Public or university library or private location	University conference room	Public library or by telephone

In all phases of the interviews, I began each session by reviewing the study protocol, obtaining informed consent or assent, clarifying intake form information, and then I eased into inductive, open-ended questions (Creswell, 2007; Maxwell, 2005). I established rapport with participants and encouraged an open milieu for sharing (Bogdan & Biklen, 2003; Creswell, 2007). I conveyed to participants I was a partner with them in a collaborative process during data collection. I communicated I was learning from their responses and responded to their lived experience with interest and engagement (Maxwell, 2005). In all phases, I employed follow-up questions based upon particular participant responses (Creswell, 2007).

**Individual interviews.** I offered and arranged for convenient, private interview sites to consider both comfort and confidentiality for each participant. With most participants, I located a public or university library in the participant's community where I reserved a conference room (Creswell, 2007). Three participants invited me to their home or office for convenience and ease in scheduling.

When library policy allowed, I arrived head of time and set up the conference room with audio-recording equipment. I prepared the room for the interviewee to avoid facing distractions through glassed windows and doors in library conference rooms. I welcomed each participant and to provide a pleasant and comfortable environment, I provided packaged snack items and bottled water. Once situated, I reviewed the study protocol and obtained informed consent to audio-record interviews and facilitate data transcription (see Appendix C). I informed participants ahead of time that initial interviews lasted between 60 and 90 minutes. Eleven of 12 participants kept their

original interview appointments; only one participant missed two scheduled interviews and rescheduled two times.

I eased into the prepared open-ended questions by reviewing the questions on the intake form to establish context for the interview. I reviewed each participant's practice setting, educational preparation, and length of practice (see Appendix D). Audio-recording this review of intake questions and general information offered opportunity for triangulation of participant responses and allowed me to hear things I might have otherwise missed during the phone intake/screening process. I used variations of semi-structured, inductive, and open-ended interview questions as participants self-reported their experiences (see Appendix E). Using open-ended questions, good eye contact, and affirmation with pauses allowed participants to describe their lived experience fully. As his or her account unfolded, I facilitated the participant's recall of lived experiences and clarified responses for meaning at appropriate intervals (Charmaz, 2006).

**Individual interview questions.** Question development included a process of piloting questions, piloting qualitative interviews, and revising questions for individual interviews. I conducted several interviews, and then reviewed and revised questions with transcript review and data analysis. Individual interview questions included open-ended questions (see Appendix E). Follow-up questions that were relevant to self-reporting clarified information which emerged during the interview.

At the end of every interview, I asked if I missed asking anything the participant had anticipated or hoped to report. In this way, the participants could think of anything I had neglected to ask which they felt would help me better understand their life experience. In several cases, participants went on to add something they felt was

important or to augment a previous point. No participants brought up concerns that were not included within the scope of the open-ended questions.

Then I described the next phase of data collection, the focus group interview. I gathered scheduling information in order to select possible focus group interview dates and times. I also requested to follow-up by email or phone if I had some questions about their responses. At the end of this debriefing, I thanked the participant and remained in the conference room to write memos and notes (Maxwell, 2005).

Audio-recordings captured every interview, both by computer audio-recording and by a tape recorder. I recorded handwritten notes of key expressions, questions, and nonverbal cues (Maxwell, 2005). By using two different types of audio-recording devices, I captured essential points without having to contact participants between interviews for clarification. One audio-recording of a participant with a pronounced accent produced a muddy recording which became difficult to transcribe due to numerous intercom announcements in a public library. With the inferior quality of audio-recordings and difficulty in determining exact enunciation, I was unable to utilize a professional transcriber for this participant's transcript. I listened to difficult passages multiple times to transcribe the audio-recording. If I were to do this again, I would invest in a digital recorder for clarity rather than using audio-recording software or a mini-tape recorder.

After I conducted the first three interviews, I contacted my content expert to review interview questions with the transcripts and made slight modifications. After conducting six interviews, I met again with my content expert who reviewed the transcripts, coding, and emerging themes. She verified the findings captured some of the

results framed in the study design. After this point, I kept the interview format similar for the individual interviews.

Four individual interviews lasted approximately 90 minutes, five interviews lasted 10 to 15 minutes longer, and three interviews lasted 120 minutes to 138 minutes with the participant's desire to self-report additional phenomena. Although I informed participants about possibilities of variation in interview length, if I were to repeat the study, I would qualify in my recruitment information that individual interviews may take longer than the estimated range.

**Focus group interviews.** Focus group interviews with three to four participants were arranged to accommodate participant schedules. I conducted focus groups with regard for confidentiality and comfort for participants in a university conference room (Krueger & Casey, 2000). Once several participants completed individual interviews, I emailed an invitation for each focus group interview with possible dates and times to fit participant schedules. I informed participants the focus group interviews were expected to last about 55 minutes upon completing the protocol for the focus group and obtaining their assent. On a first-come, first-served basis, I filled the groups as participants verified their availability. In the first focus group, I accommodated one participant who needed to leave a few minutes early. I cancelled and rescheduled the third focus group due to child care and work schedule changes among participants. When I realized I could not accommodate everyone's schedule for the last focus group interview with the approaching holiday schedules and diverse work settings, I contacted my dissertation chair and content expert about conducting the last focus group to capture the most participants possible. Ten of 12 participants completed the focus group interview phase.

Before each focus group interview, I sent an informational email with proposed focus group questions about a week before the scheduled focus group interview (see Appendix F). I modified the focus group questions after capturing the emerging data set from the first several participants and reviewing individual interview transcriptions with my content expert.

During each focus group interview, I provided food and bottled water to help participants feel more at ease, encourage discussion, and promote a milieu for sharing (Creswell, 2007). Depending on the time of day, I provided bottled water and either an assortment of muffins, bagels, fruit, and juice, or sub sandwiches, chips, and fruit for the focus group interviews.

Once I welcomed participants and they were seated, I reviewed Krueger and Casey's (2000) focus group protocol about privacy and confidentiality. I explained to participants that inductive, open-ended questions encouraged self-reported expression or terminology and I encouraged them to share divergent opinions and ideas. I established ground rules for focus group participation and explained the importance of maintaining confidentiality and mutual respect regarding other participants' responses (Creswell, 2007; Krueger and Casey, 2000). I referred participants to the consent form, provided them each a second copy for their records, and asked them to assent verbally prior to starting the audio-recording.

**Focus group interview questions.** Focus group interview questions included open-ended questions (see Appendix F). I moderated the focus group and incorporated follow-up questions based upon participant responses to enhance internal validity and contextual understanding. To start each session, I asked participants to disclose



information which they felt comfortable in sharing such as practice settings, years in nursing, and educational preparation. I eased each group into the focus group questions I provided beforehand. I utilized the focus group to clarify earlier participant responses, verify aggregate data, and pose additional questions to draw previous individual responses into the discussion. In addition, I asked several participants about points of clarification regarding their individual interview either when they arrived earlier than other participants or were the last to leave the conference room.

At the end of each focus group, I asked if there were questions I had neglected to ask or if there were points needing clarification. In summary, I identified some key points from the discussion and asked participants if they wanted to amend or add to the summary (Krueger & Casey, 2000). I asked participants to offer any parting thoughts about the topic or clarification which they had intended to discuss with the group during the exercise. Before excusing participants, I briefly reviewed the procedure for individual follow-up interviews. I thanked participants and encouraged participants to leave after they had their questions answered.

Once the focus group participants left, I saved my audio-recordings and electronic files. I wrote notes about observations concerning group dynamics, synergy, and nonverbal communications (Krueger & Casey, 2000). I especially noted moments of agreement and energy or times when there was reservation, disagreement, or dissent (Creswell, 2007).

Between the second and last focus group interviews, I attended a Krueger and Casey (2010) workshop and confirmed my understanding of focus group mechanics and method. I believe I moderated the third focus group interview more effectively as a

result. I used more intentional seating configurations and utilized some moderating strategies from the seminar.

**Follow-up interviews.** I conducted face-to-face or phone follow-up interviews to clarify meaning and confirm triangulation (Maxwell, 2005). I informed participants the follow-up interview would take up to 50 minutes. One participant met me for a face-to-face follow-up interview at a public library location and I conducted the other follow-up interviews by phone. Once I obtained assent to informed consent, I used a speaker phone feature in a private office for audio-recording individual participant responses. With follow-up interviews, I established saturation and triangulation of data collection along with enhancing internal validity and contextual understanding for participant responses after transcription (Creswell, 2007). Follow-up interviews ranged from 21 to 55 minutes in length. All participants completed the follow-up interview phase.

### **Data Saturation**

After conducting six individual interviews, I felt I began to hear similar responses across participants with varied backgrounds. I met with my content expert to review the preliminary analysis and confirmed data saturation with some themes after reviewing transcripts. Because some participants were in the process of scheduling individual interviews, I continued to conduct interviews with those who had been screened that potentially represented different practice settings and unrepresented or unheard life experiences from the previous interviews.

### **Mode of Data Analysis**

I processed participant responses, beliefs, and perceptions as real phenomena and checked for internal validity, contextual understanding, and obtaining data saturation

(Charmaz, 2006; Creswell, 2007). I respected and honored participant responses whether or not they were congruent with recurrent themes or ideas across responses from multiple participants. Using MS Word searches and paper sorting, I checked data for congruence in themes, characteristics, and threads; I printed, manually sorted, and verified themes and threads.

After completing each individual interview, I wrote notes after the session. I began transcribing completed interviews and conducted ongoing data collection sessions (Maxwell, 2005). A professional transcriber signed a confidentiality form (see Appendix H) and completed transcripts for the last five participants and the third focus group. Once transcribed, I read the interview transcripts and listened to the original audio-recordings to recapture initial impressions and find themes. I wrote additional memos and notes as appropriate. I simultaneously incorporated additional or follow-up questions for focus group interviews and follow-up interviews for triangulation to establish internal validity among participants (Bogdan & Biklen, 2003; Maxwell, 2005).

Based upon the data with individual interviews, I considered tentative ideas for categories and emerging relationships. I utilized a content expert to look at the data analysis and confirm themes. I introduced some of the threads and themes from individual interviews that were repeated across participants into open-ended inductive questions to invite data saturation and internal validity during subsequent interviews (Creswell, 2007). After each phase, I started the transcription process while conducting further data collection (Charmaz, 2006; Maxwell, 2005).

After I conducted the first two focus groups interviews, I revisited the methodology for internal validity and reliability. Again, I looked at categories and

relationships across multiple methods (Maxwell, 2005). A researcher/content expert reviewed the transcriptions, checked coding, and reviewed preliminary data analysis. Together, we checked if more adjustments were warranted in the design, order, construction, or content of open-ended questions (Charmaz, 2006). I utilized subsequent interviews to establish data saturation.

Later, after conducting some preliminary data analysis, I reflected upon the methods and theory which follow from emerging data. I utilized a nurse reader who provided feedback on the analysis and coding. I wrote memos and notes to facilitate critical thinking about how the data was related, how discrepant data appeared, and if validity threats emerged (Maxwell, 2005). After checking with my content expert, I conducted followed-up interviews with individuals to establish contextual understanding and clarity about what the participant meant in their responses and confirm data saturation. Once I completed the final follow-up with each participant, I thanked the participant for his or her contribution to nursing knowledge, issued him or her a gift card, and terminated the researcher/participant relationship for the study.

### **Coding Reliability**

I continued data analysis through categorizing strategies and coding responses from open coding, axial coding, and selective coding (Creswell, 2007). I wrote continual notes and memos to capture insights and coding connections among the data. I fractured and rearranged data to facilitate identification of broader themes and issues (Charmaz, 2006). I checked individual responses against the interview questions, first in individual interviews, and then with their responses in focus group interviews.

Once I verified emerging themes and issues, I checked responses across participants. Then, I checked each focus group complement of participants against the individual interview responses. I identified similar category types as organizational categories, substantive categories, and theoretical categories (Maxwell, 2005). Once a schema of themes and categories emerged along with intersections and connections, I confirmed my findings with a nurse reader. Finally, I checked focus group responses across groups. I organized data to check for data saturation and triangulation between phases of data collection (Charmaz, 2006; Krueger & Casey, 2000).

### **Triangulation**

I selected mixed methods for this study to incorporate credibility and increase opportunity to establish triangulation. An interview comprises a description of what a participant said and a single interview does not allow inference simply from one description. Therefore, I conducted multiple interviews to enhance triangulation. The focus groups operated in this study as a method of triangulation to confirm data and participant meaning contained in individual interviews. In subsequent interviews, I asked individual participants about missing data or nuances and the accuracy of the meaning he or she attached to his or her personal expressions. I checked for internal validity along with contextual understanding of individual responses (Creswell, 2007; Maxwell, 2005). In addition, I utilized my notes and memos to incorporate participant observation cues to use in triangulation. Triangulation proved to be useful in connecting theory and participant responses (Charmaz, 2006).

## **Validity and Generalizability**

Validity includes triangulation of sources, correlating methods and theory, searching for discrepant evidence, and comparing findings with the relevant literature. Validity concerning interviews with open-ended questions comprises triangulation of sources of data collection, harmony of methodologies, and utilization of theoretical constructs to explain what is happening with the data (Creswell, 2007; Maxwell, 2005).

Generalizability may be limited to internal generalizability within the sample studied rather than external generalizability which may infer broader applications with the findings (Creswell, 2007). Qualitative studies are considered to have “face generalizability” where there is believed to be no reason why the results would not apply more generally (Maxwell, 2005, p. 115). Other factors affect generalizability such as participants’ perceptions of whether the findings apply more generally or whether the phenomenon may be universal across studies.

In this study, examining potential validity threats included eliminating possible contamination of individual interview data by design. By conducting individual interviews before participants engaged in focus group interview sessions, internal validity and contextual understanding were established with each participant without possibility of introducing language and bias from other participants (Bogdan & Biklen, 2003).

When conducting focus groups after individual interviews, the process provided me, as the researcher, further opportunity for adjusting the design and methods for triangulation both with internal validity and with similar themes or stories raised by more than one participant. If more than one participant raised certain salient points, saturation

was more readily achieved. This also contributed to triangulation with theory, discrepant evidence, and comparisons with similar studies in the literature (Maxwell, 2005).

By conducting a follow-up interview, I again tested internal validity of individual responses, checked for triangulation between methods, and examined both similar and dissimilar themes. I checked again for discrepant data and ruled out alternative explanations while I collected additional data. Identifying how I ruled out plausible alternatives and threats became essential. Two particular validity threats included researcher bias and reactivity.

### **Personal Bias**

In the past months, I reflected on how my life experience, education, work, comfort with spiritual care content, and doctoral studies contributed to my personal bias and how I acted as an actual instrument of research. I considered how my assumptions, beliefs, and perspectives may have affected how I performed as a researcher. I dealt with minimizing bias through academic rigor, maintained personal and professional integrity, and employed safeguards to counter possible validity threats. Rather than seeking to eliminate personal bias as a researcher completely, I utilized my unique background and expertise to more effectively conduct qualitative research, especially when moderating focus group interviews (Charmaz, 2006). I employed my own tacit understandings as an instrument of research and sought to explore participant responses more fully.

I utilized nurse readers with participant transcripts, early data analysis, and emerging findings to help eliminate bias yet limit variance in analyzing the results. I sought to be deliberate and intentional about looking for possible bias during interpretation and analysis of participant responses. I utilized a content expert along with

faculty and nurse readers, doctoral students, and business professionals with research expertise to look at my content analysis and look for potential bias. Moreover, I purposed not to self-report my own perspective among participants during data collection beyond answering their direct questions and concerns.

### **Reactivity**

In each data collection, I conducted debriefing sessions with a content expert. We explored reactivity and potential validity threats. We examined how I conducted myself as a researcher, established rapport with participants, and posed inductive, open-ended questions. Prior to interviews, I practiced my questions with a nurse informant who gave feedback on the content of questions and how my demeanor and affect impacted the experience for the interviewee. My content expert provided feedback after reviewing transcripts and examining my consistency in responding to participants; she reported little reactivity.

At most interviews, I arrived early to prepare, positioned materials and equipment, and gained the proper mindset as an interviewer. Some variance occurred with set-up for individual interviews at a participant's office or home. I took time to greet participants, offered snacks and bottled water, and purposed to convey a uniform, caring attitude and create an open atmosphere for sharing. I paced each interview session in a similar manner during data collection.

### **Ethics and Confidentiality**

I numerically coded participant names to secure information. I assigned pseudonyms for all participants, locations, and practice settings. Audio-recordings were secured, transcribed to written documents, and locked the documents and audio-



recordings in a cabinet in my home. I hired a professional to transcribe the audio-recordings. The transcriber signed a confidentiality agreement (see Appendix G). I destroyed audio-recordings upon completion of reporting.

This study included little to no risk with an open forum for each participant to self-report his or her own knowledge, beliefs, and openness about spiritual care. With inductive qualitative research questions and open-ended methodology, participants determined the extent of self-reporting and shared their informed impressions and life experiences with me as the researcher. Inductive, open-ended questions provided risk *only* if participants chose to self-report and disclosed personal or sensitive information. The individual interview and focus group interview questions were framed with a positive orientation toward participants and were not self-disclosing in nature (Bogden & Biklan, 2007). I respected and honored participant responses during the interview process. Environmentally, I attempted to facilitate participant expression in an atmosphere of openness and provided a milieu for sharing (Charmaz, 2006).

To minimize risk of probing for personal or sensitive information in the interviews, I obtained informed consent before any data collection. I instructed each participant if they became uncomfortable or unwilling to reveal his or her story or experience, he or she was free to withdraw from the study at any time. No participants indicated a need to withdraw nor did any participants indicate any intent to withdraw. I did not ask the participant to answer any questions he or she was reluctant to answer and most participants answered all questions.

Before focus group interviews, I informed participants that sensitive topics may be introduced by others who choose to self-report and share personal information during

data collection. Due to the potentially sensitive material, I instructed participants, if some material caused them discomfort, they could choose not to answer particular questions or they could withdraw from the study. No participants elected to withdraw. I informed participants how to remove themselves from the study due to discomfort. I provided referral information for a counselor if individuals needed follow-up.

### **Summary**

The purpose of the study correlated to evaluating possible methods and designing the chosen interactive model. The protocol for the study articulated a procedure for selecting a convenience sample, recruiting participants, providing informed consent, collecting data, transcribing and recording data, coding and analyzing data, and identifying emergent threads, themes, and eventual findings. Although I planned for alumni from two liberal arts universities as potential participants, alumni from one institution responded.

I employed several methods for qualitative data collection including individual interview, focus group interview, and follow-up individual interview. The sequence and complement of methods produced data saturation and triangulation. My previous personal and professional experience with moderating small groups and focus groups proved to an asset in conducting inductive individual interview and focus group interviews. Participant responses confirmed field observation would not have produced similar results due to participant responses about individual nurses refraining from carrying out spiritual care in the presence of others. Ten of 12 participants completed all phases of data collection except the focus group interview. It became apparent

scheduling a focus group presented challenges with participants in multiple work settings, schedules, and geographical locations.

Coding data and identifying threads, themes, and findings verified the importance of planning effective design and following safeguards. I employed safeguards throughout data collection, review of transcripts, and analysis to verify analysis procedures and emergent findings. I utilized a content expert or nurse reader to check coding, interpretation, and comments and notes during interviews.

Personal bias may have affected my understanding of participant meanings. Seven of 12 participants were former students and I purposed to rely on what they self-reported in the study. Several students referred to experiences they discussed in past classes during the study. Even though I refrained from asking participants about experiences they may have previously discussed in the classroom, my understanding from the past may have affected my current interpretation of the findings. I believe my previous experience in conducting focus groups and proctoring standardized testing in K-12 and nursing education improved my ability to perform more evenly with all participants.

Although I believe reactivity remained minimal due to safeguards I employed, connections through relationship in the classroom may have caused some participants to respond to the study and the interview questions differently. In examining transcripts, inter-rater reliability found few differences in how I handled interviews among participants. In one particular aspect, reactivity may have affected my ability to explore participant perceptions about educational experiences and baccalaureate education in particular; I followed intuitive nudges to avoid eliciting responses or asking further

questions, which may have been perceived as leading questions with former students. I used follow-up questions with former students but refrained from asking additional questions when I perceived doing so might constitute a validity threat. This may have prevented me from more fully exploring participant experience or meaning.

## CHAPTER FOUR: CHARACTERISTICS OF PARTICIPANTS AND FINDINGS

Phenomenology allows individuals to tell their life experience in order to shed light on factors previously unknown, misunderstood, or discounted (Bogdan & Biklen, 2003). In this study, participants described their perception of influences on eventual practice in spiritual care. In this section, I reported demographic information, characteristics of participants, and findings about participant characteristics and behaviors. Findings that emerged regarding nurse lived experience include life stories, educational experiences, nurse socialization, and spiritual care practice.

In this study, I interviewed 12 Registered Nurses (RNs), 2 males and 10 females, who reported 5 to 35 years in nursing practice with the mean (average) being 14.3 years. Regarding years of career experience, five participants reported 5 to 8 years, three had 10 to 13 years, two had 20 to 25 years, and two had 25 to 35 years of experience in nursing. To ensure confidentiality, I assigned a pseudonym for each participant, the schools of nursing attended, the organizations where they worked, and other locations, persons, or entities mentioned in self-reporting.

### **Description of Study Participants**

Participants reported they began nursing practice after completing associate degree programs in various community colleges or diploma programs; eleven graduated as associate degree (AD) graduates and one graduated with a nursing diploma, having attended a hospital school of nursing using the apprenticeship model. All participants continued to work toward baccalaureate credentials and finished their RN to baccalaureate programs of study within the last four years at Unity University, including

three who finished within the last calendar year. Most participants reported they grew up in the Midwest ( $n = 10$ ). However, one reported growing up on the East Coast, and one reported moving from West Africa to the US and then to the Midwest as an adult.

Although it was not my original intent to select participants based upon practice settings, participants reported a complement of settings and a broad cross section of nursing. Beginning practice settings in acute care metropolitan hospital units including: behavioral health, bone marrow transplant, burn, cardio-renal, cardiovascular, critical care, emergency, labor and delivery, medical surgical, neurological, oncology, pediatric intensive care, polytrauma, and telemetry along with long term care (see Table 2).

Most participants continued to work within the same or similar specialty as their first assignment as a staff nurse in a metropolitan hospital or health care system. Some participants progressed from being staff nurses in their first hospital setting to charge nurse, assistant manager, unit manager, case manager, care coordinator, and administrative roles. Several participants were promoted to leadership roles as unit charge nurses, unit managers, or nurse educators and then elected to return direct patient care as staff nurses. Currently, three participants no longer provide direct patient care but continued direct patient and family contact as part of their regular job responsibilities.

Participants ranged in age from 36 years of age to 57 years of age with the mean age (average) of 46 years of age. Two participants were in their 30s, five participants were in their 40s, and five participants were in their 50s. Eleven participants reported their ethnic background as Caucasian and one participant reported his ethnicity as African immigrant.

Table 2:

## Participant Background Information

Nurse Position	Education AD or Diploma	Education BA	Years as RN	Practice Setting/ Expertise
Charge nurse	AD 2005	2009	5	Oncology
Staff nurse	AD 2005	2008	5	Transplant/ICU
Care coordinator	AD 2005	2010	5	Polytrauma/Follow-up
Staff nurse	AD 2002	2010	8	Cardio-Renal
Charge nurse/Staff nurse	AD 2002	2009	8	Peds ICU
Charge nurse/Staff nurse	AD 2000	2008	10	Cardiovascular/Hospice
Staff nurse	AD 1998	2006	12	Neurology/School Nurse
Staff nurse/Charge nurse	AD 1997	2008	13	ER/ICU
Care manager	AD 1989	2008	21	Labor and Delivery
Care manager	Diploma 1988	2010	22	Burn unit/Orthopedic
Staff nurse/Charge nurse	AD 1982	2008	28	Diagnostic Procedures
Administrator	AD 1975	2010	35	Mental Health/ Chem. Dependency

There were no gender requirements for this study. Because RNs are predominantly female, I expected the majority of my study participants to be females. The total sample included 12 participants ( $n=12$ ) with two male participants ( $n=2$ ) and 10 female participants ( $n=10$ ). Nurse participants represented a variety of practice settings, life experiences, and spiritual care practices or perspectives.

Concerning marital status, participants reported the following: one widowed, two single, three divorced, and six married. Individuals disclosed previous divorces and

remarriages, being single parents prior to their current married status, being married prior to their single status, and previously being widowed and remarried. These life events were described in relation to participant life stories.

Regarding previous degrees and work experience, seven participants reported they worked in other careers. Participants reported earning previous and advanced degrees: five earned baccalaureate degrees, two earned master's degrees, and one earned a previous doctorate degree in other professions prior to entry to the nursing profession. Some participants earned previous degrees in other fields including baccalaureate degrees in biology, economics, education, and psychology; master's degrees in organizational leadership and biology; and a doctorate degree in molecular biology. Participants reported working in previous occupations prior to attending nursing programs which included: certified nursing assistant (CNA), store manager, consumer services, police dispatcher, teacher, information technology (IT) developer, and scientific researcher.

Personal motivation for being in this study varied among participants. Some participants reported a need to give back to nursing as they learned in nursing programs of contributing to nursing research. This relates to the theory undergirding the study with social cognitive theory and learning: people approach relations with others based upon previous interactions with "the generalized other" in the past; their social constructions transfer to how they interact in the future (Collins, 1994; Mead, 1938). One participant stated, "It's more about my curiosity on the topic because I didn't know how you defined spirituality." Several reported they wanted to explore the topic and their own journey of spirituality. Seven of 12 participants were former students, which was unanticipated because I had invited over 250 alumni who completed RN to baccalaureate programs



over the last 10 years to be in the study. Several of these former students reported they volunteered to be in the study because they related to me as an instructor or felt they wanted to contribute to my research because of the connections they felt I made with them as students in the classroom.

In reporting her motivation to be in the study, one participant described her need to reflect on this aspect of her practice as she had not had opportunity to do so before. “When I saw the word, ‘spirituality in nursing practice,’ it was like, oh, boy, I’ve had some interesting moments with that over the years.” Another participant wished she would have included spiritual care in her practice earlier: “I wish I would have been more confident in my role as a nurse, so that I could have incorporated that as a standard part of my care and not have been afraid something in the system was going to pound me down for doing so.” This statement supports evidence in the literature concerning nurse subordination under hierarchical systems and nurses who may fear repercussions for providing spiritual care (O’Brien, 2008; Reverby, 1987). In the last phase of data collection, several participants self-reported their personal interest in exploring spiritual care further as a result of participating in the study.

### **Life Stories**

Participants reported a variety of stories which affected their views on nursing and how they practiced. They self-reported experiences including family constellations and formative experiences. Many described educational experiences as teens or adults that affected their educational decision-making and eventual career choices in life. Finally, many participants confronted major life events, gradually finding purpose and meaning in life, which affected their view of providing spiritual care. These perspectives are relevant

to the topic due to Felgen's (2006) findings that whatever nurses learned through life experience with their families, education, and socialization provided a foundation for providing spiritual and cultural assessment.

### **Family Background and Formative Experiences**

The self-reported themes concerning family background and formative experiences are representative of all participants. Stories will be presented in order of the lifespan and chronological order. More than half of participants described the influential persons in their background as being parents or grandparents. Some participants described behaviors and values they derived from these role models. Participants described a range of environmental and social influences from growing up in a variety of environments ranging from a farm or in a small town to suburban or urban neighborhoods.

Holly related her appreciation of the basic strengths of being a part of nuclear family. She valued her own experiences with being with an extended family of grandparents, aunts, uncles, and cousins, on a farm. She reported her parents' happy marriage in contrast to her own:

My parents are married. They were married when my mom was 16 and my dad was 21. She got married for her 15th birthday, and for her 16th birthday, I was her sweet 16 birthday gift. And my parents are still happily married, and they are like the happiest married couple you ever saw.

She described how she grew beyond her parents as a young woman by moving to a metropolitan area, seeking a career, and having her own family. Once Holly experienced marital challenges, she stated life happenings brought her closer to her family and "all of a sudden, I realized there was this huge piece" about "sharing the things that were so wonderful in my childhood" with her own children. She reported spending more time on

a rural farm with her family of origin and her children to give them a sense of belonging as she felt in her own youth.

Wendy described her family life in a city neighborhood as being the American dream where her family valued working hard for their aspirations. She stated:

I grew up in a little house with a picket fence. We didn't have tons of money, but I felt like I had the world. It was as close to the white picket fence family as you could get. And if you worked hard, things worked out.

She described the work ethic she learned from her parents, neighbors, and extended family. Feeling connected in her neighborhood, Wendy described community projects where she canvassed city blocks and collected monies for charities as a child. She remembered, "It was all about wanting to help people." She offered her services and collected donations for muscular dystrophy, the kidney foundation or other causes when her mother was called to find volunteers. She stated her mom would ask, "Wendy, want to go collect for the kidney foundation?" She responded, "Sure, I did because I wanted to help." She explained how her family members participated, first, in their own neighborhood while growing up and, eventually, in her own neighborhood where she and her husband presently reside with their own family:

My family is awesome, and I mean people like my parents. [Today] we have a great neighborhood where we all party and have so much fun together. It's an incredible neighborhood. With my parents, everyone invites them to their parties as well because they're just so warm. My dad is so warm—I got it from him, I suppose. He's real talkative; he really cares and listens, and he doesn't have to talk just to talk. I have an incredible family.

She explained how she and siblings integrated the relational values of her parents into their lives. Wendy described her grandmother as a role model and her mother followed as a role model and doing things for others. She reported how these women, and her grandmother, in particular, dealt with hardships by persevering. She said, "I never heard

the woman say a bad thing about anybody,” even though her grandmother endured living with her sometimes difficult grandfather. She stated, “She was so pleasant to people, and had a quietness about her. She had this way of not necessarily having to say things to make people feel better, but just maybe holding them” to give comfort. Wendy acknowledged the positive influence of adults in her upbringing, stating, “I just love older people. I mean, they have such wisdom. They have seen so much in their lifetime.”

Nancy described small town life when encapsulating her formative years and early experiences. Her local parish was significant in forming her values and worldview.

I was born in a small town. I mean really small: 300 people, 400 people with a little parish, a picture postcard church kitty-corner from my house. My mom ironed the frocks and altar cloths. It was a priest who taught me how to braid dandelions...very picture-postcard perfect, no abuse, no bad nun stories.

She described the town priest and his influence in her life in a matter of fact manner. She lingered in describing the clergy as being an important part of ordinary, everyday life.

Nancy later described other incidences to delineate her respect and appreciation for the enduring roles which role models and community leaders played in her life.

Rachel conveyed similar values and experienced a somewhat sheltered life in a small town. She expressed her perception of feeling safe and comfortable.

I remember when I was young, we rode our bikes all over town because we lived in a small town. Sometimes I would just ride my bike to church, and I always felt comfortable praying there... I would ride to church and be there for a while, and then go home—and Mom never knew where I was.

Later, Rachel described how her choice of a nursing school was based upon similar perceptions as her small town. In selecting a nursing school, she valued safety in negotiating a neighborhood and her association of comfort with being in a religious environment when she was young.

These accounts represented safety and stability in home, community, and church life. Fowler's (1981) faith development theory provides background for how individuals form their own perspectives based on those from others in an earlier stage of intuitive-projective faith. As participants reported accounts from their youth, their experiences correlated to a mythic-literal faith where their individual perspective became distinguished from that of others. This relates to how individuals form self-identity in microinteractionism and interpret relationships based upon on Mead's (1938) "the generalized other" (Collins, 1994).

Amy expressed her sense of personal independence came from her mother. "I came from a very stable family with very loving parents, but my mother absolutely instilled in all of us, but more so in me [as the only daughter], that you need to *do* something to make a difference." She characterized her mother as being an actual force in the community, a model of decisive and assertive leadership. "My mother was a powerhouse. She was a powerhouse in every aspect of her life."

I've always been very independent, which I'm sure is a product of my upbringing. Like I said, my mother was a dynamic powerhouse and raised us – I have two brothers. I was adopted; they were not. My mother was a very strong believer in women being independent and not relying on anybody for anything, ever.

Amy explained her mother "raised me to ensure that whatever I wanted or needed, I would do on my own." She felt the deeply engrained values of advocating and caregiving within her. She grew up knowing an effective woman works in the church and community. This composed an integral part of her upbringing and worldview.

In contrast, several participants described difficult or unusual experiences in growing up. Lloyd described how his grandmother raised him and four siblings when his mother was unable to do so. He felt his grandmother's influence had great impact in his

life and yet he expressed difficulty in being able to understand or being patient with his mother's illness. Melissa's older sister raised her. She regularly attended a little Baptist church with her grandmother until her grandmother died when Melissa was in the 8<sup>th</sup> grade. After her grandmother's death, she began a new search for meaning and purpose. From then on, she felt more connected to her sister and her own circle of friends while her worldview shifted.

Brenda grew up in a single parent family. She felt the impact of struggling financially and moving from a city to a medium-sized town. She described how she felt connected to her grandmother when she was struggling to feel a sense of belonging in a new school and community.

The other person who was very influential in my life was my grandmother. I spent a lot of time with her in the kitchen, listened to stories of the family, watched her bake bread, and sometimes participated in that. It was just a very good time, a very healing time, especially with some things I just felt I couldn't talk to my mom about. I think that's very common—having a gap between the generations. Grandma was more accessible because she was one step away, a little safer. With mom... there's sometimes too much emotional stuff going on at the time, so grandma was safe.

Brenda's mother, a single mom, worked a couple jobs yet didn't have much money. She described her perception of how "doors opened and we were taken care of."

We found groceries on our doorstep lots of times when my mom didn't have any money. God used people to fulfill the need, but definitely it was because my mom was praying and believing we'd be taken care of—and we were. We never slept out on the street; we had a house. We didn't know we were poor. We were poor—but we didn't know it.

"I know my mom had a huge influence on me in the way she raised my sister and me.

She had a no nonsense attitude with an unwillingness to accept failure and weakness."

She conveyed respect for her mother's perseverance. "My mom was, some would say, very strict in certain areas and because she believed we were to live by faith; and we were

never allowed to be sick.” Her mother often said, “If you didn’t feel good, too bad; you’re going to school. You better believe you’re going to be fine by the time you get there.”

Brenda described her perception of the resilience she learned during childhood.

It’s not a bad thing, but people that don’t understand it could look at it as being a bad thing. But it toughened us up a little bit. Truly, you’re either going to be fine when you get there or you’re not. It really helped develop our attitude that we’re not going to allow something to get in the way of what we need to do.

Her mother taught her to do whatever was needed “to make ends meet.” “If money got tight, my mom got another job, so it was very much work ethic.” She thought it worked out well when her mother insisted “we were never allowed to feel sorry for ourselves.” Her mother would say, ‘Oh, you’re going to have a pity party. You better go up to your room because I don’t want to hear it.’ She reflected, “It was a hard line, but I can look back and see it was good for us.”

Several participants described their understanding of growing up in other places than the Midwest culture or understanding those who are different from them. Diana said, “I have lived in a lot of different places. And I seemed to have grown up in a lot of different places.”

Valerie reported her experience of growing up in an urban area as living a separate experience and not knowing what was happening around her to others who were different:

I was very protected, I would say, growing up. It was just something we didn’t discuss. We didn’t discuss that kind of thing, but we read about it. Whenever we drove through a bad part of town growing up, my dad was like, lock the doors in the car; keep it out. Part of it was fascinating; part of it was frightening.

She described how her eyes opened as an adult to disparity that she wished she would have been allowed to experience in her youth. Later, she reported her difficulty as a new RN in discharging the homeless to the streets in her first nursing position.

Anna described growing up and knowing her parents loved her, but she realized something was off. “I grew up pretty prejudiced. My family was very prejudiced.” When she started school later in life for a second career, “I opened up to all of these different people and different cultures... And I just blossomed.”

Participants reported formative life experiences that correlated to Fowler’s (1981) synthetic-conventional faith of adolescence and early adulthood in recalling where they recalled instances where they engaged in personal reflection and synthesized meaning from youth. They described some common life experiences scholars may label as rites to passage and other experiences were uniquely separate. Participants reported early life events where their personality, identity, and interpretation resonated through and outlined early faith development (Fowler, 1981).

### **Educational Experiences**

Participants cited a variety of educational influences affected their perspective. Self-reported themes about education are ordered in chronological order of increasing levels of education. Participants described incidences from high school, community college, and returning for baccalaureate credentials. Some participants identified others in education who affected their learning and educational choices either positively or negatively. Some described life experiences opening their eyes to possibilities in education. Many participants described how they were the first women or persons in



their family to get a degree in higher education. Educational influences appeared to have some impact on participant experiences in choosing nursing or how he or she practiced.

Several participants earned previous degrees in other disciplines. Previous college degrees among participants included: biology, economics, business management, education, psychology, and molecular biology. Life events described as a turning point for participants to choose nursing as a career ranged from discontent or dissatisfaction with other careers to major life traumas.

Melissa described how her experiences in world travel changed her view and her selection of a college and career. “My sister was stationed overseas so I spent my 16<sup>th</sup> and 18<sup>th</sup> summers in Turkey. One year, we traveled around all over Europe.” A tour of multiple countries changed her perspective of cultural issues and altered her self-identity when she started in pre-med during college.

I came from a small rural area. Most of the people in my pre-med classes were from large Midwest cities. Lots of them had already had anatomy and physiology classes so I felt very behind. I went from being at the top of the class to the middle of the class.

Her eyes opened up to the world and her perspective changed her attitudes to be more global. In the classroom, her academic sense of self remained challenged. This narrowed her career choices. At the time, she found a connection with professors in another department and pursued a different major. When she was studying economics, she realized she “should have done nursing. But I was too invested [in the other major] to go back.” Once graduated, she worked in a business-related field for several years. Then she said she went through “a mid-life crisis at age 25” because her work was not fulfilling. She took personality tests which indicated she should be a pharmacist, a nurse practitioner, or a nurse. Melissa identified nursing as being something “that sparked.”

Then she dared to think “it can be nursing” after all. She decided to pursue an associate degree in nursing.

Brenda described how a high school counselor discouraged from her goal of being a nurse. “When I was little I dreamed of being an army nurse. Vietnam era nurses were some of my heroes.” Her plan took an about-face.

When I was in high school, I was really discouraged by a counselor to pursue nursing as a career because I didn’t have high scores in math and I struggled in science. She just looked at me and said, ‘I really don’t think this would be a good career path for you.’ So at 17, instead of doing what other normal kids do, I decided I was going to go in the military. It was really discouraging and I didn’t realize how it affected me. I just shoved it aside and thought if I can’t do my dream, then I’ll do something else. For me it was logical because I had wanted to be a military nurse. I was at least going to be able to pursue part of it, even if I could never be a nurse.

Brenda determined there were two ways to interpret this discouraging moment in the past. She thought the counselor “really slammed the door” on her dreams. She reflected, “Maybe I needed the life experience I was going to have [in order] to be successful in nursing.” She described choices in viewing negative experiences and proposed, “you can look at it in two different ways.” With her perspective, either the counselor’s negative feedback allowed her more life experiences that added to her eventual success, or, on the other hand, delayed a potential nurse from contributing to the profession earlier.

After serving in the military and working as an emergency dispatcher, Brenda wondered about the feasibility of continuing her stressful job. She described how a casual conversation at a friend’s cabin suddenly changed her thinking by someone asking, “What did you want to be when you were growing up?” She thought back to writing to soldiers while in high school. After “the bombing of the Marine barracks in Beirut, I had written to Marines.” After this weekend at the cabin, she went back and

“looked through some of those letters” she received from Marines. When she read them, she saw Marines had said, “Good luck with your nursing career.” Brenda suddenly remembered how she was enthused about a possible career in nursing and decided she “must have been excited about it” with this evidence. At the time, she thought there was more to this conversation among friends than simple reminiscence. She related:

After this weekend and after reviewing those letters, I thought there was something more to this. Being a person of faith, I prayed and I said, ‘God, if this is something I’m supposed to do, just open the doors. Let me know.’

She pursued nursing school after this. Brenda applied and was placed on a two-year waiting list for an associate degree program until she got a call during the summer when there was an opening. “I’ll never forget it.” Someone called from the college and stated there was an opening, asking if she could start within two months. “I thought, well, yes I can.” She scrambled to get scheduled for a pre-requisite science class “and there just happened to be one.” “I don’t think it just happened” because only one class was available during August. “It was a two-week class, and suddenly I was in.” The beginning of her associate degree program was memorable: “My first day of nursing school was September 11 of 2001.”

Rachel believed she was called into nursing as a profession. She made her decision as a high school sophomore to be a nurse after visiting a nursing school. “I knew right then; I was going to that nursing school.” She described her visit: she noticed “they had a dorm mother sitting down at the desk” in the single women’s dorm with six floors. “It was such a homey thing” and the small town atmosphere seemed reassuring to her even though the school was in a large city. Rachel related her immediate connection with the faith-based nursing school even though it was associated with a different faith

tradition than her own. She was intrigued when hearing nurses in this hospital and school of nursing prayed for their patients as standard practice. She recalled, “That’s why I felt like I wanted to be a nurse in the first place...I felt this calling to help people.”

These accounts describe the formation of self through interactions, both positive and negative, in the high school to college years. In symbolic interaction, these participants interpreted their self-image through the interactions during this period. Participants described both internalization of roles as inner-direction and conformity to a group over themselves as other-direction (Collins, 1994). Those who experienced role compatibility made decisions to fit the social group and those who experienced role incompatibility chose to defer from their social constellation and find new associations which contributed to a sense of self. Role compatibility or incompatibility correlates to MRM theory where nurses first learn how to model the client’s world by looking back to their own formative years; in addition, role compatibility or incompatibility in social theory or faith development theory correlates to Modeling and Role Modeling (MRM) theory’s adaptive coping that leads to health promotion or maladaptive disequilibrium that leads to impoverishment or deprivation of self-fulfillment (Erickson et al., 1983).

Anna decided to return to school as a second career after staying home to raise her family. She believed her education may have been discouraged earlier in life due to her parents’ view where a daughter did not need to pursue education. Even though her home life while growing up was not ideal, she stated, “I guess I always felt loved and secure from my parents.” However, as she looks back, she realized she was not encouraged to consider acquiring education or pursuing a career as a woman.

When I look back on it now, I think education was important for me. I think I was expected to be just the wife and mother. My parents never talked about me

going to college or brought me to see any colleges. I was expected to be a wife and mom.

Anna looks back at her accomplishment in going back to school and becoming a nurse with great pride. “You know, going back to school later in life was hard for me.” Yet she found she enjoyed being back in school. In great detail, she described what she learned in her program, and despite having classmates from many walks of life, backgrounds, ages, and experiences, she related “we all brought different things to the classroom.” Then she recalled almost nostalgically, “and we had amazing discussions.”

This contrasted with Wendy who reported how she chose a nursing program right after high school when women had not been educated in previous generations of her family. Having entered a baccalaureate nursing program, she settled for an associate degree program after failing one course. With emotion in her voice, she stated, “They booted me out of the program because of one class [years ago].” Wendy described this experience as being “the lowest time in my life” and perhaps more painful than her subsequent public and devastating divorce. She stated it was “a huge step” for her to go to the associate program because “it felt like it was second best.” “I thought, just wait, someday, somehow they’re going to find out about what I did and how they made a mistake.” When she came back years later for her baccalaureate credentials, Wendy remembered her thoughts from years before—she was “going to make her mark in this career of nursing.” She exclaimed, “And I have!” She added, “They almost took away someone from nursing who proved to be a fabulous nurse.” For her, earning her baccalaureate credentials in a second degree meant she retrieved some of the dignity and identity lost in early adulthood.

Amy quit her job to switch to nursing as a career. She stated, “I was in the information technology (IT) industry doing software development projects for an insurance company and traveling around the country.” Then she acknowledged, “I was completely burned out. I switched gears a little bit and went into recruiting” until her grandmother was admitted to a nursing home. At the nursing home, someone in the family sat with her grandmother constantly because she posed problems for the staff. One day, a nurse commented to Amy, “Your grandmother must have been a wonderful woman.” Amy recalled, “I remember just looking at her dumbfounded.” Because her grandmother was a challenge to manage, Amy asked, “Why do you say that?” The nurse replied, “Because you wouldn’t sit here every day if she wasn’t.” Amy stated, “That conversation turned my whole life around.”

Then, on her way to work, she did some soul searching. “I decided whatever the heck I was doing really didn’t mean anything to anyone, and I wanted to do something that mattered.” She finally knew what she wanted to do: “I went to work that day and put in my two-week notice, and came home and told my husband.” She enrolled in an associate degree program and earned her degree. When Amy delivered a speech at her community college graduation, she expected some praise or accolades from her family. She stated her mother seemed to be very proud, but in the same breath, it was never enough. She also heard “you need to go for your next degree” and “you need to keep going.” Beyond what was stated, she heard her mother saying more:

Never rest on your laurels; there’s always more to do. Don’t think this is ever going to be enough. You’ve got to look ahead, look ahead, look ahead. So what are you going to do now? How is that going to benefit anybody? You’ve got a lot to do in your life; get moving. What’s your statement going to be? What’s your next act going to be?

With this in mind, Amy stated she kept going forward and went on to get her baccalaureate credentials. Had she not earned such a lucrative salary in her previous IT career, she would have looked for a meaningful career like nursing much sooner.

Selected to go to a Catholic boarding school for promising youth, Oliver immersed himself in his studies and life away from his family of origin and his community in Africa. He grew up in a first generation Christian family. His father first worked as a translator or interpreter for a Methodist missionary and converted to the Christian faith. Oliver was selected and “sent to boarding school” approximately 120 kilometers away from home. The rest of his eight siblings remained living at home and attending the local school. “My parents were very proud of me when I completed the [standardized] test” because not many were selected in the competition for government scholarships. “It was a disciplined, scholarly school” and “very organized” with daily routines. Oliver related how he believed the values were consistent from his community to the school. He respected the teachers and appreciated how much he learned. Years later, a patient later asked him where he attended school:

I remember one time at work in the hospital when one lady asked me, ‘Oh, did you go to Bible school?’ And I said, ‘No, I haven’t gone to Bible school, but I have read the Bible a lot, many times in fact.’ I remember growing up when we [students] were competing about who could read their Bible within six months... and the one who did this first would get a prize. And I was good at reading and I read and read and read and read.

Oliver related the gift set others said he had even when he was young. A classmate recently reminded him of what he did even at a young age in the fourth grade. “I guess I was helping to care for my classmates.” His lifelong friend prompted Oliver to recall teaching others, saying, “Don’t you remember you were maintaining discipline and peace in the classroom?” Later promoted for teacher education and college, he described

himself as a just or lenient teacher. As a teacher, “I was kind of lenient most of the time.” He went on, “Not lenient as in being weak, but being lenient in order to help people whenever I can...I want to be sure to help [when they are] getting into some problems or difficulties.” He listened for problems in students’ lives before he entered nursing as a second career. He taught in Africa and in the United States before changing careers.

These accounts, although varied, show common themes of being challenged, pursuing academic excellence, and overcoming life circumstances. These themes correlated to Fowler’s (1981) synthetic-conventional faith where students develop an individual ideology or a worldview during their educational experience. At this point, participants reported awareness of the values and ideals they espoused and began to translate these into their own ideology. This relates to how symbolic interaction operates as well because students often perceive a teacher as “the generalized other” and interpret interactions with different teachers in the future as being congruent with other interactions they had in the past (Collins, 1994; Mead, 1938).

Some participants described singleness, whether never marrying or being a young single mother and needing financial security, as a major factor in impacting their views in pursuing nursing. One reported, “My education was a little sporadic. I had a child very young...when I was 18. I did everything to ensure I could support her, so I climbed the ladder...without a college education.” She described other attempts to finish education in other majors as ones that “bored me to tears.” She reported, “When I decided I was going to go to nursing school, it was definitely the right fit and I can’t imagine doing anything else.”



Other participants described separation or divorce as being a life-changing factor that, at least in part, informed their decision to obtain a nursing degree. Sometimes nursing provided the means of financial survival. In other cases, nursing provided a diversion and a sense of having one sphere in life that was normal or going well, where the nurse could positively affect the lives of others. One participant described her circumstances after her husband left her.

He left me [and the children]... and just left. I mean we had this big, nice house and I had nothing. I had to get money from my mom for groceries and gas. It was terrible. I took a couple of months and cried. Then I went to school at the community college. And I got my answers. You know, I had come a long way myself...

Some participants reported they were the first in their family to get a college education or degree. Holly described how she believed getting a degree changed everything. "I do feel like getting a degree changed my life." She was the first to try a different path "knowing no one from my family had ever graduated from college." She described taking classes one or two at a time, described her progress in the program, and, at the end of her account, she burst out and exclaimed, "I'm the first person to get a two year degree and then I turned around and got a four year degree also!"

Nancy became the first in her family to go to any college. She felt pragmatic decisions propelled her toward an associate degree in community college. "I was the first person in my family to ever go to college. I didn't know how to do it. My family didn't know how to do it." Being aware of limited resources, she attempted to make the smartest decisions from purely a cost benefit perspective. She considered the cost of the degree against earning a year's salary. "I have been trying to catch up ever since." She admitted, "If I had to do it over again, I would have gotten my four year degree first."

Brenda also described how she was “the first person in my family to attain a college degree” when she earned her associate degree. She reflected on what her degree meant, “It’s very much instilled in you that education is a key component of being an effective nurse. With the associate degree, you’re starting and you know it’s considered junior nursing.” She explained she had always understood in order to “truly finish or complete your education” a nurse really needs a baccalaureate degree. When she earned her baccalaureate credentials, she stated, “I was the first person in my family to have a four-year college degree.” She offered her perspective concerning the different levels of nurse preparation.

Looking back on it, I would say, after finishing the associate degree program, you think you’re very ready to be a nurse and you can’t possibly learn anything else. Then you realize how little you know when you actually get experience. Then you begin to think, what do I use all that theory for?

Your last two years [in the baccalaureate], you find out how much you do need to learn. You find out how much an extra two years means; it is totally necessary for how it rounds you and broadens your view of things. It allows you to be able to articulate things you might not ever have gone to otherwise.

Brenda described the pressure to go on for more education in nursing. She completed her four year degree, knowing then “I’ll be at the standard.” She conveyed a prevalent feeling among nurses, “I felt like I would have left it unfinished had I not completed my four year [degree].” She added, “Anything over and above that will be my choice.”

These participants reported affirmation of core values and ideals instilled in formative experiences upon achieving a personal goal like college graduation. This transformation into adult autonomy and independence produced an increased sense of self-worth (Fowler, 1981). Even though some participants found a sense of self at an earlier point, they emerged from being the first in their family to graduate with a college degree with an increased awareness of self and ascribed new meaning to this

achievement. In working through individuative-reflective faith to new growth, they also completed more cycles of interaction with “the generalized other” to reflect on a growing sense of self (Collins, 1994; Fowler, 1981; Mead, 1938).

Several participants recalled being taught spiritual or holistic care content in their associate degree or diploma programs. Some participants felt their baccalaureate education did not address the spiritual dimension nor did it impact their understanding of spiritual care practice. Others described how they changed through their baccalaureate education in unexpected ways.

Melissa described, “In the RN to baccalaureate program, I wrote most of those papers with a different slant from my economics degree. It made me reflect and open up.” She felt she grew in her ability to reflect and to communicate, especially in writing papers. More than the readings or texts, she felt the dialogue in the classroom pushed or stretched her in her growth as a nurse. The discussions with peers challenged her. She maintained, “Overall, it did improve me.”

Valerie claimed her learning in the baccalaureate program validated what she had already learned in the years after her associate degree. She learned broader concepts that applied to directly to practice. Learning more about holistic practice enhanced her ability to work with patients and families in having meaningful interactions. “Let them lead the way and be careful what you say.”

In a RN to baccalaureate program, Wendy considered her first prerequisite course to be of little value.

I thought I knew everything that I needed to know with an associate degree. I really didn't get that next piece...and I still didn't think it was missing. I remember thinking, this is not going to change me at all.

She recalled, despite her initial attitude, taking a liberal arts class about reflection offered her the first opportunity to broaden her own perspective about nursing.

Wendy acquired an ability to see things through fresh eyes. “I started looking at the patient differently.” She tried to look at the “whole patient” before, but the program helped her understand holistic care and why patients might act like they do. “For instance, you don’t get the public health piece and what’s out in the community [in the associate degree]. Now, I use it all the time with patients. I look past what happens when they leave my door out into the community.”

Wendy described, “It was a spiritual thing” to have gone through community nursing and family nursing visits. She expressed how shadowing a parish nurse reinforced the power of being with someone in silence. Seeing this type of nursing practiced with real clients changed her perspective.

By just [seeing] a loving presence and watching how someone else modeled it made me realize sometimes just sitting there and holding the hand or asking, ‘should we just say a prayer together?’ can mean the world to patients and families.

Wendy had always had a positive regard for chaplains. Since her experience, she feels even more at ease and learns from chaplain interactions with patients. “I can be right there, and we’re saying a prayer together...because I feel like I am part of their world.” She reflected about how seeing spiritual care being done empowered her to be more confident in her own work with patients. Being known among peers as a caring nurse, Wendy acknowledged, “It enriched my practice.”

These accounts exemplified how students who complete a RN to baccalaureate program, or any higher education program, may have low expectations and believe education will not affect their practice either positively or negatively. Some students may

also have high expectations and believe education will benefit practice, which supported Bandura's self-efficacy theory (Bandura, 1977; Resnick, 2004). In examining responses, many participants changed or altered their perspective by attending a program to earn baccalaureate credentials. Even though education is believed to be an academic and not a spiritual exercise, these accounts present evidence that participant faith development occurred due to educational experiences or education as treatment or intervention (Fowler, 2004). This correlated to education theory and developmental theory concerning professional development (Magnusson, 1995; Merriam & Caffarella, 1999; Perun & Bielby, 1980, as cited in Black; Peters, 1989).

Educational experiences contributed to the social construction of the individual. Even if participants completed secondary education or other educational programs, their identity as nurses remained tied to their nursing education experiences. Mead (1938) posited the individual has multiple selves, multiple roles or relationships with others, which contributed to self-development. Education contributed to developing successive roles rapidly: constructing the organized self, the generalized self, and self-image (Collins, 1994). Professional development in nursing provided an analytic lens in understanding the phenomenon of nurses processing learning for the multiple roles they play (Benner, 1984).

### **Major Life Events and Critical Life Incidents**

Participants self-identified life events that served as turning points or opportunities for development and growth. Similar life experiences will be presented in sequence. Participants communicated openness regarding difficult or challenging life circumstances, which either guided them toward nursing or changed how they practiced spiritual care. Often participants communicated these events early in the individual

interview. Perhaps these experiences defined a context of self for understanding each participant's life experience. Major life events related by participants included bad experiences with family members in health care settings, health crises such as having cancer or a stroke, separation or divorce, and death of a parent, a child or a spouse.

Some participants reported these sometimes catastrophic events changed their viewpoint and focus in their nursing practice. Participants' reports are consistent with the findings of Ross (1994) reporting nurses who resolved crises in their own lives were more secure with their own spirituality than their counterparts and were more able to respond at a deeper level in how they provided spiritual care. This correlated with Fowler's (1981) faith development theory where individuals who reconciled difficult life circumstances with their faith traditions grew to new understanding as a result of social interactions.

Holly described how dealing with cancer affected her marriage and family. She and her husband were struggling to find friendship and a sense of belonging in a church community when she was first diagnosed. Pregnant when diagnosed with cervical cancer, her husband "didn't get it" when she needed aid. She expressed incomprehension during this "life-changing event" when her husband remained focused on his work and not the family. "You know, my husband always had a big focus on saving for retirement. He worked 16 hours a day," she qualified, "It was not [about] the money for me. I missed him. I missed having people around. I felt very alone." She described being distanced from her family, "I was just raising the kids by myself. And I had cancer. He was gone 16 hours a day." She lamented, "There was nobody there for me." She found herself alone and isolated; she found herself on the bottom without support.

I went through the divorce because he doesn't get it whatsoever. He is incapable. He is an office guy with the five-star resort taste so that was a little part of the problem when we got divorced— he didn't get it when I got cancer. That was a life-changing event, a life-changing event for me! So I sat with one child on my lap and another inside me, scared I wasn't going to get to see their weddings, graduations...It brought me a lot closer to my family. And it changed the course of my marriage.

Holly also expressed disbelief when she found herself without support from her faith community as well. Having tried to establish friendships and relationships in a church, she was stunned when she lacked support. When growing up, she and her husband never had a “grounded religious experience” and they wanted their children “to have that because we both felt like strangers at every church.” During her cancer, she discovered she felt unaccepted at her church and stated, “It just feels like you're never really in the club there.”

Holly went on to explain how cancer changed everything and “it was a spiritual bat over the head, so to speak.” She knew, “All of a sudden, I realized I may not have forever. Nobody, nobody does. But until you have it in your face, you don't really realize you have to live your life.” She came to a realization: she needed her family.

Family is always there...I became closer to my family. (Pause) You can turn your back on your roots, you can rise above them, and you always wind up when you really, really need it...that's who you turn to, your family.

Valerie described similar circumstances and life lessons when she experienced a stroke while pregnant. She worked on her unit for a little over a year when she had a stroke. Pregnant with her third child, she could not believe what was happening to her. Working through her emotions, Valerie expressed she felt an insult upon injury when “I was offered an abortion the day I came in with the stroke.” She said the doctor came to tell her, “You’ve had a massive stroke and you’re pregnant. Do you want to terminate?”

She remembered asking him, “Can you tell me the implications of the stroke on the pregnancy?” and he could not answer. Valerie described how decades later, research shows the pregnancy hormones help recovery. Despite her impaired condition at the time, she recalled, “I do remember looking at him and saying, ‘it was a planned pregnancy’ and ‘there will be no abortion or termination.’”

Valerie had open heart surgery and ended up with time off to recover and deal with her own high-risk pregnancy after helping many others with this difficulty. When she took a year off from work, she reported, “It was horrible. My identity of self was being a nurse, so after the stroke when I couldn’t work, I lost part of myself.” She described many dark moments after her stroke including having a neurologist who told her whatever function she regained in two weeks’ time would be “all I’d ever get back.”

Valerie could not understand some of the comments from her faith community. She described how people would try to comfort her by saying “It’s a blessing. It’s a blessing you kept the pregnancy and then they found the heart condition.” She will never forget some of the things people said. “For some reason, people kept saying it was so wonderful I had had the stroke... and that God would intervene.” She struggled just to come to the point where she understood “they have no idea of how bloody hurtful they are.” Valerie delivered her third child safely.

Starting back at work, Valerie admitted “emotionally I lost it.” She explained her nursing practice became more complicated because she had so much anger after the stroke. “I would say my own spirituality was very confused for a while. I was so angry at everything.” After working a shift, she recalled, “It was very difficult to settle.” She realized while sitting at home one day, “I hated everything.” She went on, “I hated



myself most of all and couldn't stand it" and she said to herself at the time, "I think I'm massively depressed." Valerie began to process what had happened to her. She read a book she had been given about spirituality about a year or two after the stroke. "I was taken with the idea that everyone in their lifetime is going to have a catastrophic event."

Friends urged Valerie to see a counselor. Reluctantly, she made an appointment and began to work through what had happened. Her therapist confronted her, "Why would you think you could block tears and not block other emotions?" She heard the therapist saying, "Yet you sit here and you're making jokes and you're being sarcastic, and you tell me you've never cried. I'd say, damn, girl, you've got a lot to cry about." Then she claimed the tears began.

Now having worked through some resolution, Valerie described how her life experience contributed to her own understanding and how it helps her in nursing practice:

I think – and it's taken me a really long time to be able to say this – having the stroke...slowed me down so I could become a better nurse, a better mother, a better person...It gave me an opportunity to grow myself spiritually. The cool thing is, hopefully, you will put something like that into all aspects of life and that's something I'm still learning...It's taken a really long time to be able to say that.

Participants reported experiences of health crises, which correlated to research about nurses who negotiate their own health problems. Ross (1994) found nurses who had a sense of their own spirituality could respond at a deeper level in providing spiritual care; this included nurses who negotiated their own health crises. These participant accounts yield some personal lessons that transfer to supporting patients.

Several participants indicated they either entered the nursing profession or changed the way they practiced, at least in part, because of what they experienced in an impending or actual separation or divorce situation. Some reported their choice of career

and work as a nurse impacted their family ties. Lloyd conveyed the common pitfalls practice has on family life. He stated, “trying to be the best” as a nurse “led me to get into trouble in my own personal life” and led to a separation. He admitted, “Because I was working in overload full-time and going to school, I had no time for my family.”

Wendy related how her early divorce affected her outlook on life and relationships with others. She married a college sweetheart, and emphasized, “I tried and I tried and I tried, and no matter what...nothing changed.” She learned one person cannot change another. With an infant and toddler in hand, she discovered her husband “had many infidelities including getting someone pregnant when he was married to me.” Then, her husband and pregnant girlfriend were involved in a highly publicized lawsuit. She described the indignity of seeing her husband’s infidelity in repeated news reports, remembering, “I mean it was everywhere... everywhere I turned, it was in my face.”

Wendy’s husband filed for the divorce because she “stayed probably longer than I should have.” She acknowledged, “But I can never look back and say that I actually should have tried harder...I couldn’t turn the page, you know...I couldn’t get past [asking], how could this happen?” She explained her husband moved out and never made a house payment. Forced into foreclosure, she rented townhome, moved with two small children, and survived on her income as a nurse. Her lawyer husband tried to represent himself in court until a judge intervened a year later. The judge told her ex, “You can’t do this anymore, you get a lawyer.” She lamented, “It cost me tons of money...It was awful.”

Despite the treatment from her husband, Wendy felt support from her faith community, friends, and family. She described her family as being supportive, especially

her grandmother. Her grandmother encouraged her during this difficult period yet she “never slammed him [her husband] to me even though it would have been really easy.”

Through her experience, Wendy came to understand a spiritual thing where “sometimes one of God’s greatest gifts is an unanswered prayer” from one of Garth Brooks’ songs. She emphasized how she “prayed and prayed” through this experience and asked over and again: “Was God listening? Did He answer? Did He care?” She learned something about herself through what she experienced and found out what she believed.

Sometimes God knows what’s best. I choose to believe that because it’s worked out. I would never have had the life I have now. And I mean [I have] a life of love with my current husband that I would never have had with my first [husband], even if he hadn’t cheated, because he was just not that kind of person... So I married a caretaker, like me.

“The good part of the change was that it shaped me to realize you can do everything right or do the best you can, and sometimes it still doesn’t work out.”

Similarly, Anna’s marriage fell apart. She knew her husband had a drinking problem and needed help. She admitted, “I really had hoped we could get our life back together” after he went through treatment. Instead, he got very ill. “One day, he just told me he didn’t want to be married to me anymore.” At that point, she recalled, “I took a couple of months and cried.” Even though her husband no longer wanted to be married, he remained in the home yet never spoke to her again. He began drinking again and things got “pretty ugly.” He experienced episodes of “being found barefoot at the bars” before he got “really sick.” Knowing she could be in danger with his mood swings, her husband somehow thought she should continue to physically care for him in their home.

He became hospitalized with his illness and declined. She acknowledged, “he got scary” before he declined in the hospital.

Although her husband remained unconscious, the doctor had been concerned for Anna’s safety and anticipated domestic violence. The doctor thought her husband “would blame me for his life” and if he recovered, “it would not be good.” The doctor also thought it likely her husband might “kill me or kill himself” later. Before she could file for a divorce, her husband worsened and died. “So when he died, it was actually kind of a good thing.” She explained filing for a divorce would have been difficult for her, given her parents’ bias against divorce. She believes her life experience affected her ability to relate to families who weather extreme circumstances.

Divorce prompted questions about self-identity and participants who experienced these events reported their struggles to reconcile changes in their families and within themselves. When a marriage failed, a faith construct became altered (Fowler, 1981). For some, reconstructing ideology and interpretation about social relationships followed. Interpretation of social interactions followed with alterations or adjustments of perception (Collins, 1994). Participant accounts of life events may suggest they revisited previous faith development stages in order to reexamine previously held beliefs and traditions. In reworking discrepancies due to unjust life experiences, participants found adaptive mechanisms of faith (Fowler, 1981).

Still others reported the tragic loss of a parent, child, or spouse, either prior to or during nursing education or practice, impacted their perspective, their choice of nursing as a career, and their ability to provide nursing care. A few participants described how personal loss shaped their professional practice.

Amy described how the recent death of her mother allowed her to reconsider spiritual care as a nurse. This experience of loss continues to impact her and her family. When diagnosed with brain cancer and spinal cord cancer, her mother was fine and ‘then the next day [my mother] reverted back 50 years and just sort of stayed there for about two weeks.’ She didn’t think her mother “could quite handle it.” She knew her mother’s behavior changed, “But then she went back to this place in her life where she controlled everything and just stayed there dictating orders to everybody and assigning you a name, whoever you were and wherever she was, except for me.” Amy related an incident where her mother gave her a lasting message.

Even when she was dying...she was in and out of this dementia period for weeks. In one of her lucid moments right before she died, she said, ‘Amy, Always remember the world does not take kindly to weak women.’ I looked at her and I said, ‘Do you consider me a weak woman?’ She said, ‘Oh no, but just remember and teach your girls it does not take kindly to weak women,’ and then she went back into wherever she was.

Despite radiation and other treatments, her mother died three weeks later. The faith community and family grieved over the loss of a central figure. She realized her mother “ran the church” and “ran the pastor” even in death. The pastor and parishioners seemed lost as to how to proceed in planning the funeral without her. Her mother’s involvement was a given in their family and everyone related how her mother always visited people in the hospital. She knew her mother “coordinated who was going where and doing what” in the home and at church.

Amy recognized her mother’s influence in her own personal skills to find out what was wrong in patient and family situations. She cited her own ability to look at underlying factors that affect complex medical scenarios when families become emotional, asking, “What else is going on?” She asked about religious affiliation to

discover support systems for patients and families in crisis; she often recommended chaplain visits for beginning conversations to help sort things out.

Anna described how watching the treatment of her father at the end of life affected her desire to pursue a career in nursing. She described her father having a severe stroke at age 57. She spoke with pride she felt for her father who overcame much in his life: “To begin with, he was a veteran and double amputee, but he had artificial legs and you would have never known.” When he was in the hospital, Anna observed both “good care and bad” at the hospital as he remained paralyzed on the left side. Once he returned home, she was bothered to see her mother treated her father “really poorly” and would “ridicule my dad” due to his incontinence. “She treated him like he was a little kid because he had this stroke, and she made him pay for everything he ever did wrong in his whole life.” She described how her father remained at home for three years under her mother’s care before entering a nursing home.

I think during this whole span, I saw him have excellent care and poor care, and the poor care just broke my heart. He had end-of-life care, which was fabulous. So I saw different spectrums of nursing and different spectrums of family care...it had a big impact on me.

Anna went on to describe how this experience led her to her being a nurse. She started at the community college with an interest in being a cardiac technologist and then “switched over to nursing.” As a nurse, she claimed, “I see things” because of personal experience and “make sure no one gets embarrassed or feels uncomfortable.” In her practice, “I go above and beyond in trying to treat people with integrity and compassion.”

Participants reported losing a parent and adjusted to alteration in the multiple roles of social interaction. When one’s self concept is altered or reinforced by interaction, losing a significant person in one’s social group alters future interactions

(Collins, 1994). Losing a parent constitutes a loss of mutual interpersonal interactions which no longer reinforce one's social roles.

Although a nurse for many years, Rachel described how the loss of an infant daughter with Down Syndrome affected her ability to understand how patients and families experience grieving and loss. "I lost my daughter." She remembered, "Susie ended up passing away after almost a month in ICU." She described her surprise at being a nurse and knowing "the ins and outs" of scenarios when patients "don't look like they're going to make it." Yet, with her own daughter, she kept reassuring herself about how strong and resilient children could be. She had seen so many young patients "pull out." Rachel related how she told herself her baby would be one who survived. "With Susie...she had been intubated and close to death so many times." In her mind, she kept thinking that her infant daughter would somehow pull through. She remembered how three days before Susie's death, it dawned on her, "Oh, she's not going to make it." Rachel exclaimed, "I felt, no way am I going to give up on my own baby!" She described both experiencing and seeing this process of wanting a child to survive and then having to let go. She related how important it was to allow families time for "the whole letting go [process]." She acknowledged families "eventually get to the point where they'll be okay with it, and they can see the other side." She knew what it was to be a family member who doesn't want to give up, which helped her relate to patients and families.

It always bothers me when I hear when someone is depressed after [a loved one] dies because I have a hard time seeing depression just because of the experience of losing someone. To me, they're very different things and yet I think they get tied together a lot. I'm not usually the first one who will say, 'She lost her husband three months ago and she looks pretty withdrawn and depressed. Get a

psych counsel.’ I’d be the first one to say, ‘She doesn’t need a psych counsel, she needs [support and] time.’

During each calendar year, Rachel described having a difficult time getting through the same season of her daughter’s birth and death. “Obviously time does heal... I definitely will never be over it entirely, but I can see my way through it.” She acknowledged that, for now, she practiced in a different area.

Diana described her experience in losing her young son during her associate degree program. Although she had already chosen to leave a university research position in the sciences, she found nursing provided her “satisfaction coming out of being with people” and “it just seemed like the logical thing” since she came from a family with many nurses. Within months of starting her program, “I had my first born son diagnosed with a brain tumor.” She described feeling alone when going through first, mediation, and then, divorce, during her son’s chemotherapy treatments. Her family lived out of state while she cared for her five year old son in treatment, his two-year-old brother, and continued nursing school. She reflected, “I was alone.” She described her son going through five long years of difficult interventions and treatments. When he died at age seven, she found a sense of peace in sitting by her son for some time in the hospital: she found this a “mentally satisfying and a very, very good experience.”

Now an oncology nurse, Diana explained how she understood, in part, what patients go through because “I had gone through this on a very personal level.” She described her need to keep her personal experience at bay in the workplace. “Sometimes, I’ve found I have to be extremely careful. You know, I don’t know what [patients are] experiencing, and I can’t begin to appreciate it.” Diana expressed her personal



philosophy about loss: “Just because I have been touched by it, doesn’t mean I understand it.”

Loss of a child affected participants in a profound way. Participants reported losing a sense of self when being separated by death. This correlated to constructing one’s sense of self through social theory and how personal identity is tied to social relationships (Collins, 1994; Mead, 1938). By revisiting one’s previously held beliefs, traditions, and ideals, participants emerged from these experiences with an altered sense of self and fewer multiple social roles (Fowler, 1981)

In another experience of death and loss, Anna described difficult circumstances surrounding her husband’s before she became a nurse. It actually provided her opportunity to find some resolution for her teenage daughters. Her husband “was an alcoholic and he actually left me a year and a half before he died.” She described how she and her daughters spent “the last two days of his life with him at the hospital.” Because he was unresponsive, she encouraged her daughters to verbalize their feelings to their father. “I made my girls talk to him. I don’t know why or how I did this, but I made both of my girls talk to their dad.” She described how she told them, “I want you to yell at your dad. Tell him you’re mad at him.” She encouraged one daughter, “Tell your dad you’re mad because he took your car away.” She explained, “I wanted them to get it out.” Later Anna declared, “I don’t know if they remember, but I just wanted to them to say it out loud when they had the opportunity.” She also told them in the same conversation at the bedside, “I want you to tell your dad that you love him.” Although she could not explain why she did this, she reflected she felt this was necessary in the

moment for her daughters. She expressed how she now looks for ways in her practice for families to have meaningful and private conversations.

Oliver described losing his wife during childbirth and how this experience propelled him into nursing as a career. As an immigrant, his wife delivered their third child at the hospital and sent him home to cook dinner for their two young children. “They did a C-section and everything was fine.” When he returned to the hospital, his wife was not in her room. After asking around, “They told me she was bleeding so they had to take her to surgery. I wasn’t panicking at all. Even in Africa, women don’t actually die from childbirth [anymore].” He explained childbirth deaths are now rare.

Four hours later, the doctor came to me [and said] my wife is not responding to the treatment. And I said, ‘What do you mean she’s not responding?’ (Not knowing she was already gone.) She was already dead...That was a big blow.

Oliver said he was not told everything that happened. “And they didn’t tell me the truth.” He reported other staff mentioned his wife’s nurse was known as one who “would always put patients aside and go out to smoke.” He exclaimed, “Now look at what you have done to somebody’s wife! She was so young.” He claimed the staff did not check whether his wife came to the unit from the OR (operating room) or from the ER (emergency room). “After the C-section, the nurse who was working did not examine her thoroughly. It was internal bleeding, to be sure.” By the time they found her on a gurney in a side hallway, “there was blood everywhere.” He lamented the fact that others were slow to tell him what happened, “But, as usual, they covered it up.” Oliver wished he had been told the truth as soon as he inquired about his wife.

“When this happened, I submitted my resignation from teaching the very next day.” Previously a schoolteacher in a suburban district, Oliver enrolled in an associate

degree program and became a nurse. He still questions what happened with his wife. “And in this time when I was mourning, I believe God has a purpose for every person in this life.” He acknowledged, “I used to pressure myself” and question, “Why should this happen? What did I do? Did I do something wrong? What should I do?” Now remarried, he finds fulfillment as a nurse where he can relate to patients and families in the most difficult situations.

Death of a spouse produced life-altering social processes. When an individual’s social world was reordered by untimely events, individuals re-examined interactions and relationships. Because marriage formed identity of the self, the loss of a spouse reintroduced more basic levels of developmental work regarding negotiating the self and responding to “the generalized other” in interactions (Collins, 1994; Fowler, 1981). Even though the death of a loved one initially caused disequilibrium, participants found their way to adaptive coping and eventually maintained equilibrium rather than ignoring unmet needs in a maladaptive mechanism like impoverishment (Erickson et al., 1983).

### **Nurse Socialization in Practice**

Nurses often identified their experience as graduate nurses as being challenging. Participants described similar incidences of choosing nursing, going through orientation and learning complex skills, and eventually being accepted into the ranks of nurses on their unit. I asked participants about their initial experiences in practice, first role models, and the first time they remembered practicing spiritual care.

### **Becoming a Nurse**

Among 12 participants, only four selected nursing as a career early in life. Of the four, two chose nursing as a pragmatic decision and a desire to serve in an altruistic

profession, one decided as a young child that she would be a nurse due to her perceptions of nursing being a noble profession, and another participant expressed her belief in being called to be a nurse as a vocation early in high school. The other eight participants chose nursing later in life as a result of life experiences they described individually to me.

Most participants, regardless of their reason for choosing nursing, described in great detail the process of considering nursing as a career, choosing a nursing program, and having that decision validated by other people or circumstances. Participants also described the reasons they chose to continue their education for their baccalaureate credentials in nursing. Again, they reported personal experiences related to starting in the RN to baccalaureate program and the events or conversations which they felt validated their choice under educational experiences.

All participants reported the intensity of the first year of orientation in the profession. Although participants stated they had previously understood the nature of nursing and felt adequately prepared by their nursing education, many stated the level of the work actually involved in providing direct patient care impacted their personal and professional lives in unexpected ways during the first year(s). Most participants described feelings of being overwhelmed or extremely challenged in their first experiences in nursing practice. During interviews, a pattern emerged where each participant seemed to take some time to begin to verbalize and work through recalling the uncomfortable nature of beginning his or her professional practice. Various descriptors included “barely surviving,” “trying not to kill anybody,” and “keeping everything straight and not screwing anything up.” Some participants described the heavy sense of responsibility that overcame them as they dealt with complex situations and high acuity

in direct patient care. These correspond to Benner's (1984) stages of professional nursing development with the novice (stage 1) or advanced beginner (stage 2) nurse.

Many participants described an overemphasis on technical skills and procedures rather than on interactions with patients and families. "As a new grad, it's really tough because you don't trust yourself," Holly stated. She went on to explain, "When it first happens, especially if you are nervous, you are looking for something that is off, you have to trust your gut...and you don't want to mess up." Anna reported, "I think when you're a new nurse, you're trying to get the skills down." Melissa described her own focus: "Graduating out of community college, I was more hands-on: let's see about [this], let's push the pills...let's do the procedures."

Lloyd described this focus as being typical of a new nurse: "Sometimes I think nurses look at diagnoses [like diabetes or heart disease] as the person. Like that's the person: that's how they label them, and identify them, and categorize them." Brenda also described how the nursing culture was sometimes unwelcoming to new graduate nurses, stating, "As a new nurse you're coming in and you're not competent in your skills ...And yet you are also being told how much you don't know. So it's trying to figure out, what am I doing here and am I doing it right?" These comments correlated to Benner's (1984) early phases of professional nurse development where nurses focus on technical skills and procedures in a manner that was prohibitive to attending to holistic concerns such as developing skills in providing spiritual care.

Amy described her beginning on a pediatric unit: "When I was a new grad, I was probably a little scared to death because of the population I went into. It was crazy and scary because people died [children died], like every day. It was intense." Lloyd stated,

“As a new nurse, I had patients dying in the middle of the night and I remember being scared and asking myself, am I doing the right thing?” He recalled being so technically focused and concerned about proficiency. He described disassociating himself in order to keep going; he disengaged from psychosocial concerns to manage his procedural tasks.

Valerie reported beginning in an urban hospital and stated, “It was harder [back] then because I was getting my skills down, trying to balance things, and going through all this heavy emotional stuff with people dying.” She described how patients were so ill and she had to adjust to the idea of discharging them to live on the streets again since her hospital treated the homeless. These comments describe the advanced beginner nurse (stage 2) in Benner’s (1984) schema and introduced themes that suggested as participants experienced conflicting values in practice, they were moving toward the competent nurse stage (stage 3).

Rachel prayed for both patient’s safety and her own every time she went to work. “One of my fears going through nursing school was, my gosh, what if you do something that kills somebody or something?” She expressed, “Hopefully, [with] all of the things they teach you to do, check and double check, you’ll avoid mistakes.”

I would always just pray before I came into work that it would be a good shift, and no matter what happened, it would be okay at the end...I’d always pray to be the eyes and the hands, the voice of Christ...to keep from doing anything that could harm anyone, and to try to just bring peace to people.

She explained, “That’s just part of who I am...I just pray during the hard times or the times when I’m afraid or not sure of things. That’s just part of who I am.”

These phrases correlated with an emerging thread among participants concerning the time constraints in providing care for the whole person including spiritual care. Most all participants explicitly identified time management as a barrier in providing spiritual

assessment and interventions in practice either in the individual interview or in the focus group interview. “Time management is very hard,” Holly stated. She described a “sense of right and wrong” when patients require different types of care and “there's a constant battle.” She delineated, “That's probably the part of work I don't like. There's just never enough time.” Lloyd stated, “I think time impacts a lot of practice. It impacts what we can provide.” These generic comments identified Benner’s (1984) earlier stages of nurse development and revealed understanding about what may be affecting particular clinical situations. Comments correlated with Vance’s (2001) findings of insufficient time comprising the largest barrier for nurses in providing spiritual care.

In the following comments, participants described movement toward middle phases of Benner’s (1984) professional nurse development as they provided evidence of their growing knowledge and ability to see the bigger picture in the competent nurse and proficient nurse phases (stages 3 and 4). Lloyd described, for patients, “distress can be the biggest indicator they are going to need spiritual help or some kind of extra time...especially with children and the elderly.” Rachel posed direct patient care is “too rushed” to allow for holistic care. She stated, “You can’t spend time with patients...that’s the whole caveat of nursing and being able to provide the spiritual-emotional care along with the physical.” These comments indicated Benner’s (1984) competent nurse (stage 3) and the following comments indicated the next shift to the proficient nurse (stage 4).

Diana said, “Those discussions take a *lot* of time.” She elaborated, “I am always very fearful of going to a very private place and have another call light go off in a different room.” Valerie reflected, “It can be a very intense relationship initially...and

it's very intensive and time consuming. It includes a lot of family involvement." These comments indicate the personal investment and cost to nurses when engaging in spiritual conversations and care. If individual participants neglected to mention time constraints through self-reporting, it came through in group discussion as a factor that impacts practice during small group interaction in the focus group interviews.

Several described difficult or negative experiences in early practice, which affected their view of practice. One participant expressed, "I had [put] nurses on such a high pedestal prior to being hired." She described negative behaviors among older nurses including "nurses who were already burnt out" and "the compassion wasn't there in their nursing." She explained, "It was a very difficult experience. Talk about being thrown to the wolves; they ate us alive." She reported new grads were given difficult patient assignments. She asked, "Oh my Lord, did I make the worst decision in my life?" These comments validated Farrell's (1999) and Meissner's (1999) findings of new graduates experiencing difficulty or hostility in the workplace; participants identified this aspect of nursing practice which is difficult, especially for those who chose nursing as a calling or as an altruistic profession.

### **Finding Role Models**

When describing role models in nursing, most participants began to describe nurses who they observed who provided consistently safe, basic nursing care that was recognized by others in the workplace. Even though few identified individual nurses as role models, most participants described a process of observing multiple nurses and taking on specific competencies as behaviors which they observed and admired. Many participants described how they synthesized a number of observations of what they



considered to be good practice, selecting particular skill sets and talking points they saw demonstrated by exemplary nurses.

Some felt supported by those whom they considered as models. “There were several nurses at work who have been there since years ago and I feel like they are there for me,” stated Holly. Diana reflected, “A lot of the nurses started me off actually... people who I gravitated toward simply because our personalities were similar, and we were into psychosocial aspects of nursing.” These comments were supported by Benner’s (1984) schema of nurses seeking mentors and exemplary nurses in early phases of being novice or advanced beginner nurses (stage 2). As nurses progressed to the competent or proficient nurse (stage 3 and 4), they sought other nurses to promote growth and development along with professional accountability (Benner et al., 2009).

Others expressed there were no role models among their peers or superiors, rather they learned from their patients. Nancy described her experience of learning.

It was no one person, no one role model. It was really the total set of a lot of experiences... just experiences with individual people over time. It doesn't matter really what the topic is, I just tend by nature to be somebody who believes there are many sides to a story. Not that there are just two sides to a story, there may be many sides to a story. I think I always have viewed my patients as teachers. It was the patients. It wasn't a role model of any one person. It was a boy in the [mental health unit]. It was a [Native American] girl who died. They were my teachers.

Lloyd reflected, “No one can teach you to be empathetic with people...you can't learn it from somebody else, it's learned from yourself through your interactions with people... I think you learn from your own experiences.” These comments indicated correlation with social theory and Mead’s (1938) symbolic interactionism where nurses learn to negotiate patient interactions by finding meaning through interaction with “the generalized other,” which is often based on those who are similar to one’s own social group (Collins, 1994).

Some described development of a skill set as, first, basic nursing skills, and later, holistic nursing skills including spiritual care. Melissa reported, “At first, I was all about the skills” and “I don’t actually remember learning about this [spiritual care in the associate degree program].” Later, after sharing a patient story where she provided spiritual care, she reflected, “I did incorporate spiritual health several years into practice, but where did I get that from? Did I actually learn it on the unit?” A couple of participants described picking and choosing what they observed, much like ordering a menu from an a la carte menu. “It’s like you take bits and pieces. You watch somebody do things. Oh, I’ve got to remember that.” Nancy stated she looked at the interdisciplinary team, learning from “the professionals, teachers, parents, different parents, clergy, good ones, bad ones, so I approach a situation going, 'okay, and... hmm.' That’s how I did it.”

A few participants described a cherry-picking process of claiming phrases and sayings which fit their own philosophy and practice of nursing. Holly stated, “As you go along in your practice, you just pick up. You take a little out of most everyone you work with. You add those good qualities...” Diana related her approach, “If I feel concerned I don’t know ‘where to go’ or how to handle a situation, I’ll bring it up with some of my friends and say, ‘How do you handle this?’”

A couple of participants acknowledged their need to check with role models and verify if they could incorporate certain phrases into their own practice. Diana described how she found some phrases: “I got this from experienced nurses” with some who are good friends and others are acquaintances. Melissa would check back with the source and stated, “With something like the phrase I borrowed, I told her, ‘I used your line

again.” Diana reported learning to say things that are relevant for patients by listening to others and said: “You give them the ability to just be and feel, in the context of the horrible hospital...And I’ve helped them more than they can appreciate at the moment.” This reinforced Shirey’s (2009) findings where competent nurses in Benner’s (1984) schema may return and become novice or advanced beginners in relation to new levels of care such as holistic care and the provision of spiritual care until they find models to follow or exemplary nurses who validate their learning.

Several participants could identify an actual person as someone who modeled spiritual care for them in practice. A couple identified a single nurse leader in practice on the unit or a single nurse preceptor during early work on a hospital unit. Wendy described a memorable moment in her early practice.

I was on the oncology floor and I cared for a younger patient. She was having those terrible fevers and unpleasant symptoms. It was near the end and she was still with it. And I happened to be in her room and the head nurse came in and greeted her and asked how she was doing. The patient said, ‘I’m dying.’ The head nurse sat down next to her, and said, ‘Mary, are you scared?’

I remember this struck me because, at that point in my life, I wanted to say, ‘no, we were going to take care of her and she would be fine.’ This was so profound to me. I was so touched by this...Little things like this stick with you. I will never forget it as long as I live.

Several could not initially identify nurses, but rather described chaplains as being role models in how nurses could approach spiritual issues. One participant reported, “I think listening to what the chaplains said helped me to find a kind of nondenominational way of saying things to patients...who doesn’t want to hear something encouraging?”

### **Spiritual Care in Practice**

To establish context regarding religious background, all participants were part of Christian backgrounds and traditions. One participant of African descent was a second

generation Christian and attended religious schools prior to resettling in the United States. Half of the participants reported they remained in a faith community congruent with their previous faith traditions. Half of participants reported they were raised in a different faith tradition, a different religion, than the one they are currently subscribed. Of this group, three remained connected with a faith community and three stated that, although they were raised in Christian traditions, they were currently exploring other religions and philosophies markedly different. Religious affiliation constituted an important part of participants' personal perspective which informs practice. Participant spiritual information is provided (see Table 3).

In regard to beginning spiritual care practice, half of the participants reported beginning spiritual care practice before or within the first year of nursing practice. All who said they provided spiritual care before becoming a nurse did so within the context of being a student nurse, Certified Nursing Assistant (CNA), or in another health care team role except for one who reported she provided spiritual care during hospital visitation through her church. Some participants reported providing spiritual care in one to two plus years into practice due to incorporating technical skills in beginning or novice practice. Several participants stated they took longer to provide spiritual care, from four to ten years. Two participants mentioned extenuating circumstances like working on busier and more technically-focused units. One participant reported her beliefs about her Catholic faith limited her ability to provide spiritual care; she was so concerned there was "a right way" to offer spiritual care according to dogma and perceived religious protocols that it took longer for her to find ways to do this in ways which fit her practice more naturally.

Table 3:  
Participant Religious/Spiritual Information

Nurse	Critical Life Incident	Religious Background	First time provided spiritual care	Role Models
Holly	Cancer	Evangelical	Within 1 <sup>st</sup> year	Mother Other nurses
Lloyd	Separation	Raised Lutheran	Pre-nursing	Grandmother
Diana	Death of son	Raised Catholic	Within 1 <sup>st</sup> year	Other nurses
Melissa	Travel abroad	Raised Baptist	4 <sup>th</sup> year	Other nurses
Wendy	Education Divorce	Catholic	10 <sup>th</sup> year	Parents Charge nurse
Anna	Death of husband	Raised Catholic	2+ year	Other nurses
Oliver	Death of wife	Methodist	Pre-nursing	Parents Teachers
Brenda	Military Single parent	Raised Nondenominational	1+ year	Mother Grandmother
Nancy	Military	Catholic	2 <sup>nd</sup> year	Other nurses
Amy	Death of mother	Lutheran	Pre-nursing	Mother
Valerie	CVA/Surgery	Raised Lutheran	Within 1 <sup>st</sup> year	Mother Other nurses
Rachel	Death of daughter	Catholic	Within 1 <sup>st</sup> year	Other nurses

### Beginning Spiritual Care

When asked about the first time they provided spiritual care, participants often took at least half of the interview to self-report this experience before I asked the

question. In easing into the topic, each participant became comfortable as we covered other information he or she felt was important. Some appeared to have difficulty identifying a patient story where they provided spiritual care. If this was the case, I returned to the topic before the end of the interview to capture this information. The following examples illustrate the range of experiences that were reported.

Responses about beginning spiritual care practice varied and seemed to correlate to the participant's motivation to be part of the study. Many participants expressed a desire to explore their own spirituality and/or come to terms with their religious upbringing, questions about spirituality, and current spiritual ambivalence. Some participants identified the need to be honest with patients and families and acknowledged their own ambivalence about spirituality; although they felt they broached the topic with patients and families, they viewed strict referral to spiritual services (chaplain visits) as spiritual care.

As participants described their early professional practice, most participants struggled to find the exact expressions that conveyed the meaning they wished to share with me. I revisited the audio-recordings to look for those moments of hesitation—the longest pause, which may have significance (Charmaz, 2006). In reporting what they described as spiritual care incidences, some participants reported highly memorable experiences in providing emotional support, end-of-life support, and support for cultural or religious practices. This correlated with Carroll's (2001) and Nussbaum's (2003) findings where nurses may perceive physical, psychological, or social care comprises care that was not distinct from providing spiritual care.

An example of this perspective included Anna who stated, “I’m more emotionally-based than spiritually-based.” She discussed her need to create space and privacy for special moments with families in her practice. She recalled, “One time I really remember and cherish is when I had a lady from the East Coast who was having her third bone marrow transplant. She had been to other places, and she came here for treatment as a last-ditch effort.” She described how she bonded with the patient and husband. “She made fun of me the first night, you know, with my Midwest accent, you know, but they were just lovely people.” When the transplant was over, the patient’s adult children came from out of state as their mother declined rapidly.

Soon the decision came for the patient to be intubated with a breathing tube. Anna watched over her patient as doctors were gathering in the room. The atmosphere changed when “everything got kind of hectic” and she noticed the husband “had a panicked look on his face.” Seeing the patient struggling to breathe with an oxygen mask, she described how she intervened.

It just seemed like I had to do something...I was at the bedside with all this commotion around her. I was getting the set-up ready to intubate her, and I just kind of took a moment with them. I paused, lifted her mask, and asked her husband to kiss her before they did the procedure.

As she lifted the mask, the husband asked, “Can I really do that?” Anna answered in the affirmative and the husband leaned in his wife’s direction with tears in his eyes and kissed her on the lips. After being stressed and in respiratory distress for some time, the patient went limp and sighed as her husband kissed her and “she showed a relaxed feeling.” Anna stated, “I was glad to make this little special moment happen in this confusion.” Within minutes, the patient was successfully intubated, but she died two days later. “You know, she was never awake again...that may not be spiritual, but I like

to make even those moments happen.” This example showed how some perspectives of spiritual care include more holistic concepts.

Rachel related an experience of participating in spiritual care when caring for a nine-year-old patient who exhibited spiritual needs. This young girl burned inside a grain bin, which caught on fire due to children playing together with matches on a farm. After retrieving and rescuing her daughter out of danger, the child’s mother suffered massive burns and smoke inhalation and had died. Even though the girl was young, Rachel recalled, “I could tell she was just so in touch with God spiritually.” The young girl would listen to Amy Grant music all day and would refuse pain medication for painful dressing changes on the severe leg burns.

Rachel described the nurses and doctors collaborating together to slip some pain medication in food before dressing changes taking as long as an hour and a half. Occasionally, the staff prayed with the young patient before the painful dressing change. During these procedures, everyone in the room struggled emotionally except the little girl who remained calm. Nurses were often in tears. The nurses talked the young girl through the dressing changes as they painstakingly debrided and redressed her extensive burns. Rachel expressed, “I felt there was a connection, just based on our spiritual beliefs. I think her mom had given her knowledge of Christ, knowledge of heaven, and what to expect.”

The girl missed having family or visitors around and Rachel prayed with her or silently for her during the evening or night shift. She stated, “We would pray out loud or sing religious songs together” when the girl was going to bed at night or during the night when she would wake up in pain. She qualified that, if other people happened to be in



the room, she would pray silently. She remembered, “As a young nurse, I wasn’t comfortable approaching [prayer] with other people.” Yet she felt she connected to this nine-year-old girl.

To me, it was overwhelming to think about this girl losing her mother. It was overwhelming to me and I wondered if I could have gone on without a mother. I still think about her and wonder how she is doing.

“I remember feeling so heavy. Here is this child who’s lost her mother and needs so much more care beyond the physical.” Rachel worked with this girl to get her to eat or get through the night. She explained, “You just want to hold them, play with them, make them happy... but she was just so mature emotionally that she didn’t act like a little kid.” She would ask herself, “How do you grow up being nine and not having a mother? This was such a stretch for me, too. She’s definitely stuck with me. Every time I hear Amy Grant I still think of her.”

Another participant related how nurses provide direct spiritual care in the moment. Brenda cared for a young Marine in his 20s who had been shot in the head by a sniper and suffered a Traumatic Brain Injury (TBI). The Marine demonstrated an inability to verbalize because he was learning vocabulary and how to speak all over again. “It’s really frustrating because they have the capacity to know they had speech before and they’re thinking in their head the way they always do,” Brenda explained, “and it just doesn’t come out that way.”

She explained how TBI patients were especially vulnerable and how nurses had to be particularly cautious in working with these patients. Some patients even became combative with nurses. In this Marine’s case, other certified nursing assistants (CNAs)

and RNs visited the ER on several occasions after he threw loaded food trays and bedpans with feces, and physically assaulted staff who attempted to care for him.

One day while working with him, Brenda observed the Marine's obvious frustration during the daily routine. He tensed up, clenched his muscles, appeared to be visibly agitated, and struggled when he could not verbalize as he wished. She recalled, "I can remember saying to him, 'God knows.' Just then, his eyes and his body language [changed], he just relaxed, and I said, 'You're here for a purpose. There's a reason why you've survived.'" The Marine immediately responded to her encouragement. He looked at her differently and she knew he heard what she had said. She felt comfortable in giving spiritual care in this particular moment. "The reason I felt comfortable to do [this] was because of something his father had shared with me a few days before this happened."

The father described what his son had done prior to the mission. "Prior to going out on this particular mission, the father told me his son, the Marine, made a specific point to go to the chaplain, and the chaplain gathered the whole squad together and they had a special prayer." This Marine had "just sensed that that was something he wanted to do, had to do, before going out on this mission." With this knowledge, Brenda spontaneously offered support within the patient's belief system. She reflected:

I just encouraged him and maybe it was the first time I had been that outward or articulated it in that manner as a nurse, or maybe have been that open. I knew I was just reassuring something which he already believed and I wasn't forcing my beliefs on him. It was something his family had shared was important to him. Had he been Muslim or had he been Buddhist, I certainly wouldn't have gone in there and said that. [Had that been the case], I would have respected his belief system.

Brenda reported how she felt a comfort level in practice at this point, just after her first year as a nurse, and she felt she had observed professional boundaries.

With TBI patients, nurses take extra time to address many areas including spiritual care due to vulnerability and how nurses' comments might be easily misunderstood or misconstrued by the patient. Because she worked steadily with this Marine as a primary nurse and confirmed the patient's spiritual beliefs with the family beforehand, she thought about how she might respond to the patient if a moment presented itself. She related how she felt good about meeting a real need and affirming someone's spiritual beliefs. However, treating the Marine well, who had been labeled as "difficult" or "noncompliant" by other nurses, created some unintended issues among colleagues for her. Peers and veteran nurses questioned how a new nurse had instant success.

This scenario indicates how nurses who provide spiritual care may incur jealousy or misunderstanding among their peers. Farrell's (1999) and Meissner's (1999) findings of nurse hostility in the workplace accentuate the difficulty nurses may face if they provide quality or exemplary care in holistic needs like spiritual care. If nurses demonstrate excellence in catheter care, an IV medication administration, or a dressing change rather than providing appropriate spiritual care, he or she may have receive positive reinforcement in the workplace. If nurses provide excellence in spiritual care, he or she may be minimized or experience negativity or ridicule; her or she may not be positively acknowledged for giving quality care in the workplace.

The Marine's account addresses another thread reported by participants concerning the role of spirituality in dealing with the patient who is labeled as difficult or

noncompliant. Many participants described themselves being identified as one of several nurses on their unit who were regularly asked to check with patients who presented with difficult moods, behaviors, or noncompliance and refusal of cares or treatments. By conducting further inquiry, participants included spiritual assessment as a possibility to delineate these specific patient concerns and needs requiring support and intervention.

### **Practice Setting Lessons**

This study captured nurse perspectives including nuances in spiritual care across the lifespan. In addition to looking at characteristics and behaviors among groups of participants, as discussed later in this chapter, differences among practice settings emerged. Looking at how spiritual care varied in caring for patients across the lifespan on different specialty units produced value in understanding the scope of practice and the relevance of the findings. Starting with patients at the beginning of the lifespan, participants reported how they approach spiritual care with pregnant women, infants, parents of infants, children, and parents of children in both labor and delivery or pediatric units. Settings provided opportunity for spiritual care of patients from children to adult care included mental health, chemical dependency, emergency, burns, diagnostics, polytrauma, cardiovascular, neurology, bone marrow transplant, and oncology units. Settings that serve adult to elder populations included similar units.

By identifying particular lessons for various practice settings in this study, participants reported insights and variations of how nurses understand and implement spiritual assessment and care. Participants delineated the effectiveness of spiritual assessment questions to fulfill the Joint Commission's (2011) requirements and how they adapted the questions or individualized spiritual care. Participant's described variations

of how they address spiritual care with various patient populations; varied foci of various practice settings are reported (see Table 4).

Some differences emerged among practice settings. In labor and delivery, a participant reported some nurses did not address spiritual care because high-risk pregnancies and infant deaths did not affect many patients. She discussed how patients do not expect an unhappy outcome in pregnancy, nor do families cope well with an infant death when they expect a normal delivery. In both cases, effective spiritual care meets holistic needs for patients and families who are at a stage in life where they may have few supports or peers who have experienced similar circumstances. In pediatric settings, a participant discussed how she differentiated between younger and older children by observing their responses when asking parents questions for spiritual assessment. If an older child or teen made eye contact, she would check back with the patient when they were alone and offer chaplain visits.

Amy reported, “In pediatrics, I do a 30-second assessment of the physical and look between the parents and child to see ‘What else is going on? How are they coping?’ Usually the children are not the problem.” She asks parents about religious affiliation because it helps families to cope with emerging problems and crises with young patients. In the Emergency Room (ER) or Emergency Department (ED) and diagnostics units, nurses may not utilize spiritual assessment questions because patients are not always admitted as inpatients. A participant reported that spiritual assessment questions were missing from the health system forms for the ER. This ER nurse related how important the spiritual component could be to patients and families in crisis. A participant in

Table 4:  
Spiritual Assessment and Care in Practice Settings

Type of Setting	Focus	Nurse Comments re: Spiritual Assessment
Labor/Delivery	High risk pregnancies; Infant mortality; Postpartum depression	<ul style="list-style-type: none"> <li>- <i>On the initial assessment, you don't really know the patient [yet]. They may or may not be willing to talk about things or open up.</i></li> <li>- <i>If people are opening and trusting, it is very important to be nonjudgmental.</i></li> <li>- <i>If you reflect something back to [the person], you can continue the conversation.</i></li> <li>- <i>I think there are doors opening all the time and it's for us to be aware [of open doors in the conversation] to support patients [in spiritual care].</i></li> </ul>
Pediatrics (Peds)	Caring for children with high risk; Potential for harmful treatments	<ul style="list-style-type: none"> <li>- <i>When I'm doing my admission assessment, I'll look to both [parents and the pediatric patient]. If it's a young child, I let the parents decide [how to answer].</i></li> <li>- <i>If an older child or teen [suddenly] looks up and makes eye contact, I make a mental note; later, I'll ask the kids by themselves if they want somebody to visit.</i></li> <li>- <i>Care of a child is not determined by a religious aspect but by human connection.</i></li> <li>- <i>I ask about religion... and check if it may be a barrier.</i></li> </ul>
Mental Health (MH)/ Chemical Dependency (CD)	Suicide risk; Behavioral disorders	<ul style="list-style-type: none"> <li>- <i>MH staff tends to see spiritual care as being intrusive, when it may not be at all.</i></li> <li>- <i>I want the visiting chaplain or pastor or whatever [cleric] to be working with the care team around how to connect in a way that will do more good than harm.</i></li> <li>- <i>I see a lack of appreciation of the role of spiritual care and support can play, and the thought-disordered patient is an excuse to keep all of that out.</i></li> <li>- <i>During assessment, patients say 'yes' or they say 'no' Is that enough of a question?</i></li> </ul>
Emergency Room (ER/ED)	Crisis; Family coping	<ul style="list-style-type: none"> <li>- <i>We're ask patients about 150 questions in 2-3 hours and little about spirituality.</i></li> <li>- <i>Now that I think about it, the spiritual assessment questions aren't on our forms.</i></li> </ul>
Burns	Social isolation; Long recovery	<ul style="list-style-type: none"> <li>- <i>I want to know if patients gave any information initially or if they had declined the questions so someone can follow-up.</i></li> <li>- <i>I anticipate patient needs, what could be prevented, and what might come next.</i></li> </ul>
Diagnostics	High anxiety; Quick turnover	<ul style="list-style-type: none"> <li>- <i>The starred items [Joint Commission standards] don't cover enough.</i></li> <li>- <i>I add on my own, 'Do you have a religious preference?' in providing support.</i></li> <li>- <i>I do think it takes doing the required questions for a while to get comfortable enough to go further.</i></li> </ul>
Polytrauma	Traumatic Brain Injury (TBI); Mood alterations	<ul style="list-style-type: none"> <li>- <i>I ask about having the chaplain visit patients and I want to make sure the family is involved in spiritual care.</i></li> <li>- <i>If patients are very emotional, I ask, 'Do you want me to call the chaplain?'</i></li> </ul>
Neurology	Head Injury; Altered Level of Consciousness (LOC); Altered perception	<ul style="list-style-type: none"> <li>- <i>Instead of asking if spiritual needs were being met, I ask how patients are doing and what they need.</i></li> <li>- <i>If a person says they have a strong faith, I know better what to offer.</i></li> <li>- <i>I don't know why it makes me so nervous because you can't do it wrongly.</i></li> </ul>
Cardiovascular	Short stay; Mixed demographic; Young-middle adults	<ul style="list-style-type: none"> <li>- <i>I offer spiritual services if someone's life is on the line or if someone is in crisis and not coping well.</i></li> <li>- <i>I use the term spiritual services, because to most people, needing a chaplain means something bad is happening or the patient is dying.</i></li> </ul>
Cardiac/Renal	Chronicity; Complications	<ul style="list-style-type: none"> <li>- <i>I ask patients, 'Where do you get your strength from?'</i></li> <li>- <i>I usually ask, 'Do you have somebody to talk to?' because people sometimes think the only time to call a chaplain is when the person is dying.</i></li> <li>- <i>I approach patients with respect and regard for their religion or beliefs.</i></li> </ul>
Bone Marrow Transplant (BMT)	Long-term stays; Last resort options	<ul style="list-style-type: none"> <li>- <i>I like to ask, 'What could we know here in the hospital to help you or what kind of activities would help?'</i></li> </ul>
Oncology	Unpleasant symptoms End-of-life	<ul style="list-style-type: none"> <li>- <i>I ask 'What services would you like to be connected with while in the hospital?'</i></li> <li>- <i>If I would offer a chaplain, patients respond, 'Am I dying?'</i></li> <li>- <i>I use reflective questions like 'How does that make you feel?'</i></li> <li>- <i>When patients are distraught or when they're exhausted, I ask about the spiritual.</i></li> </ul>

diagnostic procedures related how most nurses on her unit do not address spiritual needs even though a fair amount of patients are very stressed and facing difficult diagnoses or prognoses of health conditions. For this reason, this nurse uses a question about religious preference or affiliation to guide how she might provide spiritual support.

On cardiovascular units, younger patients present a variety of conditions with heart procedures. A participant reported nurses on her unit may gloss over spiritual assessment questions if patients are admitted for short term observation; unless patients appear to be anxious or in crisis, spiritual care and support may be not be offered. Similarly, nurses on burn, polytrauma, and neurology units who have younger patient populations may conduct spiritual assessment differently depending upon how patients present themselves. A participant reported TBI patients present challenges with mood alterations and vulnerability; most often, spiritual assessment includes family involvement and chaplaincy services, but nurses proceed with caution in providing spiritual care to patients with neurological symptoms. Many participants reported when patients answer spiritual assessment questions, most nurses do not revisit spiritual care questions unless other signs emerge that spiritual intervention is needed. Most participants acknowledged adequate spiritual assessment and care is lacking for adult populations that are perceived to be healthy or present chronic, yet stable conditions.

A participant discussed “the uneasy relationship between how spiritual care fits and integrates” with other modes of treatment and differences about staff attitudes and nurse practice between mental health and chemical dependency units. Whereas mental health is based upon empirical approaches, chemical dependency utilizes a holistic approach which supports spiritual care and interventions due to its reliance on the 12-step

program with vital ties to a Higher Power. Because the two disciplines often exist in the same domain in health care systems, managing inpatient or outpatient services challenges both nurses and leaders. Managing how nurses may deliver spiritual care better presents difficulty.

She reported, “Spiritual care and mental health care have an uneasy relationship, a very uneasy relationship. A part of it is, with some diagnoses, there is religious preoccupation that is part of the condition.” She described situations where patients who were psychotic became fixated on religious people and beliefs.

When you've got a patient in your face, who thinks he or she is Jesus, and he or she thinks he's or she's been crucified, the provision of spiritual becomes difficult. When it comes to decision-making about where to go with the provision of spiritual care in mental health, people are locked in an in-patient unit...they're vulnerable.

On the other hand, the participant reported, “Chemical dependency treatment grew out of a peer support model, not a medical model, and so in a way what you share is peer support, and it's [confidential]. So that's built in and it creates a different comfort environment for talking about some of these issues.” Chemical dependency staff grew very comfortable working with religious resources, framing Higher Power, and providing spiritual care. She stated, “You have the clients and the staff who culturally buy into the Higher Power, the traditional AA (Alcoholics Anonymous) model. As you give over to the Higher Power, you have no control.”

Overall, participants reported incongruent practices for spiritual assessment and care exist among colleagues who work with vulnerable populations such as the very young, emotionally or mentally affected patients, and the very old. Two participants asserted concern that sexual abuse questions precede the questions about spiritual care



and may affect how patients and families respond to inquiries about spiritual need in pediatric and young to middle-adult settings. They also offered how this may impact patients and families who have difficulty understanding English or use interpreters.

Participants cited inconsistent spiritual assessment and care for young to middle-aged adults who present acute symptoms with short stays. Nurses reported presenting signs for spiritual distress or need would necessitate investigation by most nurses on their units. Signs needing investigation include the patient appearing anxious or stressed, the patient being upset or disturbed, or the patient experiencing emerging or cascading symptoms. Participants acknowledged spiritual needs of patients who are dying or who require accommodation for religious practices are more frequently addressed by most nurses on their units than the young to middle-aged adult populations or those who present chronicity. Most participants posed concern that spiritual care be more intentionally addressed with all patients.

### **Privacy Considerations**

Some participants identified lack of privacy as a significant deterrent to providing spiritual care. Melissa delineated the impossibility of keeping a private conversation private with a thin fabric curtain separating patients in semi-private rooms. “To even say the curtain does anything goes against [common sense]. I was told that by pulling the curtain, I attempted to make a conversation private and this satisfied HIPAA (Health Insurance Portability and Accountability Act) requirements. Everyone knows it doesn’t work that way.” Other participants working on units with semi-private rooms identified this as a barrier to having spiritual conversations with patients and families. Diana asserted, “Having patients in semi-private rooms affects having privacy in interaction on

certain levels, including things like spiritual care.” Lloyd identified privacy concerns as particularly challenging among multicultural patients and families.

Some participants worked in practice setting with private rooms. In contrast to those who dealt with semi-private rooms, some participants indicated that caring for patients in private rooms afforded more opportunities for talking about personal and controversial issues including spiritual needs. Many participants indicated the need for a safe environment and privacy in order to approach spiritual assessment and spiritual care more effectively.

### **Summary**

Characteristics of participants yielded few variations of religious background, educational backgrounds, and demographics. Twelve participants, 2 male and 10 female, ranged from 36 to 57 years of age who completed baccalaureate education in the last four years after working as practicing RNs from five to 35 years. With the exception of one participant, the sample consisted of Caucasians of European descent. Participants were all raised in Christian traditions; half of participants continue in the same or similar faith tradition and half do not.

Having participants from similar religious and ethnic backgrounds was not intentional; seven participants were former students. All participants earned their baccalaureate credentials in the same institution within the last four years. Because participants attended a religiously affiliated and faith-based institution, those who volunteered for the study may have done so based on similar faith heritage.

Participants identified significant relationships with parents or grandparents, which influenced their values, beliefs, and outlook on life. In addition to immediate

family members, some connection with extended family or the community positively impacted participants. These relationships provided nurses with a sense of identity and support for their life work. With life stories in the study, it appears nursing practice began to be shaped prior to entering the nursing profession and during nursing education.

Educational experiences impacted both personal and professional development. Although participants exhibited variations on the point of entry into the nursing profession, they reported early that life experiences produced both positive and negative values, eventually drawing them to the advocacy within nursing. They cited early mentors who provided encouragement. Some identified those who discouraged them along their career pathway. Most participants shared ideas for improving nursing education. Many felt their associate degree programs did not prepare them for holistic interventions, which nurses are expected to carry out in practice including spiritual care. About half cited their RN to baccalaureate programs either directly or indirectly impacted their ability to see the bigger picture behind practice and gain psychosocial skills in addressing spiritual care.

Similar patterns of professional development emerged. Common threads included transition into practice and the beginning of technical skill proficiency and skills in providing psychosocial support including spiritual care. Some nurses cited particular mentors and some did not. Previous health care experiences contributed to nurse perspective about spiritual care. For some participants, early work in health care and exposure to patient environments produced opportunity for personal growth that affected professional practice.

In considering influential people, educational experience, nurse socialization, and professional development concerning the role of nurse, some common threads emerged among participants. All participants presented personal characteristics including: (a) being open and willing to learn and consider new things; (b) being curious, conducting inquiry, and questioning things they did not understand; and (c) enjoying listening to others and giving permission for patients and families to explore holistic needs. Participants presented two or more of the following behaviors: (a) acting as a “go to” nurse on their unit and being identified as a nurse who was willing “to go there” (as in provide spiritual care); (b) showing ability to handle difficult, noncompliant, resistant, or combative patients and/or families and understanding that holistic needs appear in a variety of ways and might indicate spiritual distress or concerns; and (c) demonstrating willingness to consider alternatives and exercising latitude in decision-making along with withholding judgment in practice.

Participants posed environmental concerns in providing spiritual assessment and spiritual care. Most participants worked in environments where patients were in semi-private rooms or spaces where others could overhear when nurses conduct assessments or ask questions. Lack of privacy in patient rooms arose as a barrier for many nurses to pose spiritual concerns and provide spiritual care.

Finally, I discussed variances among a broad range of practice settings. Participants described nuances and variations in conducting spiritual assessment and providing spiritual care for different age groups across the lifespan. In Chapter Five, the meaning of the findings was interpreted through the lenses of the analytic theories.

## CHAPTER FIVE

### ANALYSIS

Having reported findings that represented individual life experiences, aggregated findings illuminated the professional development of providing spiritual care. Groups of participants shared similar characteristics and behaviors in their patterns of providing spiritual care. In forming groups which exhibited similar responses, I used a combination of analytic theories. The analysis of aggregate data yielded identifiable patterns that will be discussed: the composition of the groups and interpretation of patterns will be described, levels of professional development will be differentiated, and interpretation of insights of focus group discussion and dynamics will be discussed.

In this chapter, I will describe the results from analysis of participant responses: how they delineated beginning practice, negotiated professional nurse development, and formed patterns in providing spiritual care. I analyzed how they conceptualized terms and meaning about spirituality and religion. Then, I examined how they established spiritual connections with patients and families, individualized spiritual care, arranged chaplain or support services, identified religious practices requiring accommodation, supported patients and/or families in varied situations, or utilized referral and follow-up in practice. Lastly, I compared how nurses participated in spiritual practices, prayer, and celebrations and refined personal communications in spiritual care. In this manner, the groups formed around shared perspectives and patterns in providing spiritual care.

Major themes emerged including: trusting intuition and sensing, connecting through comforting and caring, surveying and spiritually supporting, affirming affiliation or accommodating religious practices. I examined all individual responses by participants and then across participants to extract threads, themes, minor themes, and

major themes. I determined the themes by looking for prevalence and strength of responses within individual participant interviews and across participant responses. Themes identified in aggregate data analysis correlated with preliminary results in piloted questions and pilot interviews. Comparison of themes with the literature suggested sequential developmental growth as participants negotiated stages of faith development and professional development (Benner, 1984; Fowler, 1981).

Identified themes corresponded to developmental stages for providing spiritual care. Acquiring the skill set for providing spiritual care involved accumulating more experience in patient interactions and time for nurse reflection. Although patients and families may or may not perceive receiving different gradations of spiritual care, participants presented differences in approaches, methods, perspectives, and interventions. Interpreting participant progression in skill acquisition revealed nurse development in spiritual care patterns as *Guides*, *Liaisons*, and *Catalysts*.

### **Interpreting Patterns of Spiritual Care**

In discerning patterns among groups of participants, distinguishing characteristics and behaviors emerged. Incremental changes were noted among groups in increasingly more complex skills and patterns that correlated to Benner's (1984) professional nurse development and Fowler's (1981) faith development theory. This study's participants showed evidence of patterns of spiritual care as the following: *Group 1*, as *Guides*, conducted others through spiritual assessment and gave guiding information to patients and families; *Group 2*, as *Liaisons*, formed a close bond or connection, thereby establishing mutual understanding and spiritual experiences; and *Group 3*, as *Catalysts*

focused on producing change in order to meet the spiritual needs for the patient's sake. They used themselves as a change agent or instrument of spiritual service.

### **Group 1: Guides**

Participants in this group acted as though tour guides to give pertinent information and explain points of interest in a patient's and family's journey regarding spiritual need. *Guides* incorporated a philosophical approach of pragmatism. *Pragmatism* proposed that ideas should be judged in light of consequences (Rohmann, 1999). Pragmatism discouraged intellectual speculation in order to apply ideas in experience through experiential learning, and considering practical effects. In pragmatism, a truth was judged by its utility in solving a practical problem (Collins, 1994; Rohmann, 1999).

In this study, nurses exhibited characteristics of serving as *Guides* despite personal ambivalence concerning their own spirituality. They persevered in finding resources and providing access which patients and families required for spiritual care despite personal discomfort. Their focus revolved around humanitarian connection and acknowledgment of the spiritual dimension with an emphasis on facilitating access and finding resources.

### **Group 2: Liaisons**

*Liaisons* believed they should establish mutual understanding and rapport through finding relationship and connection. Although concerned about spiritual status and the spiritual dimension, *Liaisons* saw themselves as co-learners with patients and families, often being willing to participate in spiritual or religious practices such as prayer circles. *Liaisons* informed their approach through personal interest and exploration in existentialism. *Existentialism* proposed an individual finds meaning in life experience

apart from any imposed doctrine from hierarchies or authorities. Existentialists claimed religious beliefs originate in a “leap of faith” and an individual exercised personal choice through finding “authenticity” to choose freedom and action toward individuality or to remain in conformity to a group (Becker, 1973; Rohmann, 1999).

*Liaisons* participated in spiritual conversations, connections, and practices with patients and families while remaining open to experiential learning opportunities in spiritual and religious practices. Already having negotiated a period of questioning concerning their religious upbringing or exploring other alternatives, they exemplified a thirst and curiosity for learning about spiritual care options and openness about existential concepts. Not having yet resolved their own faith development quest or codes for spiritual and religious conduct, they experientially explored spiritual and religious conversations and practices with patients and families.

### **Group 3: Catalysts**

*Catalysts* provided focused discovery of a particular patient’s own lived reality, finding creative ways in which they could be agents or instruments of service in attending to another’s spiritual care. In desiring to impact change in meeting spiritual needs, they practiced with discretionary ability and an understanding of the temporary nature of the nurse-patient relationship. *Catalysts* incorporated a philosophical underpinning of constructivism by either gaining an understanding of the patient’s point of view or constructing a mutual connection or affiliation whereby they provided spiritual care. *Constructivism* proposed the individual develops a reality based on social construction (Nash, 2004; Noonan, 2007). Constructivism in human behavior originated with Piaget where developmental categories were socially constructed during childhood through



interactions with others, rather than being innate from birth (Fowler, 1981).

Constructivism incorporates the idea of social interaction forming or constructing one's lived reality and is consistent with Mead's (1938) symbolic interaction and microinteractionism (Rohmann, 1999).

*Catalysts* added distinguishing features to their skill sets. Having questioned or examined their faith and religious history, they found a new balance of navigating conversations and interactions about spiritual care with heightened awareness. They employed individualized measures to gauge how they offered spiritual care. In particular, they determined whether the spiritual needs they assessed could be fulfilled by affiliation or accommodation. The underlying question for this group remained consistent: Whose interest is involved in this spiritual task or activity? Who benefits from this spiritual involvement? As a result, *Catalysts* participated more judiciously in spiritual practices including prayer. They established connection with patients and families including religious affiliation if they determined it was for the patient's and family's expressed benefit and not their own.

Descriptors of *Guide*, *Liaison*, and *Catalysts* provide interpretation for first, the personal meaning of spirituality and religion that frame the construction of patterns, and then, the spiritual care patterns that emerged among participants.

### **Framework: Personal Meaning of Spirituality and Religion**

Beyond initial practice, early assimilation, and beginning spiritual care in the nursing profession that was discussed in the last chapter, I analyzed participant responses to discern nuances of meaning and perceptions of spirituality and religion. Personal meaning provided a frame for finding patterns among participants. Groups of

participants emerged upon analysis of the words they used to describe individual conceptualizations of what constituted spirituality and religion.

Throughout hearing responses, it became clear each participant embraced particular understandings ascribed to broad concepts of what comprised both spiritual and religious conceptualizations. Some expressed strong opinions concerning how they delineated the terms and how they saw colleagues handling these concepts in practice; some offered these insights without prompting. Others raised issues of the current landscape of openness with spiritual practices. Findings supported similar conceptualizations clustered among groups of participants who reported characteristics of personal beliefs which differentiated how they ascribed personal meaning related to spirituality. In addition to sharing characteristics, they used similar behaviors in spiritual care practice (see Appendix H).

### **Group 1: Guides**

Findings among the first group of participants, *Guides*, approximated Fowler's (1981) individuative-reflective faith due to their rationale for evaluating their beliefs and how they respond in providing spiritual care (see Appendix H). This correlated with Narayanasamy and Owen's (2001) *personal approach* within nursing where nurses approach spiritual needs as mediators or counselors. *Guides* also utilized the *cultural approach* within nursing where nurses acted to cultivate cultural sensitivity and provide for accommodation for spiritual practices (Narayanasamy & Owens, 2001). Within a cultural approach, this group focused on providing support or resources with personal involvement in patient interactions but with minimal direct spiritual care involvement. *Guides* utilized referral for chaplain and spiritual resources as a primary skill set. During

Fowler's (1991) individuative-reflective faith phase of questioning faith traditions, there can be an overreliance on logic or reason to deal with questions or discrepancies that surface in the process. *Guides* acknowledged ongoing, active questioning of their faith tradition, religious upbringing, and spiritual affiliation.

Although they may have previously reached a different stage of faith with Fowler's (1981) schema, new questioning may have situated them in an earlier developmental stage. It should be noted Fowler (1991) proposed the content of one's faith is not important when looking at stages of faith; the individual can revisit stages when reexamining beliefs, values, and assumptions. Rather than sharing similarities in what they believed as the content of faith, *Guides* shared similar characteristics in how they constructed what they believed and how they interacted with patients and families based upon their personal and professional development. While some, as a *Guide*, varied in their ability to provide rationale for personal meaning regarding their beliefs, they shared similar characteristics and behaviors regarding spiritual care practice.

Holly described her exploration of personal faith, "I don't know how it comes out with faith. I have been on a long journey and I'm not reaching for anything in particular." On the other hand, she wanted "to believe in Jesus, I want to be saved" and yet did not necessarily want to embrace "mainstream Christian beliefs." To her, spirituality and religion were "intertwined" and related to "conscience" because when "doing the right thing, it motivates me and makes me feel good inside." Her explanation for God was this: "there is something telling you what is right or wrong." In practice, she preferred to find someone who was more comfortable in providing spiritual care when unsure or uncomfortable.

Diana reflected, “I think I spent my 20s becoming someone who my family wanted me to be, and after that, I blossomed in my 30s.” She explained, “I really feel comfortable with who I am now. Exploring things like religion and spirituality are new, and I would have never done this before, nor would I have ever contemplated it.” She described how it was easier to associate with agnostics and atheists than with others from traditional Christian religions. “My friends happen to be people who read books by Buddhists, popes, mystics, saints, and the whole bunch...It’s been a really cool journey.” She described herself as someone who would have a conversation about spiritual concerns but would bow out of spiritual interventions.

I tried to fake it and I’ve been caught, so I won’t do that anymore. I remember being caught in it because the family said to me later, ‘But you said he or she is going to go to heaven!’ And I realized the power of my position. I was like, ‘Oh, my God, what have I done?’

She elaborated, “I tried to empathize, but it’s just not worth it. Now, that’s not my area. No, I will give you everything you need [as far as resources, but concerning involvement in spiritual interventions]...it is for someone else.”

Melissa defined the spiritual as the inner soul. “I became a very spiritual person, and I don’t have a certain religion. I feel life is tri-fold...where we have the physical, the emotional, and the spiritual components.” She believed there is a God or Higher Being but qualified, “I think any religion is fine as long as it gets you to the destination you want. I don’t think one is better than the other.” She revealed her personal philosophy of spiritual care, “It’s not that we shouldn’t have spiritual or religious conversations with the patients, but it is actually more important [for us to] get in there and give support and reassurance.” She advocated for nurses “to be receptive” in order to allow patients to “verbally process.” After they verbally process what is going on, patients and/or families

will be “more comfortable or feel at ease in the situation” requiring some follow-up for spiritual referrals.

Amy’s philosophy has always been to approach spiritual care as another facet of practice by looking at patients and families while asking, “What else is going on?” and “How are people coping?” She believes it was not for a nurse to judge someone’s religion or spirituality, but to get patients past any barriers that prevent them and their families from accessing a potential resource for their own benefit. She described how a nurse’s own experience matters.

I always talk about the backpack that everybody has. Each experience is something for you to put into your backpack to take out at some point when you need it [in life’s journey]. I think spirituality is in in a person’s backpack, should be in the backpack, because it means different things to different people.

Although she believes in God or a Higher Power, she qualified a personal tendency to be more spiritual than religious. She continued to question why religious systems put fear into people because “God doesn’t care whether people are in church or not” and “I am still sorting out what I believe” after being a Lutheran.

### **Group 2: Liaisons**

A second group, *Liaisons*, shared similar characteristics and behaviors in practice (see Appendix H). Within Fowler’s (1981) stage of faith schema, *Liaisons* embodied the individuative-reflective faith phase as critical reflection of the values and beliefs that were held by the individual. This critical thinking process involved re-examination of one’s previously held traditions, beliefs, and ideals. This group also personified the Narayanasamy and Owens (2001) pathways of both the *personal approach* of nurses in finding meaning through partnering with patients and involvement in spiritual needs and the *cultural approach* of assuring cultural sensitivity and accommodation of religious

practices as cited in the previous group. Whereas the *Guides* exhibited commonalities in using a cultural approach with indirect strategies, *Liaisons* demonstrated cultural awareness and sensitivity in advocating for religious and cultural practices by actively participating in some spiritual care practices.

Lloyd described his experience while growing up Lutheran as “going through all these different phases of religious exploration” and considered a friend’s parents as being influential in his personal spiritual development.

There is a difference between religion and spirituality. I think religion is a concrete thing like a physical building... it's quantified, named and categorized... Spirituality is a sense of deeper understanding and connection... On just a spiritual level, I think we are all healthy in our spirits.

“I think personal awareness and personal insights help you become more aware of other’s needs...I think it's opened me up to viewing people differently.” He reflected on his development in providing spiritual care in his practice setting through the years.

I didn't have a lot of time to sit down and talk to people about their spiritual needs. I think spirituality is put on the family. We tend to ask the family more about their spiritual needs and how they were, and support their needs versus the patient’s needs.

He described how his practice in nursing changed more recently, taking time to reflect on how he related to patients and families. He reported a new awareness of how people “need to have someone there in their life that can get them back on track.”

Anna related, “I believe in God, but I don’t believe so much in hell anymore. I used to be Catholic, and there was heaven, purgatory, and hell. Now, I think we would be in concentric circles or something and moving closer to God.” After pausing, she offered, “I know when I’m in trouble or in time of need, I’ll pray to God.” In describing what she meant by spiritual or religious, she stated, “I guess I was brought up to think

they were one in the same.” She viewed spirituality as being defined by religious traditions such as being Catholic or Lutheran. “Now, I would say my spirituality is more well-rounded. I still believe in God. I think religion is more focused. When I talk about spirituality, it’s wholeness.” Anna went on to say, “I believe there’s something more after the end of life.”

I’ve actually sat and thought of this. Did they teach me this in Catechism [class]? Did my parents? I don’t know where I learned when you die, your spirit leaves your body and it goes up to heaven. I don’t know where I learned it, but I know I’ve used it since I was young in coping with death.

Anna explained how this was related to nursing practice. “How does spirituality fit in that whole picture? I really feel people’s attitudes make a big difference in their wellness.” Going on to explain, she stated:

Sometimes I think a person’s attitude and spirituality can turn a patient around and help them heal. I also see this in the [continuum of life and death] where they accept death. Sometimes to get to a level of acceptance and comfort, it isn’t always about getting better. Sometimes it is going to be to die. But I’ve also seen miraculous things happen with spirituality, and with family, and with love, to make a person keep fighting through the tough times.

Nancy identified herself as being an “a la carte Catholic.” She qualified she believed in God and continued in her faith tradition but did not ascribe to all the teachings of the Church. She related the importance of “remaining open” because there could be “wisdom in all faith” because “no one [tradition] is so wise as to have all the wisdom.” She described a process of “thinking that spirituality is part of cultural sensitivity” and her practice experience “acted to open up [her] thinking about role of spirituality of healing outside of Christian denominations.”

Rachel described her experience of growing spiritually through life lessons. “I definitely feel even closer to God in my spiritual walk. Personally, I know I am very

connected to my Catholic faith. The traditions of the faith have held me up along with other members of my family.” She attended church, prayed, and participated in other religious practices. Despite having more traditional beliefs, she went through a difficult period of questioning during a personal crisis, which changed how she saw practice.

Rachel distinguished, “When I was younger, I didn’t question things, you just take it as truth.” After taking theology classes more recently, she had questions and felt challenged “to question and search what the meaning was for me.” She considered past influences.

I think my parents always role-modeled their faith, although they didn’t question it as much as I did. But when I questioned it [later], I was confirmed in my beliefs. I always saw them being very strong, but I saw that they didn’t question.

When asked to describe how she differentiated between what was spiritual and religious, she reflected, “To others, to be spiritual is enough, but I need my religion and my traditions. I am spiritual within my Catholic faith. I guess spiritual is a loose term to me, it can be anything.” Now understanding faith even more, she expressed, “I feel a stronger connection when I go to Mass. I’m very open with my family, and I want them to have a very close relationship with God.”

### **Group 3: Catalysts**

*Catalysts* shared characteristics and behaviors that typify Fowler’s (1981) conjunctive faith phase where they demonstrated an ability to balance binary perspectives and rework or reclaim their own perspectives as they became aware of other voices and perspectives (see Appendix H). These individuals demonstrated more freedom in practice as they had an increased awareness of both self and others to be able to bridge relationships. With Narayanasamy and Owens (2001) model of approaches to spiritual needs, *Catalysts* moved among personal, cultural, and evangelical approaches. The *evangelical approach* proposed nurses connect with others with similar religious



affiliation or background (Narayanasamy & Owens, 2011). Overall, *Catalysts* determined who they were and were not. Even though they could identify or connect easily with those who shared similar spiritual or religious affiliation, *Catalysts* exercised more caution in how they provided spiritual care with all patients and families. Even though incorporating prayer in appropriate situations in practice, they verbalized employing extra measures to assess the patient and family or having criteria in mind for selecting particular kinds of spiritual care. *Catalysts* shared characteristics and behaviors that were consistent yet demonstrated variance in handling individual situations.

Wendy described being raised in a Catholic family and going to religious school through the eighth grade. She remembered going to church every Sunday when growing up. Even though her faith tradition provided a foundation for life, she related, “I feel my faith is stronger now than it was then.” She still discusses her faith with friends, “I still have that wonderful, awful Catholic guilt when Sunday morning comes by and I don’t go to church.” She related she was not avoiding her religion, “I’m just trying to be more at peace with how I worship. Sometimes think I might like to explore other churches, which are more in keeping with my personality.”

Wendy acknowledged her comfort in keeping matters of faith simple. She believed God is all-loving and questions how He can allow horrible things to happen in the world. In remembering her own life events, she knew her faith in God and the support of her family and church kept her strong. “I choose to view God as Someone to turn to in the bad times and to thank in the good times. So often, we forget to be grateful.”

When asked to define what spirituality is for her, Wendy linked the Catholic religion to the spiritual. At the same time, for her, spiritual meant being with someone and discussing things about religion. “I realized there are different ways to look at that. Religion can fall into spirituality and spirituality can come under religion.” For her, a deeply spiritual person may believe in God or not.

Oliver described a process of growing up with influences of the Bible, his family, and the community. His parents instilled morals, values, and beliefs, which were consistent with both a traditional native culture and Christian teaching. He stated, “I knew my Redeemer and I knew Jesus Christ.” He recalled his father reinforced teaching about doing the right thing and wanting the children to choose the right things as free choice in their own hearts.

Simultaneously, Oliver respected the traditional culture which surrounded his community and family identity. His culture retained spiritual values and a traditional religion and acknowledged a Supreme Being, God, as Creator. He reported the traditional religion and language of his culture differed from his Christian upbringing in the way God was translated into a different object. Although some in the community conferred God to objects as idols, Oliver focused on the common faith in God as a Higher Being. He cited the strong moral teachings of his culture along with the strict and observed moral code in the community. Despite this difference, his faith and the community supported similar underlying values.

Oliver stated he utilized his lived experience of cultural acceptance into his spiritual care. He identified that he approaches the other person with respect. “I find a way to figure things out together with the patient.” He stated the importance of

acknowledging the fact the other person is spiritual in each conversation. Although another person may have a religion or no religion, Oliver maintained every person has spiritual need. He sought clues about their spiritual and cultural background. Listening carefully to what patients and families are saying, he draws out the other person especially when engaged with “diametrically opposed” religious traditions. He reported how he used his knowledge of cultures to reach out and establish a relationship with patients who are struggling.

Brenda relayed concern about distinguishing the focus of spiritual care. She asked, “As a person of faith, who am I more concerned about, my patient or me?” She posited the tendency of nurses to invest substantial energy in their work. She described her belief about the patient being the focus of quality care. She reported how she deals with the demands of caregiving. She stated, “You know where you’re getting your support from; it’s not going to be from the patient or the family; it’s going to be from your faith and God.” She spent time reflecting about where she received her strength and encouragement. She stated she felt her nursing practice was part of giving back for those who in the past had contributed to making this a better world.

Valerie reflected on those who role-modeled strong faith for her. She reported the reading she had done as a youngster and teen set a foundation for what she believes and how she lives. She stated being open comprised an important part of developing faith. When she went to college, she decided do things differently than her mother, a strong woman of faith. Although expected to go to church throughout her youth, she made other choices in college. Later, when she experienced crisis in her own life, she stated, “I

decided life was a leap of faith. It's a leap of faith we have when we choose to believe. There is the same leap of faith to have hope and believe.”

Personal meanings of spirituality and religion informed how nurses integrated patterns. As beginners, nurses relied on a checklist, rarely venturing beyond basic questions. Forming a sense of tuition, sensing, and awareness followed beginner stages.

### **Trusting Intuition, Sensing, and Awareness**

Participants described developing awareness in responding to spiritual need as they provided spiritual care over time. They identified a learned skill to trust one's intuition or ability to sense a spiritual need or spiritual distress. This skill required personal development in working through self-identity and learning to gauge interactions with others. Intuition implied a pattern of knowing developed by repeating a number of interactions in order to perceive slight differences or nuances.

#### **Group 1: Guides**

Becoming aware and sensing among *Guides* compared with Benner's (1984) competent nurse (stage 3) developing an “innate sense” when something is off, does not make sense, or does not feel right according to one's “gut” feeling. At this stage, the *Guide* knew to trust his or her developing intuition, recognized something “cannot be ignored” and acted upon the promptings of his or her skill (see Appendix H). Holly maintained, “From the spiritual, when you get to know someone, you get the feeling when something is not right.” Sensing also included having awareness when something was about to happen such as a patient “crashing” or dying. When referring to a learned sense of trust in responding to patients and families in emerging situations, Holly stated, “The person is changing, things around the patient are changing, and you *know*.”

Diana used reflective questions when patients mention their troubles. “You get intuitive after a while...and if you follow-up on it, often you get right into [the spiritual].” By allowing the patient some control and giving attention to little things, she developed a sense of identifying or acknowledging underlying patient issues. Melissa described being “compelled” to check on something, as if being nudged. Amy discussed her need to keep asking what she was missing, looking for additional cues, and watching family members for missing pieces of the information puzzle concerning underlying needs including the spiritual.

### **Group 2: Liaisons**

*Liaisons* ranged from competent to proficient nurses (stage 4) in Benner’s (1984) schema and added additional skills in sensing spiritual cues (see Appendix H). Lloyd characterized an ability to “be present” and focus on “just the person I have right now” as he listened more closely to patients and families. He believed a nurse needs to give more and be open to hear what was actually being said. He described listening for what was behind what being said, for what underneath the obvious in a patient scenario.

Lloyd maintained multicultural patients necessitate listening better for some additional background. He framed this skill as one that “looks like an art” and often includes spirituality and beliefs affecting care. He explained, “I know with different cultures, it gets complicated” because there are families, others, or interpreters around, and, with more people in the interaction, sometimes “I don’t know who to ‘sense’ from.” Through learning empathy, he recognized needs in others.

Anna described her skill set as being able to read people and situations well, even gauging slight differences. “I’m able to look at a patient and know if they were going

downhill.” She believed a nurse needs to see the bigger picture and “spirituality is part of the whole picture.” Likewise, Nancy discussed her “pragmatic experience-based intuition” about what worked and what did not. By learning from patients, she identified skills from “years of experiencing what families react to, what patients react to, what people grieve about, and what can be a trigger.” She described developing more tools over time to recognize when something might be a problem. She reported the feeling of knowing and trusting professional intuition: when a nurse “begins to instinctively know” something needs attention.

### **Group 3: Catalysts**

*Catalysts* practiced as proficient nurses in Benner’s (1984) professional development theory, used holistic skills, and exercised intuition for spiritual care (see Appendix H). With Fowler’s conjunctive faith perspective, *Catalysts* relied on their own spiritual sense for assessment (Fowler, 1981).

Brenda explained “you sense when things are not right” according to a sense of spirituality. She relied upon her own spirituality to sense when something needed attention. She maintained, “I believe it was God making an impression.” She believed her faith gave her an enhanced ability to respond to patients about spiritual needs on a professional level while her personal faith informed that response.

Oliver described a similar understanding of developing a spiritual sense to guide interactions.

I try to understand. Where this patient is coming from? What are his or her beliefs? What can I say that will not be offensive? What can I say that will [help] make spirituality, the spiritual sense, something understandable and will make him or her feel welcome here? What can I say to convey the idea that I am not neglecting his or her [worldview]? These are some of the things I consider when

I try to help a patient to understand his or her own self, his or her own strengths and/or weaknesses, and how he or she sees things.

“Then I ask, what can I do to make this person feel like they are whole? What can I do to treat this patient well?” He described this as an open-ended process until he sensed how he might approach the patient and family. He posited his underlying concern, “What can I do to uplift the spirit of the other person?” He relied on his own spiritual sense to establish some common understanding.

Wendy learned to use her intuition, especially with patients who embodied negative attributes. She found patients, and men in particular, exhibited behaviors such as resistance, anger, grumpiness, or a lack of humor when they experienced spiritual distress. If she still sensed sadness or resignation after using encouraging comments or light humor to relax the patient, she relied on sensing what else may be wrong. “That’s when I think about the missing piece about the patient [including spirituality] and what can I pull out of my bag to help?” She described her ability to look at the other’s inner person and sense “how they are feeling” about what is happening to them. From experience, she claimed some can hide needs for a while, but “they can’t keep it together for very long.” She used her own faith and experience to check her intuition.

Valerie learned to trust her ability to sense when she heard something different in the patient’s voice. When she asked a post-partum depression patient how the patient was doing and heard an answer of “fine,” she replied, “I’m not hearing fine.” She used open-ended questions to guide the patient toward identifying her own positive outcome. Then, she engaged the patient by asking, “How are we going to get you there to do this?”

These threads among *Catalysts* indicated how nurses learned nuanced skills in practice along with developing an internal gauge about whether their hunches were

correct or verified. This correlates to Fowler's (1981) stages of faith where individuative-reflective and conjunctive faith included adaptive and maladaptive mechanisms. Combined with the Erickson et al. (1983) Adaptive Potential Assessment Model, *Catalysts* assessed whether patients found adaptive coping toward equilibrium or maladaptive coping toward impoverishment. Nurses used intuition, sensing, and awareness to assess and evaluate spiritual distress and other spiritual needs. Once intuitive capacities were awakened and honed, nurses established connection as caregivers who provided spiritual comfort.

### **Connecting Through Caring and Comforting**

Participants reported numerous threads of establishing connection, caring for others, and comforting those who hurt and suffer. Making connections through relationship comprised the essence of nursing and emerged in accounts of practice. Although participants used a variety of synonyms for these terms, the theme of making connections, caring holistically, and comforting effectively emerged in all interviews.

#### **Group 1: Guides**

In Benner's (1984) competent nurse (stage 3) schema, *Guides* demonstrated the ability to provide multiple levels of care and elaborated how they want patients and families to feel they received quality care. Fusing caring and comfort comprised meaningful practice (see Appendix H). Holly conveyed, "When you make a connection, the patient tells you about [his or her] situation and you can tailor care [better to his or her] individual needs."

*Guides* agreed connections with patients came even before effective assessment could occur. Diana proposed nursing encouraged her own skills of creativity and



empathy in building and bridging human connection. She described developing an ability to remember personal preferences as one mechanism of caring and providing comfort. When paying attention to the “tiniest little things,” which permitted patients some control, her patients “open up a little bit” to her and allow further caring and comfort measures. She claimed once a patient demonstrated willingness to receive caring and comfort, the dialogue about the personal and the spiritual dimension expanded.

Amy described her practice as caring for both the patient and family in order to find whatever may provide extra comfort. “If somebody has a spiritual reference or they have any sort of spiritual connection, like religious affiliation, it’s a comfort to them.” She conveyed this became a necessary step to help a patient and family get beyond the immediate complexity of technical cares to the real concerns, which affected their reality. Melissa purposed to make things comfortable for patients and believed nurses should provide ongoing reassurance. She viewed reassurance and supporting a patient’s belief system comprised holistic care. With her own spiritual ambivalence, she identified her ability to work around personal discomfort.

### **Group 2: Liaisons**

In Benner’s (1984) schema, *Liaisons*, as competent to proficient nurses (stages 3 and 4), advocated for needs beyond the individual (see Appendix H). *Liaisons* described skills to engage families, groups of supporters, and extended families around patients in providing spiritual care. Lloyd described an end-of-life situation where he connected with a large extended family and advocated for their need to be present at the death scene. Getting clearances for 28 people to be in the room and a space adjacent to it

proved to be a challenge. He presented a compassionate and caring solution to allow closure for one family system.

Nurses, no matter who they are or where they are at [in life], have connections that they cannot explain. Any nurse, even those nurses who say that they do not incorporate spiritual care, have made connections—they just may not realize it. They have made connections, but they just think of it as something else. On a deeper level, it really is a spiritual awareness besides connection. I think awareness means there is a connection and you are aware of someone else's needs—and that has got to be spiritual.

Anna conveyed, “I go above and beyond in trying to treat people with integrity and compassion.” She defined caring and compassion as spending time with the patient and family, listening attentively, and trying to help them find meaningful moments together. She articulated her passion for helping families to reclaim some normalcy during crisis or at end of life. She described working with patients as being a part of family systems, which comprised a critical component of spirituality and providing spiritual comfort.

Nancy described her “first wrestle” in caring for a young man with mental health issues when she realized providing compassionate spiritual care was not easy. She recalled the struggle to find balance between the patient “who might have been comforted through spiritual resources,” and yet at the same time, his sickness did not allow him to process spiritual or religious stimuli well. She described a tension between what comprised appropriate care for his spirit and his psyche along with what promoted his well-being along with caring for his family.

Rachel related her philosophy of allowing special consideration for families dealing with end-of-life decisions. “You just have to meet people wherever they're at.” She indicated compassionate caring means giving people “the benefit of the doubt” in

making tough decisions in the process. Several participants conveyed similar values of allowing time for decision-making. She expressed “if it’s not today, then we’ll wait for tomorrow” when the family may be ready. From her life experience, she conveyed, “Dying is pretty real and you have to take it for what it is.”

### **Group 3: Catalysts**

*Catalysts*, as proficient nurses (stage 4) from Benner’s (1984) schema, provided caring and compassion on a level that demonstrated Fowler’s (1981) conjunctive faith (see Appendix H). *Catalysts* described added levels of complexity in providing compassionate spiritual care. Some described developing spiritual care skills when caring for difficult or challenging patients.

Oliver described how he makes connections with patients who are labeled as being difficult or a challenge. “The approach is very important, how you look at a person and how you accept the person— can easily create a connection and a relationship.” He created nonjudgmental conversations to convey understanding to patients and families. “You cannot judge.” He inquired about both strengths and weaknesses of the patient to think together about what worked in the past and what did not. He asked many questions, encouraged the patient, and figured out how best to support the patient.

Valerie believed her spirituality affected her approach in providing caring and comfort to patients who do not expect problems or heartaches with childbirth. Her own experience changed her perspective especially about grief and being angry. She described how she probed for discomfort with her patients. When a patient told her she was angry when bad things happened, she responded with remarkable candor.

Everybody is always embarrassed when they’re mad at God, and I remember being embarrassed about that myself. You know what? God’s a big God, and He

can take anything. What makes you think He already doesn't know that you're mad? I've been mad. I've sworn at God. God's a big God; He can handle it. You think He doesn't know you're doing this? You think He doesn't know what you are saying?

She utilized her own experience in connecting with mothers in high-risk pregnancies or those who lost their babies. She acknowledged, "God gives us many opportunities. I think there are doors opening all the time; it is for us to be aware of those doors opening in conversations, and to do the right thing." She supported her patients by being aware and vigilant. She described her mission as trying to provide compassionate care for those who are hurting and feeling alone.

Wendy strove to learn individual patient's routine to convey caring and compassion. "I'll admit my faith is very simple—comfort, guidance, and thanksgiving." She described how she used her faith to guide her spiritual care and comfort patients.

It is all about comfort and care—and that's spirituality, to me. That is God-like. That puts God back in what spiritual really means because what is God? In my mind, He is all-caring, all-loving, and comfort. He is the Source of comfort and strength.

She acknowledged her passion for caring. "Comfort is a spiritual thing." She used touch to comfort and help relieve tension with her patients. She's massaged arms or hands to aid patients in relaxing and minimizing stress before difficult procedures. She described her need to convey concern for each individual in her care: "I need to connect with each patient, even if it's just for a brief amount of time."

Brenda delineated the need to build rapport and connect with patients and families. She expressed her awareness of being accountable for her patient's care. "When you believe that God has ordained a plan for a person's life and He created each person, then there's an element of dignity involved. There is an element of respect for

the individual's personhood." She believes this respect and regard for another's dignity allowed her to listen and ask questions when another nurse may have missed the opportunity: "maybe someone who does not have a strong faith wouldn't ask, or wouldn't go there." With her patients, she identified a need to open the conversation to provide spiritual encouragement. Believing her patients need motivation and inspiration to get up each day and try again to heal and recover, she tells them, "God does have a plan for you, there is a purpose, and you are here for a reason." For those patients who share similar affiliation, this provided spiritual affirmation and comfort.

This theme showed evidence of *Catalysts* valuing similar characteristics of providing spiritual care in a compassionate and caring manner. All groups provided evidence of providing spiritual care beyond a *procedural approach*, which a novice or advanced beginner nurse (stage 1 or 2) in Benner's (1984) schema might employ in practice that preceded patterns of participants in this study (Narayanasamy & Owens, 2001). *Guides*, *Liaisons*, and *Catalysts* delineated different levels of development in how they considered and provided spiritual care, often surveying a situation to assess need.

### **Surveying and Offering Spiritual Support**

When considering Benner's (1984) developmental stages of nursing practice, offering spiritual support involved competency of other assessment and communication skills to precede it. Skills preceding nurses offering spiritual support included trusting intuition, sensing, and awareness and connecting through comforting and caring, presented previously. Offering appropriate support for spiritual care required an individualized approach.

### **Group 1: Guides**

*Guides*, as competent nurses (stage 3) who practice spiritual care, indicated a number of threads which undergird nursing skill in accurately supporting spiritual practices (Benner, 1984). Moreover, *Guides* moved between Fowler's synthetic-reflective faith and earlier stages as they reevaluated their own faith perspectives (see Appendix H). Their faith development work restrained their provision of spiritual care. The *Guide's* primary strategy consisted of making effective and timely referrals for spiritual services in his or her hospital, which were important for patients and families.

Melissa described her willingness to help patients and families secure spiritual support through chaplaincy and spiritual services in her hospital. She used her interest in holistic and hospice care to be involved and look for clues in patient situations. Finding rosaries, Bibles, amulets, or other spiritual objects guided her assessment in making referrals for spiritual resources. She gained awareness from hospice classes and enjoyed supporting patients with diverse spiritual practices with human resources.

Referral for spiritual services at the end of life through chaplain or clergy visits comprised a primary intervention for a *Guide*. Holly described the importance of having those who are close to the patient or those who spiritually supported the patient to be present during key times especially at the end of life. Diana qualified, "If you mention religion, people think they are dying. If you mention the journey they're on, that's a separate thing all together." Her usual practice included talking with patients about "their odyssey and where it has led them" along with identifying who has been a support for them. She re-iterated chaplains served as another resource to patients and families including effective spiritual interventions. At the end of life, she recalled, "I've been

there holding hands” and supporting the family. Regardless of spiritual status, she proposed, “They are done with this Earth and looking beyond you.”

Amy respected the value of the patient’s/family’s perspective. She observed that people usually calm themselves by describing their spiritual support system. She claimed, “They know a lot more about their spiritual health than their biophysical system’s health.” She highlighted the importance of chaplain visits regardless of spiritual or religious preference. She maintained a chaplain functioned as a neutral person with whom families could discuss concerns beyond a need for spiritual support.

### **Group 2: Liaisons**

*Liaisons*, as competent to proficient nurses (stage 4), provided meaningful links with spiritual resources for patients and families (Benner, 1984). *Liaisons* desired to learn how to approach spiritual care from chaplains and staff in spiritual services. This correlated to Fowler’s (1981) synthetic-conventional faith orientation and Narayanasamy and Owens’ (2001) cultural approach in viewing patient situations of spiritual need (see Appendix H).

Lloyd emphasized when nurses asked patients and families about needing spiritual support, they must provide that support. “Once you've asked, then you're obligated to provide services.” He indicated the family was a focus of spiritual support in some settings, especially in high acuity units. “We tend to ask the family and be supportive of their needs versus the patients.” He attributed this to the numerous medical interventions patients received in emergency or critical care situations when an individual’s health status declined or changed rapidly. He viewed chaplains as critical supports of empathy, compassion, and gratitude for patients and staff alike.

Anna maintained the family often played an important part in someone's well-being and spiritual support system. She encouraged chaplain involvement with most patients and families. She informed families a chaplain is a good resource apart from a spiritual support. "I tell them the chaplain just might have some ideas to help you go through this journey. It doesn't have to be religious." She reflected, "I purpose to enrich family involvement."

Nancy wondered how the issue of spiritual support is changing. "There are experts that can come in and know more about the skills involved with spiritual care than I will ever know." She indicated chaplain visits usually provide support, yet had reservations about individual situations or practice settings in making referrals. Whereas she used to think spiritual support related directly to religious overtones, she related, "I think a part of offering spiritual services is really about cultural sensitivity, and spirituality is an outgrowth of that."

Rachel described how her sense of providing spiritual support has changed. As a younger nurse, she felt spiritual supports involved patients receiving communion or last rites which were an absolute necessity. Now, she felt the issue can be approached with the idea of "wherever patients are at is okay" even if they don't want any support. "I can understand when people say no, they often [believe they] have their own means of being supported spiritually."

### **Group 3: Catalysts**

*Catalysts*, as proficient nurses in Benner's (1984) schema, developed ability to offer meaningful spiritual support to those with similar affiliation or diverse perspectives (see Appendix H). Oliver learned that patients and families think that the chaplain visits



patients only when a person is dying. He's conversed with patients and families to investigate whether they may be depressed or whether they "need some spiritual counseling." He's noticed that after the chaplain talked to the patient, the patient's "mood changes." He described holistic benefits from patients and families who utilize spiritual resources and services within the hospital system. He advocated for facilitating spiritual services that fit the patient and family's belief system rather than the nurse's spirituality.

Wendy planned to offer spiritual support with chaplain visits for all patients because she witnessed how "it opened the door" for her to approach patients and families in stressful circumstances. When conducting spiritual assessment for chaplain visits, she conveyed the vast majority of people say no, because their own pastor or clergy may stop by. She heard another alternative "classic answer" when offering spiritual support; patients replied they were not going to be at the hospital beyond a day procedure to require a visit.

Brenda found spiritual support with chaplain services to be quite common in her setting. Family involvement became crucial with her patients due to potential vulnerability with TBI (Traumatic Brain Injury) patients. Comfort or care from the chaplain was supported in every way. She described a practice setting where spiritual care belonged to the domain of the chaplain and not of nursing; where spiritual assessment conducted by nurses resulted in spiritual interventions being carried out by chaplains or families. Rather than nurses being involved in follow-up regarding spiritual or cultural assessment, she reported social workers initiated these conversations.

Brenda described colleagues who “in their own quiet way, talk to patients when they don’t know they are being observed.” She felt some nurses talk around spirituality and prayer, but until nursing opens up the dialogue about nurses’ spirituality, evaluating how others provide spiritual care can be subjective. She related how nurses need spiritual support in practice as well.

I think one of the things not taught adequately in nursing school was having resiliency as a skill set. We rely more on the individual nurse to have a spiritual background or adequate support, whatever that means, to weather practice, but it should not be that way.

She explained resilience comprises deliberate skill because nurses experience “secondary trauma when experiencing other people’s emotional pain, grief, injury, whatever it is.” She described the need for nurses to be taught how to care for themselves. “Nurses are told to ‘go there’ and be a support for the whole person, but they are not taught all the skills necessary to do the work.”

Valerie used reflective questions to assess the need for spiritual support or spiritual services. She asked patients, “When you’re getting stressed out, and you can’t cope any more, how do you cope? What are things you like to do?” She formulated these questions in order to have her patients lead the way in spiritual care. “It’s a huge cue when someone says, ‘I like to pray.’” Valerie recorded a cue like this as a support and knows she can bring it into a later conversation. It is not unusual for some patients to have little or no support. When she confirmed background information, she asked patients, ‘Is there a church you attend? Do you belong? Are you members there? Do you have any support that way?’ Valerie maintained multicultural patients often report better support systems and “they’re not afraid to use them” in diverse communities.

Beyond surveying the need for spiritual supports and facilitating links to appropriate spiritual and religious services, evidence emerged with differences in regard to how *Guides*, *Liaisons*, and *Catalysts* handled religious affiliation. In addition, patterns arose in how groups accommodated various religious practices and requests. Once again, leveled similarities revealed patterns among the groups.

### **Affirming Affiliation or Accommodating Religious Practices**

Participants identified common types of spiritual practices which require support. In discussing accommodation for religious practices, several participants asserted some practices may be cultural in nature rather than spiritual. Some stated oftentimes cultural preferences equated with religious practices. Some claimed that dietary restrictions, even though cultural or ethnic in nature, may be attributed to religious practices rather than cultural preferences due to the current dialogue in health systems about accommodation for religious diversity.

Participants purported some populations presented particular challenges with spiritual and religious practices. Most participants experienced making accommodation for Muslim prayer rituals or other religious traditions. Nurses found resources such as prayer rugs, items required for ritual cleansing, and signage to secure privacy for patients and families when observing regular prayer times. Some described the need for negotiating workable compromises with patients' religious practice observances when diagnostic tests, treatments, or procedures occur during regular observances.

#### **Group 1: Guides**

While most participants in the study reported similar experiences, *Guides* focused on providing referrals and support for religious practices (see Appendix H). One

example involved an Iraqi or Syrian mother of twins. Speaking no English, the family depended upon interpreters to make their concerns known. Despite interpreters helping with daily communications, Amy observed a sense of fear in the mother's eyes. When she asked about the family's concerns, the mother looked down even with an interpreter present. This behavior was consistent with cultural orientations for women among some ethnic groups (Chang & Taylor Harden, 2002). One day, Amy found the mother in tears next to her child's bed. Without a shared language, an interpreter, or another family present to mediate, she put her arms around the mother and sat with her in her arms. She maintained that spiritual care with different religions consists mainly of connecting on a basic human level. Her personal philosophy consists of "checking her own religious beliefs at the door" when she goes to work and she purposed to remain being open. She believed the care of the child was not "determined by any religious aspect" but rather a human connection, a hug from one mother to another. Later using an interpreter, she helped this mother find spiritual support and connected the mother with resources that supported her religious practices.

With Hmong patients and families, decision-making becomes complicated in practice settings. Amy reported that, although Hmong patients often convert to Catholic, Lutheran, or other Christian denominations, many retained their cultural or traditional spiritual identity and practices. In caring for pediatric patients, Amy found difficulty implementing treatments or interventions which required expedience. "Before you can intervene with a minor, you have to go through leaders, various family members, and spiritual people in the community." Minors in life and death situations were left untreated until the right decision-makers assembled (Jenko & Moffitt, 2006). "Here, kids

are next to death and, with the Hmong belief system, you can't do anything for them. Ethically, some of it goes against your grain.”

She cared for a set of Hmong twins when one twin exhibited declining symptoms. Prior to coming to the hospital, the grandfather cast a spell on the mother because she missed religious observances when the child had been ill. The three-week-old infant suffered with a painful abscess in the throat, yet could not be treated with the standard resolution of surgery. Hospital nurses watched while spiritual leaders came and performed various religious or cultural practices to try to cure the child. As a last resort, surgical intervention became imminent. In this case, the child could not be touched until a grandparent gave permission. Nurses regularly questioned if a particular child could live another day with many disease or emerging conditions among multicultural groups. “This is tough. Do you go through Child Protection Services and take away parental rights to treat the child? If you do, you forego everything, knowing a child will be marked for life.” If health professionals intervene, they risked imposing cultural ramifications on the child and parents within their own community, which correlated with Jenko & Moffitt’s (2006) findings. With the stigma in Hmong culture, Amy explained that children who may be called beautiful, cute, or attractive by strangers were believed to have incurred a curse on their life. In this way, even minor actions such as a well-meaning observer compliment caused social sense of shame for the patient and family.

### **Group 2: Liaisons**

In the second group of *Liaisons*, practice represented opportunity for experiential learning especially in learning about other religions and cultural traditions that impacted spiritual practices (see Appendix H). *Liaisons* engaged with multicultural families as an

opportunity for experiential learning and adding to their own knowledge. An example of accommodation substantiated the intersection of religious and cultural practice concerns.

Lloyd remembered caring for a Hindu yogi who exhibited cascading symptoms when admitted after a long plane ride from India. He described this as a “profound spiritual experience” due to making an immediate connection with the patient and a nontraditional family unit, three women followers who attended to the spiritual leader. “I immediately felt connected to him and I knew I had to help him. At the time, I felt he knew I sensed this.” Lloyd easily bonded with the patient and the women followers, despite the yogi’s inability to speak during the episode; the yogi followed a lifestyle of silent meditation without vocalizing since the 1970s. “I knew something else was there guiding me.” In the room, he sensed both calm and urgency. “On one hand, things needed to be done immediately, and on the other, the atmosphere felt positive.”

The yogi required quick interventions with a Bilevel Positive Airway Pressure (BIPAP) machine to relieve respiratory difficulty. The small room became cluttered with multiple pieces of electronic equipment. Lloyd initiated intervention after intervention: monitoring peripheral IV (Intravenous therapy), BIPAP (Bilevel Positive Airway Pressure), cardiac monitor, and CVP (Central Venous Pressure) equipment. With respiratory distress, heart failure, unstable diabetes, and other symptoms, the patient improved despite serious complications. Lloyd managed fluid replacement, multiple medication administration, and insulin coverage. With tubes everywhere and team members coming in and out to run tests or do procedures, the women appeared nervous and concerned about remaining the room, yet Lloyd made allowances for them.

Lloyd felt a spiritual connection in this situation. He understood of the role of these women as nuns due to their supportive spiritual role in the life of the Hindu cleric. Although unmarried, the three women had lived with the yogi, attended to his every need, and one in particular operated as his spokesperson. Lloyd encouraged the women to stay and contribute to the patient's well-being; he believed this affected the outcome. "I appreciate family presence because I use family as a barometer." During difficult moments in Lloyd's efforts to stabilize the patient, the women maintained an attitude of calm and serenity. Everything in the room seemed "peaceful and serene" as the women supported the patient in "their mission" as they continued "to be the conduit for his voice." Lloyd cared for this patient and followed up by visiting the patient and women on another unit on his next shift. "They seemed to be so hopeful—and grateful."

Although *Liaisons* reported spiritual perceptions in accommodating religious practices, analysis correlated with research that nurses sometimes equated spiritual care with holistic care where physical, emotional, and spiritual needs appeared similarly in the same patient, especially in high acuity situations (Jenko & Moffitt, 2006; Nussbaum, 2003). When working with multicultural patients with different religions, nurses made breakthroughs in their own thinking about caring for multicultural patients in different religious traditions or with different religious practices; perhaps nurses may be affected more by the experience than the patients and families themselves.

Another example of accommodating religious practices involved women's health. Nancy conveyed concerns for religious and cultural accommodation for girls and women of the Islamic faith in her practice. She encountered Muslim females who described a cultural norm informed by their religion concerning female circumcision or Female

Genital Mutilation (FGM). She asked, “What’s cultural? What’s spiritual? Does it matter?” She encountered patients who became pregnant as teenagers or outside of marriage. “I would be hard-pressed to view the predicament women are in within their families as anything other than abuse.” She viewed these women as suffering physical consequences from having cultural procedures. “Sorting that out is challenging.” She asserted bringing in human resources who have credibility within the culture itself to help manage how nurses deal with religious practices that have a basis in cultural traditions.

She distinguished between what is faith and what is culture. “I have been known to say just because it's a cultural practice doesn't make it right, or it doesn't make it right here [in the hospital].” She argued recognizing something is cultural may not necessarily mean it needs accommodation as a religious or spiritual practice on a hospital unit. This correlated to research about cultural group decision-making and how others arbitrate women’s choices (Chang & Taylor Harden, 2002; Jenko & Moffitt, 2006).

Nancy recalled reaction from the Native American community when a patient committed suicide during a hospital stay. A minor experienced a very troubled past and had been shunned and banned from her tribal community prior to her hospital stay and subsequent death. The abandonment of the tribe contributed to the patient’s decision to take her life on the unit. When community members met with hospital staff and cultural liaisons, Native American leaders maintained that religious tradition dictated a drum and sage ceremony in the room where the patient died in order to allow the patient’s spirit to exit the physical location. She described how she participated in the conversation with the community about making religious accommodation and in the actual ceremony itself. “It was dark, there was drumming, it was smoky, and it was odd and unfamiliar.”



Nonetheless, she identified this experience as a turning point in how she viewed spiritual care. She related that, despite her early misgivings, this experience positively affected the team and opened up the conversation about how the hospital could provide better spiritual care for all patients. She asserted this provided an opportunity to consider how far nurses could go to honor the needs of an individual without introducing something that could do more harm than good for everyone else.

Nancy provided an example of religious practices disallowed. A Hmong patient's family requested to sacrifice an animal on the unit, which was supported by members of the interdisciplinary team who had expertise as cultural liaisons. In this case, a hospital supervisor did not grant the request and recommended the patient be released during the hospital stay to conduct the ceremony in the community.

She explained how some religious practices may contain risk; sometimes the needs of one cannot be met without affecting the needs of other patients. She described how having a religious practice that involved the death of a living being seemed it could introduce something which could potentially do more harm than good for everyone else. She qualified that, although the religious practice may have provided some benefit or comfort to one patient and family, it could have had seriously negative consequences for others.

Cultural differences especially affected child and adolescent mental health among immigrant populations where diagnoses created cultural and social stigmas for the patient and family. When assessing spiritual needs, "you are looking at the spiritual, cultural vehicles where you are dealing with people who see manifestations of mental illness as a spiritual problem, and the cure can be herbs or a sacrifice." Regardless, "it's a spiritual

illness, and there is a difficulty understanding without even having language or vocabulary for the health conditions themselves, the symptoms, the treatment, the disease process, and so on.”

These examples from *Liaisons* represented nurse involvement in spiritual practices that reflect an openness and support of religious practices including affirming religious individuals and communities. From the lens of Fowler’s (1981) individuative-reflective faith, *Liaisons* continued to question and reform their own views while supporting spiritual care in practice. Because they self-identified themselves as being in the process of reconciling matters of personal faith and belief, they worked under tentative guidelines for practice. *Liaisons* tested experiential learning and continued reflection in regard to evaluating, supporting, and participating in religious practices.

### **Group 3: Catalysts**

With Fowler’s (1981) conjunctive faith, *Catalysts* demonstrated ability to offer emotionally neutral accommodation of spiritual practices apart from their own core beliefs due to their faith perspective (see Appendix H). An example of religious accommodation included a common experience several participants reported in caring for Muslim patients including preparatory washing and ritual ablutions (Taylor, 2003). Most participants expressed similar concerns cited in the literature about language barriers, communication concerns, and variations in how hospitals address cultural and religious practices (Chang & Taylor Harden, 2002; Jenko & Moffitt, 2006).

Oliver discussed frequent encounters with patients who have religious affiliation in the Islamic faith. He related one scenario with a patient who had been categorized as difficult by other nursing staff. He described how religious practices differed from

cultural ones. His nurse manager asked him to address this situation because he had previously demonstrated ability in working with patients of diversity who appeared being difficult, angry, or disgruntled. He approached this situation knowing there may be both religious and cultural beliefs having an impact on behaviors.

Oliver introduced himself to a patient and family recognizing the patient had a thick and difficult accent. He deduced the patient was Somalian and responded to the patient with a common greeting in a regional dialect. The patient broke into a full smile, extended and shook his hand, and assumed he was a Muslim brother originally from East Africa. The patient offered information about himself because of this assumption and asked some questions.

The patient asked me, ‘Do you read the Koran?’ I responded, ‘No, but I have friends who love it and I have seen the Koran before.’ If you look at the first page, it says, ‘Blessed be to Mohammed who...’ and so on. Then the patient and I began to talk—now we shared something.

The patient expressed amazement when he quoted the Koran. He told the patient and family he happened to know a quotation or two. He conveyed a simple gesture of learning a cultural greeting or knowing something about another’s sacred writings, affording opportunity for relationship. Making a connection through spiritual support, he identified something known to the patient to help in coping in the hospital environment. He inquired if the patient and family needed a Koran or a religious elder to visit.

During a subsequent conversation, Oliver understood a passing comment about doing the “khat” which may have been missed or misunderstood by other nurses. Khat is an amphetamine-like substance similar to cannabis or marijuana that is utilized for hallucinogenic and medicinal purposes among cultural groups in Africa and the Middle East. It produces a stimulating or euphoric effect. His patient who used khat may have

exhibited mood alterations when in the hospital either due to its effect or withdrawal. He asked the patient some questions and followed up with health teaching about the effects of khat and implications for health and healing. With the patient and family, Oliver clarified using khat while in the hospital was not a religious practice.

“Sometimes the way you approach the other person, even when one person is a Muslim and another is a Christian, comes down to the regard for his religion.” Oliver learned to look at “why” the patient was in the hospital and what was important to the patient. He recognized this approach changed the response. “If I had gone into the room thinking the patient was difficult and mean as others characterized him, I don’t think it would have worked.” Oliver approached the patient “as if the two of us are together.” He related “how you look at a person” and “how you accept the person” became the foundation that could “easily create a connection and a relationship.” He claimed patients sensed when a nurse is judgmental or nonjudgmental.

Oliver recounted his philosophy about looking at diverse perspectives about spirituality and spiritual care. “What one thinks is spiritual is not spiritual to the other.” He approached patients with an attitude that spiritual care was not explicitly spiritual. He continually asked himself, “How can I understand the other person? How do I make the other person understand?” He reached out to patients without infringing on someone else’s beliefs. He acquired “spiritual know-how” by working with patients in “all circumstances” and “all situations” to explore what may be done. He identified the importance of going further to explore “why” patients either refuse or insist on accommodation in spiritual care.

## Participating in prayer

Another theme concerning how participants chose to participate in religious practices related to their own affiliation; prayer most frequently was cited. Prayer comprised a familiar spiritual practice on most units. Aggregated data supports different behaviors among nurses in participating in or offering prayer with patients and families.

### Group 1: Guides

*Guides* described a need to distance themselves from providing direct spiritual care such as prayer. When they approached patients and families, they related their perceptions about negotiating relationships which became uncomfortable for them as nurses because of their spiritual ambivalence. *Guides* advocated for chaplain or clergy visits for direct interventions beyond providing access to religious objects, human resources, or spiritual services. If staff were invited for prayer, *Guides* generally declined from attending and participating. One participant posed her reasoning:

I've been asked to join prayer circles before, and I politely decline. I tell [the patient and family] that this is something [for] people who follow their religion. I have stood there before if people have asked me, but I will not participate. I feel it is a private ritual.

*Guides* expressed conceptualizations of needing professional boundaries and keeping individual spirituality separate from professional practice. Rather than using spirituality as an instrument to use in providing spiritual care, they declined engagement in spiritual activities or practices.

Holly related her personal spiritual ambivalence as she currently revisited her family's faith traditions and sought out Eastern religious practices due to both her curiosity and unfortunate experiences in church. Despite her inability to define her own spirituality, she offered spiritual support to patients in a metropolitan hospital:

...[For me] it's kind of uncomfortable topic. I like to hear what people have to say, but it's hard for me to approach it...I don't often pray with patients, but if they ask me to pray with them, I will pray with them. When I'm with them... I don't have a real organized prayer for myself so it's hard to fake it with somebody else. And if I did it would be a disservice to both of us. I usually find someone who is more comfortable doing that.

Holly's willingness to pray with patients if they asked was interesting when considering her own spiritual indecision. She identified herself as being uncommitted concerning spiritual belief. She also identified a need to be honest, that she could not deceive someone else. Even when she was uncomfortable, she participated in prayer when no one else was available.

### **Group 2: Liaisons**

Experiential learning encapsulated the *Liaison's* approach to providing spiritual care. *Liaisons* related instances where they participated in prayer circles or corporate prayers because they "felt it was the right thing to do." They expressed openness about being a part of religious ceremonies, spiritual practices, and special prayers with patients and families.

Lloyd felt comfortable to join prayers when a family member prays in a patient room or at the end of life. Most frequently, chaplains led prayer sessions with patients and families. "I feel it's a moment of shared spirituality. It's not that I'm obligated to pray, but, in the moment, it's the right thing to do." He remained open to participating in spiritual experiences with patients; he explained he became uncomfortable only in situations where he did not understand a cultural factor in relation to a spiritual practice.

Anna related her experience in participating in prayer with patients and families with chaplains present or not. "I've sat and held an individual patient's hand while they are asking help from God or whatever. I think saying a prayer for any type of religion is

what patients need to do.” She expressed her belief that nurses should be involved in prayer. She related several instances where patients and families received benefit from engaging in prayer. She believed, despite her working on her own faith development, participating in prayer provided real support.

Rachel described praying with patients who had difficulty sleeping or who suffered with pain particularly during the night. She related how she would pray aloud with a patient when she shared religious affiliation and when she knew she was alone with the patient. She qualified that she would pray silently if someone else entered the room. She identified a need for nurses to ask patients about their nightly bedtime rituals and discover if prayer comprised a part of a familiar routine, which would be especially comforting to younger or older patients.

Her description of how she refrained from verbal prayer if other people were present demonstrates how difficult spiritual care could be to administer. Spiritual practices comprised a private and reflective component of what was considered sacred or religious. Even though spiritual care constitutes part of the hospital admission assessment, nurse behavior in this description revealed a social constraint or a socialized need for nurses to exercise stealth when providing spiritual care and support. Some participants described social conditions of incurring criticism or jealousy from peers, possible disciplinary action if others perceived the spiritual care was inappropriate or crossed professional boundaries, and fear of keeping their position if their actions were misunderstood.

### **Group 3: Catalysts**

*Catalysts* in Fowler's (1981) conjunctive faith phase exercised more caution in affiliating with patients and families in a religious or spiritual way. Although they developed a confident faith and more easily gauged religious affiliation, *Catalysts* participated in religious and spiritual observances and practices when they felt it was needed for the patient and family's benefit. They exhibited a judicious approach in how they connected with patients and families in a spiritual way. Rather than participating for their own learning, *Catalysts* articulated the importance of weighing the balance of whose need the spiritual practice supported: whether it provided real support for the patient and family or whether it provided the nurse with a personal sense of comfort, validation, and affirmation as a caregiver.

Valerie used her own life experiences to establish a relationship with patients and explore their spiritual need. She developed probing questions allowing patients to relay difficult or uncomfortable information about their spiritual status. Having been in similar circumstances, Valerie understood the importance and potential power of spiritual care and prayer. After validating their religious/spiritual preferences and status, she offered prayer.

I will ask them, 'Is it okay if I pray for you? Can I pray for your baby?' Usually people are very taken aback and surprised. 'Why would you want to?' I tell them, 'Because it helps—and because I care.'

She conveyed she came to see spirituality as one element requiring ongoing assessment. She inquired, "How important is this in the life of my patient? How great is the need or the deficit?" She reflected about opening up the conversation to ask, 'Is this



important to you?' If she "goes there" then she needed to understand the patient's response.

Am I an instrument in this? Do I have the skills to go there? Can we keep it there or is there a depth of need beyond what I am capable to manage? Do I have the knowledge to manage that or am I going to say, 'This is important and I'm going to get somebody who can really help you.'

Sometimes when patients experience loss, Valerie found herself helping the patient do the work by naming the grief and working it through. One patient suffered a severe concussion during a car accident and lost her baby when the placenta separated. When the baby died, the mother kept inquiring about the baby and could not comprehend what had happened.

What did I think was spiritually happening to this child? This mother couldn't grasp what happened. She struggled and finally said, 'I think all we've got left is the shell here.' I said, 'I think your baby is in heaven. This is all that is left here, and your baby is being cared for in heaven.'

At the time, Valerie could not get enough information from the mother to know if she realized comfort. With the severity of the condition, recovery took time. She used spiritual affiliation, spiritual comfort, and offered prayer to help the mother through her grief.

Wendy related how she felt more at ease in providing spiritual care since her experience of shadowing a parish nurse in her RN to baccalaureate education. After observing how a parish nurse offered presence, times of silence, and prayer to clients, she gained confidence to incorporate more spiritual care in her practice.

It was watching someone else do it. Maybe I was doing it all along, but watching how someone else modeled it made me realize sometimes [it's] just sitting there and holding the hand or asking...but now I am much more comfortable with saying, 'should we just say a prayer together?'

After asking about religious or spiritual preferences, Wendy claimed she was more comfortable in offering some patients spiritual support by offering prayer. Her practice changed when discharging patients. “Now, I will regularly say, I’ll keep you in my prayers this week.” She qualified she conducted assessment to ensure this would be well received and was not making someone uncomfortable.

Wendy observed even patients who were agnostic responded positively when someone offered a prayer on their behalf when facing difficult diagnoses or health issues. In watching numerous patients over the years, she proposed patients accept any positive statements from others when undergoing invasive procedures. If a nurse offered spiritual support such as intercessory prayer on his or her own time for patients, she stated, “They’ll take it.” This correlated to studies reporting health benefits when clients were told others would pray for them (Beery, Baas, Fowler, & Allen, 2002; Taylor, 2003).

In order to understand patterns that emerged among *Guides*, *Liaisons*, and *Catalysts*, additional dialogue from focus group interactions proved useful. Although I used focus group data as individual data for analysis in this study, the dynamic and evolving dialogue revealed information and insight. Participants drew one another out in the group interviews and responded to the interaction in interesting ways.

### **Interpreting Focus Group Dialogue**

In focus group interviews, the intersection of affirming affiliation among familiar faith traditions which nurses understood and accommodating dissimilar religious practices from unfamiliar traditions emerged. Participants described the accounts previously reported from individual interviews in this chapter to one another. One participant raised the point: “Why did it take accommodating our multicultural patients’

requests and spiritual practices to get us to consider how we could do spiritual assessment better?” A second countered, “Why do we embrace opportunities to support other religious practices, but we are reluctant to support the religious traditions of the majority [of our patients]?” “I think a lot of people compartmentalize things in the Midwest,” offered another, “it’s okay to have faith as long as you are at church. You don’t bring church to work.” “As I think back, a big part of the tool is the relationship and being able to establish a relationship,” the first responded, “Even in the relationship in my earlier years of practice, spirituality was not a part of the discussion.”

Brenda raised a concern from a patient scenario she encountered in her hospital. She cited a black female patient with a head injury from the South who prayed in the shower and exhibited demonstrative faith in the privacy of a private bathroom; the patient sang loudly, prayed out loud, and swayed with hands raised. She described how a nurse colleague later characterized the patient’s behavior as unstable, imitated the patient and ridiculed her among peers in the break room, and documented the incident with a recommendation for a psychiatric consult.

I was offended because [the patient] should have had the right to express her faith in any way she wanted to in the privacy of her own shower. It was bad enough to come out to make fun of it openly and get other people involved in inappropriate talk, but everyone thought it was acceptable. What bothered me was, had this person been somebody practicing Buddhism or a Muslim doing [his or her] practices, there would have been a whole different attitude. To me it challenged my own beliefs...because had she not been a Christian, she would not have been attacked this way.

Nancy related how a Native American ritual to release a patient’s spirit from the physical environment “threw” her “deeply into a spiritual place which wasn’t Christian.” She described how, after this experience, nurses thought entirely differently about the initial spiritual assessment and what spirituality brings into a situation. “That changed

the dynamic [of practice] for me.” She explained how other requests for spiritual accommodation had been honored previously, “but you didn’t really make it real in the environment.” She conveyed this spiritual experience helped to changed everybody’s perspective on the unit. The act of bringing religion into the unit instead of going out to a chapel, a church, or a synagogue changed everything. “Because you couldn’t shift this service out, you brought spiritual practice in. You embraced it.” She relayed how the belief of the Native American community transferred to staff who participated in the spiritual practice and considered the importance of acknowledging spirituality in the hospital environment: “We have to be here in the room where this happened.”

She recalled a time in her earlier practice when Christian holidays were celebrated on the unit. She proposed there is a political correctness in society, which prohibits conversation about spiritual care. With spirituality, she asked:

How do you go there and when do you go there? If you do ‘go there,’ are you offending somebody or are you leaving somebody out? It almost takes the thing that is respected [about Christian faith traditions] and mixes the message if you honor cultural diversity.

Others asserted that in the climate of current practice, attention was paid to diverse populations and various religious practices, but the faith traditions of participants were virtually ignored among their patients. One participant offered, “How can we pay attention in a better way?” “Yes, we are making everyone neutral, watering down everything,” said a second. “Making everyone so much alike that we can’t appreciate and respect the differences,” replied a third. A fourth asserted:

When we get to the art of our nursing, which is our spirituality and our own emotions, how many of us have been approached [by peers or superiors] about boundaries? What is acceptable?...There is an investment in providing spiritual care and if you’re not someone who relies on spiritual support for yourself, how do you keep yourself motivated to [be consistent] every time?

I've been in the position of walking in the room and I just can't do it. I'm not emotionally or psychologically prepared to have this conversation today because my emotions are [imbalanced].

Another responded:

I agree with you because part of becoming at ease with having those conversations or being in the moment with patients is knowing yourself... There's going to be follow-up, then what do you do?... Spiritual care is a process and there's more. It doesn't end with one conversation.

Others concurred spiritual conversations and spiritual care relied upon the nurse's comfort level and personal spirituality.

Another participant described her visit to a patient with pneumonia who was comforted by the prayers over the loudspeaker in a Catholic hospital. She listened intently as the weakened patient told a family member, "I really want to pray, but I just don't have the strength." The idea that someone lacked energy to even pray had not occurred to her before. "I thought to myself, if she is comforted by the fact that she can at least mentally assent to the prayer over the loudspeaker, what would it mean to her if I offered to pray with patients like her as a nurse?" Even though she offered prayer previously in practice, she pledged new resolve to be more aware of potential situations where spiritual care could make a difference.

### **Summary**

During analysis, interpretation of the findings explained how nurses' lived experience informed and formed different stages of professional and faith development. Examining aggregate data yielded a description of incremental skills nurses learned in practice settings. Patterns among groups of participants produced testimony of congruent characteristics and behaviors that answered the research questions.

First, I examined aggregate data and derived themes determined by prevalence and strength both within individual participant responses and across all participants. I found similar behaviors and characteristics regarding personal meaning of spiritual or religious terms, language, and concepts. I correlated this analysis with themes that arose. I analyzed how participants made meaning in ways that were compatible with their worldview and how they made sense of their experiences. Then, I interpreted the findings through various lenses including my personal bias and perspective as an instrument of research. To address personal bias and reactivity, I utilized a nurse content expert and colleagues to review transcripts and coding; I dialogued about emerging themes and possible interpretations.

Second, I identified themes revealing varying stages of development in regard to spiritual care patterns. The first theme, *trusting intuition, sensing, and awareness*, rendered interpretation of how participants perceived implicit data and used tacit understandings to form intuition regarding spiritual distress and providing spiritual care. The second theme, *connection through caring and comforting*, produced increasing evidence of how the groups of participants shared similar values regarding the theme but differed in their approaches in providing spiritual care. The third theme, *surveying and offering spiritual support*, showed how groups of participants followed different patterns in offering referral or promoting spiritual support. Finally, the fourth theme, *affirming affiliation or accommodating spiritual or religious practices*, explains interpretation of participant perceptions regarding the juxtaposition of affiliating with or supporting familiar faith traditions and accommodating religious or spiritual practices that are unfamiliar.

Third, I analyzed identified themes and aggregate findings with various theoretical lenses to derive various stages of development of spiritual care patterns. Social cognitive theory and microinteractionism informed how participants transferred both positive and negative attributes from previous interactions to ongoing interactions along with Fowler's (1981) faith development theory, Benner's (1984) professional nurse development, and Erickson et al. (1983) Modeling and Role-Modeling theory's Adaptive Potential Assessment Model. Common patterns in practice emerged among participants concerning the study's major themes. With correlations to the literature and theoretical constructs, I identified developmental patterns of spiritual care. Over time, I returned to the data sets to confirm or modify the emergent themes as I considered alternative perspectives or viewpoints. A progression of developmental spiritual care patterns became evident among the groups: *Guides*, *Liaisons*, and *Catalysts*.

An overlay of theory presented a theoretical model for how nurses inform and form their patterns in providing spiritual care. Combining Mead's (1938) microinteractionism, Fowler's (1981) faith development theory, and Erickson et al. (1983) Adaptive Potential Assessment Model (APAM) within Modeling and Role-modeling (MRM) produced a hypothetical theoretical model for professional development in providing spiritual care (Appendix I). The new model could be either specific to nursing or applied to other helping professions which approach holistic needs assessment and provide interdisciplinary interventions that address the spiritual dimension. Tentative overlays of existing theory formed the foundational structures for the theoretical model and require further refinement in post-doctoral work.

## CHAPTER SIX:

### SUMMARY, DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

I approached this study with a purpose: first, to understand what may influence nurses' conceptualization and formation of patterns for practice, and second, to understand how nurses internalize and operationalize those patterns in providing spiritual care. Participants completed similar educational requirements and practice with parallel standards and expectations in a variety of clinical settings. Upon analysis and interpretation, I found experiences and influences that formed a common narrative of how nurses negotiated spiritual care. Using analytic insight of nurse accounts in a variety of practice settings, I identified common practice patterns among participants. In addition, I gleaned some insight about the spiritual domain for nursing practice.

#### **Summary of the Study**

In this study, participants in a variety of practice settings self-reported descriptions of how they linked nursing knowledge to practice, how they developed patterns of spiritual care, and how they connected their personal beliefs about faith, religion, and spirituality to spiritual care. Upon examination and analysis during several months, I identified themes and formed linkages; the themes explained what happened between nurses gaining knowledge in nurse preparation and providing spiritual care.

Following the theoretical underpinnings of the study, I discovered both individual meaning and developmental theory coalesced into a process of spiritual care development. I utilized analytic theories, nursing theory, social cognitive theory in microinteractionism, and faith development theory, which provided structure for interpreting nurses' lived experience. Participants articulated sequential growth as they



negotiated stages of faith development and provided varied levels of spiritual care. From these intersections, I derived practice patterns among *Guides*, *Liaisons*, and *Catalysts*, which explained how nurses negotiated providing spiritual care.

### **Conclusions and Discussion**

The findings showed that participants demonstrated common characteristics and behaviors related to factors which influenced them. Participants reported influences shaping practice including family and formative experiences, educational experiences, nurse socialization, major life events, philosophical influences, and personal meanings about spirituality and religion. I found a number of significant themes and patterns upon analysis and interpretation which provided insight about factors and influences that impact how nurses provide spiritual care.

Findings indicated multiple external factors affected the practice of spiritual care. In looking at influential people, educational experience, and nurse socialization, I isolated factors shaping participants' perceptions and eventual behaviors in nursing practice that occurred prior to entering nursing education or the profession. For some participants, early work in health care and exposure to patient environments produced opportunity for personal growth and affected professional practice. For others, work in other careers prior to nursing formed a mindset about organizations and relationship building that may have transferred to the nursing profession. Factors correlated to social cognitive theory whereby individuals transferred their learning from early interactions with "the generalized other" to future associations, molding their perceptions of the self and how they interact in practice (Mead, 1938). Fowler's (1981) stages of faith correlated to early

identification with faith constructs, which continued to impact nurse perception of spirituality and religion including interactions about spiritual care.

In this study, I discovered various intrinsic factors which impacted what nurses thought and believed about spiritual care. Approximately half of participants confronted their faith traditions and reconciled contradictions and half of participants continued the process of questioning and exploring alternatives. Among those who were ambivalent, I uncovered that they were actively forming their own construction of faith by reflecting upon religious upbringing, finding spiritual identity, and continuing faith development. Fowler (1991) posited individuals can revisit previous stages of faith development when life crises force them to reevaluate religious issues or questions of spiritual import. In all phases of data collection and analysis, participants consistently provided evidence of working through personal issues or spiritual quandaries that directly or indirectly influenced their ability to relate to patients and families when providing spiritual care.

I discovered reflective work among participants predisposed them to comfort with spiritual care. The influence of parents and family affected nurse perception of the importance of religious background, religious affiliation, spiritual exploration, and role modeling about dealing with the spiritual dimension in holistic interventions.

Participants identified significant relationships with parents or grandparents, which influenced their values, beliefs, and assumptions about life. This included repeated mention of mothers, fathers, grandparents, and siblings. In addition to immediate family members, connections with extended family such as aunts, uncles, and cousins, or the community positively impacted participants. Identity building and validation work supported Fowler's (1981) faith development theory, whereby an individual continually

looks back to his or her traditions and key interactions as a point of reference. In a fluid process of response to major life events and periods of questioning, individuals looked back to their religious heritage or spiritual quandaries to reevaluate how they changed or accommodated their internalized faith to external problems or circumstances eliciting a spiritual response (Fowler, 2004). These relationships provided nurses with a sense of identity, support for their life work, and a feeling of spiritual safety or comfort.

Educational experiences impacted both personal and professional development, affecting nurse preparation, knowledge acquisition, and applications in practice.

Although participants reported variations on the point of entry into the nursing profession—four with early entry into nursing and eight after other work experiences—I found both positive and negative feelings toward education continued. In addition, both positive and negative incidences drew nurses to advocacy in nursing.

Many participants offered ideas for improving nursing education. Many felt their associate degree programs did not prepare them for holistic interventions including spiritual care. Only two offered examples of learning about holistic interventions in pre-licensure education and none recalled explicit exploration of spiritual care provision in nursing preparation. Moreover, I learned nurse preparation provided some content knowledge without application or meaning.

I learned RN to baccalaureate programs change how nurses practice. About half cited their RN to baccalaureate programs as either directly or indirectly increasing their ability to see the bigger picture behind practice and gain relational skills in addressing spiritual care. Some posited their view of nursing practice changed upon completion due to attaining a broader, global perspective, and a holistic view of nursing. Some

considered spiritual care more intentionally as a result of exposure to community health nursing concepts in baccalaureate education.

All participants reported nurse socialization affected their entry to practice, development of professional competency, and acquisition of spiritual care skills. I utilized Benner's (1984) schema to clarify developmental progression related to spiritual care competency; other applications of the stages of nurse development might apply differently to other aspects of practice such as technical expertise in managing highly complex patient situations with numerous technically supported interventions. For example, in another application, an expert nurse, who practices complex scenarios with high acuity in a critical care unit, might demonstrate Fowler's (1981) synthetic-conventional faith yet express discomfort in meeting holistic needs such as spiritual care.

Previous health care work experiences contributed to nurse perspective about spiritual care. Some nurses cited particular nurse mentors, but most did not. I found nurses made meaning of previous career experience which fit into their view of order in the world. Making meaning correlated with social cognitive theory and Mead's (1938) symbolic interaction of participants transferring positive and negative attributes from previous interactions to ongoing interactions along with Fowler's (1981) faith development theory. This also correlated with Modeling and Role Modeling (MRM) theory; individuals responded to life and career stressors and selected adaptive strategies that resulted in equilibrium or career satisfaction (Erickson, et al., 1983). I found all participants practiced spiritual care despite the impetus of previous work influences, both positive and negative. Some participants described previous careers producing stressors,

resulting in maladaptive processes or impoverishment (Erickson, et al., 1983), yet others experienced a process of anticipatory socialization as they progressed in a program.

Although patients and families may not perceive differences in spiritual care patterns among nurses, participants demonstrated differing perspectives, reflections, and abilities in meeting spiritual needs. Through analysis and interpretation of actual situations in practice, I defined varying levels of delivering spiritual care. Participant ability to develop increasing levels of spiritual acuity seemed related to their ability to process nursing knowledge, life events, and practice issues through critical reflection.

### **Strengths**

By acquiring participants who represented a broad spectrum of practice settings, I developed stronger findings. Few studies previously explored participant accounts of how nurses conduct spiritual assessment and administer spiritual care across the lifespan. Moreover, the findings in this study suggest spiritual care deserves renewed attention.

In utilizing an interactive model, I adapted with individuals and explored nuances during interviews to gain rich data. Whereas the pilot surveys and interviews tested components of the design before my research proposal, an interactive model provided extra measures to make needed adjustments during all phases of the study. The actual data collection and analysis resembled pilot data collection and analysis, therefore, I did not modify the questions as much as I anticipated. Had the data collection or analysis differed from the pilot data, or had participants chosen to self-report narrow or shallow data, an interactive model would have proved to be even more important and effective for this study.

Through mixed interview methods, I gained rich information and unique insight about nurses' lived experience. In addition, the focus group interview rendered rich dialogue and active engagement for most groups. Perhaps the mixed methods of individual and focus group interviews provided some safety or comfort level for potential participants. Knowing others would be involved in the second of three data collections may have appealed to some participants and increased the likelihood of volunteering for the study and/or offering rich responses in the individual interview. Focus group interviews may have motivated participants who may not have responded to another study design lacking group interaction. Using interactive data collection aligns with current emphasis on participant-centered pedagogies in higher and adult education.

Perhaps the greatest strength of this study concerned the effective use of the phenomenological tradition's idea of self and the researcher perspective as an instrument of research (Bogdan & Biklen, 2003; Creswell, 2007). My experience in leading focus group interviews allowed me to use open-ended questions, timely pauses, and appropriate follow-up questions to capture rich data and description from participants. The depth and breadth of the data may have been achieved because of previous field experience and ability to read nonverbal cues when clarifying personal or evocative information. Data analysis and interpretation may have been positively affected as well.

I utilized my background in a variety of nurse settings and roles to conduct interviews and respond to major and minor cues. In particular, my work in six health care systems with student clinical in several nursing programs added to my knowledge of the content participants shared. Due to this knowledge of multiple metropolitan health care systems, I already had some familiarity with some work settings and systems. This

allowed me, as researcher, to remain focused on underlying conceptualizations and meanings of individual participants rather than needing to clarify details for basic understanding and context.

These nuanced skills aided the study's purpose in addressing the research questions. In follow-up interviews, some participants spontaneously reported their perceptions of the study. Some felt that I effectively led the focus group which they felt became meaningful and enriching experience for them. I relied on implicit understandings and learned in numerous interactions including emotionally sensitive and evocative topics.

### **Limitations**

I acknowledge there may be other perspectives of nurses that were not represented in this study. All participants earned their baccalaureate credentials in the same faith-based institution. Moreover, the make-up of alumni from a single institution may differ from others. Participant life experiences and findings drawn from the sample may not be directly transferrable or generalizable.

With the exception of one participant, the sample consisted of Caucasians of European descent who were raised in Christian traditions. One participant with African roots reflected a Christian upbringing and early Catholic schooling. Half of participants continued in the same or similar faith traditions in which they were raised; half do not. Having a sample with homogenous faith background may render findings which may differ from those of other ethnic or religious backgrounds.

This study sampled alumni from RN to baccalaureate programs who completed baccalaureate credentials after practicing with an associate degree or a diploma. With the

proliferation of RN to baccalaureate programs in the United States, this population represents a demographic which exponentially infuses higher education enrollment. The findings may not be generalizable to others with different educational models including traditional undergraduate baccalaureate degree preparation.

Although the research design, mixed methods, and sequential interviews produced rich or sufficient data for most participants, I would consider several alternatives if I were to repeat the study, such as: (a) I would invite a convenience sample who shared a common geographical location such as a workplace or educational activity, such as a course or educational program, to better accommodate and encourage participation through all phases of data collection; (b) I would invite alumni from more than two institutions to possibly secure more divergent demographic characteristics and data from participants; (c) I would delineate a greater variation in the length of time for each interview to accommodate different learning styles and participant communication skills; (d) I would add a contingent data collection in the design to allow for greater flexibility to accommodate variance among participants; (e) I would consider a strategy to combine convenience sampling and workplace location to capture more complete data collection; (f) I would consider accessing a major metropolitan health care system for a convenience sample; and (g) I would consider using an observer to record observations during focus group sessions. In this study, time constraints limited some of these options.

For some purposes when moderating a focus group, I would recommend having another recorder or observer to assist in recording observations. Early in my planning, my dissertation chair, content expert, and I determined, when studying a topic with personal or emotionally evocative content like spiritual care, a secondary observer might



prove to be a distraction rather than an asset. Due to my previous experience in conducting focus groups, I felt having another person present may have altered participant responses. We agreed the advantages of gathering more information and deeper responses outweighed the disadvantage of missing some of the nonverbal cues. This meant I lost noting some nonverbal communications or behavior which I could not record or correlate with the audio-recordings.

### **Implications for Theory, Research, and Practice**

#### **Theory**

I began to delineate how nurses link knowledge of the spiritual to practice and how they internalize spiritual knowledge to affect their attitudes, implicit understandings, and externalized actions. More studies should follow regarding spiritual care in nursing. With its broad utility, I recommend further study of faith development theory and its relevance in how faith impacts the helping professions and the nursing profession. Social cognitive theory and nurse professional development theory show potential for future investigation of theoretical correlations and added constructs. I recommend further development of theory specific to spiritual care in nursing.

Implications for nursing education include creating further theory concerning the transformation from RN in practice to graduating with baccalaureate credentials. In this study, several participants related their perceptions about the change in their thinking about nursing and practice during baccalaureate coursework. I recommend further study to compare and contrast students in RN to baccalaureate programs with traditional undergraduate/post-high school students. Finding how practicing RNs utilize experience

and practice knowledge and how students process nursing knowledge in traditional baccalaureate programs would inform nursing education.

Adult learning theory requires new attention in nursing education due to the proliferation of RN to baccalaureate programs for US nurses. Considering the margins of associate degree RNs practicing in health care systems today, assessment of how RNs with rich life experience respond to curricular and pedagogical concerns requires further study. I recommend further study of how learning styles, life experience, and reflective capacity impact learning possibilities and provide nursing education the ability to retool itself for changing student populations and provide more relevant programs.

Further analysis of Modeling and Role-Modeling (MRM) theory offers potential insight as to how nurses develop spiritual care practice. Developing MRM with analysis may inform how nurses process various factors that influence their provision of spiritual care and how they assist the patient in working through the Adaptive Potential Assessment Model (APAM) of the theory (Erickson et al., 1983). This study's findings corresponded to spiritual care development among nurses in creating grounded theory.

### **Research**

Developing evidence-based practice (EBP) for providing spiritual care in nursing requires attention. I recommend the study be replicated with participants who completed RN to baccalaureate programs in other institutions to check for similar or discrepant findings; in addition, I suggest a follow-up study with multiple participants in various practice settings. To correlate findings among different models of baccalaureate education, I would replicate this study among participants who completed traditional undergraduate baccalaureate programs. This study should be replicated with practicing

RNs who completed baccalaureate programs prior to entry in the profession to investigate patterns of spiritual care. Furthermore, a similarly designed study should be done comparing RNs who completed baccalaureate programs in public institutions to those who completed RN to baccalaureate programs in private or faith-based institutions. With the renewed emphasis on spirituality and healing in health care systems, collaborative research between nurse researchers in education and practice institutions could contribute to nursing knowledge.

I intend to conduct follow-up analysis and report the focus group data. In this study, the focus group data provided data saturation and triangulation. Beyond confirming individual meaning, the focus group data may yield further understanding of the research questions in this study. Moreover, a follow-up focus group with the participants in this study might yield additional clarity of findings and themes of the study: all 12 participants volunteered to be invited in a longitudinal data collection or follow-up study.

### **Practice**

The findings from this study inform nurses in both practice and education. In clinical practice settings, nurse leaders empower and encourage the nurses who may provide them and their family spiritual care in the future. In light of the current atmosphere of cultural sensitivity and diversity, I recommend revisiting how the profession has framed and practiced spiritual care across settings.

I recommend nurse leaders within healthcare systems and in the community evaluate the effectiveness of the Joint Commission's mandate for spiritual care and consider how they may impact future policy regarding inclusion of the spiritual in holistic

care standards (Joint Commission, 2011). Perhaps with new evidence, the nursing profession could make recommendations for the provision of spiritual assessment and care rather than relying on the mandates of accrediting organizations. Nurses as advocates may be better able to provide improved guidelines for consistent assessment.

I applaud efforts in professional development and continuing education regarding spiritual assessment and spiritual care, which are sorely needed. Continuing education and staff development afford opportunities for nurses to gain evidence-based knowledge. Adding to nurses' knowledge about faith development facilitates content knowledge.

If nurses identified a different technical skill in which proficiency was not uniformly established nor measured, it would be addressed post haste. Spiritual care affects health and healing for every human being. To continue its neglect comprises violations of human rights, social justice, codes of ethics, and nursing's core values.

In academia, nurse scholars need to evaluate the current state of what is happening with spiritual content in nursing curricula: whether spiritual care content and discussion is included but glossed over, or whether it may be excluded intentionally. Faculty should consider how to frame the issue of spiritual care as a non-religious issue; faith development can be considered apart and separate from the potentially divisive religious tenets or debates of the past. Nurse educators can promote a need for openness and readiness to learn the spiritual perspective of "the other" in our increasing global society. Transformational learning strategies provide possibility for infusing nursing with new dialogue about the spiritual and spiritual care in nursing education, advanced degrees, and continuing education in nursing.

### **Concluding Remarks**

For several decades, spiritual care has been relegated to oncology nursing, hospice nursing, and parish nursing. Frequently associated with end-of-life care, nurses often express discomfort in dealing with the spiritual dimension—an existential element often confounding human understanding, seeming out of reach from human control. However, holistic frameworks for humanitarian efforts and humane health care demand new attention to the spiritual well-being of the whole person. Acknowledging and attending to spiritual well-being becomes imperative to reach holistic health outcomes. If nurses refuse to pursue an active spirituality for themselves, it does not preclude them from assessing and meeting spiritual needs in practice. Like it or not, nurses are mandated to document spiritual assessment of every individual upon admission to health care systems.

The variance in how nurses fulfill the mandate is concerning and even reprehensible. Such a variance would not be tolerated in relation to infection control. As an example, if nurses claimed that standard precautions for infection control made them uncomfortable and, therefore, they might neglect or refuse to wear gloves and gowns, they would fail to prevent the spread of Methicillin-resistant *Staphylococcus aureus* (MRSA), *Clostridium difficile* (C-diff), Carbapenem-resistant *Klebsiella pneumonia* (CRKP), or a host of other infectious agents, which might start an epidemic. Such an occurrence would quickly incur the prompt attention of administrators, the CEO, the health department, the nurses' union, and the investigative team from the evening news. Rather, because spiritual care involves the existential, it is relegated to philosophical or intellectual limbo, where it remains without requiring nurse action. Assessment without

action means spiritual needs remain unmet and unaddressed. Furthermore, one could argue if spiritual care exists in theory without implementation in practice that nurses who neglect or ignore spiritual needs remain complicit in regard to this issue.

Nurses who recognize the need for spiritual care also recognize potential implications for exercising strength in its provision. For the past few decades, nurses were conditioned that the spiritual dimension was a forbidden subject, likened to religion, sex, and politics, which became topics of discussion that were to be avoided in the public square. As societal evidence over the last decade demonstrates, our mass media effectively dispelled our collective inhibitions about having sex and politics in the foreground of our public discourse. However, the discussion of the spiritual dimension continues to be hidden or thought of as taboo because of its association to religious systems and their foibles. In our society, separation of church and state misconceptions continue to plague open social discourse about spirituality.

Leaders in nursing—who understand the import of the spiritual and its integration into health care, nursing care, and society by improving health and healing for all—should advocate for renewed focus on spiritual care. Nurses, among the most respected profession, ought to start a national discourse about how they may improve the condition of the human being within their own communities. With all the new initiatives on health and wellness, the time is ripe for solving nursing's problem with providing spiritual care. Whether nurses regard themselves as spiritual or not, they have the ability to educate themselves through research, adjust their perspectives through reflection, and change their practice by resolve. Out of care and concern for all of humanity, every nurse should provide meaningful spiritual assessment and spiritual care.

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APPENDICES

## APPENDIX A

**IRB Approvals****IRB Proposal # B10-200- 02 Patterns Under Construction:  
Nurses' Lived Experience in Shaping Spiritual Care Practice - Expedited**

**Sent:** Wednesday, June 23, 2010 12:52 PM  
**To:** [Kumpula, Renee B.](#); [Boyle, Kathleen M.](#)  
**Cc:** [Roulis, Eleni](#)

Dear Renee,

**IRB Proposal # B10-200- 02  
Patterns Under Construction:  
Nurses' Lived Experience in Shaping Spiritual Care Practice - Expedited**

**Researcher:Renee Kumpula  
 Advisor: Dr. Kate M. Boyle**

**Full Status Approval**

Your application for your proposed research involving human subjects has been reviewed by the Institutional Review Board of the University of St. Thomas and been given Full Approval Status. Your application has satisfied all of the criteria necessary for full status. This means that you may proceed with your research immediately. This is your official letter of approval.

Please place the IRB log number on all of your future correspondence regarding this protocol.

Please note that under IRB Policy principal investigators are required to report to the IRB for further review when changes in the research protocol increase the risks to the rights and welfare of human subjects involved in the study and /or in the event of any adverse episode (e.g. actual harm, breach of confidentiality) involving human subjects.

Thank you for all of your work.

Please contact me if I can be of further assistance and if I need to provide you with any other paperwork.

Best wishes as you begin your research.

Eleni

Eleni Roulis,Ph.D.



Institutional Review Board Chair  
 2115 Summit Avenue #5037  
 St. Paul, MN 55105  
 Aquinas 314A  
 651-962-5341  
[e9roulis@stthomas.edu](mailto:e9roulis@stthomas.edu)

May 11, 2010

Renee Kumpula  
 13500 211<sup>th</sup> Ave. N. W.  
 Elk River, MN 55330

Re: RB#10-EXP-30 Patterns Under Construction: Nurses' Lived Experience in Providing Spiritual Care

Dear Professor Kumpula:

Thank you for submitting your research proposal to the [REDACTED] Institutional Review Board (IRB) for review. The primary purpose of the IRB is to safeguard and respect the rights and welfare of human subjects in scientific research. In addition, IRB review serves to promote quality research and to protect the researcher, the advisor, and the university.

On behalf of the IRB, I am responding to your request for approval to use human subjects in your research. Two members of the [REDACTED] IRB have read and commented on your application as an expedited review. As a result, the project will be approved when the following stipulations are met:

1. In your consent form, the procedures section lists the interview, the focus group, and the potential subsequent interview. The remainder of the consent form seems to focus on the 1<sup>st</sup> interview only. For example, under Voluntary Nature it mentions the right to withdraw within one week of the 1<sup>st</sup> interview. Is this consent form intended to serve for all 3 sessions of data collection? If yes, the consent form needs to reflect this, and in subsequent sessions you would need to reaffirm the participant's desire to continue in the study. There is a slight difference in confidentiality risk with focus groups, given that the investigator can request but not guarantee confidentiality on the part of the other participants. Alternatively, you could have separate consent forms for each session.
2. If gift cards will be offered for compensation, this should be listed in the consent form under compensation. The process for earning the gift card should be clear to the participants; i.e., whether they receive any compensation after the first interview or whether they need to complete all phases of the study.
3. One reviewer had concerns about tape recording interviews in a location where the conversation could be overheard, such as a busy coffee shop. Please describe how you will assure there will be adequate privacy for your participants.

Please respond to the IRB copy with an electronic copy of the application and copies of the revised consent form(s). **Highlight any changes you make.** Send your electronic response to [REDACTED], with a copy to me. When we have received and reviewed your reply, I will respond to you by e-mail. You should not initiate your data collection until you receive written IRB approval. **Please use the reference number listed above in any contact with the IRB.**

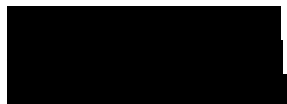
If you have questions or concerns about these stipulations, please feel free to contact me by phone [REDACTED] email [REDACTED] or campus mail [REDACTED]

We appreciate your work ensuring appropriate treatment of your research subjects. Thank you for working cooperatively with the IRB; we will be waiting to hear from you.

Sincerely,



John Schmitt, PT, PhD  
Chair, Institutional Review Board



June 3, 2010

Renee Kumpula  
13500 211th Ave. N. W.  
Elk River, MN 55330

Re: Project SU-01-10 Patterns Under Construction: Nurses' Lived Experience in Shaping Spiritual Care Practice

Dear Renee,

On June 2, 2010 members of the [REDACTED] Institutional Review Board approved the above referenced study with the following qualifications:

- (1) While it appears that you are aware of the risks to confidentiality associated with the use of focus groups, please elaborate on the phrase "Krueger and Casey's (2002) focus group protocol." At a minimum the protocol should include a statement that the researcher can request participants to maintain confidentiality but cannot assure participants that other participants will not violate confidentiality. The latter constitutes the risk to confidentiality for participating, and the need to obtain voluntary consent with knowledge of that risk. Please send me an explanation of the protocol [REDACTED], and if it does not contain this information please add it to the protocol. Please do not begin data collection until this has been clarified.
- (2) Please reword the Consent Form to read specific to [REDACTED] participants. For example, in the Voluntary Nature of the Study section include a statement about [REDACTED], and again in the Contacts and Questions mention the [REDACTED] IRB.

Please be reminded that it is the responsibility of the investigator(s) to bring to the attention of the IRB any proposed changes in the project or activity plans or any emergent problems that will affect human participants.

We wish you success with your proposed research.

Sincerely,

Peter Jankowski, Ph.D.  
Chairperson IRB

## APPENDIX B

### Study Recruitment Materials

#### Recruitment Flyer:

##### A Study of Nurses who Shape Patterns of Practice in Spiritual Care

**Study Purpose:** Research studies show that nurses integrate habits and patterns for providing holistic care including spiritual care based upon life experience. Spiritual care comprises one aspect of holistic assessment and care legally required in nurse documentation and practice. The purpose of this study is to understand how nurses shape their knowledge and life experience into practice and how they form patterns for practice in providing spiritual care.

**Background:** Among the health professions, nurses alone are required to provide comprehensive care for all dimensions of the human being including the spiritual. A holistic view includes the Joint Commission on Accreditation of Healthcare Organizations' (2008) requirement of nurses' spiritual assessment and provision of spiritual care as an accreditation criterion for hospitals and providers of care. The requirements include: guidelines for spiritual assessment and documentation on hospital admission assessment forms, provision of pastoral care for patients who request it, and the hospital's provision for the spiritual needs of dying patients and their families (Joint Commission, 2008).

**Patterns of Practice in Providing Spiritual Care:** A 2003 study reported that 75% of Americans said that spirituality and religion are important to them (Young, Wiggins-Frame & Cashwell, 2007). It is reported that nurses understand spiritual concerns by first being aware of their own background, bias, and beliefs, thus acquiring a core of essential spiritual understandings (Taylor, 2005). Nurses are uniquely situated to promote spiritual wholeness and may implicitly incorporate patterns for practice (O'Brien, 2008). How nurses shape their patterns in providing spiritual care is not yet understood.

**Study Participants Needed:** As part of my doctoral dissertation, I am interested in interviewing nurses who completed baccalaureate graduation requirements and have had an educational exposure in the last 10 years. To volunteer to become a participant in this important study, please contact Renee Kumpula, MA, RN, PHN, at 763-913-9339 or [renkumpula@aol.com](mailto:renkumpula@aol.com). All contacts are confidential and professional. Thank you for your interest!

**Subject Recruitment Announcement**

**ARE YOU A RN WHO INTEGRATES SPIRITUAL CARE INTO NURSING PRACTICE  
AND HAS FINISHED A BACCALAUREATE COMPLETION PROGRAM IN THE LAST 10  
YEARS?**

Please assist me with a study about how nurses integrate patterns  
for practice in providing spiritual care. I am interested in understanding  
how your own life experience influenced and shaped your practice.  
This study is part of my doctoral research at the University of St. Thomas.  
Please call if you are interested in becoming a volunteer or for more information.  
All contacts are confidential and professional.

Renee Kumpula, MA, RN, PHN  
Cell: 763-913- 9339. Please leave a voicemail or contact me at: [renkumpula@aol.com](mailto:renkumpula@aol.com)

APPENDIX C

**Consent Form  
Patterns Under Construction: Nurses' Lived Experiences Shaping Spiritual Care  
University of St. Thomas [IRB# 200]**

I am conducting a study of nurses who completed baccalaureate credentials and have had an educational exposure in the last 10 years. You were selected as a possible participant in this study because you are practicing as a RN and completed baccalaureate credentials in nursing. I invite you to participate in this research. You were selected as a possible participant because you responded to an announcement of this study and expressed your willingness to share your experience. I invite you to participate in this research study. Please read this form and ask any questions you may have before you agree to be in this study.

This study is being conducted by Renee Kumpula, MA, RN, PHN, Researcher; under the direction of Dr. Kate Boyle, Faculty, Department of Leadership, Policy, and Administration at the University of St. Thomas. This research study is conducted as course requirement for the Educational Doctorate Degree at the University of St. Thomas.

**Background information:**

The purpose of this study is to understand how nurses integrate spiritual care into practice. I hope to learn how your life experience relates to how you formed patterns of providing spiritual care. A new focus on holistic health in this millennium includes the spiritual dimension of health care as evidenced by the Joint Commission on Accreditation of Healthcare Organizations' (2008) requirement of nurses' spiritual assessment and provision of spiritual care as an accreditation criterion for hospitals and providers of care. Understanding how nurses with recent educational exposure form their patterns for practice of providing spiritual care may inform nursing education and practice settings.

**Procedures:**

If you agree to be in this study, I will ask you to do the following things: After obtaining your informed consent, we will discuss and agree upon an interview site that is convenient and private for you. The initial interview will be between 60 and 90 minutes. I will interview you about your experience in how you formed your patterns for practice in providing spiritual care and ask you about what and who influenced the formation of those patterns. You will be asked to participate in a focus group session of about 55 minutes where you will share your experiences and stories with other nurses. You may be asked to participate in a subsequent interview, lasting up to 55 minutes to clarify and/or expand upon topics that we have previously covered.

**Risks and Benefits of Being in this Study:**

Participation in this study has minimal risks to you other than whatever information you reveal that you may feel is sensitive to you. You will be free to decline answering any question and I will listen respectfully, maintaining strict confidentiality. The subject matter may involve questions or topics which may contain some emotionally evocative or sensitive information that participants choose to disclose. If a question creates discomfort, you may choose to pass on the question. You may withdraw from the study before your data is pulled for content analysis with no penalties to you.

There is no direct benefit of any kind to you for participating in this study.

**Compensation:**

You will be given a gift card upon completing all portions of data collection for this study including an individual interview, focus group interview, and follow-up for clarification.

**Confidentiality:**

The records of this study will be kept strictly confidential. In any sort of a report that I publish, I will utilize pseudonyms and not include information that will make it possible to identify you. There should be no way of knowing that you have participated in this study.

Each interview will be audio-recorded with your permission to facilitate my ability to accurately transcribe your responses. The recordings will be transcribed by a professional who will sign a form to maintain strict confidentiality. The transcriber will return all the recordings and transcription copies to me. I will also take some notes during our interviews. The audio-recordings, transcriptions, and notes will be kept in a locked cabinet in my home to which I only have access or in a password protected digital computer file to which only I (the researcher) have access for the purposes of analysis and potential publication of my dissertation.

Audio-recordings and transcripts of the audio-recordings will be available only to me (the researcher) and will be kept in a locked cabinet in my home to which I only have access or will be digitally filed in my home in a password (known only to me) protected computer. Written notes will be available only to me and will be stored in a locked cabinet in my home. I will not use your real name on any of the notes or published material. The transcriber I use to transcribe the audio-recordings will sign a form to maintain strict confidentiality and security. The transcriber will return the audio-recordings and all transcription digital files to me for storage in my password-protected computer or in the locked cabinet in my home. Upon completion of this research, all transcriptions and notes will be de-identified and maintained in this protected state for potential use in future research. Audio-recordings will be destroyed when I have completed my dissertation, which I expect to be no later than September 30, 2011.

**Voluntary Nature of the Study:**

Your participation in this study is voluntary. Your decision whether or not to participate will not affect your present or current relations with University of St. Thomas, St. Catherine University or any other organization with which you are professionally affiliated. If you decide to participate, you are free to withdraw within one week of the first interview. If you withdraw at that point, I will not use the data collected. If you decide to withdraw after that time, I will de-identify your interview data and will count your input together with similar input from other participants to identify themes from which to perform an analysis of the data. I will ensure that there is no way to identify your interview information with you.

**Contacts and Questions:**

My name is Renee Kumpula. You may ask me any questions that you have now. I will ask you to respond to the following open-ended questions to be sure that you understand informed consent for this study:

1. Can you tell me what this study is about?
2. Please describe your understanding of how I will keep your information confidential.
3. Describe any risks of participation and how participating in this research might affect you.
4. How can you respond to a question that makes you uncomfortable?
5. How do you remove yourself from this study if you are uncomfortable?
6. How do you understand the voluntary nature of this study?
7. What are your concerns about participating in this study?
8. What questions do you have that you would like to ask me about this study?

If you have questions later, you may contact me on my cell at: 763-913-9339 or via email at: [renkumpula@aol.com](mailto:renkumpula@aol.com) . My advisor, Dr. Kate Boyle may be contacted at the University of St. Thomas at 651-962-4393 or via email at: [KMBOYLE@stthomas.edu](mailto:KMBOYLE@stthomas.edu) . You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns. You will be given a copy of this form to keep for your records.

**Statement of Consent:**

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I consent to have my responses recorded by audio-recording.

---

**Signature of Study Participant**

---

**Date**

---

**Code #**

---

Print Name of Study Participant

---

**Signature of Researcher**

---

**Date**

## APPENDIX D

**Potential Study Participants Intake Form**

## PERSONAL

Name:

Age:

Gender:

Practice setting (type of nursing unit or specialty within nursing):

Length of nursing practice:

Contact Preferences:

Phone:

Email:

## CRITERIA

Have you completed baccalaureate credentials in nursing in the last 10 years?

Yes\_\_\_\_ No\_\_\_\_

In what year\_\_\_\_\_

Do you practice spiritual care as a RN? Yes\_\_\_\_ No\_\_\_\_

## APPENDIX E

### **Individual Interview Questions**

**Inductive, Semi-structured Design:** The following questions may be asked dependent upon participant's responses.

Questions may be skipped if pertinent information is covered in previous answers.



1. Tell me about what motivated you to participate in this study.
2. Describe your practice and how you integrate spiritual care.
3. Tell me about your life experiences that influenced how you provide spiritual care. Tell me about resources and people who helped shape your behavior.
4. Describe when you first realized that you were providing spiritual care. Tell me about a patient story where you experienced this. When did this occur?
5. Tell me about what influenced you. Who helped you? Where did this come from? Did you have role models for this?
6. Tell me about the skills that you developed in providing spiritual care. How did you form that skill set?
7. Tell me about your beliefs, biases, and values. How did your beliefs inform practice? Describe what you mean about terms such as spiritual, religious, etc.
8. Tell me about what you wish you could have done differently. Tell me if you were ever hesitant or reluctant to provide spiritual care.
9. What have I missed that you wish I would have asked? Is there anything else that you wanted to tell me that I have not covered?

## APPENDIX F

### **Focus Group Interview Questions**

**Inductive, Semi-structured Design:** The following questions may be asked dependent upon participant's responses.

Questions may be skipped if pertinent information is covered in previous answers.

1. How do you think the average nurse on your unit forms his/her pattern of spiritual care? What are the major influences on your colleagues in forming this pattern?
2. Share an encounter that most influenced how you approach spiritual assessment and/or intervention.
3. Describe how your approach in dealing with patients/families developed over time.
4. How do you think making connections on a spiritual level affects nurses?

## APPENDIX G

CONFIDENTIALITY AGREEMENT FOR TRANSCRIPTION SERVICES

This Confidentiality Agreement made effective this 6<sup>th</sup> day of October in the year 2010 by and between Tybee Types, a provider of transcription services, and Renee Kumpula, a doctoral candidate.

As part of my dissertation, I desire to hire Tybee Types to transcribe audio data files of interviews conducted under an agreement of confidentiality into Microsoft Word files. Tybee Types agrees to maintain files in confidence and not to disclose, distribute or disseminate files to anyone, except to Renee Kumpula, the researcher. Tybee Types shall exercise a reasonable degree of care to prevent any unauthorized disclosure of files. Disclosure of files by Tybee Types to third parties shall constitute a breach of this agreement.

Upon the request of Renee Kumpula, the researcher, Tybee Types agrees to immediately return or destroy all written, machine readable or otherwise tangible files received or created.

Transcription Company: Tybee Types

Researcher: Renee B. Kumpula

Signature: 



Printed Name: Marj Schneider, Partner

Address:

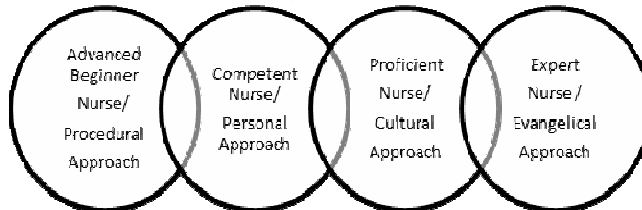
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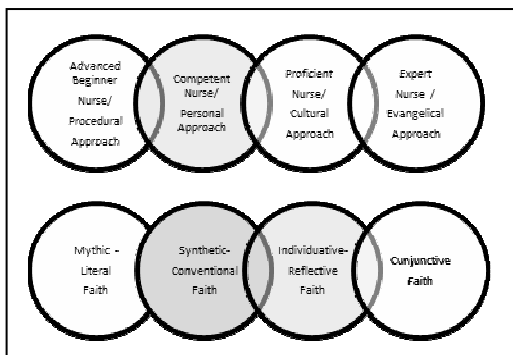
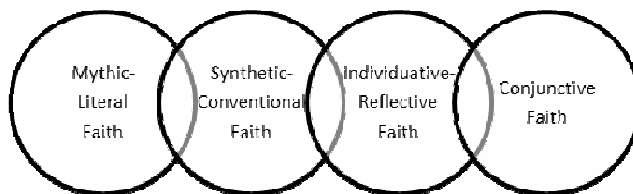
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763-441-4108

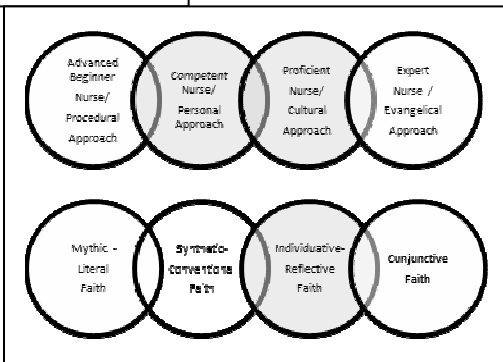
**Analytic Theories: Benner's (1984) Professional Nurse Development**



**Fowler's (1981) Faith Development Theory**

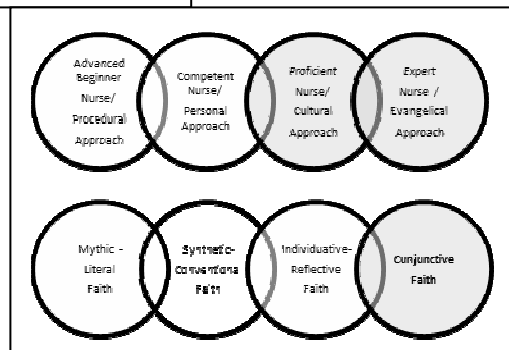


Group 1: Guides



Group 2: Liaisons

Included with Benner's (1994) stages:  
 \*procedural, personal, cultural, evangelical approach  
 (Naranayanasamy & Owens, 2001)



Group 3: Catalysts

APPENDIX I

Overlay of Theories for Theoretical Model Under Development

