THE LIVED EXPERIENCE OF GIVING SPIRITUAL CARE

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

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DENTON, TEXAS

DECEMBER 2008

TEXAS WOMAN'S UNIVERSITY
DENTON, TEXAS

July 28, 2008

To the Dean of the Graduate School:

I am submitting here with a dissertation written by Belinda Deal entitled "The Lived Experience of Giving Spiritual Care." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Nursing.

Dr. Jane Grassley, Major Professor

We have read this dissertation and recommend its acceptance:

Associate Dean, College of Nursing

Accepted:

Dean of the Graduate School

ACKNOWLEDGMENTS

I would like to acknowledge the doctoral faculty at TWU. Dr. Gail Davis, Dr. Sally Northam, Dr. Patricia Hamilton, Dr. Maisie Kashka, Dr. Tommie Nelms, and Dr. Lynn Wieck all mentored and joined me in this journey. Appreciation goes to my chair, Dr. Jane Grassley, and my committee, Dr. Maisie Kashka, and Dr. Jeff Huber, for their guidance.

This accomplishment would not have been possible without support of my family, thank you to my husband and daughters. The University of Texas at Tyler College of Nursing faculty has been especially supportive. Special thanks to Dr. Jackie McVey and Dr. Susan Yarbrough for encouraging me and guiding me with their qualitative research experience.

I would like to recognize the nurses in this study who shared their experiences with me. I hope that other nurses will use their stories as an example and understand how meaningful it can be to give spiritual care.

ABSTRACT

BELINDA DEAL

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DECEMBER 2008

Health care researchers have suggested a correlation between better mental and physical health and a person's spirituality or religious practices (Koenig, 2002). Indeed, using spiritual and religious resources gives patients and families strength to cope during a crisis (Kloosterhouse & Ames, 2000). Given that little is known about nurses' experiences with spiritual care, one wonders how spiritual care is given (Taylor, 2005), what the experience means to nurses, and how the experience affects nurses and their future actions. The purpose of this phenomenological study was to explore nurses' lived experience of giving spiritual care in order to know more about the meanings of this experience. The researcher interviewed 10 nurses who worked in dialysis units to gather information about their experiences of giving spiritual care. The researcher used a descriptive phenomenological approach to conduct the study. Trustworthiness of the study was established through member checks with the participants, peer debriefing, and thick description. Data were analyzed using Colaizzi's (1978) phenomenological method. Five themes were identified: "Drawing close," "Drawing from the well of my spiritual resources," "The pain of spiritual distress," "Lack of resources to give spiritual care" and

"Giving spiritual care is like diving down deep." Findings illuminated nurses' experiences of giving spiritual care as a continuum dependent upon the needs of the patient. The study findings suggest that patients and nurses draw close during the giving of spiritual care, that nurses have spiritual resources they use to prepare for and give spiritual care, and that giving spiritual care can have an emotional cost. These findings have implications for nursing practice, nursing education, and nursing research.

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CHAPTER I

FOCUS OF THE INQUIRY

Introduction

An elderly patient gasps for air as her heart fails and her lungs fill with fluid. Desperately looking to the nurse for help, she struggles to breathe, sensing she could die. How will the nurse address her distress? Will the nurse recognize the patient's spiritual need and intervene? Nurses routinely monitor the effects of diuretics and oxygen, but often neglect the patient's spirit.

Health care authorities recognize spirituality as an integral part of the human experience. "Most people have some religious or broader spiritual foundation in their lives...and when they are undergoing medical treatment, health care professionals shouldn't ignore that dimension of their care" (Koenig as cited in Hemmila, 2002, p. 17). Spiritual distress, the "impaired ability to experience and integrate meaning and purpose in life through a person's connectedness with self, others, art, music, literature, nature or a power greater than oneself," (Wilkinson, 2005, p. 507) is part of serious or chronic illness. Patients' spirituality enhances coping with illness. For example, research findings supported the centrality of spirituality in how dialysis patients coped with their illness (Al-Arabi, 2006; Baldree, Murphy, & Powers, 1982; Berman et. al, 2004; O'Brien, 1982; Patel, Shah, Peterson, & Kimmel, 2002; Tanyi, Werner, Recine, & Sperstad, 2006; Walton, 2002). Walton found that spiritually related concepts such as connectedness with

God, relationships with others, and prayer facilitated adjustment to dialysis and increased patients' ability to find meaning in their illness.

Spiritual care by nurses can help alleviate a patient's spiritual distress. Nurses can recognize the need for spiritual care and intervene with appropriate interventions for the patient's spirit. This can be particularly important for nurses caring for patients with a chronic illness such as renal failure. Tanyi et al. concluded that dialysis nurses were in a unique position to assess and provide spiritual care because of the close relationship these patients develop with their nurses.

While many nurses would agree that spiritual care is a nursing responsibility, a disparity exists between believing and giving that care (Bradbury, Mingus, & Webster, 1988; Chadwick, 1972; McSherry & Ross, 2002; Piles, 1990; Stranahan, 2001; Vance, 2001; Yancy, 1987). Lack of skill or education regarding spirituality, no desire, lessened institutional support, and fear of rejection by the patient or coworkers are potential barriers to giving spiritual care. Although the nursing shortage and increased patient acuity limits time for individual care, nurses are in a prime position to assess spiritual needs, plan and implement spiritual care interventions, and evaluate their effectiveness (Highfield & Cason, 1983; Shelly & Fish, 1988; Wright, 1998).

Both nurses and patients may experience benefits such as inner peace when nurses attend to patient's spiritual needs (Baumann & Englert, 2003; Krebs, 2001; Ruffing-Rahal, 1984; Sherwood, 2000; Walton & Sullivan, 2004). Health care researchers have suggested a correlation between better mental and physical health and a person's spirituality or religious practices (Baetz, Larson, Marcoux, Bowen, & Griffin, 2002;

Beery, Baas, Fowler, & Allen, 2002; Ellison & Levin, 1998; Koenig, 2002; Landix, 1996; Maddox, 2000; Mueller, Plevak, & Rummans, 2001; Paloutzian, 2002; Smucker, 1998). Indeed, using spiritual and religious resources gives patients and families strength to cope during a crisis (Gioiella, Berkman, & Robinson, 1998; Kloosterhouse & Ames, 2002; Walton & Sullivan, 2004).

Because a patient's spirit influences other aspects of his or her healthcare, spiritual care is a concern to nurses. Yet although patients, their families, and nurses agree that spiritual care can be beneficial (Kociszewski, 2003; Stephenson & Wilson, 2004), the nursing literature reflects a lack of guidance to give spiritual care in nursing (Highfield & Cason, 1983; McSherry & Ross, 2002; Malinski, 2002; Oldnall, 1996; Sellers, 2001). Given that little is known about nurses' experiences of giving spiritual care, one wonders how spiritual care is given (Taylor, 2005), what the experience means to nurses, and how the experience affects nurses and their future actions. Dialysis nurses have many opportunities to offer spiritual care to their patients because of the close relationships that develop. Therefore, a dialysis unit provides a rich setting for the study of nurses' experience of giving spiritual care.

Statement of Purpose

The purpose of this phenomenological study was to explore nurses' lived experience of giving spiritual care in order to know more about the meanings of this experience. The researcher interviewed nurses who worked in dialysis units to gather information about their experiences of giving spiritual care. Knowledge from this study

may lay the foundation for strategies and interventions, which could assist other nurses to incorporate spiritual care into their nursing practice.

Background

In the mid 1980s, only a handful of researchers studied religion, spirituality, and their connection to health. Now, major professional organizations such as the American Academy for the Advancement of Science, the American Public Health Association, the American Psychological Association, and the Gerontological Society of America recognize the field of religion and health. Additionally, according to a *Newsweek* poll, a majority (72%) of Americans will willingly discuss faith with their physicians (Kalb, 2003). Moreover, half of medical schools were offering courses in spirituality in 2003 compared to only three medical schools ten years before. The National Institutes of Health and private foundations like Templeton, Robert Wood Johnson, and Fetzer are earmarking money to fund studies that explore the relationship between religion and health (Koenig, McCullough, & Larson, 2001).

Spiritual care is a vital part of the requirements of health care accrediting organizations and is included in the philosophy of professional and nursing education associations. Patients expect nurses to assess and tend to spiritual aspects of their care (Taylor, 2002). The Joint Commission (2008), which accreditates healthcare organizations, mandates assessment of patients' spirituality. Professional associations' values and ethical codes address spirituality as well. The *American Nurses Association's (ANA) Code of Ethics* describes ethical behavior that includes considering a patient's "...lifestyle, value system, and religious beliefs ..." as the nurse plans health care (ANA,

2001, p. 7). Likewise, the International Council of Nurses (ICN) in their *ICN Code of Ethics for Nurses* (ICN, 2000) affirms promotion of an environment where there is respect of individual's spiritual beliefs. The American Holistic Nurses Association's core values embrace a therapeutic environment by recommending conditions that are conducive to reflection, prayer, and spiritual growth (Frisch, 2001). Spiritual needs are included in the standards for professional nursing education set by the American Association of Colleges of Nursing (AACN) in *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2005). AACN believes opportunities to "anticipate, plan for, and manage physical, psychological, social, and spiritual needs of the patient and family/caregiver "(AACN, p. 13) should be part of baccalaureate education.

Nursing practice supports holistic care, which includes care of the body, mind, and spirit (Mauk & Schmidt, 2004). In 1860, Florence Nightingale asserted that spirituality was part of human nature and that a nurse's work was a way of finding God (Macrae, 1995). Nurse researchers have alleged that nurses are not giving holistic care when ignoring a patient's spirituality (Kearns, 2002; Piles, 1990).

Definitions of spirituality vary as individuals vary in their perspectives and opinions. Wilt and Smucker (2001) define spirituality as "...the recognition or experiences of a dimension of life that is invisible, and both within us yet beyond our material world, providing a sense of connectedness and interrelatedness with the universe (p. 5). Others have said spiritual care is not limited to activities emphasizing religion but

is any activity that "touches the spirit of another" (Carson, 1989, p. viii). Solari-Twadell and McDermott (1999) addresses spiritual needs in their definition of spirituality:

> That life principle that pervades the entire being, integrating, and transcending all other dimensions of life. It gives meaning to life and death. It offers love and relatedness. It includes the need for forgiveness. It includes hope, trust, and faith. It involves a belief in a supernatural or higher power. (p. 44)

Spiritual distresses disrupts core principles like meaning and purpose in life, faith or trust in someone or something beyond us, hope, love, and forgiveness. Persons experience spiritual distress when they face cancer, traumatic injury, or chronic disease (Lemmer, 2002; Raholm, 2002). Patients exhibit spiritual distress typically by depression, withdrawal, expressions of anger, and crying (Van Dover & Bacon, 2001; Wilt & Smucker, 2001).

Nurses provide strength and comfort through giving spiritual care (Sherwood, 2000). Spiritual care is conveyed by being caring and respectful which can assist the patient to regain meaning and purpose in life, faith or trust, hope, love, and forgiveness (Grant, 2004). By asking about spiritual needs, nurses may encourage or awaken the patient's spirituality, which can help the patient cope. Additionally, nurses can perform spiritual interventions such as praying with and for the patient, reading holy writings, obtaining and playing music that lifts the patient's spirit, and calling in spiritual advisors. Interventions can involve tasks as basic as listening and holding the patient's hand, or as complex as arranging for communion or another religious or spiritual ritual. Although spiritual care can be specific, nurses can have a generally caring attitude that pervades

every nursing action. Walton and Sullivan (2004) echo this idea, "If spirituality permeates all aspects of life..., then any nursing intervention has the potential to be spiritual" (p. 148).

Grant (2004) studied 299 bedside nurses at a university hospital to examine their spiritual care practices. Nurses, in the study, believed benefits of spiritual care for patients included inner peace, strength to cope, decreased bodily pain, and a deeper meaning of their illness. Participants reported using touch (holding the patient's hand), active listening, laughter, prayers, and presence as spiritual care interventions they recommended or provided.

Although barriers to giving spiritual care exist, the benefits outweigh the difficulties. Barriers that inhibit spiritual care include decreased time, no desire to give spiritual care, lack of institutional support, deficient skill/education to give spiritual care, embarrassment or possible rejection by patient or staff, increased patient acuity requiring more emphasis on physiological needs, and not wanting to intrude on the patient's privacy (Cox, 1995; Piles, 1990; Vance, 2001). Additionally, nurses may not understand or realize a patient's spiritual needs (Harrison & Burnard, 1993; Highfield & Cason, 1983).

Certain characteristics make nurses more likely to give spiritual care than others. For example, nurses who have a high level of spiritual well-being are more likely to give spiritual care (Bullard, 1994; Cimino, 1992; Meyer, 2003; Van Dover & Pfeiffer, 2005; Yancy, 1987). Persons with a high level of spiritual well-being have a focus on the transcendent or spiritual.

In addition to having a high level of spiritual well-being, graduates from nursing schools that emphasized spiritual care were more likely to give spiritual care (Hall & Lanig, 1993; Meyer, 2003; Piles, 1990). However, high levels of spiritual well-being and religiosity were not enough. Nurses need specific education regarding spiritual care with accompanying life experiences in order to be ready to give spiritual care (Van Dover & Pfeiffer, 2005).

In summary, while nurses may believe spiritual care is part of their responsibility (Harrison & Burnard, 1993), they may not give spiritual care, thus creating a disparity between what nurses believe and what they do (Chadwick, 1972; Musgrave, 2000; Yancy, 1987). Even though health care is associated with advanced technology, spiritual matters are still important to patients, especially patients in the crisis of a disease, injury, or chronic illness (Keller, 2004; Lemmer, 2002). In addition, although literature espouses the importance of nurses giving spiritual care, few studies have looked specifically at this experience for nurses. Spirituality positively affects patients' health, and it is important in their everyday lives as well as in times of crisis. Exploring the experiences of nurses who give spiritual care is important because nurse researchers do not know much about how nurses give spiritual care.

Researcher's Relationship to Spiritual Care

As a child, the researcher knew she wanted to be a nurse. The researcher was fortunate to be successful in nursing school. In addition, she enjoyed the challenge of nursing. She and her family were active in a local Protestant church. The church was a source of community and comfort to them. In retrospect, the researcher's immaturity on

graduation from nursing school influenced her lack of attention to spiritual matters in care giving at the beginning of her career.

During nursing clinical, the researcher felt drawn to the fast-paced and challenging emergency department. There were no positions in the emergency department, and her first job after graduation was staff nurse on a postoperative surgical unit. After six months, she transferred to the emergency department and remained there for the next 12 years.

The researcher experienced personal challenges including the death of her mother, who was a diabetic and on dialysis, when the researcher was 26. She observed the day-to-day drama of life and death in the emergency department. These experiences heightened her attention to the complexity of living and dying with illness and injury. Many of the patients she cared for while she was an emergency department nurse and flight nurse did not survive, were critically injured, or were chronically ill. During those experiences, she was aware of spiritual needs but never directly attempted to meet them. Instead, she made referrals to the chaplain or the patient's spiritual advisor as appropriate. Although, she did not routinely pray for patients, she does remember praying for those who were alone and without family after their discharge from her care.

Recent experiences with spiritually distressed patients have made a profound impact on how the researcher viewed spiritual care. As a nurse educator, she observed a student and the patient she was caring for, an elderly patient in congestive heart failure. The student and her nurse preceptor were taking care of the patient's physiological needs, giving furosemide to reduce her fluid overload status and oxygen to support her

respirations. The patient labored to breathe and the researcher could sense her anxiety and fear of death. As she tried to really listen and attend to her, she realized the gravity of this situation. The researcher asked if the patient would like the researcher to pray with her, she seemed relieved and nodded yes. The researcher said a very short prayer, something like, "God, please be with Mrs. _____ during this time and comfort her and let her know of your presence. Amen." As the patient opened her eyes, the researcher could see a sense of relief in her face. She felt very close to the patient and felt like she was able to assist in giving her comfort through the prayer. This was a very important experience for the researcher, and she remembers relating the experience to several nurse faculty colleagues. She later learned that the patient died later that day. In recalling her experiences as a nurse in the emergency department, including life-threatening situations, she cannot remember a previous specific situation where she actually prayed with a patient.

Other similar experiences added to the researcher's interest in spiritual care. J. Cromer, a student nurse (personal communication, February 21, 2002) shared an experience with an elderly patient, who had cancer,

> ...one patient began to stand out to me that she needed more from me than just basic nursing....She was in terrible pain and it was hard to see her suffer....I asked her if it would be ok for me to pray with her. She began to cry again. She told me yes, she would love that....She squeezed my hands and said, "Let's pray." I was overwhelmed with joy as we held hands and prayed for God to wrap his loving arms around her, to comfort her, and protect her. I also prayed for her

family. It was really a life changing experience for me....I wish I could help people like this every single day for the rest of my life.

Through the researcher's life experiences, especially difficult times, her personal spirituality has increased. She found comfort and hope in all situations through prayer and reading the Bible. After a recent experience with a serious injury, she experienced her own spiritual distress but found a peace and a deeper spiritual well-being as time passed. During the ordeal, friends, family, and coworkers as well as pastoral support from three different churches provided spiritual care. It became more apparent to her after this experience how spiritual care positively affects all aspects of recovery.

As the researcher began the doctoral program, her interest shifted from care of acutely ill patients to chronically ill patients who use spirituality to cope with their situations. While taking her first course on health care outcomes, an article by Rydholm (1997) piqued her interest because the author reported the results of a federal grant encouraging nurses to start parish nurse roles specifically to assist elderly patients cope with their health concerns. Parish nurses routinely give spiritual care and are associated with religious congregations in various roles to promote health of the faith community.

Rydholm (1997) found that when parish nurses supported caregivers of elderly patients, results included fewer nursing home and hospital admissions resulting in substantial savings. The findings intrigued the researcher, which validated that parish nurses who routinely use spiritual care in their role could have a positive impact on the economics of health care as well as improving patient outcomes. Unfortunately, it became clear that it would be impossible to conduct a similar study comparing health

care outcomes of two populations of elderly cared for by home health nurses compared with parish nurses due to lack of similar parish nurse programs in the East Texas area.

At that point, the researcher was curious about spirituality and read more spiritually related literature. A 20/20 television special (ABC News, 1999) on spiritual care became a touchstone for increasing her interest in spirituality. A large teaching hospital on the East Coast started a spiritual care program, which included training of nurses, physicians, and social workers by chaplains to give spiritual care. The examples shown were meaningful. For example, one nurse prayed with a patient with terminal pancreatic cancer. The look of peace on the patient's face and the connection between the nurse and the patient was powerful and reminded the researcher of her experience praying with a patient. Another example included an anesthesiologist offering spiritual care to a pre-surgical patient who, when asked, was not comfortable with prayer or matters related to God. The anesthesiologist honored the patient's request and continued the exam. That scenario was a great example of how not to push individual beliefs on a patient and to respect patient beliefs.

About the same time, the researcher was reading and seeing more about Harold Koenig, MD (Koenig, 2002) and his research on spirituality and coping with illness. He found that personal spirituality helped persons cope. All of this information validated the researcher's need to know more about spirituality from a nursing perspective.

During another pivotal doctoral course, Threats to Women's Health, the researcher explored spirituality and women. Reviewing the literature sparked a continuing interest related to how nurses give spiritual care and how that care affects

patients. As she examined qualitative studies on spiritual care, she realized interviewing nurses would be the best way to understand the experience of giving spiritual care.

Assumptions

1. Spirituality is an integral part of being human that assists individuals to find meaning in their life experiences.
2. Patients bring their spirituality to experiences of illness.
3. Nurses assist patients to find meaning by giving spiritual care.
4. Spiritual care encompasses general supportive care as well as specific interventions related to religious rituals.
5. Giving spiritual care is an important role for nurses.

Theoretical/Philosophical Framework

Phenomenology served as the framework for this study. Phenomenology is the study of lived experience where the researcher is discovery-oriented. The researcher is on a quest to know, "What is this everyday experience like? What is its meaning? How is it experienced?" Through reflection, a deeper knowing of the essence of an experience emerges (van Manen, 1990).

Oiler (1982) maintains, "Phenomenology is a philosophy, an approach, and a method" (p. 178). Sociologists and anthropologists have traditionally been interested in humans' relationships with other persons and with objects. Edmund Husserl (1859-1938) founded the school of phenomenology (Welch, 1939), which was further defined by his colleague, Heidegger. The following is a discussion of the philosophical themes of phenomenology.

Philosophy

In a 1956 article, drawing on Husserl and Heidegger, the French phenomenologist Merleau-Ponty defined phenomenology as a study of essences and human interaction (Munhall & Oiler, 1986). Phenomenology is a human science because the researcher's aim is to find out about human beings. The development of phenomenology was a result of Husserl's attack on traditional scientific method, which measures and values concrete, observable events (Powers & Knapp, 1995). The scientific method could not appropriately capture the abstractness of phenomena, and Husserl recommended a "return to 'the things themselves', essences that constitute the prescientific world of human consciousness and perception" (Powers & Knapp, 1995, p. 123).

Phenomenology is the tool for deep exploration into human existence and experience (Munhall & Oiler, 1986). Husserl described a life world (*Lebenswelt*) or lived experience. In order to understand this experience, a person reflects on a realm of what persons normally "...take for granted and therefore fail to explore..." (Powers & Knapp, 1995, p. 123). The qualitative researcher seeks to understand the actual lived experience of a phenomenon by examining persons' accounts of their experiences.

Consciousness and Embodiment

To be conscious with the world is simply to be present, to experience the world, and to "be in" the world. According to Husserl (1964), "Every act is consciousness of something..." (p. 175). Therefore, subsumed into consciousness is "All acts of consciousness—remembering, judging, dreaming, and so on..." that take place because humans are in the world (Munhall & Oiler, 1986, p. 49). However, in order for the

experience to be meaningful, the physical body must be present as a reference point or contact to the world. van Manen (1990) provides a further illustration of the connection between consciousness and the world, "Consciousness is the only access human beings have to the world. Or rather, it is by virtue of being conscious that we are already related to the world." (p. 9).

Individuals have unique perspectives that are subjective and dependent on how they interpret their experiences. As van Manen (1990) states, "...to know the world is profoundly to be in the world in a certain way..." (p. 5). According to Munhall and Oiler (1986), "Consciousness is always of something. Through the body we have access to the world where consciousness expresses itself in various attentions to life" (p. 52). Merleau-Ponty (1956) called this process "embodiment."

In summary, human scientists are involved in the following disciplines: anthropology, history, literary criticism, philosophy, psychology, and sociology (Powers & Knapp, 1995). The underlying quest in human science research

> ...is always to question the way we experience the world, to want to know the world in which we live as human beings. And since to know the world is profoundly to be in the world in a certain way, the act of researching--questioning --theorizing is the intentional act of attaching ourselves to the world to become more fully part of it...(van Manen, 1990, p. 5)

Natural or traditional science seeks to classify subjects and explain their behavior, compared to human science, which seeks to understand the meaning of life experiences.

Phenomenology and human science both agree in the credo that human life is complex and worthy of thoughtful investigation.

The nursing world is fertile ground for phenomenological study. The idea that the act of nursing is a type of lived human dialogue is appropriately associated with the concept of the lived experience of phenomenology. Finding out the complexities of the lived experiences of nurses can raise awareness and help nurses understand the benefits of giving spiritual care (Oiler, 1982).

Methodology

Since Edmund Husserl's beginning work, phenomenology has been widely used in various disciplines. The flexibility and interpretation of experiences within the method is certainly a strength that has developed over time (Paterson & Zderad, 1988). Positivists examine only observable, objective events and phenomenologists believe there is no objective reality (Powers & Knapp, 1995). The only reality is what the person perceives. Phenomenology is both concerned with "...a preoccupation with both the concreteness (the ontic) as well as the essential nature (the ontological) of a lived experience" (van Manen, 1990, p. 39-40). The resulting viewpoint constitutes the person's perspective and is the very essence of what the experience means (Patton, 2002).

According to van Manen (1990), "the essence or nature of an experience has been adequately described in language if the description reawakens or shows us the lived quality and significance of the experience to a fully and deeper manner" (van Manen, p. 10). The researcher must conduct in-depth interviews with persons who have direct experience with the phenomena. Persons may think they understand a phenomenon, but

until they "...understand by reflectively bringing into awareness what has been taken for granted" (Powers & Knapp, 1995, p. 123), they cannot really know or understand the essence of the experience.

Associated with the idea of essences is the idea of "orienting to the phenomenon." In accordance with the definition, to orient is to direct attention toward an item of interest. A researcher is interested in or oriented toward the phenomenon. Similarly, a nurse is interested in the nurse-patient relationship. Phenomenology is a personal action, directed by the person's interest in the phenomenon; the nurse cares about the act of nursing and the patient's response to nursing care. van Manen (1990) described the passion of this process, "So, phenomenological research is a being-given-over to some quest, a true task, a deep questioning of something that restores an original sense of what it means to be a thinker, a researcher, a theorist" (p. 31).

Using phenomenology, the researcher generated data through face-to-face interviews with nurses to determine their lived experience of giving spiritual care. Purposive sampling guided the selection of participants (Lincoln & Guba, 1985). Dialysis nurses were recruited using flyers posted in their work areas. Participants contacted the researcher by telephone or email if interested in sharing a memorable experience giving spiritual care. Interviews began by asking nurses to, "Tell me about a memorable experience with a patient taking care of spiritual and/or psychosocial needs that you will never forget." The researcher analyzed data using Colaizzi's (1978) phenomenological method.

Significance to Nursing

When nurses address spiritual needs, benefits to nurses and patients include inner peace, increased mental and physical health, and strength to cope during a crisis (Sherwood, 2000). Although spirituality is important to nursing practice, little research exists about how spiritual care is given, what the meaning of the experience is, and how spiritual care affects nursing actions (Carroll, 2001; Cone, 1994; Harrison & Burnard, 1993; Kociszewski, 2003; Ross, 1997; Taylor, 2002; Vance, 2001). Researchers did not find any evidence to describe how giving spiritual care affects nurses professionally and personally.

Knowledge gained in this study may include information regarding benefits and barriers to giving spiritual care. Such knowledge could lay the groundwork for identifying and implementing the best ways for the nurse to give spiritual care to patients. By increasing the frequency of giving spiritual care, benefits such as inner peace, improved health, and increased coping can increase as well.

While nurses seem to have embraced a renewed interest in spiritual matters (Carson, 1989), the nursing literature reflects a lack of theory to guide spiritual care in nursing (Highfield & Cason, 1983; McSherry & Ross, 2002; Malinski, 2002; Oldnall, 1996; Sellers, 2001). Physiological concepts relate to the body and psychosocial concepts relate to the mind, but spiritual concepts are less clear (McSherry & Draper. 1998). Knowledge from this study might help to clarify spiritual care in nursing and contribute to theory development in the area. Findings from this study could lead to increased understanding of the complex concept of spirituality, which nurses can use to guide the

practice of spiritual care in nursing by adding meaning and spiritual well-being of patients and nurses.

It is not clear how nurses give spiritual care. Many nurses would agree that spiritual care is a part of their nursing responsibility, but a disparity exists between that belief and the actuality of giving spiritual care (Bradbury et al., 1988; Chadwick, 1972; Musgrave, 2000; Yancy, 1987). Nurses who understand and are comfortable talking to patients about spirituality can give other nurses information about how to incorporate spiritual care into their nursing practice.

It would seem that all persons who enter the health care system and require nursing care are in spiritual distress to some degree. Nurses need to be able to assess spiritual distress. Findings from this study might lay the groundwork for implementation and assessment of the best ways to give spiritual care to patients in need. With this knowledge, nurses could integrate spiritual care more fully by giving examples of ways to plan, implement and evaluate spiritual care.

The following is an example in order to gain insight into the different worlds of patients and nurses. The first is the world of the nurse, doing tasks, being professional, and performing many routine tasks such as giving medications and changing dressings. For the most part, the nurse is in control of her environment, she leaves the room when she decides; she leaves work at the end of her shift. On the other hand, for the patient, this experience is a major life event. The patient's world is one of loss of control, isolation, and uncertainty. Although the patient and the nurse are in the same room, there

are two very different worlds playing out. Attending to spiritual needs can bridge the gap between these two worlds (Myggen, 2004).

Significance for Nursing Education

Nursing education curricula include but do not define spiritual care (Catanzaro & McMullen, 2001; Denham, 1990; Lemoine, 2002; Meyer, 2002). Lemmer (2002) reported that while curricula in the majority of U.S. nursing programs include the spiritual dimension, only 5 out of 250 baccalaureate-nursing programs had defined spiritual care. Piles (1980) investigated the inclusion of spiritual care in nursing curricula in both associate degree and baccalaureate programs, finding that spirituality was subsumed into psychosocial care and was not a distinct component of nursing care. Although, nursing education curricula do not consistently define spiritual care, it is valued and may be included under the broad heading of psychosocial care.

Meyer (2002) surveyed 280 senior nursing students and 111 nursing faculty from twelve different baccalaureate nursing programs and found the greatest predictors of perceived ability to give spiritual care were spirituality, religious commitment, and student and faculty ratings of the nursing program's emphasis on spirituality. While both having received spirituality content in nursing school and a high degree of personal spirituality are strong predictors of giving spiritual care (Meyer; Schnorr, 1988), spiritual care education varies widely and many nurses may not feel qualified to give spiritual care (Cox, 1995; McSherry & Ross, 2002). The results from the study may clarify spiritual care so knowledge from this study will facilitate the inclusion of more appropriate and consistent content in nursing education programs and provide beginning nurses with

effective spiritual care interventions. As nurses conduct more research about spiritual care, differentiation between spiritual care and psychosocial care could be included and integrated into nursing curriculum. Nursing graduates whose education includes emphasis on spiritual care will be better equipped to enter the health care arena and meet patients' spiritual needs.

Societal Significance

Spirituality and spiritual care are vague terms, and society often fails to differentiate spirituality from religion. The meanings of the terms lack clarity for nurses and other healthcare providers, as well as the public. The public may not know that spiritual care is available from health care providers other than chaplains. Such knowledge may give persons coming into the health care system permission to request and even require spiritual care from nurses. As patients exhibit spiritual distress, the nurse could assist persons in attaining or maintaining spiritual well being. Knowledge gained in this study may help clarify meanings of religion and spirituality and contribute to greater understanding of spiritual care for people within healthcare and society in general.

Benefits for Participants

Participating in a qualitative study can also be therapeutic and rewarding for participants. This phenomenological study involved asking nurses questions about the experience of giving spiritual care. Participants in general find the process of interviewing positive because they can fully explain their experience and they can really be listened to (Streubert & Carpenter, 1999). Benefits for the participants of qualitative

research studies include catharsis and a sense of relief, self-acknowledgment and personal validation, sense of purpose and knowledge that others will be helped, self-awareness and a new perspective, empowerment, and healing of past traumas (Cutcliffe & Ramcharan, 2002; Hutchinson, Wilson, & Wilson; 1994). Being interviewed allows a participant a safe, non-threatening way of telling their story. This opportunity allows the participant to communicate to someone who is interested in an experience that he or she would not find in another situation.

Along with the above benefits, the participants received feedback on the results of the research. This not only is a form of recognition but is also a method of thanking participants for sharing their story (Ethics in Health Research, 2005). Other positive benefits include connecting with other nurses who may be encouraged to give spiritual care after hearing of their experience (Cutcliffe & Ramcharan, 2002). As with the experiences of participants through internet interviews (Beck, 2005), it is hoped that participating in the interviews will provide a voice for nurses' experience of giving spiritual care.

Literary Context

Humans have always searched for God or a higher power to give meaning to their lives. Americans have found fulfillment in a variety of religions and varieties of spirituality. In a survey of 1,004 Americans by *Newsweek* (Adler et al., 2005) and *Beliefnet* (2005), 57% of the persons said spirituality was very important in their daily life and 27% said spirituality was somewhat important. Over half (64%) of the persons surveyed pray every day and 29% meditate every day. Therefore, if the average person

finds meaning through spirituality, the nurse is in a prime position to assist the patient in this process.

Studies that look at the experience of giving spiritual care are limited (Carroll, 2001; Cone, 1994; Harrison & Burnard, 1993; Kociszewski, 2003; Ross, 1997; Vance, 2001). Studies of patients confirm that spiritual care can be positive for them. Hermann (2001), Sellers (2001) and Stephenson and Wilson (2004) conducted qualitative studies and found the patients wanted nurses to include spiritual care. Moreover, although many nurses would agree that spiritual care is a nursing responsibility, a disparity exists between that belief and the actuality of giving spiritual care (Bradbury et al., 1988; Chadwick, 1972; Dettmore, 1986; McSherry, & Ross; 2002; Musgrave, 2000; Piles, 1990; Stranahan, 2001; Vance, 2001; Yancy, 1987).

More research could validate the role of spiritual care in holistic nursing care. Spiritual care has been studied widely in oncology and hospice nurses (Broten, 1991; Brown, 2000; Gioiella et al., 1998; Highfield, 1992; Highfield & Cason, 1983; Meraviglia, 1999; Taylor & Amenta, 1994; Taylor, Highfield, & Amenta, 1994; Taylor, Highfield, & Amenta, 1999) as well as nursing care of HIV patients (Tuck, McCain, & Elswick, 2001), and one study has been reported on spiritual care and intensive care nurses (Kociszewski, 2004). However, the literature has not represented or has under represented other diseases and populations. In addition, nursing education is generally lacking regarding teaching spiritual care. Nurses want to give spiritual care but their preparation may be lacking, and other barriers prevent them from giving spiritual care (Cox, 1995; Piles, 1990; Vance, 2001).

Summary

This chapter presented an introduction and overview of the study, along with the theoretical and philosophical frameworks. Phenomenology was the framework that guided the study, as the researcher asked dialysis nurses to describe the lived experience of giving spiritual care. Face-to-face interviews guided data collection, and then data were analyzed using Colaizzi's data analysis.

Nurses need to recognize patients' spiritual needs because spiritual care can provide strength and comfort. Although spiritual care can be specific, nurses can have a generally caring attitude that pervades every nursing action. Exploring the experiences of nurses who give spiritual care is important because nurse researchers need to know more about how nurses give spiritual care.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

Holistic nursing care includes consideration of the mind, body, and spirit. For nurses to support patients spiritually, they must be aware of patients' spiritual needs. Early studies of spirituality in health and illness found that patients believed nurses could meet their spiritual needs (DeWitt-Weaver, 1985; Martin, Burrows, & Pomilio, 1976; Stallwood-Hess, 1969; Yanosh 1966). However, these researchers found that not only did nurses not recognize spiritual needs, but also spirituality was rarely discussed in nursing curricula (Lewis, 1957; Piles, 1980). In these studies, nurses and patients identified increased workload and patient acuity as barriers to spiritual care. Indeed, nursing has been wrestling with these issues for almost 50 years without resolution. Currently, spiritual care is considered an ethical mandate (Pesut, 2006), but how do the differing foundations influence how spiritual care is given? This chapter provides a context for exploring and understanding spiritual care by discussing literature related to spirituality and spiritual care. The following will be discussed: spirituality, spiritual care, barriers, the lived experience of giving spiritual care, and spiritual care and dialysis patients and nurses.

Spirituality

Spirituality is complex and difficult to define (Albaugh, 2003; Davis, 2005; Grant, 2004; Harrison & Burnard, 1993; Highfield, 2000; Oldnall, 1996; Taylor, Highfield, & Amenta, 1999). Older definitions associated spirituality with religion and religious experiences and used these words as synonyms. *The World Book Unabridged Dictionary* (Barnhart, 1967) defined "spiritual" as relating to the spirit or soul and "of or having to do with spirits; supernatural; having to do with or belonging to the church, sacred, religious" (p. 1877). Definitions of spirituality and religion are discussed, and perspectives of persons with various spiritual and religious beliefs and those without religious beliefs will be explored to better understand spirituality.

Religion involves a belief system that incorporates spiritual experiences and values in a social institution with groups of people that take part in its practices (Mauk & Schmidt, 2004). Along with a set of beliefs, religious traditions are based on historical, sacred writings, which provide a sense of purpose and answers to difficult questions. Judaism, Christianity, and Islam comprise Western religious traditions and Buddhism, Taoism, and Hinduism comprise Eastern religious traditions (Kneier, Silberman, Freinkel, Rosenbaum, & Spiegel; 2007).

Newer definitions of spirituality have diverged from religion, and spirituality has been increasingly defined as a common life experience (Narayanasamy, 1999; Taylor, 2002). Puchalski (Weber, 2003), the founder and director of the George Washington Institute for Spirituality and Health argued, "There are spiritual aspects of nature and relationships. Religion offers a set of beliefs that have been written about for years, but

not everyone subscribes to that" (p. 12). Taylor (2002) defined spirituality as a "highly individual" (p. 3) and universal experience that is not restricted to religious practices. Solari-Twadell and Dermott (1999) summarized spirituality as:

> ...that life principal that pervades the entire being, integrating and transcending all other dimensions of life. It gives meaning to life and death. It offers love and relatedness. It includes the need for forgiveness. It includes hope, trust, and faith. It involves a belief in a supernatural or higher power. (p. 44)

Research is emerging which attempts to define spirituality within the context of nursing practice (Burkhart & Solari-Twadell, 2001; Coyle, 2002; Draper & McSherry, 2002; Goddard, 1995; McSherry & Ross, 2002; Martsolf & Mickley, 1998; Meraviglia, 1999; Shelly & Miller, 1999; Tanyi, 2002). Walton (2007) wrote, "...nurses are beginning to understand that spirituality involves so much more than religion" (p. 378).

Nurses need to have an understanding of different religions and spiritual perspectives in order to give holistic care (Reed, 2003). Religions, which are theistic include a belief in God or gods and include Judaism, Christianity, Islam, and Hinduism. Nontheistic views include Buddhism, atheism and agnosticism. Atheists do not believe in God, and agnostics believe that God can neither be proved nor disproved. Secular humanists focus on human characteristics such as the intellect to cope with difficult events. Humanists may hold varying degrees of belief in God as well. The religions of Buddhism, Christianity, Islam, and Judaism were chosen for more in depth discussion because they represent the world's main religions; they will be discussed in light of the

major tenants of each and how persons of those religions deal with suffering, which may be related to illness.

Buddhism, a nontheistic view, stresses individual responsibility rather than dependence on a divine being (Reed, 2003). Buddhists seek to attain the spiritual release of Nirvana through spiritual and mental discipline and through a series of births and rebirths. A sense of cause and effect is believed to be a part of *karma*, which concludes that there are consequences to moral acts. One of the central components and *Noble Truths of Buddhism* is that everyone suffers in this life and dies. Buddhists do not seek to find purpose or meaning in suffering, but accept it and attempt to overcome it. Ways to overcome suffering include detaching oneself from the suffering by mental discipline and meditation.

Judaism presents God as a historical and scriptural figure whose existence goes beyond the present situation. Other aspects of Judaism that may affect patients' views of illness include a strong sense of community with other Jews (Reed, 2003). Jewish patients may view suffering as an indication of their need to make things right with others. They also believe that God is eternal, omnipotent, and in control of life, even when bad things happen. Jewish patients may find meaning in suffering as others act in caring ways toward their suffering. A greater, eternal purpose may be recognized as someone suffers.

Christians perceive God as a redeemer in the person of Jesus Christ who died and rose to life again to save persons and provide eternal Life. They link suffering to God's ultimate purpose for that individual (Reed, 2003). Christians hold diverse views of why

suffering occurs. They may see their suffering as punishment for wrongdoing, as a chance for God to be glorified through healing, as an opportunity to share in Christ's sufferings, or as a chance to depend on God and to gain strength or spiritual growth through the suffering. Christians believe that this life and its sufferings are temporary; there is no suffering in Heaven but only eternal joy.

Islamic belief centers on the judgment and power of God or Allah (Reed, 2003). A central tenet of Islam is to do God's will and to do good to others. The five pillars of Islam have implications to health care providers. They are 1) a belief in Allah as the only god and Muhammad as his Prophet, 2) devotional worship and formal prayer five times a day, 3) helping the poor financially, 4) a month of fasting during Ramadan, and 5) a journey to Mecca. To a Muslim, suffering may have natural causes, although punishment may be a possible cause. Believers of Islam may view suffering as a test of faith with its resulting benefit of increased faith through enduring the suffering.

Nurses need to be open to patients' religious and spiritual views. In a study of patients with mental health problems and spiritual care, Koslander and Arvidsson (2006) described nursing in a culture of many religions. They wrote:

> This dimension [spiritual] is fundamental in care that is provided in a multi-faith society. Nurses must be open to all ideas that spirituality can entail, and it is their duty to become involved in patients' spirituality, without stipulating what spirituality may be and without regard to what spirituality may mean to the nurses themselves. (p. 601)

Although, patients' views can vary according to their cultural, regional, and individual differences, finding out individual beliefs and needs applies to all patients. Nurses need to understand patients' perspectives about spirituality in order to provide spiritual care.

Patients and Spirituality

According to Taylor (2003), patients described spirituality and the search for meaning in life as a universal experience. Sellers (2001) agreed that spirituality was a dynamic, lifelong process that arises from life and spiritual experiences. Patients turn to matters of spirituality when faced with life threatening situations. Hospitalization is associated with vulnerability so ill persons, who are in a crisis, think more about their relationship with God (Albaugh, 2003; Conco, 1995; Davis, 2005; Raholm, 2002; Schomus, 1980; Stephenson & Wilson, 2004). A patient's spirituality helps them cope and have hope during their illness experience, and in order for nurses to give appropriate spiritual care, it is important to understand the patient's view of spirituality.

Many studies found that spirituality was a positive factor for patients as they coped with illness (Albaugh, 2003; Baldree et al., 1982; Beery et al., 2002; Conco, 1995; Kociszewski, 2003; O'Brien, 1982; Raholm, 2002; Stephenson & Wilson, 2004; Woodard & Sowell, 2001). Patients found new and deeper meaning to their lives after an illness such as an increased appreciation of life and health (Albaugh, 2003; Beery et al., 2002; Hermann, 2001; Mickley, Soeken, & Belcher, 1992; Raholm, 2002, Walton & Sullivan, 2004). Some patients found every day to be a blessing and a gift after going through a difficult surgery or illness (Raholm, 2002). Even those who had a poor prognosis were able to be thankful as exemplified by the following patient who told a

researcher, "You become actualized. It's like I've had a conversation with God. How lucky I am! I'm dying, but I'm lucky because every day I'm one day closer to heaven" (Albaugh, 2003, p. 596).

Patients' spirituality can provide patients the inner strength to face the experiences associated with the illness (Raholm, 2002). Several studies have found that patients facing a critical illness seemed to use their spiritual resources to cope with their illness. O'Brien (1982) studied 126 dialysis patients in a longitudinal study over 3 years. She used quantitative and qualitative methods to find out the role of religious faith and patients' adjustment to end stage renal failure and hemodialysis. Ninety-three or 74% of the participants associated religion with acceptance of their disease and treatment management. Quantitative measures found that patients who placed the most importance on religion were more compliant and had a more positive attitude when compared to patients who did not place importance on religion as a coping method. Three years later, the researcher interviewed 63 of the original participants to see if their perspectives had changed. It was evident that the role of religious faith had increased over time as described by statements like, "Oh, yes. A lot of people couldn't have gone through what I went through without faith in God" (OBrien, 1982, p. 75). O'Brien concluded that religion as a coping behavior becomes increasingly important to hemodialysis patients over time.

These findings agreed with those of Baldree et al. (1982) who studied patients' stress and coping patterns during dialysis. Prayer ranked as one of the top three coping

mechanisms identified by patients in this study. Findings suggested spirituality helped patients cope with their disease.

Patients who faced cancer searched for meaning and purpose in their experience and found benefits in their spiritual practices (Feher & Maly, 1999; Walton & Sullivan, 2004). Walton and Sullivan conducted a grounded theory study and interviewed 11 men with prostate cancer. The men were motivated to make the most of each day and to focus on nurturing important relationships. The authors concluded, "Spirituality for men with prostate cancer is a connection to God through prayer and involved receiving support from family and friends" (p. 139). Participants said spirituality was a part of every aspect of their lives and cancer experience. These findings are similar to those in Woodard and Sowell's (2001) study of 21 women infected with HIV who said, "God was in the details of everyday life" (p. 240).

Hermann (2001) interviewed 19 hospice patients to determine their perspectives of spirituality and their spiritual needs. Patients identified their spiritual needs as "need for religion, need for companionship, need for involvement and control, need to finish business, need to experience nature, and need for positive outlook" (Hermann, p. 67). These findings about the meaning of spirituality concur with Burkhardt's (1993) study of five Appalachian women who were asked about their view of spirituality. From the data, Burkhardt identified the following themes: relationship with self (drawing on one's inner strength), relationships with others, relationships with nature, and relationships with God or a Higher Power.

Patients may express their spirituality through their religiosity, particularly when terminally ill. Using the *Religious Perspective Scale*, Reed (1986) compared two similar groups of 57 non-hospitalized adults. One group was healthy and one group was terminally ill. Reed found a greater religiosity in the terminally ill group when compared to the healthy group. In the terminally ill group, females had a significantly higher religious perspective score than males ($r=.47$, $p < .001$). Based on these findings, nurses need to be aware that terminally ill patients draw upon their religion to cope with their illnesses. No matter how patients defined spirituality, patients used their spirituality to help them transcend their experiences of illness and suffering and find meaning and purpose.

Nurses and Spirituality

Spirituality is important to nurses (Brown, 2000; Narayanasamy & Owens, 2001; Sterling-Fisher, 1996). Nurses agreed that spirituality gives meaning to life (Raholm, 2002; Taylor, 2002). Grant (2004) conducted an exploratory study of 299 nurses who worked at the bedside in a university hospital. These nurses believed that spirituality "...could give their patients inner peace; strength to cope; bring about physical relaxation and self-awareness; and help them forgive, connect, and cooperate with others" (p. 39). Harrison and Burnard (1993) found that nurses thought spirituality was important as they cared for patients. One nurse said,

> I think it's extremely important because it's a vital part of people whether it's a religious need or just the basic needs and beliefs that people have that affect the

way they think or the way their illness affects them. It's something that has to be addressed. I think it's an important part of you. (p. 71)

In conclusion, patients and nurses valued spirituality as an integral part of their lives and of illness. Spirituality included love, forgiveness, hope, trust, and faith as well as dependence on a higher power (Solari-Twadell & McDermott, 1999). Since spirituality was important to patients as they experienced illness and made meaning out of their experiences, it is essential for nurses understand how spiritual care enhances spirituality.

Spiritual Care

Vulnerability during illness sets the stage for spiritual care (Martin et al., 1976). Nurses are in a position to employ the nursing process related to spiritual care and assess, plan, implement, and evaluate spiritual care. Govier (2000) describes the complementary relationship of spiritual care to nursing care:

> If medicine involves the recovery of the body, spiritual care involves a recovery of the patient as a person. These areas do not sit in contention, but aim to complement each other and remind us that: "There is no profit in curing the body if in the process we destroy the soul." (Anonymous, p. 12)

To better understand spiritual care as integral to the nurse-patient relationship, the following tropics will be discussed: psychosocial and spiritual care, patient's perceptions, spiritual care as connectedness, spiritual care as feeling known and understood, spiritual care as finding meaning in illness, and spiritual care interventions.

Psychosocial Care and Spiritual Care

The similarities and differences between psychosocial care and spiritual care are not clearly understood. Psychosocial care is defined as encompassing "both cognitive function and emotional health" (Missouri Department of Health and Senior Services, 2005, slide 13). Psychosocial interventions include a wide range of modalities. Fawzy (1999) identified four general categories of psychosocial interventions that included education, coping, emotional support, and psychotherapy. Psychosocial interventions range from simple to complex and some require sophisticated training (Thompson, 2007) and can include family intervention, cognitive behavior therapy, early intervention, and case management. Psychosocial interventions are associated with treatment of mental disorders such as correcting a mood disorder, decreasing anxiety, and treating attention deficit disorder. Specific psychiatric conditions such as schizophrenia are linked to psychosocial interventions (Brooker, 2001).

In an effort to determine the psychosocial needs of ICU patients, Hupcey (2000) interviewed 45 persons who had been patients in an ICU and who identified an overall need to feel safe. Patients noted four categories that affected their experiences: knowing, regaining control, hoping and trusting. In addition, religion, family and friends, and the ICU staff helped patients meet their needs. Specifically, religion and hope were complementary. The presence of the nurse made the patient feel safe. As one patient said, "No matter morning, noon, or night, when I called the nurse, she was there. Just to comfort me and try to relax me so I could breathe calmly, not breathe and get in a panic..." "The nurse was a shoulder to cry on, somebody to lean on I guess. Especially at

night" (Hupcey, p. 365). For some patients, religion was "what has gotten me through" (Hupcey, p. 365). Similar to the presence of the nurse, the idea of a higher power watching over them made the patient feel safe, and prayer by the patient and by others was also a source of comfort. In this study, religion, prayer, and an idea of a higher power protecting the patient were identified as psychosocial care even though they are commonly associated with spiritual care.

Spiritual care interventions may overlap psychosocial interventions. In a Japanese study, Hirai, Morita, and Kashiwagi (2003) surveyed 701 psychiatrists, 118 psychologists, and 372 palliative care nurses to determine their perceptions of which psychosocial approaches to interventions were most helpful for terminally ill patients in psychological distress. The researchers identified an overarching need for psychosocial interventions that consist of a supportive-expressive approach including art therapy, life review, exploring patient values, and relaxation. Participants also identified a meaning approach and a religious approach as helpful to terminally ill patients. These concepts are related to spiritual care.

Spiritual care is like psychosocial care in that it is conveyed by caring and respectful actions, which can assist the patient to regain meaning and purpose in life, faith or trust, hope, love, and forgiveness (Grant, 2004). Spiritual care interventions, however, can go beyond the usual practice of psychosocial care. Nurses have defined spiritual care through their identification of spiritual interventions such as praying with and for the patient, reading holy writings, obtaining and playing music that lifts the patient's spirit, and calling in spiritual advisors. Interventions can involve tasks as basic as listening and

holding the patient's hand, or as complex as arranging for religious rituals such as communion. Although spiritual care can be specific, nurses can have a generally caring attitude that pervades every nursing action. Walton and Sullivan (2004) echoed this idea, "If spirituality permeates all aspects of life..., then any nursing intervention has the potential to be spiritual" (p. 148).

Patients' Perspectives

One of the difficulties in investigating patients' perspectives on spirituality and spiritual care is that patients have defined spirituality in both religious and nonreligious terms. Davis (2005) found that 9 out of 11 formerly hospitalized participants did not expect nurses to give spiritual care, with one participant specifically not wanting spiritual care. The researcher concluded that this finding could be because of differences in religious affiliations among the study participants and their association of spirituality with religion. Three participants identified their religious preferences as atheist, agnostic, and none, therefore it follows that if participants were not associated with a religion, they would not perceive spirituality as something helpful in their illness. The participant who identified as an atheist suggested the term "meaningful" instead of spiritual. Davis concluded that participants in her study defined spiritual care narrowly and related to religion. However, when she expanded what spiritual care could include, participants generally agreed spiritual care would be beneficial but not expected.

Creel (2007) interviewed 11 persons with no religious affiliation to find out how they experienced spiritual care from nurses. Very little research has taken place with this population. Patients identified spiritual care as the nurses' *extension of self.* This was

described as care and actions that were beyond physical care including seeing patients as individuals, asking about their families, and making patients feel special. One patient aptly described how the nurse was, "looking past the...clipboard...Looking past what's written on the paper, and I guess that goes along with seeing you [as] more than just a patient..." (Creel, p. 19). Two other key actions noted by patients as spiritual care were that the nurse encouraged their freedom and control over their situations and allowed them to talk. Participants identified nurses' caring attitudes as spiritual care. The findings of this study indicated that behaviors linked with spiritual care for patients without a religious affiliation are similar to those with a religious affiliation. Additional interventions related to spiritual care include specific actions generally associated with a religion like prayer and referring to a chaplain or spiritual advisor (Creel).

In comparison with the previous two studies, participants in Conco's (1995) phenomenological study all considered themselves "Christian" and reported benefits of spiritual care. Conco interviewed 10 volunteers to find out the nature of the spiritual care they had received when their illnesses had required hospitalization. Patients said having an illness caused a state of vulnerability that created a need for the spiritual care. Patients described benefits of spiritual care such as "feelings of reduced anxiety, peace, comfort, inner strength, acceptance, hopefulness, calmness, safety, general well-being, a stronger faith, and a positive change in attitude and outlook on life" (p. 271). The patients said they received spiritual care in the context of physical and emotional vulnerability due to their illness. Actions noted by the patients that demonstrated spiritual care were when the nurse answered the call bell quickly, touch (holding the patient's hand), and staying with

the patient while nausea medicine took effect. "Meaning, purpose, hope and connectedness" (p. 275) described the essential structure of the study.

Like Conco's (1995) participants, patients in Taylor's (2003) study reported the comfort they experienced from spiritual care by nurses. Taylor conducted a descriptive qualitative study with 21 cancer patients and seven of their family caregivers regarding how they expected nurses to meet spiritual needs. Some patients did not expect nurses to meet spiritual needs and some said it would be welcome. Participants said that in order to meet spiritual needs, the nurse could be kind and respectful, talk and listen, use prayer, connect with the patient (spend quality time and be authentic), and mobilize religious or spiritual resources such as calling clergy or having Bibles available. Patients and families considered nurses a spiritual asset if they did not have a relationship with a clergy or if the patient's clergy was far away. One patient, agreeing that nurses could give spiritual care, said, "After all, why did they ask our religion in admitting? Just for stats?!" (p. 589). A male patient recovering from a bone marrow transplant summarized the place of spiritual care and kindness for oncology nurses:

> If there is any place that needs any spirituality, it's here. If there's a place that needs God's kindness, it's here...Because you're at your end. Some of them are going to die. Some of them are not going to die, but still in this time in life, you need someone to be able to be kind and show God's love. Because otherwise, it would be hell...I couldn't stand to be here that many days without some kindness. (p. 590)

Stephenson and Wilson (2004) conducted a qualitative study to explore eight patients' perceptions of spiritual care during hospitalization. The researchers identified three stages of spiritual care. The first stage, the occasion for spiritual care, took place during physical patient care, which was supported in other studies that identified spiritual care as occurring in all phases of nursing care (Carroll, 2001; Davis, 2005; Stephenson & Wilson, 2004; Yanosh 1966).

Observation of nurses' behaviors was the second phase (Stephenson & Wilson, 2004). Patients described examples of positive behaviors such as when the nurse returned to check on the patient. Patients perceived this as the nurse extending herself in loving concern. These findings compared to Creel's (2007) study whose participants had no religious affiliation, but who described spiritual care as the nurses' *extension of self.* Initiation, the third stage of spiritual care, was exemplified by nurses offering a spiritual intervention such as prayer. Patients also initiated conversations about spiritual topics. The final stage was receiving spiritual care.

When asked by researchers to describe spiritual care, patients listed nurse characteristics and activities that were consistent with holistic nursing care. Patients mentioned consideration, dedication, attentiveness, kindness, sincerity, reassurance, empathy, love, and spiritual mindedness as nurse characteristics (Conco, 1995; Davis, 2005; Stallwood-Hess, 1969; Sellers, 2001; Yanosh, 1966). Spiritual care activities included interventions consistent with nursing care. Conco concluded that "taking time, active listening, being available, doing, sharing self, and showing acceptance and understanding were all valued and perceived as spiritual" (p. 275). These studies support

the importance of spiritual care to patients as well as identify the interventions patients indentified as spiritual care. Further review of the literature defined spiritual care as connectedness, as feeling known and understood, and as finding meaning in illness.

Connectedness

Connectedness is a major element and key process identified in the literature as spiritual care (Bullard, 1994; Cone, 1994; Sellers, 2001). Several studies of spiritual care describe connectedness between the patient and the nurse (Conco, 1995; Davis, 2005; Tanyi, et al., 2006) as manifested by presence of the nurse. Nurses have used presence, quality time, listening, shared beliefs and experiences (especially suffering), music, touch, and humor to enhance connection with patients. In addition, nurses have made connections with patients by showing respect, listening, and being genuine and authentic (Sellers; Taylor, 2003).

Many studies described the connectedness between the patient and the nurse during the giving of spiritual care (Conco, 1995; Cone, 1994; Davis, 2005; Sellers, 2001). By sharing of themselves with the patient, nurses enhanced connectedness and gave spiritual care (Conco; Creel, 2007; Davis; Schwartz, 1995). Taylor (2003) found that cancer patients considered the simplicity of being kind and showing respect as the most frequent spiritual care intervention. The nurse's friendly demeanor, a smile, and a respectful manner when addressing patients conveyed kindness and respect. One patient said nurses set the tone and raised morale by their positive behaviors.

Nurses gave spiritual care by being present to patients through spending quality time, giving attention to the patient, active listening, and physical touch (Belcher &

Griffiths, 2005; Carroll, 2001; Grant, 2004). A nurse in Bullard's (1994) study discussed the experience of being there for a patient:

> I sort of sensed what she needed, because I just listened to her and got to know her and found out what she needed. And even though there is all that other stuff out there, Hospice and Living with Loss and therapists, that's not what she needed, you know. She just needed somebody to be with her...I've just decided rather than trying to fix things I could just *be* there. (p. 24)

When nurses spend quality time with patients, they are giving spiritual care. Nurses may not realize that the quantity of the time is not as important as the quality. One participant felt cared for when the nurses spent only "a few minutes" to connect with her even though the participant knew the nurse had other patients (Davis, 2005, p. 130). The nurse took the time to see her as a person and not just evaluate and care for her disease. Schwartz (1995), a patient with lung cancer wrote, "I realize that in a high-volume setting, the high-pressure atmosphere tends to stifle a caregiver's inherent compassion and humanity. But the briefest pause in the frenetic pace can bring out the best in a caregiver and do much for a terrified patient" (p. 4). Patients remembered spiritual care in the context of touch and five-to-ten minute visits years after they occurred (Conco, 1995).

Listening was a key intervention described by patients and nurses (Carroll, 2001; Cimino, 1992; Dettmore, 1986; Grant, 2004; Martin et al., 1976; Maddox, 2000; Sellers, 2001; Sellers & Haag, 1998; Stallwood-Hess, 1969; Tanyi et al., 2006; Yanosh, 1966). Being a good listener, letting the patient talk and referring to a chaplain were the most common spiritual interventions (Dettmore; Lemoine, 2002; Belcher & Griffiths, 2005;

Sellers & Haag). Patients were very appreciative when nurses took time to listen to their concerns, because they had a real need just to be listened to (Bullard, 1994). When listening sincerely, the nurse showed that the human spirit was something sacred, to be respected and honored (Raholm, 2002).

Nurses can listen even though they may not agree with patients' spiritual beliefs or be religious themselves. Gooch (2007), a nurse who described herself as someone who did not believe in God, asserted that nurses do not need to be religious to give spiritual care. Treolar (2001) related how a student described incidents involving spiritual care:

> "I am not religious. However, there are many occasions in which my presence, knowledge and caring are appreciated." Although she said it took a long time to do this, she ministered to two families with dying members by listening to them express their anger and sadness. She indicated that her actions were vital to their "getting through a terrible time in their lives." (p. 20)

Another student, who was not comfortable with spiritual matters, asked a patient what nurses could do to help. The patient, who had been recently been diagnosed with liver cancer, said, "Just listening" (p. 20).

Even though some nurses may think spirituality and religion are too private and may be uncomfortable discussing these matters with patients, most nurses can listen and accept what the patient talks about. Martin et al. (1976) concluded that nurses did not need to know all the answers about specific religions, but rather nurses needed to appreciate how important it is for the nurse to listen and allow the patient to talk.

On one hand, the nurse does not have to be a spiritual or religious expert and know all the details about spiritual care or religious and cultural practices. Listening intently and accepting what a patient or family member shares are basic spiritual care. On the other hand, having shared spiritual beliefs can further enhance connectedness (Conco, 1995; Davis, 2005). By sharing of themselves with the patient, nurses enhanced connectedness and gave spiritual care (Conco; Davis; Schwartz, 1995). Patients saw sharing of beliefs as a bond that transcended occupations or the hospitalization of the patient. Another dimension of connectedness occurred if the person giving spiritual care had also suffered a similar situation, which increased the spiritual caregiver's understanding of the patient's circumstances (Conco; Schwartz).

Music has been identified as another aspect of connectedness. Carson (1989) described the benefits of music as relaxing and refreshing; music can reduce anxiety and lessen depression and suffering. A nurse described the power of music in a story of an acutely ill elderly woman, who was being prepared for surgery. She said,

> She looked up at me and said, "I've lost my song." She was very upset and kept telling me she had lost her song. I leaned down close to her and asked her what song she had lost. She started singing *Amazing Grace*; I placed my mouth close to her ear and sang with her. I thought I was being quiet but the next thing I heard was the other people in the room singing also, the scrub tech, the assistant and the anesthesiologist; all of the verses then we put her to sleep. The lady never woke up, she did survive the surgery but died in ICU a couple of days later. I hope the music helped her; I know it did us. (Adams, 2005, pp. 1-2)

The use of touch can create a connection between the caregiver and the patient. (Davis, 2005; Conco, 1995; Tanyi et al., 2006). Patients perceived they received spiritual care by the nurse's touch when giving physical care (Stephenson & Wilson, 2004). Physical contact conveyed by a touch or a hug also communicated acceptance and encouragement to patients (Sellers, 2001). Schwartz (1995), a patient with advanced lung cancer, told of the importance of connection between the nurse and patient:

> For as skilled and knowledgeable as my caregivers are, what matters most is that they have empathized with me in a way that gives me hope and makes me feel like a human being, not just an illness. Again and again, I have been touched by the smallest kind gestures-a squeeze of my hand, a gentle touch, a reassuring word. In some ways, these quiet acts of humanity have felt more healing than the high-dose radiation and chemotherapy that hold the hope of a cure. (p. 4)

In addition to touch, patients and nurses described humor as a positive intervention that facilitated their connectedness (Belcher & Griffith, 2005; Davis, 2005; Grant, 2004; Johnson, 2002; Maddox, 2000; Sellers, 2001). Johnson noted that when nurses and patients used humor, trust was increased and the nurse-patient relationship was enhanced. The use of humor by the health care provider also helped the provider cope, relieved the patient's stress and encouraged them spiritually. Humor "...has an incredible capacity to heal body, mind, and spirit" (Carson, 1989, p. 198).

In many ways, giving spiritual care is an extension of the already intimate nurse-patient relationship. In a community health setting a student realized the connection in the nurse-patient relationship. She said,

> We are already in an intimate relationship, and it is only appropriate to talk about spirituality if they so choose. I mean we can clean their bottoms, stick needles in their arms, but we cannot speak of God, who is so prevalent in the lives of so many. (Cantazaro & McMullen, 2001, p. 223)

Studies have found nurses enhanced connectedness by their presence, active listening, shared experiences, and asking about the patients' spirit, music, touch, humor, and quality time. Another key spiritual need of the patient is to feel known and understood.

Feeling Known and Understood

Several studies reported that when nurses acknowledged patients as individuals, patients felt understood (Belcher & Griffiths, 2005; Davis, 2005; Sellers, 2001). Patients said they felt known and understood when they were listened to and respected and described feelings of uniqueness, feeling human and feeling like a "real person" as benefits or outcomes of spiritual care. "Of note, good nurses seemed to make the patient feel special" (Davis, p. 129). The participants in Sellers' ethnographic study of the meaning of spiritual care to adults in the Midwest said that nurses' recognition of the unique lived experience of the patient was the most important way nurses could understand the patient's experience of spirituality. Patients felt valued and important when they were cared for as an individual (Davis).

Patients remembered negative experiences with feeling known and understood more often than positive experiences. One participant, who had had multiple hospitalizations in one year, stated it was difficult to have a different nurse each day and wondered if this scheduling was deliberate on the nurses' part to avoid developing a

relationship with patients (Sellers, 2001). When nurses ignored the spirituality of the patient, one patient said, "I couldn't tell if the doctors or nurses knew I was a person, let alone a spiritual person" (p. 8). Participants compared lack of spiritual care with the removal of humane care. A participant who had a mastectomy said spiritually ineffective nurses were cold at a time when she was "low" and needed spiritual care the most. Nurses recognize patients' uniqueness by listening, showing respect, acknowledging his/her spiritual needs, and giving spiritual care. Giving individualized care is basic to spiritual care. Another need recognized by patients was to find meaning in illness.

Finding Meaning in Illness

Studies described how patients received spiritual care and found meaning through their religious practices (Belcher & Griffiths, 2005; Dettmore, 1986; DeWitt-Weaver, 1985). Actions related to religion included praying and reading sacred literature. Spiritual care interventions used by nurses in hospice and home health care included arranging for patients to attend their church services. Specific to a hospice environment, audio tapes that enhanced spirituality (Bible readings or music) and singing were additional spiritual interventions (DeWitt-Weaver).

One hospice nurse expressed how she helped a terminally ill leukemia patient find meaning by locating a specific reference in the Bible so the patient did not have to wait for a clergy referral (Van Dover & Bacon, 2001). After reading the requested Bible verse, the patient had a peaceful look. Another hospice nurse encouraged a dying child's mother to read Bible verses about heaven to her daughter; this brought the mother peace and allowed her to give spiritual care to her daughter (Van Dover & Bacon). A

participant in Sodestrom and Martinson's (1987) study of cancer patients and their nurses pleaded for nurses to support patients spiritually, "People fall back on their religion in times of crisis...nurses should recognize this and support the patient's beliefs as a strength and resource for him, but make it specific to the patient's religious background" (p. 45). Nurses also reported spirituality assisted them and their patients to make meaning out of their circumstances and assisted with the decision-making process at the end of life (Brown, 2000; Sterling-Fisher, 1996).

Persons who are suffering seek to find meaning through their experiences. What patients believed about their suffering was related to their religious and spiritual convictions (Reed; Wright, 2005). However, persons who were not religious made meaning of their suffering based on their past and present situations (Black, 2007). Nurses commonly encountered their patients' pain and suffering (Davitz & Pendleton, 1969; Wright); alleviation of pain and suffering was a focus of nursing care (Reed, 2003). Spiritual care was defined in the literature as connectedness, as feeling known and understood, and as finding meaning in illness, Specific spiritual care interventions were also identified in the literature.

Spiritual Care Interventions

Spiritual care interventions can be as general as listening and nurse presence or as specific as prayer or assisting with a religious ritual. Grant (2004) studied 299 bedside nurses at a university hospital to examine their spiritual care practices. Nurses in the study believed benefits of spiritual care for patients included inner peace, strength to cope, decreased bodily pain, and a deeper meaning of their illness. Participants reported

using touch (holding the patient's hand), active listening, laughter, prayers, and presence as the spiritual care interventions they recommended or provided.

Nurses described spiritual care as rewarding and important. Van Dover and Bacon (2001) described how nurses were eager to give spiritual care, "...they prayed and sought God's direction, were familiar with spiritual resources, were experienced in praying, and reading Scripture, and were willing to address spiritual needs promptly" (p. 27). The importance of spirituality in the professional and personal lives of the nurses participating in this and other studies was evident in the definitions they discussed and the role spirituality played in end-of-life issues (Sterling-Fisher, 1996). Narayanasamy and Owens (2001) found that nurses felt rewarded after giving spiritual care. From the nurses interviewed, it could be inferred "... spiritual care interventions directly or indirectly reduced distress and enabled patients to gather emotional strength to cope with their illness and suffering" (p. 53).

Sometimes, just asking the family or patient what they needed to help their spirit allowed the nurse to facilitate spiritual care (Van Dover & Bacon, 2001). Van Dover and Bacon told the story of a patient with lung cancer. He and his family were angry about their situation. When asked what would help, the family said, "Prayer." The nurse then facilitated a prayer around the patient. The researchers described this as a powerful moment for the family members: "The nurse described the prayer as a eulogy while the patient was still alive" (p. 26).

Nurses reported praying with the patient as a frequent nursing intervention (Stallwood-Hess, 1969). Furthermore, many nurses listed prayer as spiritual care (Belcher

& Griffiths, 2005; Bullard, 1994; Carroll, 2001; Grant 2004; Sellers & Haag, 1998; Van Dover & Bacon, 2001). Nurses who practiced in a variety of settings such as the hospital, community health, hospice and church parishes all described how they assisted patients with prayer (Van Dover & Bacon). They prayed with and for patients and facilitated hospital staff, family, and friends to pray with and for patients. They sat and held patients hands when they prayed even if they felt uncomfortable or unprepared. Studies found activities like reading scripture, helping patients attend church services, providing audiotapes of scripture and music, and facilitating prayer helped patients find meaning as they faced illness. Regardless of their level of personal spirituality, nurses provided spiritual care by listening and referring to clergy, and conveying a non-judgmental attitude (Dettmore, 1986).

In a qualitative study of patients' views of nurses giving spiritual care, Sellers (2001) concluded: "Nurses can enhance spirituality by understanding the unique human experience of each person through the establishment of a caring human relationship characterized by the art of being present, listening, respecting, and giving of self" (p. 8). Another informant succinctly summarized his perspective of and confidence in nurses and spirituality:

> Nurses are in a profession that I would rank, potentially, as equal to clergy in dealing and administering to spiritual needs. Their genuine caring, the connectedness that nurses have with persons is such a foundation for spirituality in their care, for encouraging patients, for listening to their patients, for practicing whatever forms of spiritual encouragement and communication they feel they can

and should do. They need to consider themselves special people. They also need to realize spirituality is a scary area and people who are concerned know it's scary—that it's scary personally and it's scary professionally. Finally, I would want them to know that anything they can do that is genuinely caring for their patients and giving their patients awareness of being cared for personally is already spiritual service. Anything beyond that is frosting on the cake. (p. 9)

Barriers to Giving Spiritual Care

The barriers to giving spiritual care include confusion about spiritual care, confusion of roles, lack of education, and increased work and lack of time. There is also an inconsistency between reported positive nurse beliefs about spiritual care and actually giving spiritual care. If nurses understood these barriers, they might be more likely to give spiritual care.

Confusion About Spiritual Care

While many nurses agreed that spiritual care is a nursing responsibility, a disparity exists between that belief and the actuality of giving spiritual care (Bradbury et al., 1988; Chadwick, 1972; Lemoine, 2002; McSherry & Ross, 2002; Musgrave, 2000; Piles, 1990; Stranahan, 2001; Vance, 2001; Yancy, 1987). Nurses in Chadwick's study reported they were comfortable giving spiritual care, but only 25% said they had given spiritual care. Similarly, nurses in Vance's study almost 30 years later perceived themselves as spiritual, yet 65% said they felt inadequate to give spiritual care. Other researchers (McSherry & Ross; Piles; Yancy) reported that nurses felt uncomfortable or inadequate giving spiritual care. Although a few studies cited that nurses did not

recognize spiritual needs and therefore could not give spiritual care (Highfield & Cason, 1983; Piles, 1980), other studies reported a readiness on nurses' part to give spiritual care (Grant, 2004; Van Dover & Bacon, 2001). As expected, nurses who had a high sense of spirituality reported placing importance on and giving spiritual care more often than nurses who had a low sense of spirituality (Bradbury et al., 1988, Champaigne, 1987; Cimino, 1992; DeWitt-Weaver 1985; Meyer, 2002; Soeken & Carson, 1986; Taylor & Amenta, 1994; Taylor et al., 1999; Wagner, 1998; Wujcik, 2003). Studies found older nurses were more comfortable in giving spiritual care (Hall & Lanig, 1993; Taylor et al., 1999).

Lemoine (2002) surveyed 50 nurses and found that 70% prayed for their patients but only 4% actually prayed with patients. Yancy (1987) and Piles (1990) also found that nurses accepted responsibility for spiritual care but felt uncomfortable or inadequate when giving spiritual care. Piles found 96.5% of respondents agreed patients needed holistic care but 65.9% stated they felt inadequate to give spiritual care. In addition, although the nurses in Vance's (2001) study perceived themselves as very spiritual, only 25% gave spiritual care to their patients.

Stranahan (2001) also found similar results from a survey of nurse practitioners using Reed's *Spiritual Perspectives Scale* and the *Nurses' Spiritual Care Perspective's Scale*; more than half of the 102 respondents said they rarely provided spiritual care. This correlated with the 57% who stated they had inadequate educational preparation for spiritual care. However, the data did strongly support spiritual care as a significant part of the nurse practitioner's sphere of practice.

Confusion of Roles

Studies described a myriad of persons who could give spiritual care such as clergy, family and friends, nurses, doctors, and other professional and nonprofessional hospital employees (Broten, 1991; Carroll, 2001; Conco, 1995). Patients recognized that nurses should assess and then refer patients to clergy as needed (Martin et al., 1976; Stallwood-Hess, 1969). They felt nurses did not need to be experts on religion to meet general spiritual needs (Conco), but clergy could better meet specific needs (Martin et al.). Govier (2000) indicated nurses should be involved in spiritual care as part of holistic nursing; however, they should also recognize their limitations when dealing with situations that required referral to chaplains and other spiritual advisors.

"Seeking help" from other professionals emerged as a theme for nurses in the care of a hospice patient (Carroll, 2001). Patients often had religious needs, which nurses referred to chaplains. Patients also had financial needs, and nurses referred patients to social workers for assistance and location of resources. Although non-religious nurses could actively listen, those nurses referred patients to chaplains for religious issues.

Taylor (2003) interviewed 28 patients and their caregivers who represented diverse religious affiliations and found that some patients did not expect the nurse to attend to their spiritual needs but rather "be the nurse" (p. 587). These patients thought family, friends, or clergy could meet their spiritual needs. Some patients saw spiritual care by nurses as inappropriate because they thought nurses would coerce them to accept certain religious beliefs. Patients related the discussion of spiritual care with a serious

situation and were reluctant to discuss spiritual issues because of this negative connotation.

Even though there is a positive relationship between nurses' spiritual well-being and their comfort in giving spiritual care, the more religious nurse may not be the best nurse to give spiritual care (Taylor & Amenta, 1994). A highly religious nurse may have difficulty relating to a patient without religious beliefs or a patient who believes differently than the nurse. In cases where there is a difference in spiritual values and beliefs, just listening can be a positive intervention.

Chaplains and clergy provide spiritual and pastoral care from an expert point of view. Patients have individual needs and preferences regarding chaplains as spiritual caregivers. Situations where patients desire a referral and nurses agree a referral is necessary, include times when the nurse has limited time to address spiritual issues and when the spiritual needs are complex and beyond the scope of expertise of the nurse. Of course, even in these situations, nurses can listen empathetically and practice presence (Taylor & Amenta, 1994).

Chaplains have requested that nurses be educated about their role, particularly how their spiritual assessment differs from the nurses' (VandeCreek, 1997). Nurses may not be aware of the professional courtesy preferred by some chaplains. Chaplains recommended nurses inform them so they can communicate directly with patients' clergy when their families are not available (VandeCreek). VandeCreek also discouraged the practice of nurses referring patients to the nurse's clergy unless the patient specifically asked the nurse to do so.

Some chaplains did not think nurses should do spiritual assessments (Breresford, 1997; Sakuraj, 2003). They argued that nurses should do nursing assessments and chaplains should do spiritual assessments. One chaplain said, "There may be some spiritual challenges that nurses and social workers shouldn't attempt to tackle...Just as I don't give enemas" (Breresford, p. 23). Rationale for this stance could be the extensive education hospital chaplains received for their role as well as a lack of appreciation and communication between nurses and chaplains regarding their respective roles in giving spiritual care (Breresford).

In some respects, patients may prefer nurses as spiritual caregivers because nurses can be less threatening than a chaplain who may be seen as a representative of God (Highfield, 1992). On the other hand, chaplains may be preferred because of their expertise in spiritual matters. Regardless of the choice, spiritual caregivers should work in a collaborative manner to meet the unique spiritual needs of patients.

Lack of Education

Another barrier to giving spiritual care is the reported lack of education nurses receive about spirituality and spiritual care. Two nurse characteristics that predicted giving spiritual care were a high degree of personal spirituality and the emphasis on spiritual care in one's nursing education (Meyer, 2003). Furthermore, spiritual care education varied widely and many nurses may not feel qualified to give spiritual care (McSherry & Ross, 2002; Meyer; Piles, 1990). Raholm (2002) advocated that spiritual care be included in nursing education because it is part of holistic care and its exclusion would be unethical.

Nursing education has lacked spiritual care content (Bradbury et al, 1988; Chadwick, 1972; Dettmore, 1986; Govier, 2000; Oldnall, 1996). In an early study, Piles (1980) found that the inclusion and discussion of spirituality in nursing curricula was limited. The actual skills taught were of the psychosocial nature. The schools that included the spiritual dimension in the curriculum indicated they taught it as part of the psychosocial nature of human beings with corresponding interventions of empathy, listening, or therapeutic use of self. Lemmer (2002) reported that the majority of United States nursing programs included spirituality in their philosophy and curriculum, but found that schools spent limited time teaching methods of spiritual care. The researcher questioned how appropriately spiritual care and spirituality could be consistently integrated in the curriculum when only five out of 250 baccalaureate-nursing programs had agreed upon its definition. Nursing curriculum in the United Kingdom also lacked spirituality-related concepts (McSherry & Draper, 1998). Therefore, although many nursing programs included spirituality in their curriculum, it was taught in the context of psychosocial care and not further defined.

Nurses and student nurses who received spiritual care education were most likely to give spiritual care (Meyer, 2002; Piles, 1990). Studies also validated that spiritual care education increased practicing nurses' comfort level and awareness of how to give spiritual care (Shih, Gau, Mao, & Chen, 1999; Sterling-Fisher, 1996). There appears to be a connection between spiritual education in nursing school and how often nurses consider and give spiritual care. Having faculty who modeled spiritual care positively influenced hospice nurses' giving spiritual care (Belcher & Griffiths, 2005).

In an early study of nurses, Chadwick (1972) posited that lack of education in how to apply spiritual care to practice was a major reason nurses did not give spiritual care. In this study, 60% of the nurse participants said they would have liked further education in meeting spiritual needs. Belcher and Griffiths (2005) described other sources that nurses could use for learning about spiritual care such as reading journals, continuing education, seminars, and other self-directed activities.

Increased Work and Lack of Time

Increased workload related to nurse-patient ratios and patient acuity were frequently mentioned barriers to spiritual care. The severity of a patient's illness decreased the chance that the nurse would give spiritual care. Nurses were more concerned with caring for physical needs, giving medications, and performing life-saving treatments (Dettmore, 1986; DeWitt-Weaver, 1985; Hill, 1987; Piles, 1990). Nurses identified being too busy as a barrier in several studies (Belcher & Griffiths, 2005; Cimino, 1992; Cox, 1995; DeWitt-Weaver, 1985; Hill, 1987; Lewis, 1957; Piles, 1990; Sodestrom & Martinson, 1987; Vance, 2001). Similarly, patients reported their nurses were too busy to offer spiritual care (Broten, 1991; Davis, 2005; Stallwood-Hess, 1969). Patients did not want to bother the nurse with their spiritual needs; one patient thought nurses were too busy, but wished nurses would attend to spiritual needs (Stallwood-Hess). From the patient's perspective, spiritual care did not require extra time; nurses could add spiritual care to their regular duties (Conco, 1995). The quality of the nurse-patient interaction was more important than the quantity of the interaction (Lemmer, 2002).

In summary, there are barriers that keep nurses from giving spiritual care. Confusion over who should give spiritual care occurs. Some nurses may think clergy are better qualified to give spiritual care, and some clergy believe they are the only ones who can give spiritual care. Nurses report lack of education regarding spiritual matters in nursing programs and in continuing education for practicing nurses. Nurses have increased work and patient acuity, which may prevent them from giving spiritual care. Finally, studies showed a disparity between nurses who say they believe spiritual care is important but who do not give spiritual care.

Lived Experience of Giving Spiritual Care

While quantitative studies may describe various aspects related to spiritual care, qualitative studies provide in-depth exploration of the experience of giving spiritual care. Few qualitative studies have explored nurses' experiences of giving spiritual care. Two grounded theory and four phenomenological studies were reported in the literature. Cone (1994) used grounded theory methodology to clarify the experience of giving spiritual care. The participants of the study included eight faculty and 29 undergraduate and 24 graduate students for a total of 60 participants, and data collection included triangulated questionnaires with Likert scales, written responses, and small groups interaction. The participants identified connection as the emerging basic social process, "The interaction between the nurse and the patient becomes spiritual care when the nurse connects on a deep, transcendent level with the patient in such a way as to provide support and enablement for the patient's beliefs, values, practices..." (p. 78).

Van Dover and Bacon (2001) also used grounded theory to interview 20 nurses who worked in various clinical areas such as general medical-surgical, labor and delivery, community health, oncology, ICU, and parish nursing in order to identify the process of giving spiritual care. They determined that nurses were actively involved in the process of giving spiritual care and that nurses needed to be involved in moving patients into dialogue with God. Nurses in a hospital setting described how they recognized patients' spiritual needs when patients were angry and when patients and patients' families requested prayer from nurses (Van Dover & Bacon). Although giving spiritual care was challenging due to lack of time and the complexity of physical needs, nurses determined giving spiritual care was a priority for specific patient situations. For example, a patient in ICU with complex physical needs responded that she wanted the nurse to pray for her. After the nurse prayed, the nurse reflected on the experience:

> Then I just waited . . . I'm (wondering) what should I do now? (I recall) the struggle to get up and deal with the medicines and her heartbeats but she was holding my hand so tightly that I knew she needed the spiritual peace far more than she needed the medicine. (p.20)

As nurses prayed for patients, they directed the patient to God and patients found comfort through this process. Nurses also found this experience very meaningful.

One of the home health nurses reported encouraging a depressed psychiatric patient to reconnect to God with religious devotionals and prayer (Van Dover & Bacon, 2001). Similarly, parish nurses used their long-term relationship with a patient, physical touch, and prayer as spiritual care interventions to assist a patient restore a broken

relationship with God. A hospice nurse encouraged a patient to connect with God by finding meaning in his dying with a Bible verse. Hospice nurses also sensed the need to assist a family and directed family members to pray for terminal patients, which provided profound peace for the family.

Through prayer and being sensitive to spiritual needs, the main process of "moving the patient into dialogue with God" crossed all settings. Nurses used prayer often to meet spiritual needs, "Nurses prayed when the initiative for spiritual care was taken by the patient or family member and in response to the nurse's assessment of the situation" (Van Dover & Bacon, 2001, p. 26). In summary, giving spiritual care was a powerful experience for the nurse and patient, "...nurses who gave spiritual care are engaging the core of who they are in caring for others. This level of interaction creates meanings and memories that are life- and health-giving for the nurse as well as the patient" (Van Dover & Bacon, p. 28).

Kociszewski (2003) described similar themes that reflected movement toward God as spiritual care in a phenomenological study of three nurses' experience of giving spiritual care. Seven themes emerged:

> the spiritual nurse, capturing the elusive and abstract nature of spirituality, the nurse-client spiritual journey, opening the doors for the spiritual journey, choosing to be silent, the nurse as a role model for spiritual behaviors, and reaping the benefits of spiritual care. (p. 131)

The theme, capturing the elusive and abstract nature of spirituality, described the complex interpersonal process of connecting from within to the outer self of the natural environment and connecting with a higher being.

Two themes "the nurse-client journey" and "opening the doors for the spiritual journey" related to moving the patient into dialogue with God. The process of knowing the patient in order to give spiritual care described the theme, the nurse-client journey. Kociszewski (2003) described this as a highly individual process depending on the nurse and the client and their relationship. The nurse did not consistently experience success in moving the patient toward God or a higher power, and those experiences created conflict and distress for the nurse, the patient, and the family. Kociszewski concluded that the nurse changes over time through his/her spiritual experiences. Through these experiences, the nurse then guides patients and their families into a relationship with God or a higher power.

In a second study, Kociszewski (2004) interviewed 10 critical care nurses to determine the lived experiences of giving spiritual care to critically patients and their families. Themes identified by the participants included: "meanings of spirituality, out of tragedy: spiritual awakening; mutual knowing: a bridge to spiritual assessment; the everydayish-ness of spiritual care; prayer and beyond: letting go to the mystical; and spiritual caring: from suffering to blessing" (p.401). Serious illness moved the patient and the nurse to a deeper spiritual journey (Kociszewski, 2003). Spiritual awakening occurred in tragedy as a nurse said, "When a patient is dying, spirituality really comes to the

forefront because for some people that is the only path left open to them" (Kociszewski, 2004, p. 404).

Nurses also increased their spiritual awareness as they experienced patients' deaths and supported their families. This awareness influenced how they cared for other patients and how they encouraged colleagues in similar situations. One nurse acknowledged that giving spiritual care helped her grow as a more experienced nurse and gave opportunity for her to offer patient care at a higher level, enabling her to provide holistic care rather than meeting only physical needs. She said, "I think that as you evolve as a nurse, that becomes very important. You have mastered the technical stuff, and now you can take that extra step" (Kociszewski, 2004, p. 405).

Although there was intense suffering and shared grief, nurses found strength in caring for critically ill patients. It was important for nurses to care for their own spirit in order to give spiritual care to others. Nurses grew spiritually and affirmed that their presence and care helped others. As a nurse shared, "Being there for that person or that family, at that time, makes me feel better. Makes me feel like I'm in the right place. I don't mean critical care. I mean Nursing—it's a beautiful profession!" (Kociszewski, 2004, p. 408).

A phenomenological heuristic study in the United Kingdom (Carroll, 2001) sought to understand the nature of spirituality and spiritual care by interviewing 15 nurses caring for patients with advanced cancer. Similar themes that suggest assisting a patient to move toward dialogue with God were "recognizing and assessing spiritual needs," "recognize when to let the patient be," and "fostering the search for meaning." Nurses

acknowledged the necessity to "recognize when to let the patient be" (Carroll, 2001). Helpful actions included just listening if the patient wanted to talk and allowing the patient to work through their concerns in their own time. An individual patient who was difficult told a nurse,

> I know you lot think I am just lying here sleeping but I am not. I have had a lot of discussions with God, and at long last I realize that he is here and for me and does care about me. I am going to talk to him about you lot when I get there. I am ready to go now. (p. 93)

The nurse related that after the patient shared his experience, the patient's attitude and demeanor changed to being less angry and more positive.

Lastly, nurses identified how they helped patients by "fostering the search for meaning." Finding meaning meant determining what was important to the patient and facilitating actions that could be helpful like giving massages and playing requested music. A nurse in Carroll's (2001) study described praying and listening as spiritual care and described the outcome. She said,

> I can remember having lengthy discussions with him, and praying for him. I felt that perhaps what he was asking for was the miracle of healing and what he was being given was the opportunity for the miracle of peace. (p. 93)

Nurses said spiritual care was the role of the nurse and nurses developed an intimate relationship with the patients that would not occur during casual conversations (Carroll, 2001). Findings supported a team approach in meeting spiritual needs of dying patients by timely referral to other professionals. The findings maintained that nurses can

integrate spirituality into physical care and in meeting psychological needs (Kociszewski, 2004; Stephenson & Wilson, 2004; Yanosh 1966) because "...spiritual care infiltrates all aspects of nursing care" (Carroll, p. 94).

Bullard (1994) conducted a phenomenological study and interviewed seven female nurses from a variety of settings who were between the ages of 32 and 47 to determine, "What is the nurse's experience in providing spiritual nursing care?" Nurses said that personal spiritual growth and spiritual awareness were qualifications for giving spiritual care and were further described as two themes, "Personal Experience" and "Professional Experience." Nurses used descriptions of holism, presence, doing, and reciprocity to describe the theme "professional experience." Connectedness as giving spiritual care epitomized and incorporated both themes. The study was limited by the homogeneity of the participants who were female, Christian, and white.

Connectedness in the nurse-patient relationship was the main concept that described the nurses' experiences (Bullard, 1994). Reciprocity was another theme illustrated by the experience of nurses and patients mutually sharing their perspectives of spirituality. Patients made positive comments about how much a nurse's spiritual care meant. Connectedness and reciprocity were aspects of spiritual care. Giving spiritual care was a meaningful and personal experience for nurses as they grew spiritually and as they assisted patients on a journey to move them toward a dialogue with God. Nurses used spiritual care interventions to help patients face their illnesses. Bullard concluded that spiritual care was an abstract concept, difficult to define.

In summary, nurses in these studies described how they connected at a deep, and intimate, transcendent level with their patients in the experience of giving spiritual care (Bullard, 1994, Carroll, 2001; Cone, 1994, Van Dover & Bacon, 2001). They experienced connecting to a higher power, both for themselves (Kociszewski, 2003) and for their patients (Van Dover & Bacon). The experience of giving spiritual care was powerful, full of meaning, highly individual for both the nurse and the patient, and had positive benefits such as creating healing and meaning (Kociszewski; Van Dover and Bacon). The literature offers an initial understanding of the experience for nurses of giving spiritual care in settings such as the ICU and oncology. More research is needed, however, in other settings such as the dialysis unit which offers a rich setting for further study of nurses' experience of giving spiritual care.

Spiritual Care and Dialysis Patients and Nurses

Spirituality is central in the lives of dialysis patients (Al-Arabi, 2006; Baldree et al., 1982; Berman et. al, 2004; O'Brien, 1982; Patel, Shah, Peterson, & Kimmel, 2002; Tanyi et al., 2006; Walton, 2002). Al-Arabi (2006) conducted a qualitative study of 80 patients in an outpatient dialysis center to determine how these patients managed their quality of life. The findings supported the centrality of spirituality in how these patients coped with their illness. Patients described how trusting God and engaging in spiritual activities like prayer and talking with friends from their church helped them cope daily. They included their inability to go to church with limited social interaction as negative aspects of dialysis. Other studies found that dialysis patients used spiritual activities such

as prayer (Baldree et al., 1982) and their faith in God (O'Brien, 1982) to cope with their illness.

The findings from two quantitative studies of hemodialysis patients support the importance dialysis patients place on religion and spirituality in coping with their illness. In their study of 74 hemodialysis patients, Berman et al. (2004) assessed the relationship between religiosity and medical and/or social factors and adherence to treatment. They found a high correlation between religious beliefs and satisfaction with life, but there was no reported relationship between religiosity and adherence. Advanced age was strongly related to adherence. Patel et al. (2002) also found that dialysis patients might use religious beliefs to help them cope with their illness. The researchers investigated the relationships between religious beliefs and psychosocial and medical factors for 53 hemodialysis patients. Strong correlations were found "between hemodialysis patients' religious and spiritual beliefs and decreased perceptions of burden of illness and increased perceptions of social support" (Patel et al., p. 1019). Patients who had higher religious and spiritual belief scores also were less depressed and had a higher quality of life score.

Walton (2002), using a ground theory framework, asked four men and seven women what spirituality meant and how it influenced their lives. The researcher found that spiritually related concepts like connectedness with God, relationships with others, and prayer facilitated adjustment to dialysis and increased patients' ability to cope. Tanyi et al. (2006) found similar findings in a phenomenological study of 16 women hemodialysis patients. The researchers asked the participants how they wanted dialysis

nurses to address their spirituality. They discovered that female dialysis patients wanted caring, a relationship that enhanced connectedness, spiritual conversation, and provision of spiritual resources from the nurse. Patients also said that dialysis nurses were in a unique position to assess and provide spiritual care. The authors argued for the need for more research, "Currently, little phenomenological knowledge exists in the nursing literature, to guide nephrology nurses..." (p. 536).

In summary, more research about nurses' experience in settings such as the dialysis unit are needed. Not only is spirituality central to how they cope with their illness, dialysis patients can develop a close relationship with their nurses because they commonly receive dialysis at least 3 days a week for a 3-hour period (American Nephrology Nurses' Association, 2006). Therefore, dialysis nurses have many opportunities to offer spiritual care to their patients. Spirituality helps dialysis patients cope with their illness and treatment. Dialysis patients and families desire nurses who are caring; spirituality is a central part of caring. There is a need for more qualitative research to understand dialysis nurses and their experience of giving spiritual care.

Summary

Spirituality helped patients cope with their illness. Spiritual perspective is important for those confronted with the end of life (Feher& Maly, 1999; Walton & Sullivan). Dossey (1999) commented that neglecting spiritual care is similar to when health care providers did not discuss sexuality, alcohol habits, and diet and exercise 20 years ago. Spirituality is a key part of holistic care. "When spirituality is taken for

granted, clients may be deprived of crucial support - including their religious belief system that could be activated as a source of comfort" (Newman, 2005, p. 35)

Nurses are in a prime position to assess spiritual needs, plan and implement spiritual care interventions, and evaluate their effectiveness (Highfield & Cason, 1983, Shelly & Fish, 1988; Van Dover & Bacon, 2001; Wright, 1998). Chadwick (1972) asserted that spiritual care is important but not done. More research regarding nurses and their experience in giving spiritual care is warranted (Cone, 1994; Hall & Lanig, 1993; Highfield, 2000; Taylor et al, 1994).

Spirituality is an important part of holistic nursing care, but little progress has been made regarding what is known about spiritual care, who can offer it, how it is different and the same as religious care, how it is given, and how it is evaluated (Breresford, 1997). This study will expand knowledge about what it is like for nurses to give spiritual care, and therefore increase understanding of the process. Nurses can apply their understanding of how nurses give spiritual care to patients in clinical settings, to nursing education, and to general public education in order to benefit patients.

CHAPTER III

METHODOLOGY

The purpose of this phenomenological study was to explore the lived experience of nurses giving spiritual care using the descriptive phenomenological method first described by Edmund Husserl (1964). This chapter will discuss an overview of phenomenology and the differences between descriptive phenomenology and hermeneutic phenomenology. A description of the research plan is followed by a report of the pilot study and discussion of the research process that includes a description of the setting, participants, and data generation and analysis strategies. Lastly, strategies to maintain rigor and protection of participants will be discussed.

Phenomenology

Phenomenology was to serve as the framework for this study. Phenomenology is the study of lived experience in which the researcher is discovery-oriented. The researcher is on a quest to know answers to the following questions. "What is this everyday experience like? What is its meaning? How is it experienced?" Through reflection, a deeper knowing of the essence of an experience emerges (van Manen, 1990). Lopez and Willis (2004) asserted that the phenomenological approach and nursing are a good fit because phenomenology seeks to understand unique individuals and experiences. The aim of this study was to understand fully the essence of the experience of giving spiritual care.

Edmund Husserl, a German philosopher, developed phenomenology as a response to the traditional scientific method, which measures and values concrete, observable events (Powers & Knapp, 1995). He argued that the scientific method could not appropriately capture the abstractness of phenomena. Husserl recommended a "return to 'the things themselves,' essences that constitute the prescientific world of human consciousness and perception" (Powers & Knapp, 1995, p. 123). Husserl described a life world (*Lebenswelt*) or lived experience. In order to understand this experience, a person reflects on a realm of what persons normally "...take for granted and therefore fail to explore..." (Powers & Knapp, p 123). To explain this idea, persons do not really think about their day-to-day experiences unless they critically reflect on them. Phenomenology, then, provides the tools for deep exploration into human existence and experience (Munhall & Oiler, 1986) in order to understand the actual lived experience of a phenomenon by examining persons' accounts of their experiences. Nurse researchers have used phenomenology to investigate a variety of phenomenon such as empathy (Ballie, 1996), the lived experience of new nurses working in a neonatal unit (Litchfield & Chater, 2006), and non-caring and caring in the clinical setting (Riemen, 1986).

In this study, the researcher planned to examine nurses' accounts of their experiences of giving spiritual care using descriptive phenomenology, which is associated with the writings of Husserl (Cohen, Kahn, & Steeves, 2000). Husserl's ideas included phenomenological or *eidetic* reduction and bracketing. *Eidetic* comes from Plato's word for idea or form and refers to the idea that essences are universal concepts (Cohen et al.). Bracketing refers to the idea of setting apart, as in a mathematical

equation, any preconceived notions or ideas about the phenomenon. The researcher planned to achieve this by purposely recognizing and setting aside attitudes, biases, and knowledge about spirituality during data collection and analysis. Descriptive phenomenology seeks to "bring out the essential components of the lived experiences specific to a group of people" (Lopez & Willis, 2004, p. 3). The researcher planned to describe the essence of nurses' experience of giving spiritual care by investigating this experience for nurses who care for dialysis patients.

Research Plan

Setting

The setting of this study was to be outpatient dialysis centers in a community of approximately 100,000 in East Texas. There were four outpatient dialysis centers in the primary city. Dialysis nurses were chosen as the study's focus because of the complex nature of care for the dialysis patient and the close, long-term relationships that form between these nurses and their patients.

Participants

Participants in this study were to be registered nurses who worked in an outpatient dialysis center and who spoke English because the researcher only spoke English. It was anticipated that 6 to 10 dialysis nurses would be recruited. After facility approval, the researcher planned to place a flyer, asking nurses to participate in the study in nurses' stations of dialysis units. The flyer asked, "Have you had a memorable experience with patients and spiritual care?" It was anticipated that nurses would contact the researcher

via email or phone if they were interested in talking about their experience in a mutually agreeable location.

Data Generation

Potential participants were to contact the researcher and a mutually agreeable time and place was to be determined for the interview. Options for locations were to include the researcher's faculty office, a conference room at the participant's work, or a conference room at the researcher's employing college of nursing. The researcher planned to obtain informed consent prior to the interview. It was anticipated that the participants would complete a demographic data form. The researcher planned to conduct audiotaped or digital-recorded face-to-face interviews with each nurse participant. The interviews were to last approximately one hour and were to be transcribed verbatim.

The investigator planned to ask participants to "Tell me about a memorable experience with a patient taking care of spiritual and/or psychosocial needs that you will never forget." The investigator intended to obtain additional information by asking questions including, "What was the experience of giving spiritual care like?" and "What is it about your relationship with the patient that allows you to give spiritual care?" Probes were to elicit more information and include statements such as, "How did you feel about that?" "In what way?" "Can you give an example?" The researcher anticipated closing each interview by asking participants if they had anything to add at the end of the interview.

Data Analysis

Data were to be analyzed using Colaizzi's (1978) phenomenological approach, because this method of data analysis is associated with descriptive phenomenology (Cohen et al., 2000). Researchers have used this approach to investigate nurses' lived experiences of giving spiritual care. Kocizewski (2004) used Colaizzi's data analysis method to discover that critical care nurses integrated spiritual care into their everyday nursing care. Spiritual care was important to the nurses and was associated with job satisfaction. Conco (1995) also employed Colaizzi's method to determine that Christian patients described how spiritual care, given at a vulnerable time, allowed them to rise above their situation and find meaning and connection with the nurse. Likewise, Ballie (1996) conducted a phenomenological study using Colaizzi's method to understand the nature of empathy as perceived by registered nurses. Colaizzi's data analysis was determined to be an appropriate methodology for this study with its focus on finding the essence and meaning of the experience of giving spiritual care for dialysis nurses. The analysis was planned to include the following procedural steps suggested by Coliazzi.

First, the researcher planned to read all participants' descriptions of the phenomenon for a general overview and then to choose significant statements that pointed to the phenomenon (Colaizzi, 1978). Then, the researcher planned to make sense of the statements by exploring formulated meanings. Then, each formulated meaning was to be clustered into themes. An exhaustive description related to dialysis nurses' experience of giving spiritual care was to be the final step of the analysis. The researcher intended to complete the analysis by returning to the participants for validation of the

description. If new data were revealed, the researcher planned to incorporate it into the exhaustive description of nurses' lived experience of spiritual care.

Protection of Human Participants

The researcher obtained approval for this study from the Texas Woman's University Institutional Review Board (See Appendix G). Permission and a letter supporting the study was obtained from the dialysis centers (See Appendix H). Procedures to ensure confidentiality included using pseudonyms rather than the participants' names in the transcripts and reports of the findings. It was anticipated that participants would sign an informed consent form and the researcher would instruct them about their right to withdraw from the study at any time. The researcher planned to keep audiotapes and transcripts in a locked file and destroy them within five years of the end of the study.

Methodological Rigor

The trustworthiness and authenticity criteria guided this study. Trustworthiness is determined by credibility, transferability, dependability, and confirmability (Erlandson, Harris, Skipper, & Allen, 1993). Credibility is determined as the researcher collects and analyzes the data through a process of "reflecting, sifting, exploring, judging its relevance or meaning, and ultimately elucidating the themes and essences that comprehensively, distinctly, and accurately depict the experience" (Moustakas, 1990, p. 32). Member checks were to be used to establish credibility. The researcher planned to send the participants their transcripts and ask them to review and verify the transcript content.

Participants were to be asked if they wanted to add information to their interview data. Changes reported to the researcher by participants were to be incorporated into the study. Doctorally prepared nursing faculty peers, who taught graduate research courses and had qualitative research experience, were to review the data analysis and provide feedback in order to assist with "debriefing."

Transferability refers to the extent to which the results of a study can be applied to similar situations. Interrelationships in one study may be applied to other situations as readers judge transferability. Thick description and purposive sampling are strategies to help foster transferability (Erlandson et al., 1993). Thick description refers to the documentation of data that reflects inferences and the context of the experience that is described (Powers & Knapp, 1995). Purposeful sampling is a method to increase in-depth understanding by selecting information-rich cases (Patton, 2002). Patients in a health crisis are more likely to seek spiritual support (Coyle, 2002; Emblem & Peverall, 2002; Wright, 1998), and dialysis nurses could yield much in determining the lived experience of giving spiritual care. The researcher planned to use purposive sampling to obtain interviews with dialysis nurses who could potentially yield rich data to capture the lived experience.

Dependability refers to the idea that the method in which data are analyzed and treated is consistent over time. Instability of data treatment could be affected by an extended period for data collection (Graneheim & Lundman, 2003). This was to be established by an audit trail, which would involve maintaining and preserving all

transcripts, notes, audiotapes, peer debriefing notes, and journals. Confirmability maintains that data can be linked to their sources, which supports the logic of research decisions made. The researcher planned to keep a reflexive journal of research observations and decisions that would assist in phenomenological reduction by writing down insights, thoughts, emotions, or reactions that might occur during the study (Erlandson et al., 1993; Streubert & Carpenter, 1999).

While trustworthiness refers to methodological sufficiency, authenticity encompasses fairness and refers to reporting each participant's story in a way that maintains respect for the context of the data. Fairness includes presenting all perspectives equally so that the reader can come to an impartial decision and setting aside the researcher's own biases (Patton 2002). Four types of authenticity were to guide the researcher. Catalytic authenticity may occur as participants and researchers change their practice because of involvement in the research study. Tactical authenticity may take place as the participants and the researcher feel encouraged and able to act based on their experiences in the research study. It was anticipated that ontological and educative authenticity would take place because participation in this study might increase participants' understanding of their environment and others' perspectives (Milne, 2005).

Pilot Study

The researcher conducted a pilot study of four nurses. Participants were recruited from a list of nursing alumni from The University of Texas at Tyler, College of Nursing. Every fifth name from the list was mailed a recruitment letter. The recruitment letter clarified what constituted spiritual care, and explained the face-to-face interview and

potential risks of the study. The nurses were asked to contact the researcher via email or phone if they are interested in participating in the study.

Participants

Only one university alumni nurse responded to the mailed recruitment letters. Snowballing took place after the first interview, and recruitment procedures had to be adapted to recruit sufficient participants.

Four participants were interviewed. Ages of the participants ranged from 39 to 49 years of age. Three identified their religious preferences as Baptist and one as Methodist. The three females were white and the one male was Hispanic. Their years in nursing ranged from 3 to 28 years. All participants worked full-time. Educational preparation was evenly divided among associate, baccalaureate, and graduate degrees. The graduate degree was in another field. Two nurses were employed at a hospital clinic. One nurse worked in a community setting and the fourth worked on a psychiatric unit.

Data Generation

After potential participants contacted the researcher to express interest in the study, a mutually agreeable time and place was determined for the interview. Options for locations were to include the researcher's faculty office, a conference room at the participant's work, or a conference room at the researcher's employing college of nursing. Informed consent was obtained prior to the interview along with completion of the Demographic Data Form (see Appendix F).

Three interviews were conducted at the participant's work. One participant was interviewed in an empty classroom at the researcher's employing college of nursing.

Prior to the interview, participants were asked to sign the consent form and complete a demographic form. Participants chose pseudonyms to identify themselves throughout the study. The researcher conducted audio-taped face-to-face interviews with each nurse participant. The interviewer began by asking participants, "Talk to me about spiritual care." Questions related to specific experiences of giving spiritual care were asked, along with questions related to spiritual distress, differences between religion and spirituality, preparation to give spiritual care, patient's expectations, and differences between spiritual care and psychosocial care. The interview guide for the pilot can be found in Appendix A. Interviews lasted approximately 1 hour. The researcher transcribed the interviews verbatim.

Data Analysis

Data were analyzed using Colaizzi's (1978) phenomenological method. First, the researcher read all participants' descriptions of the phenomenon for a general overview. The researcher read each interview two times and began to choose significant statements. Formulated meanings were determined from the significant statements. From the meanings, themes became apparent. Then the researcher wrote an exhaustive description of the nurses' experience of giving spiritual care. This description can be found in the next section. The researcher sent each participant a copy of their transcript along with a summary of the researcher's perceptions of the interview for validation. No new data were revealed from the participants.

Themes

Following Colaizzi's (1978) data analysis method, the following themes were identified: "Spiritual Care is Patient-Centered," "Importance of Spiritual Care," "Simplicity of Giving Care," "Patients do not Expect Spiritual Care but Welcome it," and "Spiritual Caregivers are Diverse."

Spiritual care is patient-centered. All participants agreed that nurses follow the lead of patients regarding discussions of spiritual matters. Joe said, spiritual care "...is what the patient wants." Spiritual care is a subjective, unique and individualized matter for the patient and the nurse. Speaking of patients, Joe said,

> I've always allowed them to initiate anything and then if they say something, then ok then I just go with where ever they lead. I let them direct wherever they want to go... I never bring my religion or my beliefs to the situation. If they initiate the conversation or if they initiate the question, you know, then I'll go with that.

Cindy shared a similar approach. She said,

> I think that often the patient brings it [spirituality] up with their concerns and their feelings ... because most patients that are struggling with some sort of some disaster ...or concern...make it pretty obvious... and I would never want to push anyone into a conversation that they are uncomfortable with.

Donna was more proactive in introducing spiritual care as she said, "I always mention Jesus or God or prayer or there's a higher power and just feel through and let

them follow up. If they don't pursue it then I don't force it." She went on to say mentioning Jesus or God was part of her everyday world.

Simplicity of giving spiritual care. As participants discussed spiritual care; they described the simplicity of the interventions related to spiritual care. Joe called them "comfort measures." Actions like taking time to sit with patients and listen, affirm, or explain procedures they might not know much about were listed as spiritual care. Linda reported praying for a patient and his spouse later. Donna reported giving out cards with specific scriptures to comfort patients who she had relationships with, such as patients who had a repeat visit to her clinic or a repeat hospitalization. She said spiritual care meant just relaying little thoughts of "yes, I agree, prayer is the most important..." Cindy reported "...it's pretty easy to step right into their [patient's in crisis] spiritual needs." Joe said that quality of the time spent with the patient was more important than the quantity of time.

Patients do not expect spiritual care but welcome it. Joe said that he did not really think patients expected nurses to give spiritual care, but he thought that patients in hospitals that were affiliated with a religious organization might expect it. Linda and Donna both said they did not know whether patients expected it but that it was a comfort when patients experienced it. Cindy said, "I think most do, I think there may be a few that don't want it and don't expect it and shouldn't be forced to experience it."

Spiritual caregivers are diverse. One surprising theme that was identified by three participants was the idea that anyone who had patient contact, such as the housekeeper mopping the room or the laboratory technician drawing blood, as well as the chaplain,

could give spiritual care and comfort. This comfort was relayed by behaviors that developed a rapport during patient contact. Donna said,

> ...if you're stronger in your faith you pick out these [people who can support you spiritually] people quicker...I think of so many times we are witnesses [of our spirituality] by the way we present ourselves by the way we respond to situations, and we don't even realize it, but the patients are very aware. They pick up on it.

Exhaustive Description

These participants reported the importance of spirituality and spiritual care in nursing. They all had given spiritual care that ranged from praying for a patient to simply sitting and listening to a patient. All participants agreed that the patient, not the nurse, leads the journey through spiritual care giving. The goal of spiritual care is the patient's peace and comfort. Not only nurses can give spiritual care, but anyone coming in contact with the patient can comfort the patient. They also agreed that they did not know whether patients expect spiritual care, but when it is given, it can be a positive experience.

Conclusions from the Pilot

The pilot helped the researcher explore the research process and make changes based on what she learned. She discovered that the interview guide was too long and did not consistently ask questions that described the essence of spirituality. Questions that did not help participants describe their experiences of giving spiritual care were deleted. Items that sought the difference between religion and spirituality were deleted and were replaced with questions about the actual experience of giving spiritual care. Other

changes to the interview guide were made at the suggestion of the researcher's academic committee. A question meant to determine how the nurse defined spirituality and psychosocial care was added. The committee also wanted to know more about the nurse's spirituality and a question was added to ask specifically about the individual nurse's spirituality. Extraneous questions like, "Who can give spiritual care?" and "Do you think patients expect nurses to give spiritual care?" were deleted in order to get at the essence of the nurse's experience of giving spiritual care (see Appendix B for Interview Guide for the Pilot Study). Brief note-taking and journaling were added to the interview process in order to jot down key words for future exploration during data collection and analysis

The researcher drew several conclusions from the findings of the pilot. First, the importance of spirituality described by the nurses was supported by research about nurses giving spiritual care (Carroll, 2001; Stranahan, 2001; Taylor et al., 1994). Second, spiritual aspects of care should be initiated by the patient and be patient-centered not nurse-centered. Third, the nurse can support patients with spiritual interventions such as time spent with them, listening, and if they request, praying with them in the hospital. Finally, spiritual care is an integral part of nursing and it can and should be offered or referred by the health care team members.

The Research Process

This section discusses the setting of the study, recruitment of participants, data collection including data analysis, methodological rigor, and protection of participants.

Setting of the Study

This section will describe the geographical setting of the study and the physical setting of dialysis units. Dialysis units in the south-central United States were the setting for this study. The area included cities of approximately 100, 000 persons that were surrounded by lesser populated rural areas. Major economic influences in the area included agricultural services such as forestry and fishing, mining, construction, retail trade, and services.

Patients in outpatient chronic dialysis units come for treatments three days each week for three to four hours per treatment. Nurses offer continuity of care because they generally work regular shifts (Monday, Wednesday, and Fridays or Tuesday, Thursday, and Saturdays) and see the same patients repeatedly. In acute units within a hospital setting, patients may need hospitalization for stabilization of renal or other systemic problems in addition to receiving dialysis treatments. Sometimes patients in acute settings need daily dialysis. Therefore, nurses and patients spend hours together week after week. It is during this prolonged time together that the patient and nurse form a close relationship.

The researcher chose to interview nurses who worked on dialysis units because their relationship with their patients is unique due to the time they spend together on a weekly, ongoing basis and due to the seriousness of a diagnosis of renal failure. Spiritual care can be an integral part of caring for these patients because spirituality helps dialysis patients cope with their illness (O'Brien, 1982).

Recruitment of Participants

The researcher initiated recruitment of participants after approval by the Institutional Review Board (IRB) of Texas Woman's University. There were problems with recruitment. Only one nurse responded to the flyer placed in four chronic dialysis units in the local area. Permission was received from a dialysis provider to place the flyer in dialysis units in a larger geographic area. Flyers and letters of explanation were mailed to ten units within approximately 60 miles. There was no response from the additional flyers. An additional measure to increase recruitment was to expand to an acute dialysis unit in a local hospital. Permission was received to place a flyer and the researcher met the nurse manager and some of the dialysis nurses and introduced the study. The nurse manager expressed interest in participating at a later date.

While waiting for responses from the flyers, discussion with the researcher's academic committee suggested a change in the wording on the flyer. The wording was changed from, "Have you had a memorable experience with patients and spiritual care?" to "Have you had a memorable experience with a patient taking care of spiritual and/or psychosocial needs?" (See Appendix C). The Texas Woman's University IRB approved changes. Unfortunately, this change did not increase recruitment.

A colleague who had connections with a nephrology nurses association offered to mention the study to other nurses. Two nurses from that contact emailed the researcher and interviews took place. Another colleague knew of dialysis nurses in a graduate class and gave them the researcher's contact information. One nurse responded from this connection. A fifth participant, a nursing faculty colleague contacted the researcher and

expressed interest in participating in the study. Then the researcher attended a retreat for nurses and a dialysis nurse attending expressed interest and was interviewed.

The dialysis nurse manager was contacted about conducting an interview based on previous interest and interviews were completed in her office with her and two other nurses, who expressed interest in the study and who were on duty that day. Lastly, the researcher contacted a nursing graduate student at a local education seminar. She mentioned another classmate at that time who was now a dialysis nurse. The dialysis nurse's contact information was shared and she expressed interest. Because she lived 90 miles away, this interview was completed by phone.

Participants in this study were registered nurses who had current or prior experience as a dialysis nurse and who spoke English. Purposeful sampling was used to increase in-depth understanding by selecting information-rich cases (Patton, 2002). Snowballing took place in the majority of cases as colleagues and participants referred other dialysis nurses to the researcher.

Data Collection

Data generation began as the first participant emailed the researcher in response to a recruitment flyer posted in a dialysis unit. Data collection occurred between November 2007 and April 2008. In response to the recruitment flyer, participants communicated by telephone and email to set up convenient interview times and locations. Interview settings included a conference room in dialysis units, nurse manager's offices, a private conference room at a local library, a conference room at the researcher's work, a private and quiet area in an acute dialysis unit, and one interview was conducted by telephone.

All but the phone interview were recorded using a digital recorder. For that interview the researcher used a device that recorded the conversation using a cassette recorder. All participants were encouraged to contact the researcher if they had additional thoughts, and none did so. The researcher interviewed the nurses using the revised interview guide found in Appendix B. Interviews lasted 30 to 60 minutes. Saturation of the data was reached after 10 interviews were conducted.

Data Analysis

A transcriptionist familiar with research data confidentiality transcribed the interview recordings verbatim. Data were analyzed using Colaizzi's (1978) phenomenological approach. First, the researcher read all participants' descriptions of the phenomenon for a general overview. The recordings were played as the researcher read the transcripts in order to correct any discrepancies in the transcription and to understand the subtleties of the interview.

The researcher then chose significant parts or statements from each interview that described the experience of giving spiritual care (Colaizzi, 1978). A total of 147 statements were identified. Then, formulated meanings were determined from the statements. A table of significant statements and formulated meanings can be found in Appendix D. The meanings were then clustered into five themes and subthemes. Lastly, all data were included in an exhaustive description related to dialysis nurses' experience of giving spiritual care.

Methodological Rigor

Methodological rigor was evaluated using the trustworthiness and authenticity criteria that guided this study. Trustworthiness refers to methodological sufficiency and was determined by credibility, transferability, dependability, and confirmability (Erlandson et al., 1993). Authenticity was determined by fairness (Guba, 1990).

Credibility was determined as the researcher collected and analyzed the data through a process of "reflecting, sifting, exploring, judging its relevance or meaning, and ultimately elucidating the themes and essences that comprehensively, distinctly, and accurately depict the experience" (Moustakas, 1990, p. 32). The researcher called upon over 12 years of clinical experience as well as her experience of observing her mother go through dialysis. These experiences enhanced data analysis as the researcher drew on her nursing experience of taking care of dialysis patients in the emergency department, comparing that experience with the participants' experience. As a daughter of a dialysis patient, the researcher had insight into how family members cope with the process of dialysis over time. The researcher used member checks to establish credibility. The researcher sent participants their transcripts and asked them to review and verify the transcript content. Participants were asked if they wanted to add information to their interview data. Three participants responded and acknowledged that it was helpful and meaningful to review the interview again. No changes in the data or additional data were reported.

Doctoral prepared nursing faculty peers, who teach graduate research courses and have qualitative research experience, assisted in ensuring credibility by reviewing the

data analysis and providing feedback. Two example summaries of data analysis were given for review. Written and verbal feedback was shared and there was agreement regarding the findings between the researcher and the peers.

Transferability refers to the extent to which the results of a study can be applied to similar situations. Interrelationships in one study may be applied to other situations as readers judge transferability. Thick description and purposive sampling were strategies that helped foster transferability (Erlandson et al., 1993). Thick description referred to the documentation of data that reflected inferences and the context of the experience that was described (Powers & Knapp, 1995). In-depth quotes were used to illustrate various themes. Purposeful sampling was used to increase in-depth understanding by selecting information-rich cases (Patton, 2002). Patients in a health crisis are more likely to seek spiritual support (Coyle, 2002; Emblem & Peverall, 2002; Wright, 1998), and dialysis nurses did yield rich descriptions of their lived experience of giving spiritual care. A reflective journal was kept and assisted in phenomenological reduction and involved writing down insights, thoughts, emotions, or reactions that occurred to the researcher during the study (Erlandson et al., 1993; Streubert & Carpenter, 1999).

Dependability refers to the idea that the method in which data are analyzed and treated is consistent over time. Instability of data treatment could be affected by an extended period for data collection (Graneheim & Lundman, 2003). The interviews took place over 5 months. Confirmability maintains that data can be linked to their sources, which supports the logic of research decisions made. An audit trail was maintained and

included preserving all transcripts, notes, emails, audiotapes, digital recordings, peer debriefing notes, and the reflexive journal.

While trustworthiness refers to methodological sufficiency, authenticity encompasses fairness and refers to reporting each participant's story in a way that maintains respect for the context of the data (Guba, 1990). Four types of authenticity guided the researcher. Catalytic and tactical authenticity were indicated through communication from one participant. Catalytic authenticity may occur as participants and researchers change their practice because of their involvement in the research study. Tactical authenticity may take place as the participants and the researcher feel encouraged and able to act based on their experiences in the research study. These were demonstrated by one participant, who emailed the researcher after reading her transcript. She communicated how helpful it had been to evaluate how she gave spiritual care. She went on to say that this experience had increased her confidence in giving spiritual care within the barriers of the environment. She was motivated to change her practice. It is not known whether ontological and educative authenticity took place. It is hoped that participants' understanding of their environment and others' perspectives increased as a result of participating in this study (Milne, 2005).

Protection of Participants

The researcher obtained approval for this study from the Texas Woman's University Institutional Review Board. Permission from the dialysis centers and letters supporting the study were obtained. Procedures to ensure confidentiality included using pseudonyms rather than the participants' names in the transcripts and reports of the

findings. Participants signed an informed consent form and the researcher instructed them about their right to withdraw at any time from the study. The researcher kept transcripts in a locked file and planned to destroy them within five years of the end of the study.

Summary

The purpose of this chapter was to describe the research plan and process used in this study. A discussion of the pilot study and changes from the research plan were noted in the relevant sections. A description of the research setting was followed by a discussion of the process used to recruit and select participants for the final study. Data generation and analysis and strategies used to protect participants were described. The chapter concluded with a discussion of the steps used to ensure methodological rigor.

CHAPTER IV

FINDINGS

The focus of this qualitative study was to explore nurses' experiences of giving spiritual care. The researcher interviewed 10 nurses who worked in dialysis. The interview process was a meaningful, shared experience between the researcher and the participants. Each interview was unique to the individual participant, but commonalities emerged as more interviews took place. This chapter presents the researcher's interpretation of nurses' experiences through a description of the participants and the themes found in their interviews. The interviews began with an open-ended statement, "Tell me about a memorable experience with a patient taking care of spiritual and/or psychosocial needs that you will never forget."

While reading and listening to the interviews using Colaizzi's (1978) method of data analysis, significant statements were selected. From these significant statements, formulated meanings were determined. Significant statements and formulated meanings are presented in Appendix D. From the formulated meanings, five common themes were discovered. The themes identified were: "Drawing close," "Drawing from the well of my spiritual resources," "The pain of spiritual distress," "Lack of resources to give spiritual care," and "Giving spiritual care is like diving down deep." Within the themes, several subthemes were acknowledged that helped in the understanding of nurses' lived experience of giving spiritual care. Themes and subthemes are presented in Table 1.

Table 1

Themes and Subthemes

Drawing close
Meeting them where they are
Holy atmosphere
Spiritual care is a way of being
Drawing from the well of my spiritual resources
Drawing on God
Drawing on prayer
Drawing on patients
Drawing on experiences
The pain of spiritual distress
Patient's pain of losses and anger
Participating in the pain of spiritual distress
Lack of resources to give spiritual care
Out of time
Out of space
Out of emotional and spiritual energy
Afraid to trespass
Giving spiritual care is like diving down deep

Participants

Eight of the ten participants were currently working in a dialysis unit; four worked in an acute dialysis unit in a hospital setting and four worked in a chronic dialysis unit in a community setting. Participants were recruited through a flyer placed in their places of work and through snowballing as those interviewed referred other nurses to the researcher. Eight participants were unknown to the researcher before their interviews. One participant had been one of the researcher's students over 10 years ago. The other participant was a faculty member at the university where the researcher was teaching.

All participants were women and ranged in age from 21 to 57 years old with a median age of 42. Nine participants were Caucasian and one was African American. Participants identified their religious preferences as Christian (n=4), Baptist (n=3), Catholic (n=1), Latter Day Saints (n=1), and Presbyterian (n=1). Participants' identification with Christianity was reflected in their descriptions of their experiences of giving spiritual care. Educational preparation included Associate Degree in Nursing (n=3), Bachelor of Science in Nursing (n=6), and Master of Science (n=1). Their total years of practicing as a nurse ranged from 6 months to 34 years, with a median of 18 years. Years worked in dialysis ranged from 6 months to 25 years, with a median of 8 years. Each participant was given a pseudonym to protect confidentiality. The pseudonyms included Ann, Sophie, Cathy, Dorothy, Eve, Faye, Gabriella, Helen, Ida, and Joy.

Ann was the first participant interviewed. She had 22 years of experience in dialysis nursing, and was a very wise and seasoned nurse. Ann had experience as a

dialysis staff nurse, unit manager, and regional educator for a dialysis company. She expressed a strong belief in God based on personal and patient experiences, which she said enhanced her faith. Ann seemed to have a high comfort level in giving spiritual care and dealing with difficult patient situations.

Sophie had worked in dialysis for 25 years. Many times during the interview, her answers focused on the importance of assisting the patient in a peaceful death and patients' experiences right before they die. She shared that her nephew's death had a profound effect on her nursing care. She did not identify with any specific church denomination but noted her religious preference as Christian.

The youngest participant was Cathy, who had completed her nursing degree 6 months prior to the interview. The acute dialysis unit was the only area where she had worked. Dorothy had 34 years of experience as a nurse and had been a dialysis nurse for two years early in her nursing career. Although many years had passed since she worked as a dialysis nurse, she remembered and related stories about her experiences.

Eve had worked in dialysis for 8 years and been a nurse for 11 years. She was currently working in a chronic dialysis unit but had experience in home dialysis. In home dialysis, the patient or a support person connects the patient to a dialysis machine and treatments are typically done while patients sleep. Nurses have one-to-one contact as they monitor the patient during the procedure. Eve openly expressed her spirituality. For example, she talked of letting God through the Holy Spirit guide her actions. After reviewing her transcripts and the summary of her interview, she emailed the researcher and noted how helpful it had been for her to evaluate how she gave spiritual care. She

went on to say she had been more confident in giving care despite the limited time and privacy typical in a chronic unit by relying on the God in guiding her care.

Faye had worked in dialysis 10 of her 14 years as a nurse and was currently employed in a busy chronic dialysis unit. Gabriella had worked as a dialysis nurse for all of the 17 years she had been a nurse. She was currently working on an acute unit at a local hospital. Gabriella had many meaningful patient care experiences that she shared. Joy had worked in dialysis for 1 year. She had 25 years experience as a nurse. She had sought work as a dialysis nurse because she could work four 10-hour days. She worked in a busy chronic dialysis unit but had recently quit and was going to work at a veteran's hospital.

Helen had experience in a community health setting as well as 5 years in dialysis. She had been a nurse for 18 years. She currently worked in an acute dialysis unit, although she had previously worked in a chronic unit. Ida had been a nurse for 7 years, the last 2 in dialysis. Her previous work experience included intensive care nursing. She spoke of the impact of her brother's death within the past year and the influence that had on her nursing care.

Themes

Drawing Close

Every participant talked about the closeness of the relationship they developed with their patients receiving dialysis. Additionally, patients formed close relationships between one other and as a group. Patients thought of themselves as members of a "family" who celebrated and grieved with each other. Because of extended time together

and shared experiences, an environment of closeness was created among the patients and between nurses and patients.

Faye described this process of drawing close as based on the time she had spent with patients. She said, "...because we see patients three times a week they tend to...become a part of your life and you become a part of their life... you really get *drawn into* their whole life, not just their dialysis..." She went on to say that during that time, "...you learn a lot." Ann explained that one of her patients called her husband "uncle" and called her "aunt." She shared, "That's how close you get in dialysis." Gabriella said. "...you get really attached..."

Just as the nurses and patients developed a close relationship, dialysis patients became like a family to one another due to the extended time together and seriousness of their illness. Helen described how the communities of patients form a bond and told how the patients prayed for each other. She also saw some of the patients come early before their treatment so they could socialize with the other patients, much like a support group. Dorothy reported, "I certainly saw some of that...ministered to others...through their experiencing, offering encouragement, friendship..."

Patients were aware if another patient did not come for their treatment and wondered if they were in the hospital or had passed away. Dorothy said, "When someone died... [they were] no longer a member of that family...coming three times a week." Joy talked about the intimacy between patients, "...because in dialysis I know HIPAA [Health Insurance Portability and Accountability Act] is huge, but in dialysis these people

know everything there is to know about the person sitting in the chair next to them because they hear it, they see it."

Ann, who had worked in dialysis for over 20 years, explained how she tried to influence patients through the relationships. She said,

> I always try and put my patients next to a positive mentor in the dialysis facility. It you put them next to a compliant patient, they will see and hear interaction between the physician and the other patients as a positive reinforcement of good behavior. Whereas, if you put them, the new patients, next to a patient who is non-compliant, you will hear more of the negative realm of dialysis.

Joy also observed how the patients influenced each other, "I mean they become a community, and they support each other and trust me, they know each other and like if somebody's misbehaving they'll fuss at each other."

Several subthemes were identified that further illuminated and defined these nurses' experience of drawing close. These subthemes included "Meeting them where they are," "Holy atmosphere," and "Spiritual care is a way of being."

Subtheme: "Meeting them where they are." An aspect of drawing close involved the nurses creating a connection with patients. Several participants mentioned meeting a patient where they were or getting on the patient's level. They described this as physical actions such as pulling up a chair, giving patients their full attention, and looking them in the eye. The nurses instinctively knew the patients who needed this attention, especially when patients began dialysis for the first time. "Meeting them where they are" fostered a

relational connection between the nurse and patient. Ann talked about how she offered the patients "...a peek that I was a real person and that they could come to me at any point, at any time, for anything." This was part of the reciprocal relationship between the nurse and the patient. Gabriella talked about the process:

> We have people come in, they're crying, they're scared, their anxiety level is heightened, you know, they're scared out of their wits and so, a lot of times when new patients start, and I've noticed most of the, most of us do this now in here, and we'll get a chair and we'll get eye to eye with them, so they won't feel like we're not dominating over them. They're angry and sometimes it's just you just go in and try to reassure them and you get on that same level.

Ann talked about how she met the patients at their level by sitting down and by assessing their literacy level about their illness so she could communicate appropriately to patients as they began the frightening process of dialysis:

> ...it's bringing you into the facility in a positive manner where you feel accepted and where you can then start to comprehend some of the issues of the next life process that you have to deal with, which is being on this machine, attached to this machine, strangers putting needles in you, blah, blah, blah, blah, blah. I always, now I'm an educator now, but as a facility manager, I always sat down and, found out their literacy level, so that I made sure that I could present them information at their level. And then I also introduced myself, trying to stay in a professional boundary. And yet, giving them a peek that I was a real person and that they could come to me at any point, at any time, for anything.

Subtheme: "Holy atmosphere." These nurses described their sense that something transcendent occurred as they drew close to their patients. Sophie described this as a "Holy atmosphere." Experiencing this unique and profound occurrence was part of the bond between the nurses and patients and contributed to "drawing close." Several participants talked about how the environment changed to a holy atmosphere that benefited the nurse and patient. Sophie used this phrase in her definition of spiritual care. She said,

> Spiritual care is...goes beyond psychosocial. Psychosocial could be just comfort. And spiritual care could be validating and creating a *holy atmosphere* and treating people very respectfully and acknowledging their beliefs and accepting that their beliefs...that I can learn from their beliefs and they don't need to follow - it has nothing to do with me.

Ann told a story about how one patient would start to say *The Lord's Prayer* during an emergency, "...all the other patients would pick it up and say it as a very low whisper. And it would just run through the unit. And it was one of the most awesome experiences I've ever had in my life." Joy explained the story of a patient singing to other patients in the waiting room:

> I went out there and he was actually singing a beautiful just a Black, spiritual hymn, and he was singing to the patients who were fixing [to have a dialysis treatment], you know he had finished [his dialysis treatment], it was the morning, it was the turn around which was our the staff's busiest time ....like he was ministering singing, you know what I mean, and they were all listening to

him and everything so I thought that was a pretty amazing...I mean they were really receptive to it. You know they were listening and watching him and there was even a T.V. on ....you know...nobody had turned the T.V. down or anything like that, but you could still hear his voice and feel the wonderful feeling. I mean it really ... you could, yes you could feel a spiritual mood in there. You know what I mean? But I really felt like he was ministering to them and I think they did too.

Subtheme: "Spiritual care is a way of being." For the participants, giving spiritual care enhanced their connection to their patients as they recognized the spiritual needs of each patient and met them. This connection also helped the nurses and patients "draw close." Examples included the routine practice of giving spiritual care and how spiritual care was integrated into the "big picture" of giving nursing care.

It became clear that the participants believed comforting patients by giving spiritual care was an important part of being a good nurse. Being a good listener was an important aspect of spiritual care and was mentioned specifically by Eve, Gabriella, and Ann. Ann said, "It's more of just an empathetic, sit with them. You don't have to teach. You don't have to talk. You're just there as a comfort measure....but that's how I think of it [spirituality]- it's the environment."

Most participants saw spiritual care as routine and integrated into everyday care. They described spiritual care as intertwined with nursing care. Faye explained how she viewed spiritual care:

> ...it's all drawn into one. It's like their emotional side, their spiritual side...it's when you hear it, it's all, to me, it's all one. It's not, I don't know if I can separate it all, because it's all entwined to me. ....I think when we're talking about it [spiritual care] we're talking about it informally. We're not saying well this is what I did for this person today. We're talking about it because it's a routine for us. We don't look at it as, well this is what I did for this patient today. It's a daily, it's not something that when I wake up I'm thinking, okay, I'm going to do this today.

For some nurses giving spiritual care was an integral part of how they lived their day-to-day lives, as Joy said, "Putting out God's name like saying 'God bless you, and thank the Lord I got that I.V.'" Helen said she thought nursing and spiritual care went hand in hand and helped her cope with "everyday demands of seeing those poor sick people." Ann agreed and said spiritual care was "ingrained between the nurturing and the care." Nurse participants in O'Brien's (1999) study noted spirituality was integrated in the nursing profession.

"Drawing Close" described the researcher's explanation of what happened to nurses and patients and patients as a group as they went through dialysis. Participants described this theme as influenced by the amount of time nurses spend with patients who are in dialysis treatment and the seriousness of the patient's renal failure. These patients have an average life span of four to eleven years (Mailloux & Henrich, 2008)

Within this theme, three subthemes were identified. The first subtheme, "Meeting them where they are," described the connection that occurred when the nurse intently

focused on patients and their needs by sitting down at eye level, listening and helping them understand what dialysis involves. The next subtheme, "Holy Atmosphere" was described as that part of spiritual care that represents the connection that occurs in these sacred moments. Several experiences described represented a time when a "Holy atmosphere" occurred. Lastly, the subtheme, "Spiritual care is a way of being" explained how, for these nurses, spiritual care was a part of their everyday life and part of how they gave nursing care.

Drawing from the Well of My Spiritual Resources

The second theme illuminated by participants was "Drawing from the well of my spiritual resources." Participants talked about how they relied on their own resources as they gave spiritual care. Although Cathy had only been a nurse for 6 months and had not observed other nurses being a spiritual care model, she described her resources for giving spiritual care. She said, "My father is a physician, I see him. He's a very spiritual person...and ...I have that example..." And, she told how her experiences in church and growing up shaped her spirituality now. She said, "And reading the Bible and praying....just on a frequent basis...helps me get through hard times."

Several participants mentioned how being a spiritual person and relying on the presence of God gave them strength and wisdom in how to care for their patients. Almost all of the participants said they used prayer as part of giving spiritual care, most of the time praying for the patient later. Patients also offered spiritual care to the nurses by what they said, by example, and how they encouraged the nurses. Nurses who had more experience giving spiritual care had increased comfort discussing spiritual topics, and

those who had gone through difficult times were strengthened in their faith. These life experiences provided a background for giving spiritual care and gave the nurse confidence to give spiritual care.

The subthemes that were determined from the main theme "Drawing from the well of my spiritual resources" were "Drawing on God," "Drawing on prayer," and "Drawing on patients."

Subtheme: "Drawing on God." Participants related how spirituality helped the nurse cope with seeing chronically and terminally ill dialysis patients on a day-to-day basis. Some of the nurses talked about how they gave spiritual care based on the guidance they received from God through the Holy Spirit. Ann said rhetorically, "Who gave me that gift [to give spiritual care]?" meaning God was the one who gave her that ability. Ida specifically said she had a revelation recently that she needed to depend more on the Holy Spirit to guide her actions as she gave spiritual and physical care to her patients,

> I need constant guidance. You know, you're hit with situations and you need the power. You need the gift of discernment. Forgive me for bringing so much religion into this, you need the gift of discernment to be able to fit in a situation and see what's wrong. It's not just critical thinking. I think a lot of it is going to be some guidance. Yeah, there are so, there's so many things you need to be aware of or be sensitive to and I just feel like I really need the Spirit there with me to help guide me and not let me miss anything that's really important...and so that's one of the things that I pray for, and it's not just for me, it's for when I'm working, not so that I can be heroic or so that I can see something that someone

else can't see. It's so that I don't miss anything that I need to.

Eve also talked about how she relied on the Holy Spirit to guide her in what she said to the patient. She said,

> I try to follow the Holy Spirit, is the main thing. I try not to portray [push] myself on people, but if I'm going to give spiritual care, I feel very....What's the word I'm looking for? I don't want to say anything without it coming from Him [God].

Gabriella spoke of how knowing the sovereignty of God helped her deal with patients. Gabriella said, "I just think everything happens for a reason. And that's, we may not always understand it. But, you know, God is the creator. He has the plan. He knows what's going to happen..." Joy also explained, "I was comforted in the fact that I do know God is in control, number one."

Subtheme: "Drawing on prayer." Most of the participants believed dialysis patients wanted prayer and they mentioned prayer as a resource when giving spiritual care. Several participants told patients they would pray for them later or keep them [the patients] in their prayers. Participants said offering prayer increased trust between the patient and the nurse and praying for someone changed, in a positive way, how they felt about a patient. Helen talked about the importance of assessing the patient's openness to spiritual care and mentioned the benefits of prayer:

> I think just knowing that I'm a believer and I can say to them, "I want to pray for you." I think, helps people...if they're kind of grumpy you don't just want to start off saying "I'm going to pray for you." You kind of got to warm up to that because some people...believe that church should be here and work should be

here, and things like that. But I've always worked long term care so you get to know the patients. You get to know their beliefs and I think the chronically ill patients that we have just having someone saying I'm going to pray for you type of thing kind of warms them up. They kind of tend to trust you a little bit more I think too.

Cathy related a time when she gave spiritual care to a 15-year-old patient with lupus who was blind and struggling with her illness. Cathy used prayer as a way of caring because this patient prayed "a lot." She said,

> [She] wasn't able to cry. And so we had a very intimate conversation about being strong, keeping your faith and it made her feel better. And she prays a lot. And I told her I was praying for her and [it] made her feel better. It was, it was nice. I felt like I was able to really touch her and comfort her which is an, to me, is a very important part of being a good nurse...is to be able to comfort your patients whenever they're in need. So, it was rewarding.

Ida talked about the transforming and transcending experience of praying for someone:

> I think the act of actually praying for somebody, or just the thought that you're going to keep them in your prayers just changes how you feel about that person, makes you more caring towards them. Because all of the sudden, you're doing something for them...above and beyond.

Subtheme: "Drawing on patients." Ann, Eve, and Helen mentioned how they as nurses received spiritual care from the patients as much as the patients received from the nurses. Gabriella remembered an experience she had while talking to a patient about end

of life issues, such as had he fulfilled his life purpose and she asked him, "Do you know where you are going?" She said, "I learned more from him than he did from me and I just was there to hold his hand and talk him through." Eve told about how a patient, with whom she had a reciprocal relationship, started ministering to her, "I just, kind of just took on this relationship of just sharing and opening with each other about how we felt about forgiveness and our past sins..."

Helen related a story about a patient who needed Cardio-pulmonary Resuscitation (CPR) and then died on the dialysis unit. Helen was crying and having a difficult time, and the other patients comforted her by asking if she was okay. Helen also comforted the family and stayed with them as they said their goodbyes to the deceased patient. The mother of the patient who passed away also helped Helen cope when she said, "You did all you could."

Subtheme: "Drawing on experiences." Participants volunteered that past experiences had equipped them and had helped shape who they were. Many participants drew on their life experiences and experiences as nurses to help them explain their spirituality and ability to offer spiritual care. For these nurses, the importance and significance of spiritual care seemed to increase with time and experience. Everyone said that spirituality was a work in progress, that there was always room for improvement, and that they were always growing. Going through difficult life experiences, like divorce and death of family members, helped increase their faith in God. Lastly, three extraordinary experiences were shared that involved healing and a near death experience.

Ida, Sophie, and Joy related profound experiences of being with immediate family when they died. They had a positive experience because they believed their family member was in heaven after they died. Ida's brother had a progressive muscular disease and passed away as a young adult. She shared:

> My brother passed away, shortly after I started here, actually, and he was on a ventilator and we were able to wean him off, but he didn't last off the ventilator and we had already discussed as a family what he felt like was important. We identified his definition of quality of life and so when it was time …to decide not to put him on the ventilator, we were all prepared and we were all able to talk as a family but, because we believed that you know, there's life after death and that we'll all be together again someday. It's not that difficult and I think that because I believe that you know, there's a purpose in this life.

Joy shared how being with her mother as she died changed how she viewed death. She had always thought that as a nurse, one would do everything one could to save the patient. However, after the experience, she realized that death did not have to be a fearful situation and that patients might welcome it. She said,

> Whereas before I'd never seen that; I'd always kind of fought death, you know what I mean. I mean I was too busy trying to save the person's life than to see them join with God. So I really am looking for a different thing in my career now.

Helen and Joy mentioned patient situations involving supernatural events. Helen said she witnessed a miracle where a dialysis patient was healed of renal failure. Helen said, "I'll keep you in my prayers. [I] Put her on a prayer list at church and when she went

for her surgery they did some tests and she no longer needed dialysis. She actually called back and thanked me..." Dorothy also said seeing miracles influenced her spirituality positively and related a story of a severely burned patient who survived.

Joy told about a memorable experience of a patient telling her about seeing her mother in heaven when her blood pressure was very low and the patient had lost consciousness,

> We had a lady whose blood pressure dropped down to where we had to stop dialysis and give her fluids and not really resuscitate her, but sort of resuscitate her and give her fluids, and when she came to, she said, "I saw my momma." I said, "Oh, you did." I said "Well actually, what happened was, you know, your blood pressure dropped but we gave you fluids and you're back now and everything is okay. You never really left the unit." She goes, "No," she goes, "I really, I saw my momma." And I said, "Well, uh, where was your mother?" And she goes, "Well my mother's in heaven." And this, I went, "Oh wow." And she went, "Yeah, It was very peaceful." and so I thought that was amazing...to have that, you know. And I said, "Well, what as it like, did you see a bright light or anything like that?" And she said, "Well there was kind of a light, but really it was my mom. I saw my mom." So, and I held her hand. And I thought that was interesting. I said "Well I'm glad." Well it actually made me realize how fragile we all are, number one, but our dialysis patients are too. And you think, oh yeah, you know their blood pressure dropped; you give them fluids because they respond, they really do respond amazingly quick, the minute you turn off the UF

> [ultrafiltration unit] you know, and you start giving them the fluids. Really, we can get them back pretty quick. You know, you think that. But when you think about the possibility of the fact that really…I mean I would relate that to a pretty…to what you hear about and I'm not an expert on this at all, but like a near death experience.

Sophie also related several incidents where patients who were near death told her they saw their mother.

"Drawing from the well of my spiritual resources," described the researcher's interpretation of how the nurses used various resources to help them give spiritual care. The first subtheme was, "Drawing on God." Nurses said giving spiritual care came from God and they relied on God to give them wisdom and words to say to patients. The next subtheme, "Drawing on prayer," explained how nurses prayed with patients to encourage them. Praying for a patient had benefits for the nurse and changed the nurse's attitude in a positive way toward the patient.

Nurses said patients ministered to them, which described the subtheme, "Drawing on patients." The next subtheme, "Drawing on experiences," described how the nurses perceived that life experiences increased their faith and spirituality. They had more empathy and understanding as they related to patients and their family members who were in crisis. Repeated experiences gave the nurses confidence to approach a similar situation in the future. Experience giving spiritual care also made the process more comfortable for the nurse. Although giving spiritual care was a positive experience for these nurses, dealing with patients in spiritual distress was challenging.

The Pain of Spiritual Distress

Dialysis patients may experience spiritual distress as they begin dialysis treatment. This theme was defined by two subthemes that described nurses' experience of the "Pain of spiritual distress." "Patient's pain of anger" illustrated how anger was a key characteristic of dialysis patients. "Participating in the pain of spiritual distress" was a subtheme developed from participants' descriptions of how they were affected by caring for a patient in spiritual distress, especially when they did not feel successful in alleviating the patient's distress.

Subtheme: "Patients' pain of anger." Anger is part of the grieving process, and dialysis patients have many losses to grieve. Sometimes the patient lashed out against the nurse. Anger was a common manifestation of the grieving process and the participants labeled it as spiritual distress. Every participant, except one, readily mentioned anger as a common characteristic of dialysis patients. Dialysis patients have little control over their environment, which can cause distress and anger. Patients grieve losses and changes that dialysis brings such as changes in body function, eating patterns, employment, and their role in their families. They also experience severe fatigue and the limitations of being tied to a machine three times a week. Gabriella believed, "They [dialysis patients] lose everything...they really do."

Ida characterized dialysis patients as, "I think the dialysis patient is typically the one, the patient, more than any other, the ones that feel they have no control over his [their] health." According to Sophie, "older white men have more trouble adjusting to the

serious illness and death because they've always controlled everything." Joy shared an experience of how a patient attempted to gain control over their situation:

> ...one time I went to an ANNA [American Nephrology Nurses Association] meeting and I did pick up a pamphlet about iron [to share with the patients]...and a lot of the men, more so than the women, would refuse their iron ...you know, *just because they could*!

Faye and Gabriella explained that patients who were angry sometimes lashed out at the nurse which interfered with their ability to communicate. Faye said:

> ...a lot of anger and if you thought that, I, if I was a dialysis patient and I saw you three times a week, then who do I, for say, four to five hours, who do I direct it at for? So, and then there's days that they fail to realize...you're providing life and its [they are] angry at you, and angry at the world and you're just right there, so you're going to take the brunt of it.

Gabriella explained the uncertainty of not knowing how an angry patient might react. She said,

> ...sometimes its like, you are, it's almost to the point where you're probably afraid to initiate something because you don't know what's going to come back out at you. You don't know what's going to come back out. You might get cussed at, something thrown at you...If they're that, at that level.

Gabriella described the challenge of dealing with a patient, who was angry:

> ...the ones that are really, really angry they're hard to connect with too, because their anger is, they're mad at everything and everybody...they're mad at God and

they're mad at this and they're mad at.... it's just like, so-so profound it's hard to get, *its hard to touch that*, you know sometimes. Sometimes you just have to go in there and they're just really angry. Sometimes you've just got to give them a chance to, build that trust and say what you want to do and that kind of thing and them know that and they usually will [build the trust]...

Experiencing anger was draining for the patient and the nurse. Dorothy thought anger sapped the energy that patients could have used for healing. She commented on the negative effect of anger, "[anger] is very energy-sapping...saps the energy from a patient that they need for healing and for dealing with their day-to-day [life processes]." Likewise, dealing with angry patients sapped the nurses' energy. Faye talked about a cumulative effect as the nurse was exposed to a patient's anger, "...if you're taking it from more than one person it tends to just tear you down."

Subtheme: "Participating in the pain of spiritual distress." Not being able to give spiritual care to a patient in spiritual distress was distressing to the nurse, especially if they were not able to help the patient. The participants described similar approaches when encountering spiritual distress. Gabriella and Faye talked about wanting to "figure it out," why the patient was in distress. The nurses experienced frustration if they could not help the patient. Cathy mentioned being a "fixer" as a nurse and wanting to make things right. She said,

... [it is] Frustrating. Cause I'm a fixer. I guess essentially all nurses are fixers. They want to fix people and help them. And whenever I feel like I can't help

them, it's very frustrating. It distresses me to a certain degree...To see my patients in distress.

Ann also mentioned the "hurt" of seeing patients in spiritual distress, and Helen stated she was frustrated when she could not help. Dorothy explained it was hard to watch some patients die, some get a kidney transplant, and some experience rejection of their transplant. Knowing that the health care team did everything they could to assist the patient helped Dorothy come to terms with circumstances out of the nurse's control. Dorothy said,

> We do as much as we humanly can do to get them to optimal functioning and I guess through all my care, it's, you know, "Is the team doing the most that possibly can be done?" And if the answer's yes, then you come to terms with, with the outcome.

The theme, "The Pain of spiritual distress" was acknowledged as descriptions of the painful experiences associated with giving spiritual care. Two subthemes were identified. The first subtheme, "Patient's pain of anger," clarified how often dialysis patients express anger as part of the grieving process and how difficult nurses find this. "Participating in the pain of spiritual distress," described with how nurses were distressed when they saw a patient in distress and how they were motivated to find the cause of the distress and correct it if possible.

Lack of Resources to Give Spiritual Care

Participants discussed how a lack of resources presented challenges to their ability to provide spiritual care. A crowded, noisy environment made giving spiritual care

difficult because of a lack of privacy. Participants mentioned lack of time as a major limiting factor in giving spiritual care. Moreover, because of the emotional energy required for giving spiritual care, nurses described how draining it was caring for patients needing "a lot" of spiritual care. Nurses also mentioned being sensitive to patients' beliefs and not wanting to offend patients in discussions of spiritual care. This section will discuss the limitations of space, time, emotional and spiritual energy, and the difficulty of trying to be sensitive to patients' beliefs when giving spiritual care.

Subtheme: "Out of space." Dialysis units are usually set up with chairs or recliners side by side in various sized rooms. Curtains can be drawn between chairs for limited privacy. This environment made giving spiritual care a challenge. Gabriella said of the space, "It is a barrier. It's too open." Joy described the hectic environment as, "...and there wasn't privacy, really, because they were just...in a big room with chairs and everything and the TVs are going and people are screaming and laughing at and talking to each other."

Eve said,

> ...when you're on the chronic unit, it's a little more difficult, because you've got the physicians coming in. You've got family coming in. You've got staff run, running around and there's things that are going on to where you really can't sit and have that one-on-one....If you give spiritual care there, it's more of a word here or [there] you know..."

She continued with a distressing example of a patient who needed spiritual care but Eve could not give it due to interruptions in the environment. She said,

> And the, transportation people were coming in and I could just see in her face that she was in distress. Cause she had just had this, you know, major change in her life, you know, going to a new nursing home and she had just gotten over this ... She had had a heart attack, is what she had. And she was just real sick. And I just felt like I needed to pray for her. But I just couldn't do it right there.

Joy reiterated, "I was in a very, very busy unit and there was no privacy....your conversations were never really, I mean they weren't real intimate because the person sitting next to you was hearing it too."

Subtheme: "Out of time." Time was a factor that limited nurses' ability to provide giving spiritual care. With decreased time, spiritual care became a low priority. Some participants listed lack of time "more than anything else" as the main reason they could not or did not give spiritual care. Contributing factors were the number of patients and their high acuity. Ida said,

> It's because so many times you want to sit with your patient and talk to them more...here especially in this atmosphere. It's hard to get into the deep conversations with these patients because you have to be able to walk off [and care for another patient if needed].

Joy went on to say, "the thing about dialysis is that there's not a whole lot of time to talk in dialysis, it really is, I mean our unit was a very busy unit." Cathy said in the acute unit, "...we don't have time to really relate to our patients on an intimate level with them. We don't get time to sit down and talk to them."

Dorothy said giving spiritual care seemed like a "left over." She said, "It's one of those, 'Are you going to spend the time getting the meds out?' You know, those 'have-tos'....that have to be done. And you feel like this [spiritual care] is constantly being a left over." Faye explained how her time was limited and divided between all the patients she talked with:

> It's not enough time. If you think about [it], there's 12 people here and, and as I go to every station, and because I go to every station every day, I mean, both shifts, I'm visiting with everybody, because I want to know...how are you today and what's going on with you and I don't have...the if one person has a lot to say, then that's taking away from the next person, so you're looking at time, to me, *time's a big barrier,* as far as having the time to really you know I may miss something with you where...because I spent a lot of time with the previous patient so um.... There's a lot to say, there's a lot to hear.

Helen was the only participant who did not describe time as a barrier and was satisfied that she could give spiritual care in her current situation. She said:

> No, because I think if you just say, "I'm going to pray for you or let's just say a quick prayer," something like that, hold their hand for a minute -- I don't think that's a factor. It doesn't have to be a long sermon type thing! "Prayers for you, my prayers will be with you, and watch over this person." He'll [God will] take care of them. That's really all it needs.

Subtheme: "Out of emotional and spiritual energy." Sometimes nurses were reluctant to give spiritual care because they knew it would take time and energy that they

did not have. Giving spiritual care could be emotionally draining. Nurses talked about the need to be quiet, read, sleep, and have time to refuel from giving spiritual care. Faye illustrated how an intimate relationship with dialysis patients could have negative effects. She said, "...sometimes you know more than you really want to know. You know about the fights, you know, it's real consuming." She talked about a cumulative effect as the nurse was exposed to a patient's anger:

> ...if you're taking it from more than one person it tends to just tear you down. I've been here 10 years and in that 10 years, I've seen so much and I've dealt with so much and this week, the last two weeks, I've taken a, just an emotional beating where I don't know if I can provide spiritual care. And then I thought, no, it's not your choice to say whether you can or not because you still have to, you know...

Ann described that there have been times where "things weren't going well in my life" when she felt like she had no energy to give spiritual care. She also talked about her anger as she grieved the death of a patient. She said, "...just like anybody else...sometimes I wasn't ready for 'em [them] to go."

Faye, Eve, and Ann described the draining effects of giving spiritual care. Faye said,

> ...then outpatient C and outpatient D and then by the end of the day *there's nothing.* I go home, there's times I don't want to talk on the phone, there's times that I don't want to eat, there's times I just want to take a bath and go to bed and I can sleep for 15 hours because it's like I'm so emotionally drained...there's nothing else left to give by the time I get home.

Ann shared a similar experience:

> Now sometimes, if you have to give a lot of spiritual care, you go home zapped. And, because I've been giving care for so long - twenty-two years in dialysis, I find myself not wanting to be around large crowds of people after work. Because, as a nurse, everybody needs something, whether it's a hug, my grandson's had this happen, or do you know the side effects of this medication I'm taking? And it's kinda [kind of] hard because, I want to go home and lick my own wounds. And I want peace and quiet and I just wanna kinda [want to kind of] refuel my own self.

Subtheme: "Afraid to trespass." Some of the nurses shared how they were hesitant to give spiritual care especially if they might offend a patient. Participants said they were afraid to trespass on the patient's religious beliefs. Faye, Helen, Ida, and Gabriella mentioned being "careful" about overstepping their bounds or offending a patient by offering spiritual care. Ida said, "I'm trying not to cross the line of infringing on somebody's religious rights, religious beliefs." Faye related how she would initiate spiritual care:

> You're definitely, very carefully, I think when approaching a patient about spirituality, you know who to approach and who not to approach about it. I mean, there's some that I, I draw the line and I don't want to overstep my boundaries with.

Most participants said they would let the patient take the lead when discussing spiritual care, but Faye had a different approach. If she did not initiate a conversation

about a topic she thought the patient needed to discuss, the patient might not see the importance or may be in denial. She shared,

> ...What I've found out, some will, some won't [talk about spiritual topics]....and it's hard to talk about, I mean, they're already fearful being here and there's things that, there's subjects they tend to not want to talk about and then there's some that they do and I think some if you wait for them to initiate it, it won't come.

Gabriella and Helen talked about how the nurse needed to assess each patient's situation before "jumping in." Gabriella says, "I don't think that initially you can jump right in to, 'I'm going to pray for you right now'....Because some people aren't really accepting of that." Helen remembered from her experience in community health nursing, how to look for ways to open conversation. She said,

> "... you kind of look around the room for clues as to like if they have their Bible out or if they have some type of a saying on the wall. Sometimes they'll have a verse or something like that and I'll say, "Oh, that's a pretty picture," or something like that, kind of start it that way...because I don't want to offend anybody if they don't go to church.

Gabriella told of a time when she called the chaplain because a patient had complicated issues regarding his spirituality and she did not feel qualified to discuss his religious concerns nor did she have the time to do so. She shared,

> There was a patient when I was at [local hospital] working for a while, and he was a young man. He was younger than I was, been on dialysis I think he was like 30 and had been on dialysis since he was 15 and just, didn't take care of himself and

was really, really sick and depressed....and he had a decent family support that was kind of eccentric too. So wild tattoos and you know, I wasn't intimidated by them but was, I knew he was just kind of out there on some things. And, I don't know how comfortable I was and he and I got into kind of a conversation and I realized, I was stepping around things and I was I was helping him to a certain degree. This man needed out *way* deep to help him. It was outside my scope; nor did I have the time. I had other patients; nor did I have the skills to take care of him because he was at a level where...between the depression and probably the confusion that there were some things that he had been dealing with reading or whatever, I didn't feel comfortable. So I decided to call the clergy. I said, "Please help me?" And he did. He stayed in there like 2 hours that day. That one was probably, the one that stands out the most.

Ida had observed a negative example of spiritual care that made her more cautious about giving spiritual care because she did not want to emulate it. She said,

I worked with a PCA [patient care associate] at one point that...felt like that [was] why she was in medicine was so that she could...I'm trying to remember what her word was for it was, anyway, so that she could give spiritual assistance to people. You know, she prayed over them often and she's a very enthusiastic person when she prayed....it made them [the patients] a little uncomfortable...

Ida also thought that nurses did not share with each other when they gave spiritual care. Although talking about giving spiritual care was not banned, it was not something that was often done with other nurses. She explained,

> ...in the hospital setting it's not something we can talk about freely I think amongst our peers....we may have some peers who feel comfortable about talking about it, but not all of them. I don't know for sure...how the people feel about me, but you just – I think when you do talk to somebody spiritually you don't tell anybody else you did. You don't, I don't think we talk about it as much as, I don't think we hear about the occasions as often as they happen because I think we're hesitant to admit that we're spiritual to each other.

This theme, "Lack of resources to give spiritual care" described the challenges that made giving spiritual care difficult. Four subthemes included "Out of space," "Out of time," "Out of emotional and spiritual energy," and "Afraid to trespass" described how the nurses viewed the environment of the dialysis center. "Out of emotional and spiritual energy" explained how drained nurses felt after giving a lot of spiritual care. Lastly, the subtheme, "Afraid to trespass," elucidated some of the views nurses had regarding giving spiritual care. Nurses felt they needed to be careful in order not to offend patients' religious beliefs.

Giving Spiritual Care Is Like Diving down Deep

The essence of nurses' experience of giving spiritual care is described in the final theme, "Giving spiritual care is like diving down deep." Gabriella spoke of "diving in deep" when she was talking to a patient who was in the last stages of renal disease,

> I guess initially it was like, whoa! You know, this is-this is *diving a little bit deep for me,* you know, it's like, you live your life or whatever, but you don't expect conversations like that to pop up at you and it does in this field and you

kind of have to help people in whatever decision you know, you have kind of lay it out this is the way it has, its going to be if you want to do this. And is this something you want to do? Or, you know, is this a different avenue than you want to take, but as far as when I first got approached to that it was like, ah, I had to, it took me a minute, you know, I kind of, I was taken back, it's like, okay, I had to think about it a second you know, and really step up, and because I know this patient needed me. They needed my advice. They needed my opinion, or needed me to help, be there for them, hold their hand...and so, I was kind of taken by it. But, after it was over, it was very rewarding.

Helen said spiritual care is "...going deeper into the patient" and "...spiritual is from the heart....It comes from deep inside if you're truly a spiritual person." Eve agreed as she compared spiritual care to psychosocial care, "I think that spiritual care is a deeper, more intimate level of care." Ann talked about the additional dimension of spiritual care when she said, "...where you're caring and you just take it one step further." Lastly, the theme "Diving down Deep" described the essence of giving spiritual care. Nurses felt that giving spiritual care was deeper than giving psychosocial care; it went one step further. Participants described how giving spiritual care was an intimate and rewarding experience.

Exhaustive Description

Participants described giving spiritual care as more intimate than giving psychosocial care. Listening, touch, and getting on the patient's level were very important as they drew close and developed a relationship with each patient. The nurses

drew from their personal spiritual resources to reach out and give spiritual care. Participants saw spiritual care as a way of being with patients and creating a holy atmosphere. Both the nurse and the patient could be affected by this interaction. At times, this sacrificial giving seemed costly to the nurses in terms of their emotional energy because of the pain of participating in patients' spiritual distress and anger. Lack of resources such as space, time, and emotional and spiritual energy presented challenges to giving spiritual care. Even with this personal cost, nurses described the rewards of "diving down deep" with patients as they offered spiritual care.

Summary

This chapter presented the findings of the study. The meanings, themes, and subthemes in this chapter characterized the researcher's interpretation of nurses' lived experience of giving spiritual care to patients receiving dialysis. The researcher provided definitions, descriptions, and supporting statements for the themes and supported them by examples of statements from the participants. The five themes recognized during analysis of data were "Drawing close," "Drawing from the well of my spiritual resources," "The pain of spiritual distress," "Lack of resources to give spiritual care" and "Giving spiritual care is like diving down deep."

CHAPTER V

SUMMARY OF THE STUDY

This last chapter is a summary of this phenomenological study conducted in order to appreciate and understand the lived experience of giving spiritual care for dialysis nurses. Ten nurses who had experience in dialysis were asked to describe memorable experiences of giving spiritual care. The transcripts of the interviews became the data for this study. The researcher used Colaizzi's method of data analysis to interpret the data. Rigor was maintained using trustworthiness and authenticity guidelines by Erlandson et al. (1993).

The researcher selected significant statements and meanings of the lived experience of giving spiritual care. Five themes were developed from the meanings. This chapter will discuss the themes developed from the participants' descriptions, their relationship to the literature, and conclusions drawn from these themes. Following the discussion, recommendations for nursing practice, nursing research, and nursing education will be presented.

Themes

Data analysis revealed five themes. These themes were identified as "Drawing close," "Drawing from the well of my spiritual resources," "The pain of spiritual distress," "Lack of resources to give spiritual care," and "Giving spiritual care is like diving down deep."

Drawing Close

The nurses in this study described the close relationships they developed with patients and that patients developed with one another. Aspects of drawing close were described in the subthemes of "Meeting them where they are," "Holy atmosphere," and "Spiritual care is a way of being." As nurses and patients drew closer in relationship, they formed a connection. Connectedness is a common theme reported in other studies of spiritual care (Bullard, 1994; Cone, 1994; Davis, 2005; Sellers, 2001). Many of the nurses' descriptions of what they did during spiritual care resembled that of psychosocial care and included showing respect, listening (Sellers, 2001; Taylor, 2003), and sharing of themselves with the patient. The subtheme "Meeting them where they are" was exemplified by getting on the patient's level physically, sitting down with them, listening intently, holding their hand, and looking them in the eye with full attention. These behaviors by the nurses enhanced connectedness and were described as spiritual care in other studies (Conco, 1995; Davis, 2005; Schwartz, 1995).

Listening was one of the core interventions described by patients and nurses and is substantiated by research (Carroll, 2001; Cimino, 1992; Dettmore, 1986; Grant, 2004; Martin et al., 1976; Maddox, 2000; Sellers, 2001; Sellers & Haag, 1998; Stallwood-Hess, 1969; Tanyi et al., 2006; Yanosh, 1966). Treolar (2001) and found that, even when the nurse was not religious, patients said they were comforted because the nurse was knowledgeable, caring, and allowed them to express anger and sadness. Studies show that patients were very appreciative when nurses took time to listen to their concerns, because they had a real need just to be listened to (Bullard, 1994).

The literature supports these subthemes, "Meeting them where they are," "Holy atmosphere," and "Spiritual care is a way of being." For example, "Spiritual care is a way of being" agrees with studies where participants said spiritual care could be part of all phases of nursing care (Carroll, 2001; Davis, 2005; Stephenson & Wilson, 2004; Yanosh 1966). There is some agreement among nurse researchers that nurses can integrate spirituality into physical care and in meeting psychological needs (Kociszewski, 2004; Stephenson & Wilson, 2004; Yanosh 1966) because, "...spiritual care infiltrates all aspects of nursing care" (Carroll, p. 94). A participant in Kociszewski's (2004) study of intensive care nurses described the "everydayish-ness" of giving spiritual care, as did participants in this study who said that it was hard to separate spiritual care from other aspects of nursing care.

The subtheme "Holy atmosphere" demonstrated how nurses showed respect for the patients and their beliefs. Participants described this sacred mood as occurring in instances such as when patients said *The Lord's Prayer* softly during a medical emergency in the dialysis unit or when a patient sang a song for other patients. Music is often used to elicit or enhance a holy atmosphere, especially sacred or religious music. Carson (1989) said music was valuable and had benefits including a spiritual release and relaxation. "Holy atmosphere" or spiritual mood has not been addressed directly in the literature, but Raholm (2002) argued that when nurses sincerely listen, they validate that the human spirit is something sacred, to be respected and honored (Raholm, 2002). This description from the literature has similarities with one participant's description of "Holy atmosphere."

The theme "Drawing close" illuminated the intimate relationship that characterized these nurses' experiences of giving spiritual care. They described spiritual care as a way of being with patients by creating a holy atmosphere and meeting patients where they were in their process of coping with critical illness. Nurses and dialysis patients have an intimate relationship that is unique. Swartz, Perry, Brown, Swartz, and Vinokur (2008), Molzahn, Bruce, and Shields (2008), and Bordelon (2001) reached similar conclusions in their studies of dialysis patients. The literature supported the theme "Drawing close" in its similarities to nursing behaviors identified as spiritual care, the connections that nurses and patients make during spiritual care, and the belief by nurses and patients that spiritual care is part of everyday nursing. Participants in Walton and Sullivan's (2004) study said spirituality was a part of every aspect of their lives and cancer experience. These findings are similar to those in Woodard and Sowell's (2001) study of 21 women infected with HIV who said, "God was in the details of everyday life." (p. 240). The idea of a "Holy atmosphere" has the potential to add to the literature.

Drawing from the Well of My Spiritual Resources

The second theme, "Drawing from the well of my spiritual resources," elucidates resources the participants used to assist in giving spiritual care. Nurses described various resources that included the subthemes of "Drawing on God," "Drawing on prayer," "Drawing on patients," and "Drawing on experiences." The idea of identifying and using nurses' spiritual resources is not well documented in the literature. There is mention of nurses using spiritual resources for patients in need (Tanyi et al., 2006; Taylor, 2003), but little on resources the nurse uses to give spiritual care. For example in the Tanyi et al.

study of female dialysis patients, patients wanted nurses to assist in mobilizing spiritual resources by having sacred writings such as Bibles and spiritual pamphlets available for the patients on the unit.

"Drawing on God" was exemplified by participants' descriptions of dependence on God for direction as they cared for dialysis patients. Nurses said they directly relied on God to guide them as they cared for patients and to help them know what to say to the patients. Reliance on God helped them cope as a nurse when they saw illness day after day. Studies by Belcher and Griffiths (2005), Obrien (1999), and Van Dover and Bacon (2001) support this. Van Dover and Bacon found that nurses used prayer to seek God's spiritual direction while giving spiritual care. Over half of the participants in Belcher and Griffiths' study reported drawing on God as an expression of spirituality by attending church, reading scripture or spiritual readings, meditating, and keeping journals.

Several nurses explained that they received spiritual care and support from interaction with the patients. There was no research found describing the subtheme "Patients as a spiritual resource" for the nurse. So, the concept of patients providing spiritual care to the nurse adds to the literature.

Nurses in this study reported "Drawing on prayer" as a common resource. Prayer as a positive coping behavior is supported by the literature. Al-Arabi (2006) conducted a qualitative study of 80 patients in an outpatient dialysis center to determine how these patients managed their quality of life. Patients described how trusting in God and spiritual activities like prayer and talking with friends from their church helped them with daily coping. Other studies indicated that dialysis patients found spiritual activities such as

prayer helpful (Baldree et al., 1982; Walton, 2002). Studies also reported nurses praying with the patient as a frequent nursing intervention (Stallwood-Hess, 1969). Furthermore, nurses identified prayer as spiritual care (Belcher & Griffiths, 2005; Bullard, 1994; Carroll, 2001; Grant 2004; Sellers & Haag, 1998; Van Dover & Bacon, 2001).

Nurses in this study said life experiences such as death of family members, divorce, and having children were life events that helped shape their spirituality and make it stronger. Nurses' life experiences gave them more confidence to give spiritual care in the future. In Kociszewski's (2004) study, nurses experienced increased spiritual awareness as they experienced patients' deaths and supported patients' families. This awareness positively influenced how they cared for other patients and how they helped other nurses in similar situations. The experience of giving spiritual care over time and gaining confidence and understanding may be a new type of life-long learning.

The Pain of Spiritual Distress

This theme depicted nurses' description of how dialysis patients experience spiritual distress. The subthemes "Patients' pain of losses and anger" and "Participating in the pain of spiritual distress" will be discussed. Dialysis patients go through the grieving process due to the losses they experience, and anger is a common emotion for such patients. White and Grenyer (1999) reported similar findings from their qualitative study interviews with 22 dialysis patients and their partners to determine the biopsychosocial impact of dialysis. These researchers found that patients exhibited anger, depression, and hopelessness. The profoundly negative impact that dialysis can have on

patients and their families was demonstrated by this study. Nurses in this study were negatively affected when faced with patients in spiritual distress.

In a phenomenological pilot study that included the experience of three nurses' giving of spiritual care, Kociszewski (2003) found that nurses did not consistently experience success in moving the patient toward God or a higher power. Those experiences created conflict and distress for the nurse, the patient, and their family. Nurses in this study talked about how seeing a patient in spiritual distress was a painful experience, which relates to the subtheme, "Participating in the pain of spiritual distress." This area offers the potential for future studies.

Lack of Resources to Give Spiritual Care

This theme was illuminated by the nurse participants' descriptions. Subthemes were "Out of time," "Out of space," "Out of emotional and spiritual energy," and "Afraid to trespass." Nurses' depictions of their experiences in this study did not agree with Bradbury et al. (1988); Chadwick (1972); Lemoine (2002); McSherry and Ross (2002); Musgrave (2000); Piles (1990); Stranahan (2001); Vance (2001); and Yancy (1987) who found reasons for not giving spiritual care included feeling uncomfortable or inadequately prepared, and not recognizing spiritual needs. Nurses in this study said they felt comfortable in giving spiritual care and characterized themselves as "very spiritual."

There was agreement among the nurses in this study with the literature that without adequate exposure to spiritual care and lack of spiritual care role models, nurses may not feel qualified to give spiritual care (McSherry & Ross, 2002; Meyer, 2002; Piles, 1990). Nurses in this study had a high sense of spirituality. Other studies also found that

nurses with a high sense of spirituality gave spiritual care more often than nurses who had a low sense of spirituality (Bradbury et al., 1988; Champaigne, 1987; Cimino, 1992; DeWitt-Weaver 1985; Meyer, 2002; Soeken & Carson, 1986; Taylor & Amenta, 1994; Taylor et al., 1999; Wagner, 1998; Wujcik, 2003).

The literature validated the subtheme "Out of time" as a common problem when giving spiritual care. Nursing has been wrestling with this issue for almost 50 years. Limited time was a main reason nurses said they did not have the resources to give spiritual care. However, when nurses spend quality time with patients, they are giving spiritual care. Nurses perceive that spiritual care takes extra time and they may not realize that the quantity of the time is not as important as the quality (Conco, 1995; Schwartz, 1995). Nurses identified being too busy as a barrier in several studies (Belcher & Griffiths, 2005; Cimino, 1992; Cox, 1995; DeWitt-Weaver, 1985; Hill, 1987; Lewis, 1957; Piles, 1990; Sodestrom & Martinson, 1987; Vance, 2001). In addition, patients reported their nurses were too busy to offer spiritual care (Broten, 1991; Davis, 2005; Stallwood-Hess, 1969).

Patients felt cared for when the nurses spent only "a few minutes" to connect although the nurse was busy with other patients (Davis, 2005). Davis wrote, "Spiritual care does not need to be seen as only something extra to provide when there is time" (p. 132). This corresponds with the idea of integrating spiritual care into nursing activities and the subtheme "Spiritual care is a way of being" that incorporates this practice into the nurses' everyday lives.

Dialysis units are not private areas and participants emphasized this fact, which represents the subtheme "Out of space." Patients are in side-by-side recliners for their time on dialysis. Although curtains separate patients, a patient's neighbor can hear everything that someone says to the patient. Several participants mentioned the lack of privacy as preventing them from giving spiritual care. No literature was found addressing lack of privacy as a barrier to giving spiritual care, and the concept of privacy can be an issue for many other health care settings. The idea of lack of privacy as a concept adds to the literature.

The nurses in this study said that caring for patients who require spiritual care can be draining at times. The subtheme "Out of emotional and spiritual energy" described this finding. Kociszewski (2004) reported a similar finding in a phenomenological study of intensive care nurses. Although there was intense suffering and shared grief, these nurses found strength from caring for critically ill patients. It was important for nurses to care for their own spirit in order to give spiritual care to others. Nurses grew spiritually and affirmed that their presence and care helped others. As a nurse shared, "Being there for that person or that family, at that time, makes me feel better. Makes me feel like I'm in the right place. I don't mean critical care. I mean Nursing—it's a beautiful profession!" (Kociszewski, p. 408). A similar response was shared in this study by one participant, who said she loved nursing and thought nursing and spiritual care went hand in hand. Participants in this study thought that giving spiritual care was very rewarding, even though it was draining at times.

Nurses in this study said providing spiritual care can be emotionally and spiritually draining, especially when patients are in spiritual distress because of their anger. This could be akin to compassion fatigue, which is defined as "a loss of sympathy for the suffering of others experienced by donors or caregivers as a result of the demands made of them" (Encarta, 2007, para. 1). Compassion fatigue is a concept studied in disaster volunteers and minimally in hospice nurses (Abendroth & Flannery, 2006). Hospice nurses in Abendroth and Flannery's study were in a higher percentage for having compassion fatigue. It could be inferred that dialysis nurses face similar situations, such as witnessing patients with terminal illnesses that put them at risk for compassion fatigue. Indeed, several nurses in this study said there were times they felt completely and emotionally spent.

The subtheme "Afraid to trespass" illuminates how nurses were concerned that they might offend patients' and their belief systems. Spiritual care is personal and private. Nurses in this study said they did not share experiences with other nurses when they gave spiritual care. After assessing the patient and the situation, nurses in this study exercised caution when offering spiritual care. Intensive care nurses in Kociszewski's (2004) study also reported they were careful about entering into spiritual care because they did not want to offend patients or push their views on them. Fear of offending the patient by offering spiritual care was validated in the literature (McSherry & Ross, 2002; Piles, 1990; Yancy, 1987).

Giving Spiritual Care Is Like Diving Down Deep

The last theme "Giving spiritual care is like diving down deep" echoed what the nurses said about their feelings when giving spiritual care by discussing life and death issues with patients. Giving spiritual care went further than usual nursing care. It involved discussing sensitive issues such as, "Have you accomplished what you need to in life?" Giving spiritual care went beyond the superficial; it was "diving down deep."

Researchers of spiritual care generally agreed with this study's finding that giving spiritual care is an intimate experience (Bullard, 1994; Carroll, 2001; Cone, 1994; O'Brien, 1999; Van Dover & Bacon, 2001). Cone used grounded theory methodology to clarify the experience of giving spiritual care by interviewing focus groups of nursing faculty and students. The participants identified connection as the emerging basic social process, such that, "The interaction between the nurse and the patient becomes spiritual care when the nurse connects on a *deep*, transcendent level with the patient in such a way as to provide support and enablement for the patient's beliefs, values, practices..." (p. 78). In the case of intensive care nurses, the incidence of serious illness moved the patient and the nurse to a deeper spiritual journey (Kociszewski, 2003). Nurses in another study believed that spiritual care was the role of the nurse, and nurses developed an intimate relationship with the patients that would not occur during casual conversations (Carroll, 2001). Spiritual care enhanced connectedness and *depth* of the nurse-patient relationship. This concept was further supported by O'Brien's (1999) findings from her qualitative interviews with 66 nurses about spirituality and the nurse-patient relationship. Nurses in O'Brien's study described giving spiritual care as "almost sacred" and a deep experience.

One nurse with 23 years of experience said it was "A gift to us as nurses is to be able to touch the core of someone" (O'Brien, 199, p. 110). Another participant shared the "sacredness" of caring for persons with HIV who were dying. "Diving down deep" has been identified as the essence of giving spiritual care.

Summary of Themes

Participants said giving spiritual care was more intimate than giving psychosocial care. Nurses described interventions that enhanced drawing close and developing a relationship with a patient, which involved such practices as listening, touch, and getting on the patient's level. The nurses drew from their personal spiritual resources to reach out and give spiritual care. Participants saw spiritual care as a way of being with patients and creating a holy atmosphere. Both the nurse and the patient could be affected by this interaction. At times, this sacrificial giving seemed costly to the nurses in terms of their emotional energy because of the pain of participating in patients' spiritual distress and anger. Lack of resources such as space, time, and emotional and spiritual energy presented challenges to giving spiritual care. When life and death issues were discussed, spiritual care was like "Diving Down Deep" for the nurse.

Conclusions

Spiritual Care As a Continuum

Spiritual care begins with the needs of the patient. Patients may express varying depths of spiritual need. Nurses can give spiritual care according to patients' needs. At one end of the continuum, some patients may not need or want any spiritual care; some may need minimal support and have their spiritual needs met by others such as a

chaplain, spiritual advisor, family, and/or friends. At the other end of the continuum, some patients may be in crisis and need intensive spiritual care from the nurse. According to participants in this study, dialysis patients were in the deep end on spiritual needs.

Nurses respond to patients' spiritual needs in a variety of ways. Spiritual care can include aspects of psychosocial nursing care such as listening, being kind, or treating patients with respect. It can include calling spiritual advisors such as the chaplain or sharing spiritual practices such as prayer or reading religious texts. There are different levels of awareness and preparedness to give spiritual care. When and how a nurse offers spiritual care seems to be influenced by the nurse's spirituality and exposure to spiritual concepts in nursing programs (Bradbury et al., 1988; Champaigne, 1987; Cimino, 1992; DeWitt-Weaver 1985; Meyer, 2002; Soeken & Carson, 1986; Taylor & Amenta, 1994; Taylor et al., 1999; Wagner, 1998; Wujcik, 2003). The novice nurse may not have the advantage of life experiences and spiritual care experiences to draw on. Some nurses' style of giving spiritual care is more supportive while some said they had to "dive down deep" to meet their patients' spiritual needs.

The researcher chose the concept of water as a metaphor for spiritual care by combining "diving down deep" with "spiritual care as a continuum." Patients can be seen as an observer on the shore who might go in the water in varying depths, and the nurse is represented as a lifeguard who is watching and ready to help. The patients who do not need or desire spiritual care are on the beach; the nurse observes them but does not have to intervene with lifesaving skills if they do not enter the water.

Patients, who need minimal to moderate spiritual support, are seen as wading in the water. The nurse/lifeguard is on alert for any problems such as if they become swept away by a wave or current. The lifeguard watches the person in the water and has lifesaving equipment ready to use if needed. The support by the nurse is actualized as presence, touch, and a connection that occurs from the relationship.

Persons in crisis are in deep water "over their heads." They may not be able to swim or stay afloat without help. There may be waves of crisis including life and death issues and physical problems that can overwhelm patients. The lifeguard/nurse comes to the rescue and provides a flotation device to keep their heads above water. Additionally, nurses could be seen as the patients' water wings that help keep them afloat. Flotation devices and the lifeguard's ability to swim and recue swimmers could be seen as the nurse's spiritual resources.

If a swimmer starts to sink, the lifeguard has to "dive down deep" to save the patient from drowning. The lifeguard comes alongside of the patient and, when possible, supports the swimmer/patient's efforts to get back to the safety of shallow water and then to the shore. This intensive spiritual care can include one-on-one attention, active listening, touch, being on the patient's level, referring to clergy or chaplains, or offering to pray with the patient.

If a swimmer begins to drown, the lifeguard would call on help from other lifeguards and use other lifesaving devices that could assist the drowning swimmer. Other resources such as chaplains and spiritual advisors could represent the other lifeguards that provide assistance. Collaborative care by referring patients to chaplains and spiritual

advisors is similar to calling for help. The more experience the lifeguard/nurse has, the better his/her skills for rescue/spiritual care. A novice nurse can gain confidence and familiarity with each experience of giving spiritual care. An alert lifeguard/nurse watches for potential problems with swimmers/patients in distress. The nurse assesses the patient's body language and asks questions about spiritual needs. At times, minimal support is needed, but the nurse is ready to "dive down deep" with the patients if they start to "drown" in their experience of illness and life and death issues.

Rescuing a drowning patient temporarily exhausts the lifeguard's physical and emotional resources. In the same way, providing spiritual care can be emotionally and spiritually exhausting for the nurse. Just as lifeguards need to take care of their own physical needs through adequate nutrition, physical training, and rest, nurses need to care for their own spirit so they can have the emotional energy to care for the patient. Nurses do that by caring for their spirit in ways that are meaningful to them (prayer, personal reflection, or meditation) getting sufficient rest and exercise, taking time away from their work, participating in critical incident stress debriefing, and grief support.

In addition to the conclusion that spiritual care is a continuum, the researcher drew several other conclusions. First, the basic component of spiritual care is connecting with the patient. Study participants agreed with existing research that the basic part of spiritual care is connecting with the patient. A relationship is a prerequisite for spiritual care. Patients with religious affiliations and those without, both, reported that nurses comforted them when they cared for them as a "person," not as a number, and when nurses listened and gave the patient a chance to talk (Creel, 2007; Sellers, 2001).

Second, no matter how patients define spirituality, patients use their spirituality to help them transcend their experiences of illness and suffering and find meaning and purpose (Emblen & Halstead, 1993). Life-threatening illnesses such as those faced by dialysis patients present an occasion for offering spiritual care. Illness causes distress due to changes in personal roles, pain, chronic symptoms, and potential hastening death. A person can be in spiritual distress because of illness and may be asking difficult questions such as, "Why is this happening to me?" and "What happens when I die?" Nurses are with patients 24 hours a day, and although chaplains have advanced education and are spiritual care experts, there are times when a nurse is in the best position to give spiritual care be it from the time of day or night or from the intimate relationship that may have developed between with the patient.

Third, nurses can offer spiritual care regardless of their own beliefs or those of the patient. Pesut and Thorne (2007) seemed concerned that nurses with spiritual or religious knowledge might consider themselves spiritual "experts" and might try to coerce patients into believing their point of view. This was not true in this study. The nurses expressed sensitivity to not wanting to trespass onto their patients' beliefs. Nurses can offer spiritual care to patients with beliefs different from their own or who express no religious and spiritual values, especially by listening, which is basic to psychosocial and spiritual care. Even though some nurses may think spirituality and religion are too private and may be uncomfortable discussing these matters with patients, most nurses can listen and accept what the patient talks about. Martin et al. (1976) concluded that nurses did not need to

know all the answers about specific religions, but rather nurses needed to appreciate how important it is for the nurse to listen and allow the patient to talk.

Time was a main reason cited by the nurses for not offering spiritual care. When nurses spend quality time with patients, they are giving spiritual care. Nurses may perceive that spiritual care takes extra time. They may not realize that the quantity of the time is not as important as the quality (Conco, 1995; Schwartz, 1995). Nurses give spiritual care by being kind, practicing active listening, being present with the patient, and assessing patients for their needs.

Lastly, many of the nurses' descriptions of what they did during spiritual care resembled that of psychosocial care, which included showing respect, listening (Sellers, 2001; Taylor, 2003), and sharing of themselves with the patient. Although it is important to understand the background and varying definitions of psychosocial care and spiritual care, perhaps the most important point is to remember that what the patient needs, whether it involves psychosocial and spiritual care or both, is the nurse's priority.

Strengths and Limitations

A strength of this study was also its limitation. The homogeneity of the participants as mostly white, female, and Christian allowed a more in-depth description of spiritual care by this population and facilitated data saturation. However, lack of diversity limits transferability of the findings to nurses who differ in race, ethnicity, gender, or spiritual world views.

Assumptions

The researcher made five assumptions at the beginning of the study, and all were supported by the study's findings. The assumptions that *nurses assist patients to find meaning by giving spiritual care,* and *spirituality is an integral part of being human that assists individuals to find meaning in their life experiences* were addressed through nurses' description of how some patients found meaning as they depended upon their religion and spirituality for support. Patients found meaning in their ability to work and take care of themselves by successfully managing their diet, medication, and fluid intake; by attending church; and by appreciating and valuing time with their family. One nurse in this study said one patient found meaning through participating in a prison ministry. The literature also supported this assumption. Studies described how patients received spiritual care and found meaning through their religious practices (Belcher & Griffiths, 2005; Dettmore, 1986; DeWitt-Weaver, 1985).

The assumption that *spiritual care encompasses general supportive care as well as specific interventions related to religious rituals* was supported by the study's participants' descriptions. Nurses said spiritual care interventions and ways to connect with the patient included listening, touch, prayer, and getting on the patient's level. Participants described spiritual care as being available to the patient by devoting time, attention, and promising the patients they would be there for them. These behaviors are congruent with findings from Conco (1995) who concluded that "taking time, active listening, being available, doing, sharing self, and showing acceptance and understanding were all valued and perceived as spiritual" (p. 275). Although spiritual care can be

specific, nurses can have a generally caring attitude that pervades every nursing action. Walton and Sullivan (2004) echoed this idea, "If spirituality permeates all aspects of life...then any nursing intervention has the potential to be spiritual" (p. 148).

Participant narratives portrayed their spiritual care experiences and supported the assumption that *patients bring their spirituality to experiences of illness.* Nurses described how patients exhibited spiritual distress by demonstrating anger. Nurses in this study said other patients used their spirituality to help them cope. Sodestrom and Martinson's (1987) study of cancer patients and their nurses pleaded for nurses to support patients spiritually, "People fall back on their religion in times of crisis...nurses should recognize this and support the patient's beliefs as a strength and resource for him, but make it specific to the patient's religious background" (p. 45). The last assumption, *giving spiritual care is an important role for nurses*, was validated as nurses talked passionately about how rewarding it was to give spiritual care. Nurses believed spiritual care was an important part of nursing (Grant, 2004; Harrison & Burnard, 1993).

Conclusions and the Literature

The study findings are discussed concerning how the findings agree, disagree, and add to the literature on spiritual care. Many studies agreed with this study's findings. There was little disagreement between findings and the literature, and there were concepts that had not been discussed in the literature.

Agreement with the literature. Connectedness was a similar theme to "Drawing close" that was found in the literature. It has been identified as a key process when giving spiritual care (Bullard, 1994; Cone, 1994; Davis, 2005; Sellers, 2001). Prayer was an

important spiritual care intervention (Belcher & Griffiths, 2005; Bullard, 1994; Carroll, 2001; Grant 2004; Sellers & Haag, 1998; Van Dover & Bacon, 2001). Life experiences helped the nurse to have more confidence when facing similar situations, and giving spiritual care increased familiarity with the process in the future and was supported by other studies (Kociszewski, 2004; Sellers, 2001). Nurses in this study had a high sense of spirituality and were comfortable giving spiritual care. This finding was in agreement with studies that found that nurses with a strong sense of spirituality gave spiritual care more often than nurses who had a low sense of spirituality (Bradbury et al., 1988; Champaigne, 1987; Cimino, 1992; DeWitt-Weaver 1985; Meyer, 2002; Soeken & Carson, 1986; Taylor & Amenta, 1994; Taylor et al., 1999; Wagner, 1998; Wujcik, 2003).

The subtheme "Out of time" was validated as a common problem when giving spiritual care (Belcher & Griffiths, 2005; Cimino, 1992; Cox, 1995; DeWitt-Weaver, 1985; Hill, 1987; Lewis, 1957; Piles, 1990; Sodestrom & Martinson, 1987; Vance, 2001). Anger is a common emotion of dialysis patients (White & Grenyer, 1999) and nurses said caring for patients that require spiritual care could be draining at times (Kociszewski, 2004). Nurses in this study agreed that, without adequate exposure to spiritual care and lack of spiritual care role models, nurses may not feel qualified to give spiritual care (McSherry & Ross, 2002; Meyer, 2002; Piles, 1990). Fear of offending the patient by offering spiritual care was validated in the literature (McSherry & Ross, 2002; Piles, 1990; Yancy, 1987). Research on spiritual care agreed that it was an intimate experience

(Bullard, 1994; Carroll, 2001; Cone, 1994; Van Dover & Bacon, 2001) and serious illness moved the patient and the nurse to a deeper spiritual journey (Kociszewski).

Disagreement with literature. Nurses in this study did not agree with Bradbury et al. (1988); Chadwick (1972); Lemoine (2002); McSherry and Ross (2002); Musgrave (2000); Piles (1990); Stranahan (2001); Vance (2001); and Yancy (1987) who found reasons for not giving spiritual care included feeling uncomfortable or inadequately prepared, and not recognizing spiritual needs. Nurses in this study had a strong sense of spirituality and provided examples of how to assess patients for spiritual distress and give spiritual care.

Advances in the literature. The idea that a holy atmosphere can occur at times of spiritual care, such as when patients or nurses pray or listen to music, has not been studied. There was little research found about nurses' spiritual resources, especially how patients could offer spiritual support to nurses. Sparse research was found on the experience of nurses' participation in the pain of the patient's spiritual distress. The draining experience of giving spiritual care may be similar to compassion fatigue. Several participants mentioned the lack of privacy as preventing them from giving spiritual care, which was not found in the literature.

Recommendations for Further Studies

As the experiences of dialysis nurses giving spiritual care were illuminated, direction for the development of recommendations for nursing practice, nursing education, and nursing research emerged. Nurses' recognition of patients' spiritual needs can lead to active ways to provide strength and comfort in illness.

Nursing Practice

Nurses generally agree that spiritual care is a part of their nursing responsibility, but a disparity exists between that belief and the actuality of giving spiritual care (Bradbury et al., 1988; Chadwick, 1972; Musgrave, 2000; Yancy, 1987). Nurses may need to first define their own spirituality and attitudes towards offering spiritual care. Nurses who understand and are comfortable talking to patients about spirituality can be a mentor to others and share information about how they incorporate spiritual care into their nursing practice. Nurses in this study said giving spiritual care was part of their everyday life; it was entwined in their nursing care. It was something they did without purposefully thinking; "Now I'm going to give spiritual care." A spiritual care nurse mentor could be available on nursing units as a resource for novice nurses or for those needing assistance in meeting patient's spiritual needs.

Caring for patients provides nurses with many occasions for encountering spiritual issues, especially when there is chronic, serious, and terminal illness. Patients' spirituality helps them to manage the losses inherent in chronic and life-threatening illnesses. Assessments could be made of patients and their current attitudes regarding the losses they are experiencing and how they are managing those losses. Nurses could then use the continuum of spiritual care in helping patients cope with their losses.

Because of the stressful environment and emotional energy needed to give spiritual care to patients with a life-threatening illness, such as dialysis patients, nursing management could assist nurses to take advantage of self-care activities such as critical incident stress debriefing, grief support, prayer, personal reflection, and meditation. A

support group including dialysis nurses with similar experiences could help nurses debrief and process their experiences. Joining and participating in professional organizations such as the American Nephrology Nurses Association is another way to seek support and experience common bonds with others.

Most health care facilities do not recognize individuals who are agnostic or atheistic because assessment tools usually do not include a category for patients with a spirituality outside major categories of religion. Creel (2007) suggests adding questions on admission for spiritual assessment to include categories for persons without religion such as "other" or "none" and volunteers with similar beliefs could be available as an option to a chaplain. Nurses might ask patients what spiritual practices they find helpful in managing difficult life events such as an illness as part of assessing their religious or spiritual preferences on admission.

Nursing Education

Nurses may give spiritual care based on exposure to spirituality and spiritual care in their nursing education (Meyer, 2002). Nursing education curricula included but did not define spiritual care (Catanzaro & McMullen, 2001; Denham, 1987; Lemoine, 2002; Meyer, 2002). Although, nursing education curricula did not consistently define spiritual care, it appeared to be valued; some included this topic under the broad heading of psychosocial care.

The literature supports that while receiving spirituality content in nursing school and having a high degree of personal spirituality were strong predictors of giving spiritual care (Meyer, 2002; Schnorr, 1988), spiritual care education varied widely and many

nurses did not feel qualified to give spiritual care (Cox, 1995; McSherry & Ross, 2002). There was a lack of good role models, such as faculty or clinical colleagues for giving spiritual care. There is a need for a focus on spirituality in nursing education and in continuing education to increase nurses' confidence in giving spiritual care (Koslander & Arvidsson, 2006). Spiritual care education could include discussions of how patients' diverse religious and spiritual worldviews influence their spiritual needs. Other topics could include education about the role of spirituality in managing chronic or life-threatening illnesses, strategies for incorporating spiritual care into usual nursing care, and ways to work with members of the spiritual care team such as chaplains.

The inclusion in nursing education of information about how nurses can utilize their own spiritual resources to manage the stress of caring for chronically and terminally ill persons might decrease nurses' stress level through understanding their own needs. In order to give spiritual care to others, nurses need to care for their own spirit (Kociszewski, 2004). Knowledge of the warning signs of "burn out" might help the nurse recognize when they need support from others.

Nursing Research

The findings of this study also illuminate potential topics for further research. An ethnographic study of how nurses and other members of the healthcare team provide spiritual care in their everyday patient care could offer guidance in developing nursing interventions. Qualitative studies exploring the experiences of dialysis nurses are lacking. Tanyi et al. (2006) argued for the need for more research. The authors wrote, "Currently, little phenomenological knowledge exists in the nursing literature to guide nephrology

nurses..." (p. 536). Companion studies with dialysis patients about their perceptions of spiritual care could also facilitate development of nursing interventions. Secondary data analysis of this study's data through the lens of grounded theory might provide needed research about dialysis nurses and the process of giving spiritual care.

According to Moore (2007), "There is much greater diversity in the workforce as a whole, and a richer cultural mix in nursing teams" (p. 21). Different cultural and religious affiliations of nurses and patients should be represented in future research. When persons with no religious affiliation were asked to describe spiritual care from their nurses (Creel, 2007), they described activities such as caring attitudes, giving patients freedom of choice when possible, allowing the patient to talk, and being treated like a person, but even without prayer and mention of a higher power, patients perceive certain activities of the nurse to be spiritual care. More research of persons who do not have a religious affiliation would help to clarify interventions that are helpful to all patients.

Several aspects of the experience of giving spiritual care for the nurse have not been studied. Research of the nurse's experience with patients in spiritual distress could add to the literature. Studying compassion fatigue and measures to decrease "burn out" and exiting of the nursing profession could be beneficial. In Abendroth and Flannery's (2006) study of compassion fatigue and hospice nurses, the authors recommended more research in different nursing specialties, exploration of management's existing policies in relation to compassion fatigue risk, and qualitative studies to provide in-depth information on the experience of compassion fatigue. Giving spiritual care can have cumulative effects over time causing the nurse to be depleted of emotional and spiritual

energy. Ways to support nurses who care for patients who face life and death issues should be represented in future research.

Because of the private and intimate nature of spiritual care between the patient and nurse, nurses tend to not talk about giving spiritual care with other nurses nor do they document their spiritual care. The research question, "How is spiritual care documented without compromising confidentiality?" would be a starting point for a study.

Summary

According to the study participants, spirituality helped patients cope with their illness. Spirituality is seen as a key part of holistic care. Clear ways to prepare and encourage nurses to give spiritual care may eventually be seen as a major commitment of nursing as a profession. "When spirituality is taken for granted, clients may be deprived of crucial support - including their religious belief system that could be activated as a source of comfort" (Newman, 2005, p. 35)

This chapter represented conclusions from the study and discussed how the themes described the dialysis nurses' experience of giving spiritual care. Conclusions related to the implementation of this study were discussed in order to assist future researchers as they investigate spiritual care. A discussion of recommendations for nursing practice, nursing education, and nursing research completed the chapter.

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APPENDIX A

Interview Guide for the Pilot Study

Interview Guide for the Pilot Study

Talk to me about spiritual care.

Tell me about an experience or experiences when you provided spiritual care to a patient.

What clues alert you that the patient is in spiritual distress? Can you give an example?

Has your attitude about spiritual care changed over time? If so, how?

What approach would you take or how would you initiate a conversation with a patient about spiritual care?

Does a patient have to be in spiritual distress before spiritual care is given?

Do you think patients expect nurses to give spiritual care?

Can you describe your comfort level in giving spiritual care?

Is religion related to spiritual care? If so, how?

Why or why not do you think it is your (or other nurses') responsibility to provide spiritual care? If not, whose job is it?

What other persons, especially list any nurses, have influenced you as you consider giving spiritual care?

What experiences, personal or educational, do you feel have prepared you to provide spiritual care?

Is there a difference between spiritual care and psychosocial care? If there is, describe your perceptions.

Is there anything about spirituality or spiritual care that I have not asked that you would like to add?

APPENDIX B

Revised Interview Guide

Revised Interview Guide

1) Tell me about a memorable time you had with a patient taking care of his/ her spiritual or psychosocial needs?

2) For you (or in your experience) how does offering spiritual care differ from caring for patients' psychosocial needs?

3) In your experience, what was it like to offer/give spiritual care?

4) I am interested in whether you shared your experience with others and what that was like for you.

5) How have you or how would you initiate a conversation with a patient about their spiritual needs?

6) What experiences in your life have prepared you to provide spiritual care?

7) Tell me about a time when you felt you would feel that you did not have the resources to give spiritual care?

8) What would have helped you?

9) What is it like for you when patients seem to be in spiritual distress?

10) In your experience, how do dialysis patients find meaning in their illness?

11) How have you helped them find meaning?

12) In your experience, how do your patients express their spiritual distress?

13) Can you tell me about a time when a patient was not receptive to spiritual care? How did you respond?

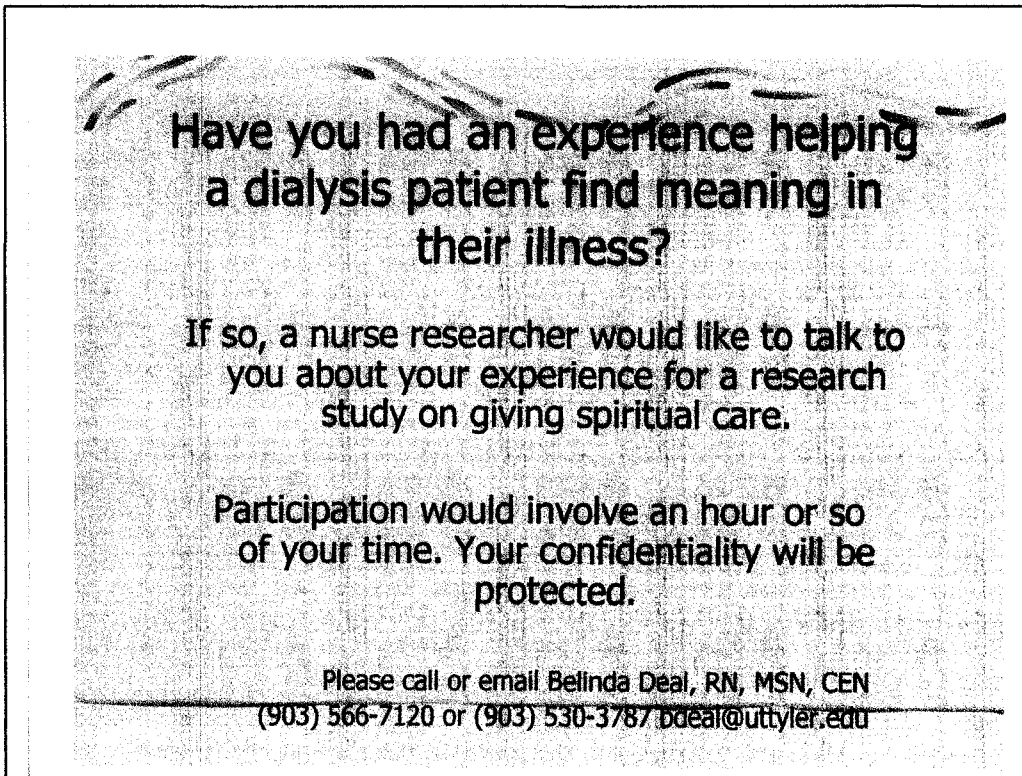
14) How has your practice of offering spiritual care changed over time?

15) How would you describe your own spirituality?
And how does your own spirituality influence how you care for your patients?

16) What should I have asked you that I didn't think to ask? Is there anything else you care to add?

APPENDIX C

Flyer


Have you had an experience helping a dialysis patient find meaning in their illness?
If so, a nurse researcher would like to talk to you about your experience for a research study on giving spiritual care.
Participation would involve an hour or so of your time. Your confidentiality will be protected.
Please call or email Belinda Deal, RN, MSN, CEN
(903) 566-7120 or (903) 530-3787 bdeal@uttyler.edu

APPENDIX D

Significant Statements and Formulated Meanings

Significant Statements and Formulated Meanings

Significant Statements	Formulated Meaning
1. Because we see patients three times a week, they tend to become a part of your life and you become a part of their life. 2. That's how close you get, in dialysis. 3. You get real attached to these people, whether they are brand new and they-they really cling to um, every word you say… 4. Probably, I learned more from him than he did from me and I just was there to hold his hand and talk him through. 5. Most of the spirituality, I have to tell you, has come from the patients to me. 6. She actually started ministering to me first…with that, her and I just, kind of just took on this relationship of just sharing and opening with each other about how we felt about, um forgiveness and uh, our past sins… 7. Kind of gets them into a little clique type thing. 8. They pray for each other and one of my other out-patients said I have been praying for him…and they know if somebody doesn't show up something's wrong you know and they'll say, "Where's Mr. So and So?"	Close bond is formed between nurses and patients and patients and patients

9. And some of them would get there an hour early just to sit out there and visit with other people and stuff 10. When someone died…was no longer a member of that family…coming three times a week. 11. I mean they become a community. And they support each other and I trust me, they know each other 12. The spirituality in the facility will come from that population of patients (Black) and they will spread it out. 13. I certainly saw um, some that, that ministered to others through, through it – through their experiencing, offering encouragement, um, friendship… 14. Sometimes they don't want to talk to a minister, but they are willing, they are willing to talk to a nurse 15. I'll give away half of my paycheck all the time. I'll provide them with things and we'll share it around. We have several little patients who, I'll bring in the books and then they know it goes from patient "A" to patient "B", and patient "B" to patient "C", and patient "C" on. And if it ever gets back to me, that's fine. If it doesn't, as long as somebody got something out of it. 16. And yet, giving them a peek that I was a real person and that they could come to me at any point, at any time, for anything.	

17. It hurts me… (seeing patients in spiritual distress) 18. Frustrating. Cause I'm a fixer. I guess uh, essentially all nurses are fixers. 19. It's frustrating if you cannot help them. 20. You know, but, um, I just, I was very disturbed over it.	Seeing patients in spiritual distress is painful
21. Just try to figure out exactly, you know, what the issue is. 22. And I just felt like I needed to pray for her. But I just couldn't do it right there. 23. So I'm looking at why, trying to figure out the why…	Nurses try to find out why patients are in spiritual distress
24. We'll get eye to eye with them, you know, so they won't feel like we're not dominating over them. …and get eye to eye with them and sit there and explain things to them, and um, try to reassure them the best way we can, 25. Getting on their level and holding their hand if we need too 26. I always sat down and, uh found out their literacy level, so that I made sure that I could present them information at their level 27. They're angry and sometimes it's just you just go in and try to reassure them and you get on that same level.	Try to connect with the patient on their level

28. A lot of them find meaning because they've been given the gift to get things in order…They know they have limited time. 29. If it's time to mend old bridges or call that daughter that they haven't called in five years or if there's some ailment in a relationship. 30. For me, spiritual care is about with all the patients, their-their day to day ah life is-is not promised	Patients are aware they have limited time to live and make the most of it
31. Spiritual care is…goes beyond psychosocial. Psychosocial could be just comfort and spiritual care could be validating and creating a holy atmosphere and treating people very respectfully and acknowledging their beliefs and accepting that their beliefs… 32. And it was one of the most awesome experiences I've ever had in my life. (describing how a patient would say The Lord's Prayer when there was a life-threatening situation in the unit) 33. You could still hear his voice and feel the wonderful feeling. I mean it really, I though it was a, you could, yes you could feel a spiritual mood in there, but I really felt like he was ministering to them and I think they did too. 34. It's more of just an empathetic, uh, sit with them. You're just there as a comfort measure, but that's how I think of it is - it's (spirituality) the environment	Spiritual care can create a holy atmosphere

35. I don't think that initially you can jump right in to, I'm going to pray for you right now, you know 36. You kind of got to warm up to that because some people they believe that church should be here and work should be here 37. Because I don't want to offend anybody if they don't go to church.	You have to warm up to spiritual care
38. Spiritual care to me is what I would call religious care. 39. I have a hard time giving it because I'm trying not to cross the, the line of infringing on somebody's religious rights, religious beliefs. 40. You're definitely, very carefully, I think when approaching a patient about spirituality, you know who to approach and who not to approach about it. I draw the line and I don't want to overstep my boundaries 41. You don't want to push it on a patient that doesn't want to hear it.	Nurses do not want to offend anyone or push their religion on others
42. I think just knowing that I'm a believer and I can say to them, "I want to pray for you." I think, helps people. 43. A simple prayer is usually all they need. 44. I'll keep you in my prayers is always something I say very frequently.	Nurses use prayer to comfort patients

45. I think the act of actually praying for somebody, or just the thought that you're going to keep them in your prayers just changes how you feel about that person, makes you more caring towards them. 46. When the patients are crude...You're more patient with them as they're going through their struggles. 47. Yes, it helps me to cope with the everyday demands of seeing these poor sick people. 48. I still, just my own spiritual self, I really, it helps me to be a better nurse. 49. And so, my spirituality helps me there. It helps me to cope.	Nurses' own spirituality helps them care for patients and cope positively
50. I really need the Spirit there with me to help guide me and not let me miss anything that's really important. 51. Because, who gave me that ability to care like that? 52. I guess it's just a strong belief in God. 53. Seeing the faith in the patient populations. 54. It's almost like I, like I can see their pain. 55. I feel like I'm very spiritual. 56. I try to follow the Holy Spirit is the main thing. But with spiritual care, we're relying on the Holy Spirit.	Nurses use God and their life experiences as resources to give spiritual care

57. But as far as the things that I've had to go through I think it's made me a stronger person and I know that I'm more at ease handling and stepping into those situations than I was 16 years ago. 58. I think some, in some situations, just being who you are in Christ, you know… 59. How would you describe your own spirituality? An ongoing work of art." 60. I'm a very spiritual person, but I don't subscribe to any particular religion. 61. We're a work in progress. 62. I see my spirituality as a work-in-progress – as a journey. 63. I'm, you know, growing in the Lord, I'm getting more spiritual and you know, just having stronger faith and you know, stronger belief. 64. I'm still growing and maturing um with my spiritual life. 65. I attend Church and I think that that's something you can always grow in, as well, your spiritual faith. 66. I'm not done yet. 67. Always needing to grow.	Spirituality is a work on progress

68. Me personally, it makes it feel where I'm relieved. 69. For me, it's made my day. 70. I feel humbled 71. I think that their spiritual needs are every bit as important as their physical needs. 72. And I feel like nursing is a gift to be able to share life and death with people. 73. I think that is a gift. 74. I felt like I was able to, uh, really touch her and comfort her which is an, to me, is a very important part of being a good nurse. Is to be able to comfort your patients whenever they're in need. So, it was rewarding. 75. It was a very…It was a positive experience (giving spiritual care in general) 76. And for that man to do that…it was overwhelming for me. Cause I must have done something right. (describing how a patient greeted her in an emotional way) 77. It's not about me. It's about them. And it's a privilege that I have been allowed to share. 78. I love nursing, and I think it goes hand in hand with spirituality.	Spiritual care is a rewarding experience

79. Now sometimes, if you have to give a lot of spiritual care, you go home zapped. 80. And it's kinda hard because, uh I want to go home and lick my own wounds. 81. I mean, it was draining at times. 82. I've, I've been here 10 years and in that 10 years, I've seen so much and I've dealt with so much and this week, the last two weeks, I've taken a, just an emotional beating where I don't know if I can provide spiritual care. 83. If you're taking it from more than one person it tends to just tear you down. 84. And then out-patient C and out-patient D and then by the end of the day um, there's nothing.. 85. I go home, there's times I don't want to talk on the phone, there's times that I don't want to eat, there's times I just want to take a bath and go to bed and I can sleep for 15 hours because it's like I'm so emotionally drained. 86. Yes, you are spent. 87. The ones that are really, really angry they're hard to connect with too, because their anger is, they're mad at everything and everybody.	Giving spiritual care can also be draining and have a negative cumulative effect

88. They're mad at God and they're mad at this and they're mad at.... it's just like, so profound it's hard to get, its hard to touch that 89. or, why is God doing this to me type thing. 90. But that is a very energy-sapping, to be angry is you know, saps the energy from a patient that they need for healing and for dealing... 91. Just a lot of anger, just a lot of frustration. 92. I think some of them demonstrate it through depression 93. We've started seeing young patients here too recently, and in that situation they're more angry. 94. Most of our patients are just angry. 95. It's because so many times you want to sit with your patient and talk to them more, and um, here especially in this atmosphere it's hard to get into the deep conversations with these patients because you have to be able to walk off. 96. There've many times in which I've been frustrated that I don't have the time. 97. We're very busy in here and we don't have time to really relate to our patients on an intimate level with them. 98. I don't have, the if one person has a lot to say, then that's taking away from the next person, so you're looking at time, to	Dialysis patients demonstrate spiritual distress by anger and depression It is difficult to give spiritual care due to lack of time

me, time's a big barrier, as far as having the time to really, you know I may miss something with you where, I because I spent a lot of time with the previous patient so um,. 99. No, (lack of time is not a barrier) because I think if you just say, I'm going to pray for you or let's just say a quick prayer, something like that, hold their hand for a minute -- I don't think that (time) is a factor. 100. It was outside my scope; nor did I have the time. I had other patients; nor did I have the skills to take care of him because um, he-he was at a level where what between the depression and probably the confusion that there was some things that he had been dealing with reading or whatever, you know, I didn't feel comfortable. 101. The thing about dialysis is that there's not a whole lot of time to talk in dialysis, it really is, I mean our unit was a very busy unit	
102. You know, this is-this is diving a little bit deep for me, you know, it's like, you know you- you live your life or whatever, but you don't expect conversations like that to pop up at you and it does in this field and you kind of have to help people in whatever decision you know, you have kind of, you know, lay it out this is,	Giving spiritual care is deeper than psychosocial care

this is the way it has, its going to be if you want to do this. 103. After it was over, it was very rewarding. 104. It's going deeper into the patient actually 105. I think nursing is – and there's a large portion of nursing - where you're caring and you just take it one step further." 106. And spiritual care could be validating and creating a holy atmosphere and treating people very respectfully and acknowledging their beliefs and accepting that their beliefs…that I can learn from their beliefs and they don't need to follow - it has nothing to do with me. 107. I see the spiritual as an addition to psychosocial. 108. I think that spiritual care is a deeper, more intimate level of care. 109. I feel like it's much more deeper…And much more intimate." 110. There's care in both, but there's love… in spiritual you're just showing…unconditional love for this person. 111. To me, it's more personal than just greeting somebody because to spiritual is from the heart, it comes from deep inside if you're truly a spiritual person.	

112. But if you're truly spiritual, it's going to show in you and your actions so. 113And I feel like if our patient's spiritual needs were being addressed, um, that they could be better taken care of as a whole. 114. I believe in holistic medicine and that's part of it." 115. I didn't really say anything, I just listened to him. 116. If you give spiritual care there, it's more of a word here or there. 117. I see them in their-- its all drawn into one. It's like their um, the-the emotional side, their-their spiritual side, their, it's, it's when you hear it, it's all, to me, it's all one. It's not, I don't know if I can separate it all, because it's all entwined to me 118. We're talking about it because it's a routine for us. 119. But I do think that one of the things that I can do is call the name of the Lord out you know, and put his presence out there. 120. But mostly it's just in passing. I mean it's not like it's a, I mean it's, it's sort of like what I would like, my, I would like to incorporate into just daily living,	Spiritual care is important for holistic care Listening is an important part of spiritual care Giving spiritual care is not separated from psychosocial care in that it is routine

121. You've got staff run, you know, running around and there's things that are going on to where you really can't sit and have that one-one-one. 122. It is a barrier. It's too open 123. There wasn't privacy, really, because they were just, you know, in a big room with chairs and everything and the T.V.s are going and people are screaming and laughing at each other and talking to each other. 124. Your conversations were never really, I mean they weren't real intimate because the person sitting next to you was hearing it too.	The crowded and noisy environment makes it hard to give spiritual care
125. So there's a lot of grieving. 126. I can definitely see the need for spiritual care um, especially with dialysis patients. 127. A lot of the time they feel like they're controlled by this environment. 128. Yes. Grieving that loss of body functioning, and having to be tied, now to this machine three – at least three times a week…that lifestyle change…the change with energy...	Dialysis patients are distressed due to all the losses (and loss of control) and life changes they experience

129. It's just kind of, it's kind of sad. It's almost like they, they get diagnosed with kidney failure, the next day they're on dialysis and then, you know, that's pretty much it. Education part of starting dialysis is very scant. 130. I think the dialysis patients is typically the one, the patient, more than any other, the ones that feel they have no control over his health. 131. I went to an ANNA (American Nephrology Nurses) meeting and I did pick up a pamphlet about iron and we had this, you know, and a lot of-of the men, more so than the women I really do believe, uh, would refuse their iron or they'd refuge their Epogen that day or whatever, you know, just because they could! 132. I've got Jehovah Witness, Catholic, Presbyterian. And all of them are very, involved. Even looking at our quality status goals compared to the other company, they're so… They do so much higher with their clearances, and they do better on their diets. They're more compliant. 133. I think I'm sure spiritual well-being and compliance are going to go hand in hand.	Patients who use spiritual resources are more compliant and have better physical outcomes

134. And helping them find that – exploring ways to find that…in all of the chronic illnesses I've seen that I've worked with, that's just very, that's very very important. When you finally have the finality of the situation, "I'm not going to get better. I am only going to deteriorate…" So what? How can I? It's all about giving. How can I give of myself? To give me purpose each and every day? 135. I think a lot of them do find meaning in their churches. In, their family life. I had one patient, for example. He is a Godly man and he ministers to the prison. 136. I think those that have probably moved on are out of the blaming stage and are accepting that you know that, dialysis is not a death list or you know, this isn't the end of my life, because it's not, for everybody. 137. I just think everything happens for a reason. And that's, we may not always understand it. But, God is the creator. He has the plan. He knows what's going to happen and you know we may not always understand it, but it's just the way it is. for both of these men, I think they just roll with it; they just accept what's going on and um, to know if they really truly found meaning, I'm not sure, but they've, they're accepting.	Dialysis patients find meaning through their illness

138. They're not placing blame. They've gotten through the mourning, more of the mourning cycle because they're not still placing blame on everybody else.	
139. And I get angry because I go through the grieving process…just like anybody else. And sometimes I wasn't ready for 'em to go.	Nurses go through grieving also
140. I feel like we did all we could.	Nurses cope with deaths
141. It helped when she said we all did what we could do.	
142. There's no democracy when it comes to health and healing And it's not up for a vote…we do as much as we humanly can do to get them to optimal functioning. And I guess through all my care, it's, you know, "Is the team doing the most that possibly can be done?" And if the answer's yes, then you come to terms with, with the outcome.	
143. I think that it's important for everybody in the medical profession to remember that we're not here to cure the patient, we're here to help their body cure its self, you know to help them, and to help their spirit.	

144. I'm comfortable doing that now. 145. But, when you do find somebody who is spiritual- based, then you want to reinforce them and give them encouragement...and, I feel comfortable doing that 146. I guess the more experience I have with talking to individual patients, the more comfortable I feel with approaching those situations and really getting to know my patients, especially when we see them frequently.	Spiritual care becomes comfortable with experiences
147. I think when you do talk to somebody spiritually you don't tell anybody else you did. I don't think we talk about it as much as, I don't think we hear about the occasions as often as they happen because I think we're hesitant to admit that we're spiritual to each other. 148. It's not like anybody's ever told us that we can't. I don't know why there's that hesitancy...Interviewer: Do you think that nurses either they do or they don't? It's either part of who they are or it's not? Participant: Yes, yes, yes I do.	Nurses do not discuss giving spiritual care with other nurses

APPENDIX E

Consent Form

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: The Lived Experience of Giving Spiritual Care

Investigator :Belinda Deal, RN, MSN, CENXXX-XXX-XXXX Work XXX-XXX-XXXX Home
Advisor: Jane Grassley, Ph.D.....940-898-2401

Explanation and Purpose of the Research

You are being asked to participate in a research study for Ms. Deal's dissertation at Texas Woman's University. The purpose of this study is to examine nurses' experiences of giving spiritual care. Nurses will be interviewed about specific situations when they gave spiritual care to a patient in order to know more about the meanings of this experience. The research question is "What is the experience of giving spiritual care for nurses?"

Research Procedures

For this study, the investigator will conduct face-to-face interviews with nurses. This interview will be done in a mutually agreeable location. You will be digitally recorded during the face-to-face interview. The purpose of the digital recording is to provide a transcription of the information discussed in the interview and to assure the accuracy of the reporting of that information. Your maximum total time commitment in the study may be two and a half hours including the interview and follow up conversations.

Potential Risks

Potential risks related to your participation in the study include the possibility of embarrassment and invasion of privacy. Participation is voluntary and you are free to withhold embarrassing or private information. You may terminate the interview at any time.

Another possible risk to you as a result of your participation in this study is release of confidential information. There is a risk of loss of confidentiality in all email, downloading, and internet transactions. Confidentiality will be protected to the extent that is allowed by law. The interview will take place at the participant's convenience. A code name, rather than your real name, will be used on the audio file and transcription, and no identifying data will be included. The audio file will be emailed to the transcriptionist. Only the investigator, her transcriptionist, and her advisor will have access to the audio files. The audio files, hard copies of the transcriptions, and the computer files containing the transcription text files will be stored in a file cabinet in the investigator's home. Consent forms will be filed separately from the interview data. The audio files and transcription files will be deleted and the hard copies of the transcriptions will be shredded within 5 years. .....

Participant or Parent/
Guardian Initials

It is anticipated that the results of this study will be published in the investigator's dissertation as well as in other research publications. However, no names or other identifying information will be included in any publication.

Participation and Benefits

Your involvement in this research study is completely voluntary, and you may discontinue your participation in the study at any time without penalty. The only direct benefit from participating in the study includes receiving a summary of the results if you desire.

Questions Regarding the Study

If you have any questions about the research study you may ask the researchers; their phone numbers are at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research and Grants at 940-898-3375 or via e-mail at IRB@twu.edu. You will be given a copy of this signed and dated consent form to keep.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

_____

Signature of Participant Date

_____

Signature of Parent/Guardian Date

The above consent form was read, discussed, and signed in my presence. In my opinion, the person signing said consent form did so freely and with full knowledge of its contents.

_____

Signature of Investigator Date

*** If you would like to receive a summary of the results of this study, please provide an address to which this summary should be sent:**

_____

_____

_____

APPENDIX F

Demographic Form

Demographic Form

Please complete the following information:

1. Age _____

2. Gender _____

3. Ethnicity _____

4. Religious preference _____

5. Years since graduation from nursing school _____

6. Years practicing as a nurse _____

7. Years in dialysis _____

8. Number of hours worked on an average week _____

9. What is your highest degree held? _____

APPENDIX G

Texas Woman's University Institutional Review Board Approval

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378 Fax 940-898-3416
e-mail: IRB@twu.edu

April 12, 2005

Ms. Belinda Deal
1715 Sampson Dr.
Tyler, TX 75701

Dear Ms. Deal:

Re: The Lived Experience of Giving Spiritual Care

The request for an extension of your IRB approval for the above referenced study has been reviewed by the TWU Institutional Review Board (IRB) and appears to meet our requirements for the protection of individuals' rights.

If applicable, agency approval letters must be submitted to the IRB upon receipt PRIOR to any data collection at that agency. A copy of all signed consent forms and an annual/final report must be filed with the Institutional Review Board at the completion of the study. A copy of the approved consent form with the IRB approval stamp is enclosed. Please use a copy of this stamped consent form when obtaining consent from your participants.

This extension is valid one year from April 30, 2005. According to regulations from the Department of Health and Human Services, another review by the IRB is required if your project changes in any way. If you have any questions, feel free to call the TWU Institutional Review Board.

Sincerely,

Dr. David Nichols, Chair
Institutional Review Board - Denton

cc. Dr. Marcia Hern, College of Nursing
Dr. Tommie Nelms, College of Nursing
Graduate School

APPENDIX H

Fresenius Medical Care Facility Approval

Fresenius Medical Care

November 19, 2007

East Texas Medical Center
1000 S. Beckham
Tyler, Texas 75701

Re: Recruitment Flyer

To Whom It May Concern:

Belinda Deal, doctoral student at Texas Women's University, has been approved to place a recruitment flyer for volunteer nurse participant in a convenient location for the following unit:

Tyler Acute Dialysis Facility
1000 S. Beckham
2nd Floor
Tyler, Texas 75701

Please call me if you have any questions or concerns.

Thank vou.

Donna Liston, RN, BS, CNN
Area Manager
East Texas Market

Fresenius Medical Services ♦ Watson Wise Dialysis
815 East First Tyler, TX 75701 903-595-2495 Fax: 903-535-9730

Fresenius Medical Care

August 10, 2007

To Whom It May Concern:

Belinda Deal, doctoral student at Texas Woman's University, has been approved to place a recruitment flyer requesting volunteer nurse participants in the following Fresenius Dialysis clinics:

Henderson County Dialysis
Carthage Dialysis
Gilmer Dialysis
Jacksonville Dialysis
Mineola Dialysis
Mt. Pleasant Dialysis
Palestine Dialysis
Sulphur Springs Dialysis
Watson Wise Dialysis
Southeast Tyler Dialysis
Tyler Home Dialysis
West Tyler Dialysis

If you have any further questions on concerns, please feel free to contact me.

Thanks,

Donna Liston, RN, BS, CNN
Area Manager
East Texas Market

Fresenius Medical Services ♦ Dialysis Services
East Texas Administration 817 East First Tyler, TX 75701 903-531-9498 Fax: 903-593-9463

CURRICULUM VITAE

Belinda Deal, RN, MSN, CEN
Clinical Instructor
The University of Texas at Tyler
College of Nursing and Health Sciences
3900 University Blvd
Tyler TX 75799

EDUCATIONAL PREPARATION

	DEGREE:	DATES:
Texas Woman's University College of Nursing Doctoral Student	PhD	2000-2008
University of Texas Health Science Center at Houston Major/Emergency-tract, Role/Education Thesis Title: Host, Agent, and Environmental Factors that Explain Injury Severity in Seat Belted Persons Injured in Motor Vehicle Crashes	MSN	1989-1990
University of Texas at Arlington	BSN	1987
Texas Eastern School of Nursing Tyler, Texas	Diploma in Nursing	1975-1978

PROFESSIONAL CERTIFICATION

Certified Emergency Nurse (CEN)	1980-present

HONOR SOCIETIES

Sigma Theta Tau member	1990-present
Vice President Iota Nu Chapter	1995-1997

HONORS, AWARDS, AND RECOGNITIONS

Honored with a named gift by the Tyler branch of the American Association of University Women to the AAUW Educational Foundation for participation in Expanding Your Horizons project, April 2004.

Chosen Alpha Chi Outstanding Faculty Member from the College of Nursing by the top ten percent of nursing majors, Spring 2000.

Recognized at 2000 Board of Certified Emergency Nursing (BCEN) Awards Presentation for being one of two nurses in Texas that took the CEN exam and became certified in 1980, the first year that it was offered and maintained it for 20 years.

PROFESSIONAL EXPERIENCE

Senior Lecturer/Clinical Instructor University of Texas at Tyler	1990-present
Emergency Department Staff Nurse and Relief Charge Nurse Hermann Hospital Houston, Texas (900 beds-teaching)	1989-1990
Emergency Department Staff Nurse East Texas Medical Center Hospital Tyler, Texas (500 beds-non-profit)	1982-1988
Flight Nurse Aeromedical Helicopter East Texas Emergency Services Air One Tyler, Texas	1985-1987
Emergency Department Staff Nurse Citizen's General Hospital Greenville, Texas (90 beds-non-profit)	1982
Emergency Department Staff Nurse and Assistant Head Nurse East Texas Medical Center Hospital Tyler, Texas	1978-1982
Co-charge Nurse 32-bed Post-surgical Unit Mother Frances Hospital Tyler, Texas (500 beds-private)	1978

SCHOLARSHIP

PUBLICATIONS

Deal, B.J., Fountain, R.A., Russell-Broaddus, C.A. & Stanley-Hermanns, M. (2006). Challenges and Opportunities of Nursing Care in Special Needs Shelters. *Disaster Management & Response,* 4(4), 100-105.

Harvey, C., Deal, B., Fountain, R., Hairston, C., Hensarling., J. & Robinson, T. (2003). Visible messenger model, *The Journal of Multicultural Nursing and Health, 9*(2), 22-28.

Miller, J., Conner,K., Deal, B., Weber Duke, G., Stanley-Hermanns, Varnell, G., Harman, K., & McLarty, J. (2003). How animal assisted therapy affects discharge teaching: A pilot study. *Critical Care Choices*..ISSN 1043-2205, 36-40.

Deal, B. (1993). The cycle of life. *Journal of Emergency Nursing, 19*(2), 75.

Albert, R.E. & Deal, B.J. (1991). Program planning for the certified emergency nursing review course. *Journal of Emergency Nursing, 17*(2), 108-111.

Deal, B. (1991). Host, agent, and environmental factors that explain injury severity in seat belted persons injured in motor vehicle crashes (Abstract*). Society of Trauma Nurses Newsletter, 3*(2), 7.

PRESENTATIONS

Poster presentation at American Nephrology Nurses Association State meeting January 18, 19, 2008. ANNA Texas Collaborative Meeting 2008 San Luis Galveston Hotel, Galveston, TX

Deal, B & Fountain, R. (2007). Oral presentation to Purdue University (via web), September 21, 2007, as invited Speaker to Purdue University (via Breeze/Internet), for Nursing 359, Disaster Healthcare course. Presentation: Caring for Populations with Special Needs during a disaster
Repeated presentation January 25, 2008

Invited to speak at the American Nurses Association (ANA), Nursing Care in Life, Death and Disaster conference June 20-22 2007 Atlanta, Georgia.
Friday, June 22, 2007 Plenary Session # 5 "Caring for Populations with Special Needs during a Disaster."

The Lived Experience of Giving Spiritual Care Pilot Study podium presentation Sigma Theta Tau Nursing Honor Society Conference, October 14, 2005.

Spirituality and Women for East Texas Parish Nurse Association 2002.

College of Nursing Research and Development Brown Bag : Heuristics as a Research Method, co-presenter 2002.

UT Tyler's Academic Enrichment Series speaker on prevention of alcohol related injuries March 2000, March 2001.

Emergency Nurses Cancel Alcoholic Emergencies (ENCARE) presentation to High School students: Gladewater High School: 1999, 2000. Gilmer High School: 2001, Sulphur Spring High School 2002, Gilmer High School and Van High School, 2003.

Co-presenter at "Excellence in Teacher Education", Center for Professional Development of Teachers Summer Institute, June 2, 2000, Arlington, Texas. Topic: Innovations to Support Teacher Growth in Technology.

AHEC conference, Exploring Health Field Careers Workshop, May 2000.

Invited speaker, Child Nurture Club, Jan. 1997, on Child Injury Prevention.

Lecturer, Course in Advanced Trauma Nursing, October, 1996.

Invited speaker, Civitan Club, on Trauma and Motor Vehicle Injury Prevention, 1995, 1997.

Invited to speak on trauma and injury prevention at Kiwani's club, Palestine, Texas, 1994.

Lecturer for KAPLAN NCLEX review course, May 1994, UT Tyler.

Developed and presented "Multiple Trauma: An Overview" for UT Tyler's continuing education department, Fall 1992 and Spring 1993.

Presented research "Host, Agent, and Environmental Factors that Explain Injury Severity in Seat Belted Persons Injured in Motor Vehicle Crashes" to East Texas Emergency Nurses Association, September 1991.

Research abstract poster presentation of "Host, Agent, and Environmental Factors that Explain Injury Severity in Seat Belted Persons Injured in Motor Vehicle Crashes" at Hermann Hospital Life Flight Symposium, Spring 1990.

Invited to speak at community mall during Drunk Driving Awareness Week re: "designated driver" and seat belt safety by Project Saf-D, a federally funded highway safety program and the DWI task force for Smith County, 1991.

Invited to deliver additional lecture for Pathophysiology Course on resuscitative fluids in hemorrhagic shock, University of Texas Health Science Center at Houston, 1989.

Invited to speak to local day care workers and teachers on child abuse, 1988.

RESEARCH IN PROGRESS, PAPERS IN PREPARATION

The Lived Experience of Giving Spiritual care, dissertation

CONSULTING

Local scientific member for Institutional Biosafety Committee	2006

GRANTS FUNDED

American Association of Critical Care Nurses (AACN) Data-Driven Clinical Practice Grant for $1000. The Relationship between Animal Assisted Therapy and the Retention Of Discharge Teaching for Post Open Heart Surgical Patients with a Median Sternotomy, 1999-present.

MEMBERSHIP IN PROFESSIONAL SOCIETIES

Member American Nurses Association, Texas Nurses Association	2002-present
East Texas Parish Nurse Association member	2001-present
Emergency Nurses Cancel Alcohol Related Emergencies (ENCARE) volunteer and presenter	1998-present
Project REACT (Cardiac Education) volunteer and presenter	1996-1997
Emergency Nurses Association	
Chapter Secretary	1993,94,97-00
Chapter President	1996
Sigma Theta Tau member	1990-present
Vice President Iota Nu Chapter	1995-1997
Certified Emergency Nurse (CEN)	1980-present
American Heart Association Basic Life Support Instructor-Trainer	1998-present
Advanced Cardiac Life Support (ACLS) provider	1994-2002
ACLS, instructor	1996-2002
American Heart, Basic Life Support Instructor and Instructor Trainer	1998-present
Society of Trauma Nurses member	1992-1997
American Trauma Society former member	
MADD former member	
Graduate Student Organization	1990
Emergency Tract Representative	
University of Texas Health Science Center	
Peer Review Committee Member (elected)	1988
East Texas Medical Center Hospital	
Emergency Department Representative	
Clinical Ladder Committee	1988
East Texas Medical Center Hospital	
Emergency Department Representative	
Trauma Nursing Core Course, provider	1987-1997
Emergency Nurse Pediatric Course, provider	1994-1997
Certified EMT-Paramedic, State of Texas	1986-1990

SERVICE TO THE UNIVERSITY

University Committees:

Safety Committee 2003-2005
Student Service Fee Committee, 99-00, 00-01
Life Safety and Emergency Response subcommittee of Safety Committee, 98-99, 99-00, 00-01
Search Committee for Dean of Enrollment and Management, 98-99
University Faculty Awards, 96-97
Emergency Preparedness, 95-96
University Honors Committee, 95-96
Faculty Senate Student Affairs, 95-97, 00-01
University Curriculum Committee, 94-95

College of Nursing Committees:

Evaluation Committee: 04-05
Professional Development Committee: 01-02, 03-04
Chair 02-03
Ad hoc MINE (RN, LVN transition) 94-95
Admission and Progression, Co-Chair 94-95, Chair 95-96, 96-97
member 98-99
Ad Hoc Continuing Education, 93-94
Student Affairs, 93-94, 00-01
Chair 99-00
Ad Hoc Advisor, 92-93
Evaluation, Chair 92-93
Admission, 92-93
Student Affairs, 90-91, 91-92, 92-93

OTHER

Mentor to new freshman students, 98-2000
Mentor to nursing education graduate students Fall 2003, Spring 2005, Spring 2006
Mentor to potential nursing student through mentor program, 95
Mentor to graduate student for emergency nursing emphasis. 92-93

Co-coordinated, developed, and lectured for new Emergency Nursing 3 semester credit hour elective summer intercession, May 1995, UT Tyler.

Coordinated and volunteered in UT Tyler faculty to participate in American Association of University Women's Expanding Your Horizons workshop" Nurses Call the Shots" for junior high girls to educate them about careers in science and mathematics, 1999-present.

Assisted with coordination and taught bi-annual CPR courses for students and/or faculty at UT Tyler, 1995 to present

Co-faculty sponsor of Nurses Christian Fellowship Student Organization, initiated formation as a student organization 1995 to present.

Volunteered to assist with student flu-shot clinics, Fall 1995-98, 2001, 2005.

Developed Website through course focusing on enhancing critical thinking using e-mail questions: http://www7.twu.edu/~g_deal/webliog.html

Developed Website through course to enhance communication in course taught: http://familyeducation.com/tx/whatadeal

LEADERSHIP AND SERVICE

Volunteer nurse monthly at Bethesda Clinic for underserved population 2003-present.

Assisted with Christmas drive for needy family through Nurses Christian Fellowship and coordinated university-wide donations, 1997, 1998, 1999, 2000.

Girl Scout volunteer 99-00, assistant troop leader 2001-2004, volunteer camp nurse, June 2000.

Volunteered at Project REACT East Texas Fair booth, September 1996.

Volunteered for mass citywide CPR rally, 1996.

Coordinated Heart Saver Course for Tyler Police Wife's Auxiliary, 1996.

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