

REHABILITATION NURSES USE OF SPIRITUAL CARE

by

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ABSTRACT

The purpose of this study is to examine the lived experiences of rehabilitation nurses providing spiritual care. The study focused on the nurses' definition of spiritual care, how they learned to care spiritually, what spiritual care actually was, and how they learned to become comfortable providing spiritual care. Using phenomenological interview techniques, 14 rehabilitation nurses attending an annual education conference participated in interview sessions. All nurses were able to remember times they cared spiritually for patients and families.

The main theme discovered when describing spiritual care was "listening to the soft voice." This "soft voice" was the inner voice that taught the nurses to be aware of the spiritual needs of patients. The nurses defined spiritual care as being supportive, respectful, and making a connection. Spiritual care also included praying with patients and recognizing a belief in a higher power. Three themes became evident when the nurses described the actual experiences of providing spiritual care, 1) "little things," 2) "received more than they gave," and 3) "being used." The spiritual care giving experiences were evident in the "little things" they did for patients such as giving baths, changing bandages, or listening to the patients. The nurses also mentioned they often felt they "received more than they gave" when providing spiritual care. Spiritual care also included a sense the nurses were "being used" by a higher power when

providing spiritual care. Three themes emerged as the nurses spoke about how they developed a sense of comfort providing spiritual care, 1) “Just Do It,” 2) “rehabilitation nursing makes it easier,” and 3) “personal spirituality.” The nurses said they became comfortable providing spiritual care by “just doing it.” The nature of rehabilitation nursing also made providing spiritual care “easier” because of the extended relationship with the patient and family. Finally, nurses considered themselves more comfortable providing spiritual care as they developed a stronger sense of their own “personal spirituality.”

Implications for practice, education, and research are discussed for both nursing and public health. Suggestions are made for further research in the area of spiritual care.

INDEX WORDS: Spiritual Care, Nursing, Public Health, Rehabilitation, Phenomenology, Qualitative Research

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DEDICATION

This paper is dedicated to the rehabilitation nurses who are using spiritual interventions when caring for patients. Because of you, our patients achieve optimal function after catastrophic injuries. This is what we all strive to accomplish. For this, I thank you.

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I would like to acknowledge all who have made this journey along with me. To the faculty members at the University of Georgia who have been a part of this educational experience, I have learned so much from you. Thank you for sharing your expertise. To the students I have been associated with; you have made the journey interesting and fruitful. You kept me on my toes, and helped me to see things from many viewpoints. Thank you. Shanta, you have made me smile, and supported me when the going got tough, thank you. To my faculty committee, thank you for all your time and helpful suggestions. You are a remarkable group of individuals and your insight is a gift I will treasure. Dr. Orpinas, you gave me encouragement when things seemed difficult, and kept me focused on the end goal. Thank you.

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FORWARD

Kelley is a nurse. It is 10:30 at night and in 30 minutes she will be getting off work. It has been a busy night and she has not stopped since she arrived on the unit at 3:00 pm. One nurse didn't come to work because she was sick, and there was not enough staff even before the nurse called out. Kelley is told that Ms. Jackson, who has had a stroke, needs her help. Ms. Jackson has difficulty speaking and it takes so much effort for her to express her needs. Kelley knows it could take a long time to find out what Ms. Jackson wants. Entering Ms. Jackson's room, she notices that Ms. Jackson has been crying. Kelley approaches tentuously. After much effort, Ms. Jackson is able to let Kelley know that she is scared. Kelley tries to comfort her without much success. The tears continue to flow, and Ms. Jackson has found no solace. Between tears, Ms. Jackson mouths the word "pray." Kelley knows that she will not leave work on time tonight because she will be at the bedside of Ms. Jackson.

CHAPTER 1

INTRODUCTION

While names of the nurse and the patient are fictitious, these events happen frequently in the hospital setting. This chapter introduces the topic of spirituality in nursing practice. Spirituality is viewed from the historical perspective, as well as from the health promotional nursing perspective of today.

Registered nurses are the largest group of health care providers. The Bureau of Labor Statistics (2005) reports there are 2.3 million nursing jobs, and as the population of the United States ages, the number of nurses is expected to increase. It is widely accepted that nurses provide direct physical care, but The Bureau of Labor Statistics continues to describe the work of the registered nurse is to “promote health, prevent disease, and help patients cope with illness” (2005, first full paragraph, p.1). In order to fulfill these many aspects of nursing care, nurses need to be aware of the diverse needs of patients, including the spiritual needs.

Spiritual care and promoting health have been important aspects of nursing care from the beginning of formal nursing practice. Florence Nightingale, the founder of nursing, had a strong spiritual base (Burkhardt & Nagai-Jacobson, 2002). According to these authors, Nightingale saw no conflict between spirituality and science. They continued by noting “in whatever ways one helped to improve conditions for another or bring about greater awareness and knowledge was, for Nightingale, an expression of spirituality and a way of connecting with God” (p. 7). These authors continue, “Nightingale believed that God intends us to be responsible for each other,

working to identify and address that which will promote a better existence for others and ourselves” (p. 7). Florence Nightingale was born in 1820 and died in 1910. Nearly 100 years ago, the founder of present day nursing, addressed the idea that spirituality and health are connected and that nurses promote health. It is interesting that today nearly 100 years after the death of Nightingale, nurses are not usually considered primary promoters of health. Nurses should be health promoters. Nurses have the biological, psychological, and social knowledge required to promote health.

Nurses experience frequent and continuing contact with clients. In particular, rehabilitation nurses, the group of nurses I will interview for this study, care for patients after catastrophic illness such as trauma, brain injury, strokes, spinal cord injuries, and orthopedic surgeries. These nurses are unique in that their extended contact with clients allows them to develop an in depth relationship with clients. Because of this relationship, rehabilitation nurses are an ideal population to discuss spiritual nursing care. While spiritual care may require the development of a relationship between the nurse and the patient, Dettmore (1984) noted spiritual needs were not usually difficult to meet. Patients in Dettmore’s study said that their needs were met by listening to them, recognizing the need existed, and contacting a chaplain. All of these nursing actions are well suited for nurses who have extended time with clients.

The literature related to spirituality in the provision of health care is diverse. Many authors attempt to define spirituality and differentiate spirituality from religiosity (Clark, Cross, Deanne, & Lowery, 1991; Emblen, 1992; English, Fenwick, & Parsons, 2003; Fitchett, 1995; Lauzon, 1998; Pargament, 1999; Reed, 1992; Sherwood, 2000; Taylor & Outlaw, 2002; Taylor, 2003; Tisdell, 2001; Todd, 2005; Van Ness, 1996; Yeaxlee, 1925; Zinnbauer et al., 1997). These definitions will be discussed in the literature review. Nursing literature often discusses spiritual

issues and the nursing theory of Jean Watson will be discussed. This nursing theorist has a strong spiritual base imbedded in her theory.

While few authors directly related spirituality to an increased state of health (Hummer, Rogers, Nam, & Ellison, 1999; Koenig et al., 1999; Sicher, Targ, Moore, & Smith, 1998), literature is abundant that discusses the need for spirituality from the patient and caregiver's perspective (Boswell, Knight, Hamer, & McChesney, 2001; Chapman & Grosseohme, 2002; Chapman et al., 2002; Ferrell, Smith, Juarez, & Melancon, 2003; Kloosterhouse & Ames, 2002; Hermann, 2001; McColl et al., 2000; Sheldon, 2000; Taylor et al., 2002; Taylor, 2003; Theis, Biordi, Coeling, Nalepka, & Miller, 2003). Literature was also found that indicated nurses identified the need for spiritual care (Greasley, Chiu, & Gartland, 2001; Hoover, 2002; O'Brien, 2000; Strang, Strang, & Ternstedt, 2002; Tuck, Pullen, & Wallace, 2001). These articles will be discussed at length in the literature review.

The concluding section of the literature review discusses phenomenological research. Two prominent styles of phenomenological research, Husserlian and Heideggerian, will be explained and contrasted. The benefits of using the Heideggerian methodology for this particular study will be explained.

Because little research is devoted to what kind of spiritual care nurses are actually providing, this study aims to discover information about the times rehabilitation nurses cared for the spiritual needs of their patients. The purpose of this study is to examine the lived experiences of rehabilitation nurses when providing spiritual care. I will interview rehabilitation nurses utilizing an open-ended, semi-structured interview. The experiences of these nurses will be analyzed for similar themes, and a final report will be written describing these themes.

CHAPTER 2

LITERATURE REVIEW

The review of the literature explores the topic of spirituality in nursing care. Section one identifies the historical perspective of spirituality in general. This section presents definitions of “spirituality” and differentiates “spirituality” from “religion.” Section two focuses on the impact of spirituality in nursing care and describes a current nursing theory considering spiritual care in detail. The next section identifies the importance of spirituality in health promotion. Section four identifies patients’ and nurses’ perception of spiritual needs and spiritual care. The final section defines phenomenological research, and identifies why this particular type of qualitative research is particularly well suited for my study.

2.1 Definition of Spirituality

In 1925, Yeaxlee wrote and expressed interest in the topic of spirituality (1925). Yeaxlee thought spirituality and religion were the same concept. Many people today continue to confuse these two terms. Yeaxlee stated the reason for studying spirituality was that individuals were experiencing “a state of questioning and bewilderment about them (spiritual values)” (p. 4). Perhaps the confusion about the definition of spirituality is the reason spirituality has continued to be a topic of research.

Kenneth Pargament (1999) notes “Religion is moving from a broadband construct—one that includes both the institutional and the individual, and the good and the bad—to a narrowband institutional construct that restricts and inhibits human potential. Spirituality, on the

other hand, is becoming differentiated from religion as an individual expression that speaks to the greatest of human capacities” (p. 3). Pargament continues to suggest that the rise in the spiritual movement may be indicative of the latest “in a series of religious awakenings” (p. 6). This is similar to Yeaxlee’s (1925) idea that the reason for the rise in the interest in spirituality is due to the increase in people’s quest for answers.

Any discussion of spirituality would be remiss without first defining spirituality. However, defining spirituality or spiritual is problematic in today’s society. Today, the word “spiritual” has a multitude of meanings. For some, spiritual, still refers to religion. However, as English, Fenwick and Parsons (2003) noted, while visiting “a bookstore almost completely devoted to the topic of spirituality” (p. 5) there were 38 categories of spiritual books. The bookstore covered topics as varied as eastern wisdom, astrology, self-empowerment, relationships, mythology, ancient wisdom and crystals to name a few. All of these topics have a spiritual connotation for some in today’s society. Spirituality has become much more than religion.

Defining spirituality is difficult. The mere assumption that spirituality can be defined “presumes that the experience of spirituality can be captured in words, its meaning contained, and its essence identified” (English, Fenwick, & Parsons, 2003, p. 6). The person using the term best defines spirituality, and usually the definition has implications to their own life. Because defining the word is specific to the person using the term, a universal definition of spirituality becomes even more problematic.

Few authors have investigated how the general population defines spirituality. For the purpose of understanding how undergraduate students in a large university define spirituality, Todd (2005) conducted a study with 20 undergraduate students at the University of Florida.

Students defined spirituality as a state of being, state of feeling, or state of mind. The students described spiritual experiences as high peaks of emotion. Spirituality also included “acquisition of meaning” (p. 7). Some students thought spirituality had a dimension of a “higher power,” while still others referred to this “higher power” as “God.” Students discussed connectedness and its relationship to spirituality. This sense of connectedness was with God, with life, and with the dead. Students also described spirituality as having a connection with worship and prayer. Another theme students identified was a sense of transcendence. Many of these definitions provided by the students in this study are similar to the definitions used in literature today (Clark et al., 1991; Legere, 2003; Reed, 1992; Sherwood, 2000).

Zinnbauer et al. (1997) conducted a study aimed at identifying how individuals define the terms religiousness and spirituality. Additionally the study asked the participants to define their own religiousness and spirituality. The study included 346 individuals from 11 different groups. The groups included college students from both mainstream colleges as well as students from a conservative Christian College. Other groups included those identified as New Age, Rural Lutherans and Presbyterians, Unitarians, Nontraditional Episcopalians, and Roman Catholics. Additional groups included mental health workers, nursing faculty and nursing home residents. The study suggests there is evidence to support the fact that the terms religiousness and spirituality describe different concepts. The respondents described spirituality in personal or experiential terms whereas they described religiousness as having both personal aspects and institutional beliefs. While the students found differences in their definitions, they also noted overlap. Differences in the way the various groups defined their own spirituality and religiousness were also noted by Zinnbauer et al. (1997). The New Age group and the mental health workers identified themselves as spiritual but not religious. The nursing home residents

and the Roman Catholics rated themselves as moderately spiritual and religious. While differences were noted, because the meanings associated with the terms varied according to each individual, no further comparisons were made.

As noted in the previous study by Zinnbauer et al. (1997) some people in today's society think the term "spiritual" is very different from the term "religious." Religion is associated with formalities, rituals and rules. Spirituality, on the other hand, identifies with relationships, purpose and inner dimension. One useful definition of spirituality is connectedness within one's self and others (Reed, 1992; Sherwood, 2000). Other authors describe spirituality as giving meaning and purpose (Clark et al., 1991; Fitchett, 1995; Legere, 2003; Sherwood, 2000). Todd (2005) noted spirituality may be used in a religious context. Todd stated that some students see God or a higher power as the source of spirituality. In Todd's study, students attributed both a sacred and secular connotation to spirituality. Vaughan (1991) succinctly describes spiritual as a "subjective experience of the sacred" (p. 105). Emblen (1992) defines spirituality as the "inner dimension of being human attuned to the most valuable aspect of life that motivates and guides one's significant choices" (p. 42). Zinnbauer, Pargament, and Scott (1999) note there is not one definition of the word spiritual and furthermore there is sizeable differences in the actual definitions. Perhaps the reason there are so many varied definitions of spirituality is words are being used to describe an essence. Words may not be sufficient to define spirituality which is the awakening of the soul (Lauzon, 1998).

Tisdell (2001), an adult educator, described spirituality as "one of the ways people construct knowledge and meaning. It works in consort with the affective, the rational or cognitive, and the unconscious and symbolic domains. To ignore it, particularly in how it relates to teaching for personal and social transformation, is to ignore an important aspect of human

experience and avenue of learning and meaning-making.” (concluding paragraph). This definition has important implications as we consider spirituality. Tisdell describes spirituality as having an impact in all aspects of one's life. Health care providers who wish to attend to the needs of the whole person, according to Tisdell, should include the spiritual aspect of care. If health care providers neglect aspects related to spirituality, they are omitting important opportunities to promote health.

The word *spirituality* actually has Greek roots related to breathing, perhaps indicating spirituality has some aspects of a fundamental function without which life cannot exist. While this definition may seem obvious, the nurses in Taylor's (2002) study had a difficult time defining the word spiritual. Taylor continued with a number of definitions nurses use to reveal the true nature of spirituality. She cites Vaillot (1970) as defining spirituality as “the quality of those forces which activate us, or are the essential principle influencing us. Spiritual, although it might, does not necessarily mean religious; it also includes the psychological. The spiritual is opposed to the biological and mechanical, whose laws it may modify.” While spiritual care is often viewed as different from biological care, this is the only definition found that actually puts it these two parameters of care in opposition to each other. Vaillot's definition of spirituality does however, indicate the closeness of spiritual care to psychological care, and this is a relationship that is often so close that many nurses cannot separate the two

The term “spirituality” may actually have more than one focus. Van Ness (1996) had an interesting idea of considering spirituality as having an inward and outward focus. For nursing, it is necessary to identify both of these aspects when discussing spirituality. The inward focus might be a personal aspect that is different for everyone. Each patient and each nurse might have different working definitions of spirituality. These specific inward ideas are not only different for

each person, but, at different points in time, may have different meanings for the same person. These inward foci are in a constant state of change depending on events in the person's life. The external dimension should be inclusive of ideas and aspects of the group as a whole. The definitions of this outward focus may be broader, and attempt to include a variety of beliefs.

While Van Ness used the terms inward and outward to describe aspects of spirituality, Amenta (1986) described similar dimensions using the terms intrapersonal, interpersonal, and transpersonal. Taylor (2002) cited Amenta (1986) who defined spiritual as "the self, or I, the essence of personhood, the God within, that part which communes with the transcendent. It is that part of each individual which longs for ultimate awareness, meaning, value, purpose, beauty, dignity, relatedness, and integrity" (p.5). Amenta continues to note that one's "relatedness" is understood as one's connectedness to the intrapersonal, interpersonal, and transpersonal. Perhaps more succinctly, spirituality is one's connection to him or her self, others, and forces unseen, which may be a God or other powers. Amenta's definition will be the foundational definition used in this study.

2.2 Spiritual Care in the Nursing Perspective

Florence Nightingale had a holistic vision of nursing care (Burkhardt et al., 2002). In the late 1800s, she identified a strong connection between spirituality and health promotion. According to these authors, Nightingale saw no conflict between spirituality and science. They continued by noting "in whatever ways one helped to improve conditions for another or bring about greater awareness and knowledge was, for Nightingale, an expression of spirituality and a way of connecting with God" (p. 7). These authors continue, "Nightingale believed that God intends us to be responsible for each other, working to identify and address that which will

promote [italics added] a better existence for others and ourselves” (p. 7). Nightingale’s vision for nursing care included a spiritual component. Nightingale was a leader in discussing spiritual aspects of the human persona.

From the beginning, spirituality was an integral part of nursing. However, many nurses are not familiar with the concept of providing spiritual care for patients. Nurses easily recognize the physical and psychological needs of patients and families, but perhaps because of lack of education, are not aware of the spiritual needs (Narayanasamy, 1993). However, nurses are probably providing for some of the spiritual needs of patients when they care for patients’ physical needs. Meeting spiritual needs requires assessment of the needs, listening to patients, and spending time with patients. The nurses may consider spiritual needs as part of the psychosocial domain of nursing and not the spiritual domain. Narayansamy noted that nurses need to realize that meeting the patient’s spiritual needs are important aspects of care.

Theories of nursing practice guide the provision of nursing care. Nurse researchers often utilize a “caring” theoretical perspective when researching spiritual nursing care (Cohen, 1991; McCance, McKenna, & Boore, 1999). Jean Watson is a prominent nursing theorist incorporating a “caring” perspective into her theoretical framework.

Jean Watson developed the theory of human caring in the 1970s. This theory was developed to “bring meaning and focus to nursing as an emerging discipline and distinct health profession with its own unique values, knowledge and practices with its own ethic and mission to society” (2004, para.1). Watson’s theory of human caring supports holistic nursing care and emphasizes the spiritual aspect of nursing care. The major components of the theory include:

1. Carative Factors-also referred to as the “core of nursing”
2. Transpersonal Caring Relationship
3. Caring Moment/Caring Occasion (Watson, 2004, para. 3)

The carative factors provide the format and focus for nursing care. “Carative Factors” is an all-encompassing term meaning both the hands on care the nurse provides, and the attitude, relationship, and set of values the nurse uses to provide this care. Watson refers to these carative factors as the “core of nursing.” These core processes point to those aspects of nursing care that potentiate therapeutic healing processes and relationships. They affect both the person providing the care and the person cared for. “Carative” is the deeper dimension of nursing care. It goes beyond the basic hands on care to the larger dimension of nursing. According to Watson (2004), the “carative” factors include:

1. Formation of humanistic-altruistic system of values
2. Instillation of faith-hope
3. Cultivation of sensitivity to one’s self and to others
4. Development of a helping-trusting, human caring relationship
5. Promotion and acceptance of the expression of positive and negative feelings
6. Systematic use of a creative problem-solving caring process
7. Promotion of transpersonal teaching-learning
8. Provision for a supportive, protective, and/or corrective mental, physical, societal and spiritual environment
9. Assistance with gratification of human needs
10. Allowance for existential-phenomenological-spiritual forces

The transpersonal caring relationship “connotes a spirit to spirit unitary connection within a caring moment, honouring [sic] embodied spirit of both nurse and patient, within the unitary field of consciousness. The nurse is able to “detect the other person’s condition of being” (Watson, 2004). This aspect of Watson’s theory implies a focus on the uniqueness of the nurse, the patient and the moment. The nurse and the patient come together in a reciprocal relationship. The nurse and the patient take something away from the experience. The nurse in this transpersonal relationship has the ability to center consciousness and intentionality on caring, healing and wholeness rather than on disease, illness and pathology.

The caring moment occurs whenever the nurse and the patient come together with their unique self (Watson & Smith, 2002). This moment is a focal point in time and space. The caring moment involves an action and a choice by both the nurse and the patient. The moment of coming together presents them with the opportunity to decide how to be in the moment and in the relationship as to what to do with the moment. The transpersonal moment allows each to feel a connection with each other. This moment opens up new possibilities for healing and human connection at a deeper level than physical interaction.

Watson's theory supports spiritual care giving. Watson recognized that the client needs, and often does not receive the "universal, mysterious, and powerful forces of love and care" (Taylor, 2002, p. 39). Taylor continues to explain the theory of human caring noting that patients need to be "cared for, loved, understood, accepted, and valued, to find harmony with life" (2002, p. 39). According to Taylor, the goal of nursing utilizing Watson's theory is to help people achieve a "higher degree of harmony within the mind, body, and soul which generates self-knowledge, self-reverence, self-healing, and self-care" (p. 39). Nursing actions that support this goal include allowing the clients to express their deep, inner feelings and communicating a feeling for and union with the client. Watson sees the act of caring as fundamentally a spiritual act. She believes caring assists clients to achieve a greater sense of self, as well as, more harmony with body, mind, and soul. Watson believes that disharmony within a person's mind, body, and spirit, or between the person and the environment can lead to inner distress, illness and possibly disease.

2.3 Spirituality and Health

Burkhardt and Jacobson (2002) stated that “healing is essentially a spiritual process that attends to the wholeness of a person” (p. 25). These authors continued by stating, “Every human experience is a whole person experience with body-mind-spirit components” (p. 25). Healing is no different. This mind-body-spirit connection is an essential component of the healing process. Burkhardt and Jacobson recognized physical, emotional, and spiritual concerns are all integral parts of the healing process. These authors believed healing can occur in absence of a cure. For example, as people near the end of life, the healing may be in the emotional or spiritual realm, but death occurs, and the physical realm dies. These authors cite the story *Tuesdays with Morrie* by Mitch Albom (1997). In this story, a man nears the end of his life suffering from amyotrophic lateral sclerosis (ALS). He experiences healing but no cure. He makes the best of his last days and experiences life and death “with dignity, courage, humor and compassion” (p. 21). Throughout his deterioration, he was to experience the fullness of life. He realized the blessing of being able to place all things in perspective, and he was able to say his final good-byes while he still was able to communicate. “In the midst of dying, Morrie’s healing became even more apparent” (Burkhardt et al., 2002, p.28).

While there is minimal research data linking spirituality and health, nursing leads the way when considering the spiritual aspect of health and healing. Nursing texts often devote entire chapters to the topic of spirituality. Burkhardt and Jacobson’s book, *Spirituality: Living our Connectedness* (2002) considers the link between spirituality and health. Another book, *Spiritual Care: Nursing Theory, Research and Practice* by Elizabeth Taylor (2002) gives specific examples of how and when nurses provide spiritual care when caring for patients. Nursing practice is different from the medical model. The medical model considers disease and the

treatment of disease. The medical model cannot explain why two people with the same diagnoses have different outcomes. One lives and the other dies. The medical model cannot explain why some people live when all evidence points to the fact that they should die. The medical model cannot explain why seemingly healthy people acquire devastating illnesses and die. Because the medical model cannot explain these types of occurrences, scientists have begun to explore other factors that influence health and healing. Nursing research, because of its focus on holistic caring, often points to other factors, including spirituality.

Many times, there does not appear to be a rational answer to particular outcomes of a patient's condition. Because of this lack of explanation, some "nurses see God or the Divine Being at work in the professional practice" (Fontaine, 2000, p. 15). This sense of another force involved in the healing process may be totally in the mind of the nurse, and the patient may be completely unaware. Fontaine continues by noting nurses believe that a spiritual force often guides their practice, and some nurses believe the desire to care serves as this guide (2000). Since Nightingale's time, nursing has been described as an art and a science. The art of nursing is this sense of being there, the aspect of caring Fontaine addresses.

Miller and Thoresen (2003) identified the relationship between religious variables and health in many studies. However, they continue by noting that many times the reporting of these links are simply represented in a table, without any elaboration in the discussion of the findings. Miller and Thoresen noted that after the 1900s more research linking spirituality and health has emerged; however, they do not speculate on why this is so.

Seeman, Dubin and Seeman (2003) attempted to identify the relation between health outcomes and religiosity or spirituality. The authors noted the relation between church attendance and better physical and mental health and lower mortality. While a relation between

church attendance and better physical and mental health was noted, church attendance may be an incomplete way to measure spirituality due to factors that might prohibit church attendance. This indicator does not take into consideration those who cannot attend services, or those for whom services are not an appropriate mechanism to express their religiosity/spirituality.

A few studies that link spirituality and health will be discussed. Hummer, Rogers, Nam and Ellison (1999) linked religious attendance to mortality rates. These authors examined a national representative sample of 21,204 adults and controlled for demographic, SES, health, behavioral and social variables. The authors linked the participants to follow up mortality data. This study followed up over 8-year period. Life expectancy was increased by over 7 years for those who indicated religious attendance more than once a week, compared to those indicating they never attend religious services. The authors used religious attendance as a proxy for a high level of spirituality. This study also indicated religious attendance protected against cardiovascular disease, respiratory diseases, and some infectious diseases. While no study controls for every variable, these authors concluded higher sense of spirituality, measured by religious attendance decreased mortality.

Koenig et al. (1999) compared the mortality rate of patients who attended religious services once a week or more to those attending services less than once a week. The study included 3,968 older adults. During a 6-year follow up period, 22.9% of participants who attended religious services once a week died compared to 37.4% of those indicating attendance of less than once a week. This significant finding was strongest for women but also present in men.

Sicher, Targ, Moore and Smith (1998) investigated the effect of distant healing (meditation to benefit another's physical or emotional well being) on the incidence of AIDS

related complications. Results in this pair-matched study indicated those patients in the treatment group, those for whom another was “praying,” had fewer new AIDS-defining illnesses and the illnesses were significantly less severe. These patients required significantly fewer outpatient doctor visits and fewer days of hospitalization.

Powell, Shahabi, and Thoreson (2003) noted the reason why there are relatively few studies actually linking spirituality to health may be due to a number of reasons. First, many studies attempting to link spirituality to health do not attempt to control for potential confounders. Often age, gender, or ethnicity are not considered, and these confounders may affect health regardless of the spiritual factor. The temporal sequence of events is often not considered. It is often difficult to determine if a spiritual person is healthier, or if an unhealthy person is less spiritual. Furthermore, when people are experiencing alterations in health, their spirituality factor may change because of their health state. These authors continue by questioning the measurement of spirituality, religion, and health. Many studies base level of spirituality or religion on the number of times a person attends church every week. Is it a reasonable assumption that people not experiencing health are capable of attending church? Alternatively, are they determined to be less spiritual because of their inability to attend service? Additionally, how do they define health? Does a physical handicap mean a person is unhealthy? Most studies use self-reported questionnaires related to health. This allows each individual to determine their health state, and this may not be the same across the participants. All of these study weaknesses demonstrate why there is a lack of literature directly relating spirituality to health.

In summary, only a small number of studies were able to provide an actual link between spirituality and health, however, these studies demonstrate a sense of spirituality impacts health.

A positive sense of spirituality may enhance a patient's perception of their health. If nurses can promote this sense of spirituality, patients will benefit by quicker recoveries and enhanced states of health. In 1998 the American Nurses Association defined health as not only the absence of disease, but also as a sense of physical, social, psychological, and spiritual well-being (American Nurses Association, 1998). This nationally recognized nursing organization determined that in order to promote health, nurses must meet these needs.

2.4 Patients and Nurses Recognition of the Need for Spiritual Care

In this section, I will describe patients, caregivers, and nurse's recognition of spiritual care. Initially I will describe studies involving patients and caregivers. Following, I will describe studies examining differing groups of patients, such as patients with disabilities, hospice patients, and pediatric patients and their families. I will then examine studies that identified nurses' recognition of patient's spiritual needs. Following this, I will examine studies that identified spiritual needs by nurses from different specialty areas such as, mental health, parish, and community health nurses. I will discuss international nursing studies considering spiritual nursing. I will conclude this section with a brief explanation of the literature citing why nurses are hesitant to provide spiritual care.

Patients and Caregivers

Studies indicated patients and families identified the need for spiritual interventions or the provision of spiritual care (Boswell et al., 2001; Chapman et al., 2002; Ferrell et al., 2003; Kloosterhouse et al., 2002; Hermann, 2001; McColl et al., 2000; Sheldon, 2000; Taylor, 2003; Theis et al., 2003). An informative study by Taylor (2003) interviewed 21 patients with cancer and seven family caregivers regarding spiritual care. Ten of the patients were men and all of the

caregivers were women. The patients unanimously identified they wanted spiritual care and while no specific number of patients were cited, most of the participants identified nurses as providing spiritual care. When the researcher asked participants, “What should nurses do to help them with their spiritual needs,” the responses yielded a variety of suggestions. Infrequently informants responded that they had never thought about nurses providing spiritual care and were in-fact somewhat hesitant to have these issues pushed on them by a nurse. However, more frequently the responses included one of six themes. Patients wanted nurses to 1) be kind and respectful, 2) talk and listen to them, 3) pray with them, 4) connect with the patient and family, 5) provide quality temporal care, and 6) assist in obtaining religious resources.

Theis, Biordi, Coeling, Nalepka, & Miller (2003) conducted another study of care receivers and caregivers with respect to spiritual care. This group of researchers interviewed 60 care dyads (receivers and givers). All of the care receivers had a diagnosis of some type of chronic illnesses. Two researchers simultaneously interviewed a different member of the dyad in the home of one of the participants. During analysis of the interviews, two overriding themes related to spirituality developed; coping and meaning. They further defined coping to mean formal spiritual and social support. They defined meaning as positive attitude, retribution or reward, and all encompassing. Females mentioned spirituality more frequently than males, and African American caregivers mentioned spirituality more frequently than Caucasian caregivers did. They reported issues related to formal religion as a coping mechanism more frequently than other forms of coping. Respondents mentioned the nurse could suggest activities of formal religion such as prayers, readings, or music if he or she assessed the patient or caregiver would benefit. The participants noted they did not expect the nurse to explore the nurse’s personal spiritual agenda, but rather when the nurse assessed the patients wanted formal religious support,

the nurse would provide this support. Furthermore, participants viewed a positive caring attitude by the nursing staff as a form of spiritual support. This positive caring attitude developed only after an extended relationship of the nurse with the caregiver or the patient took place. The patient and caregiver thought this positive caring attitude was helpful if it was genuine, and if a prior relationship had been formed with the patient. Finally, the participants thought nurses played an important role in contacting other religious personnel such as clergy or chaplains.

In another study, Ferrell, Smith, Juarez and Melancon (2003) examined the patients' expectations from their caregivers. These authors utilized a unique method to collect data. These authors analyzed 21,806 letters, cards and E-mails correspondences from ovarian cancer survivors. Patients had sent these communications to a newsletter specifically for the survivors of ovarian cancer. Analysis of the correspondence was completed using data from the "Quality of Life Cancer Instrument." In these correspondences, spiritual support was mentioned 20% of the time. The patients identified meaning in life and all 11 themes of the quality of life inventory were validated by this study. Five quality of life themes emerged in this study. Quality of life in cancer survivorship meant, 1) having a balance between the experience of increased dependence while seeking both independence and interdependence, 2) seeking a sense of wholeness after a life-changing experience, 3) struggling between the elements of basic survival, counterbalanced by the profound search for meaning, 4) gaining a sense of control in life rather than being controlled by cancer and reclaiming one's life, 5) facing multiple losses. This ethnographic study was unique in that it analyzed the correspondence and did not interview the cancer survivors directly. It was also interesting to note that in these informal correspondences, spirituality in general was mentioned 29% of the time when no impetus to mention spirituality was given, since the correspondence was unsolicited.

Disabled Patients

Two studies evaluated the needs of disabled patients. Both of these studies identified disabled patients had unique spiritual needs. McColl et. al. (2000) interviewed disabled patients regarding their expression of spiritual issues. Brain injury patients, compared to spinal cord injury patients, placed a higher importance on family support and the spiritual theme of trust. The researchers hypothesized that this finding was due to the issues related to memory problems in the brain injury population. These patients also identified themes that included awareness, closeness, purpose, and vulnerability. Caregivers of the disabled should consider these needs as they provide care for other patients. Both spinal cord and brain injury patients identified a need for interpersonal, intrapersonal, and transpersonal relationships.

Boswell, Knight, Hamer and McChesney (2001) interviewed women with severe disabilities to examine the association between disability and spirituality in this population. These authors found spirituality emerged as an important aspect in the lives of these women with severe disabilities. This seemingly simple finding has huge implications for nurses working with disabled patients. If spirituality is an important aspect in the lives of these women with disabilities, it is possible that spirituality will be an important aspect of others with disabilities. If spirituality is an important aspect of the lives of these women, and their caregivers do not recognize or act this fact, how can caregivers provide holistic care, a common goal of nursing care? According to the women in this study, aspects of spirituality actually helped them cope with their disability. Reciprocally, their perceptions of self, disability and the world positively influenced their evolving spiritual beliefs. The dimension of spirituality dealing with meaning of life actually helped these women accept themselves as whole people, which in turn, they felt, aided in their recovery.

Hospice Patients

Sheldon's (2000) study identified how the concept of spirituality applied to the dying patient. This author found hospice patients have a unique set of spiritual needs. Sheldon noted every human being has a "spiritual part connected to each person's physical, mental and social nature" (p. 101). This author identified the barriers nurses note when providing spiritual care. Sheldon noted that some nurses thought spirituality was a sacred intimate issue. Spirituality "involved many feelings some nurses do not want or know how to deal with, and so they may simply say this is the chaplain's role" (p. 103). A second barrier Sheldon identified concerns nurses' sense of awe or mystery about aspects of spirituality, and therefore nurses are fearful to enter conversation on the topic. Some nurses stated that they are uncomfortable discussing spirituality because they are not "in touch with their own spiritual nature" (p. 103). Finally, the nurses cited a lack of education related to spiritual care as a barrier for providing spiritual care. Sheldon discussed the importance of meeting the spiritual needs for all patients, but especially patients near the end of life. She continued by saying, "all nurses need to be aware of the tangible and intangible aspects of care, especially in this spiritual care giving role" (p. 104).

In a study by Herman (2001) dying patients' definition of spirituality and their specific spiritual needs were identified. The researcher interviewed 19 hospice patients using semi-structured interviews. Initially these patients identified spirituality as relating to "God or religion." As the interviews continued, it became apparent that the patients actually wove the essence of spirituality throughout their lives, and spirituality was part of their total existence. These patients identified 29 different spiritual needs, which the researchers grouped into six themes. The patients identified a needs relating to, 1) religion, 2) companionship, 3) involvement and control, 4) finish business, 5) experience nature, and 6) a positive outlook. These patients

thought that spirituality may or may not include religion. The spiritual needs identified were very broad and were closely linked to attaining a meaning in life.

Pediatric Patients and Families

Pediatric patients and their families also have spiritual needs. While it may seem children are not in touch with spiritual needs, two studies indicated that both children and their families experience unique spiritual needs. One study by Chapman and Grossoehme (2002) compared referrals for pastoral care from psychiatric and medical surgical pediatric populations. The authors noted that during a 16-month period, 73 referrals were made to the pastoral care department of a pediatric care facility. Most of the referrals were made from the psychiatric unit (65%), and interestingly the population of the psychiatric unit comprised only 6% of all hospitalized patients at the facility. Additionally, of all the referrals, the patients themselves made 66% of the referrals. Chapman and Grossoehme noted that nurses and patients refer to pastoral care for different reasons. Nurses referred patients to pastoral care when they identified “spiritual crisis” as an issue, whereas, patients self referred when they felt depressed. Nurses also mentioned that pastoral care was beneficial when patients suffered from anxiety. These authors identified the need for spiritual care in the pediatric population. While these authors reported that the pastoral services department provided the spiritual care, the implications for nurses can be inferred. Nurses need to care for pediatric patients spiritually, and patients sense the need for spiritual care when they are depressed. This study also indicated that patients sense the need for spiritual care referrals more than the nurses do.

Kloosterhouse and Ames (2002) sought to determine if there was a relationship between the use of religion and spirituality as a psychosocial resource and the ability of the family to cope with the hospitalization of a child. Over a 6-week period, a family member of every child

discharged from the hospital (n=306) was given a questionnaire to complete. Of the questionnaires distributed, 35%, (n=107) distributed were returned, and 69 of these were included in the study. This study concluded that nurses should consider religion and spirituality as a source of psychosocial support because the families indicated that they felt religion and spirituality were a source of strength giving a sense of meaning, and hope. The families in this study indicated religion and spirituality was one of their resources when dealing with a stressful situation. From this study, it is clear that not only patients, but families also think spirituality is important in their lives. In order to care for these patients and families, nurses must be able to meet these spiritual needs.

Nurses' Recognition of Patients' Spiritual Needs

Many studies indicated that nurses identified the need to provide spiritual care (Greasley et al., 2001; Hoover, 2002; O'Brien, 2000; Strang et al., 2002; Tuck et al., 2001). Most studies included a specific sub-group of nurses. Interestingly, I found no study that interviewed medical surgical nurses the largest sub group of nurses in practice today. Mental health nurses, parish nurses, and community health nurses were studied. All of these sub-groups of nurses recognized the need to provide spiritual care.

Two studies evaluated mental health nurses provision of spiritual care. Tuck, Pullen and Wallace (2001) conducted a study of the spiritual perspectives and interventions of mental health and parish nurses. Ninety-one mental health nurses from a Southeastern metropolitan area responded to the survey. Tuck, Pullen and Wallace obtained a comparative sample of parish nurses utilizing a snowball technique. The participants completed demographic data and completed a ten-item spiritual perspective scale (SPS) questionnaire. The authors also asked participants to respond to three open-ended questions. Both the parish nurses and the mental

health nurses reported a high sense of spiritual perspective, but the parish nurses, as might be expected, had a higher spiritual perspective. More interesting however, the mental health nurses believed that in the ideal situation, listening, referring and encouraging were the interventions that best supported patients spiritually. The parish nurses noted that prayer, listening, and touching were the interventions in the ideal situation. Both groups of nurses reported that after the completion of the study, they provided more spiritual care than before the study. This result may have reflected that the increased awareness of providing spiritual care may indeed have led to increased provision of spiritual care. A limitation of the study by Tuck, Pullen and Wallace (2001) includes the fact that this study was conducted in an area known as the Bible Belt, and therefore, it may not be generalizable to the population at large. It is also important to understand that hospice and mental health nurses typically spend more time in conversations with their patients than the typical hospital-based nurse does.

Greasley, Chiu, and Gartland (2001) examined the concept of spiritual care in mental health nursing. Mental health nurses formed nine focus groups of four to six nurses each. The authors conducted interviews with the focus groups. One of the authors moderated each focus group for continuity. Each focus group lasted approximately 1 hour. Participants of the focus groups defined spirituality and the particular meaning of spirituality was identified for each nurse. The nurses differentiated religious needs from spiritual needs. The nurses identified an association between spirituality and health. The nurses were able to describe elements of spiritual care. These nurses thought spiritual care related to the knowledge of a person's "sense of meaning and purpose in life which may, or may not, be expressed through formal religious beliefs and practices (Greasley et al., 2001). The nurses who participated in the focus groups expressed concern that the nature of mental health nursing was becoming more "mechanical" in

nature and the opportunities for personalized, individual, compassionate care were being lost. Greasley, Chiu, and Gartland (2001) hypothesized that this trend in nursing care and in fact, medical care, might be due to the emphasis that “readily observable and measurable elements in care practice (have) assumed a prominence over the more subjective, deeply personal components” (p. 629). These authors suggested a more holistic approach to care is necessary to provide adequate spiritual care for patients.

O’Brien (2000) identified themes noted by community health nurses with respect to the relationship between community health nurses and their clients. The author interviewed five community health nurses considered experts in their field. These nurses identified themes of “being there,” “being connected,” “establishing trust,” and “facilitating transitions” as spiritual care interventions. O’Brien noted that nurses use “self and knowledge autonomously and skillfully for the purpose of helping the client achieve a better being-in-the-world” (p. 190). Because the author interviewed only five expert nurses in the field of community health nursing, the author made no effort to generalize to all community health nurses. It is interesting to note, these nurses had a very good grasp of what holistic nursing meant in the community health setting. They valued the relationship with their patients and realized the importance of this relationship in dealing with the complex issues arising in the community setting.

Spiritual care is not unique to the nurses in the United States. Two international studies identified the need for spiritual care in nursing. Strang, Strang and Ternstedt (2002) conducted a study among Swedish nursing staff at six different facilities to identify spiritual needs in their patients. These researchers also wanted the nurses to identify any particular group of patients for whom spiritual needs were of utmost importance. Strang, Strang and Ternstedt mailed a questionnaire consisting of two open-ended questions and six background questions to a

purposeful sample of 191 nurses and nursing auxiliaries. The authors did not define the term “auxiliaries”, but it was interpreted to mean nursing support staff such as nursing assistants and technicians. Of the 141 questionnaires returned, 102 respondents completed the two open-ended questions. The questions, “How would you define and describe the term spiritual need?” and “Are there any special areas or groups of patients for whom spiritual needs have an especially important role?” were analyzed according to categories of answers. The nurses defined spiritual needs as relating to religion, general care, and existential issues. Existentialism was further subcategorized into “meaning, freedom, loneliness, and death.” About half of the nurses reported that they practiced holistic care. While the majority of the nurses interviewed indicated that spiritual care was important, many reported they did not practice it. More than half of the participants stated that spiritual education for staff should be a high priority. The open-ended questions identified the staff had a hard time distinguishing between spiritual, existential and psychosocial care. The respondents thought that cancer patients and terminally ill patients had special spiritual needs. Interestingly, another group of people thought to have special spiritual needs was people from other cultures and people with foreign religious beliefs.

The second international study by Hoover (2002) investigated the effects of an educational module on human caring on nursing students in Wales. The study included 25 part-time nursing students. The researcher divided the students into four focus groups. The researcher held discussions before and after the module. The students experienced an increase in spiritual awareness. The participants characterized this experience as enhancing connecting relationships with self and others, finding purpose and meaning in life and clarification of values. Professionally, the students noticed an increased knowledge and understanding of the caring theory, a more holistic approach to care and enhanced caring practice. This study made it clear

that education related to caring, and specifically spirituality, enhanced the nursing students ability to be caring professionals. The students saw this module as a positive way to increase spiritual awareness in both their personal and professional lives. This study was the only one to investigate the impact of education related to spirituality.

While many studies reported patients, caregivers, and nurses identified the need for spiritual support, other articles (Dettmore, 1984; Narayanasamy, 1993; Narayanasamy, Gates, & Swinton, 2002; Vance, 2001) noted some of the barriers to providing this care. Dettmore (1984) noted nurses did not feel comfortable utilizing interventions related to spirituality and therefore often did not provide care related to these spiritual needs.

Dettmore (1984) interviewed a clinical psychologist to determine the changes he had seen in patients over the years. The psychologist claimed that while many people have abandoned formal religious practices, those that have retained these values often can not draw on these values when they are hospitalized. Dettmore also cited a nursing interview in which nurses claimed that a lack of time might be the reason they did not attend to patient's spiritual needs. Dettmore continued to suggest that while nurses may cite time as the reason they did not meet spiritual needs of patients, fear or lack of comfort in the spiritual domain may be the underlying reason they did not meet the spiritual needs of patients. Dettmore (1984) noted that the nurse-patient relationship is bound by respect and confidentiality. The very nature of this relationship allowed the nurse to deal with issues not normally discussed, like spirituality. Consequently, spirituality should be an acceptable topic within the nurse-patient relationship. Dettmore continued by noting that spiritual needs were not difficult to meet. Patients said nurses met their needs by listening to them, recognizing the need existed, and contacting a chaplain.

Narayansamy (1993) studied how nurses developed an awareness of patients' spiritual needs, and examined their education related to caring spiritually for patients. In his study of 33 registered nurses, some nurses were able to identify ways in which they met the spiritual needs of patients. The nurses' responses indicated they might not have been prepared educationally to meet the spiritual needs of patients. Narayansamy described nurses as being limited in their education related to spiritual care and therefore the nurses were not able to meet the spiritual needs of patients. Narayanasamy identified that nurses often delegated patients' spiritual needs to the pastoral care staff. The researcher found that nursing interventions related to spirituality included care of the dying patient, hospice care and calling the priest, minister or rabbi when the patient requested. Only two nurses in his study cited prayer as a viable intervention. Unfortunately, Narayanasamy did not specify if the prayer was with the patient, or for the patient, as both are viable prayer options.

Vance (2001) conducted a study to examine the influence of the nurses' belief system toward providing spiritual care. Nurses self reported a higher level of spirituality than the expected mean of the instrument. The author found a significant and positive correlation between nurses with a stronger sense of personal spirituality and the spiritual care they provided. Unfortunately, Vance found that only slightly over a quarter of the nurses provided adequate spiritual care for their patients. The nurses reported time was the greatest barrier to providing spiritual care. Spiritual care was considered a "low priority much like a luxury and not a necessity for the hospitalized patient" (p. 268).

In summary, patients and caregivers identified spiritual care was important to them. The researchers noted that various groups of patients had specific spiritual needs. Nursing care has included aspects of spiritual care since Florence Nightingale's time. Nurses in different specialty

areas were able to identify what spiritual intervention included. Some nurses were able to identify why they did not provide spiritual care. However, I found no study that examined how rehabilitation nurses provide spiritual care. This study will fill this void by asking rehabilitation nurses to describe how they provide spiritual care.

2.5 Phenomenological Research

Because I developed a study utilizing phenomenological research technique, I conducted literature review based on phenomenology. I will examine phenomenology from Husserl and Heidegger's perspective. This section includes a comparison of these two techniques. This section will conclude with an explanation of the appropriateness of the phenomenological approach in this research study.

Husserl

The philosophy of phenomenology began in the late 19th and early 20th centuries with Husserl's work in Germany. Husserl, who lived from 1859 to 1938, was educated as a mathematician. Rose, Beeby and Parker (1995) cite Husserl as saying, that as a research method, "phenomenology was a science which was intended to supply the basic instrument for a rigorously scientific philosophy and in its consequent application, to make possible a methodological reform of all sciences" (p. 1124). According to Lauer (1965), early in Husserl's career, Husserl was trying to gain an audience for his "radically new scientific manner of philosophizing" (p. 2). He wanted to elevate philosophy to the level of a rigorous science. Husserl did not start out trying to develop a new method of scientific inquiry, but rather an entire new way to think. Lauer continued to describe Husserl's work as an attempt to establish "a detailed method for attaining the goal of universal rationality" (p. 2).

Husserl attempted to distinguish phenomenology from other philosophies. According to Lauer (1965), Husserl thought that phenomenology could only be “truly scientific and only scientific philosophy can be truly philosophy” (p.4). In other words, this total dedication to the truth set the foundation for what we describe today as the qualitative method of phenomenological research. This attempt to search for the truth, the “essence of the lived experience” is the common understanding of phenomenological research. Husserl sought the truth by verifying the results found, one after the other, and ultimately compiled a group of established truths. Lauer continues to note that Husserl envisioned the philosophical phenomenological method to be a “cooperative endeavor” which required the “establishment of truth after truth” (p.5). Lauer acknowledges this type of research requires not only an enormous amount of time, but also a number of researchers all belonging to the same philosophical school in order to agree on the truths found.

Cartesian tradition influenced Husserl, which considered man’s relationship to the world in which they lived. This relationship was viewed in terms of humans; the subjects, knowing objects. This sense of knowing is a dominant theme in phenomenology.

Rose, Beeby and Parker (1995) cite Kearney (1986) and break down Husserl’s methodology into five key components. The first component, bracketing, is the attempt to remove the researcher’s bias, and the subsequent attempt to see the other side of the argument or issue. During bracketing, the researcher allows the mind to be open to other possibilities and opinions of others. During this process, the mind wanders and alternative viewpoints may be seen for the first time.

The second component, reduction, is the researcher absorption in the phenomenon. When the researcher is fully absorbed in the topic, and because of bracketing, the researcher may

actually be seeing the phenomena in a new perspective. This process leads to the essence of the phenomena. “Essence” is a fact or entity that remains unchanged over time. An essence will be true and absolute. “Essences, however, do not exist in isolation from conscious experience” (Walters, 1995, p. 792). Reduction involves careful thought regarding the essence of the phenomena, and considers the significance of seemingly unimportant aspects of the observed phenomena. These “taken for granted” or trivial aspects of the experience move the researcher to the meaning of the experience.

Third, free variation, allows the researcher to think of the phenomenon in a variety of circumstances. During free variation, the researcher thinks about the phenomena in a number of different situations. This allows the meaning of the phenomenon to be determined for the situation under investigation.

Intuiting is the fourth key feature of phenomenological research according to Husserl’s technique. Intuiting, or ‘grasping’ allows logical thought based on the careful consideration of the examples. Rose, Beeby and Parker (1995) cite Bartjes (1991) and note that it is not “second sight or inspiration,” but rather utilizes the bracketing, reduction, free association and finally begins the transformation of the information. This is the act of posing the information from the viewpoint of the person interviewed. Intuiting, because of bracketing, allows the researcher to experience the phenomena from the participants point of view, free from bias. This component of phenomenological research allows the researcher to see the phenomena as the participant sees it and to understand the essence of the phenomena as the participant understands it.

The final key component is describing. In this activity, the transformation becomes complete. It involves the exploration of the meaning as it became evident to the participant and presents the meanings as they appear in the phenomena. The writing of the description attempts

to express the feeling of the experience the participant shared, in order to generalize the meaning to similar experiences of others.

Koch (1995) describes the Husserlian philosophy as including three dominant components as opposed to the five components cited by Kearney. She describes bracketing, intentionality, and essences as the major components that differentiate Husserl from other phenomenological philosophers. Bracketing is the first defining characteristic of Husserlian Phenomenology, according to Koch. This allows the researcher to disconnect their own assumptions about the causation and consequences of the processes under investigation. This is not a matter of doubting the existence of these aspects, but separating from them. It is in bracketing that the research demonstrates validity according to Koch. By bracketing, the researcher “defends the validity or objectivity of interpretation against the self-interest of the researcher” (Koch, 1995, p. 829).

In Koch’s interpretation, intentionality is the idea that conscious thoughts are those ideas of which we are certain. This is similar to Kearney’s concept of reduction. Koch describes this as conscious awareness. This is similar to the description of reality.

Koch’s final concept of Husserlian phenomenology relates to essences that “constitute the consciousness and perception of the human world” (pg. 828). These essences are comparable to Kearney’s concepts of free variation and intuiting. Koch continues to identify the mind-body split assumed by Husserlian phenomenology. This Cartesian duality describes the body as the “container for the mind” (pg. 828) and it is within the mind that the symbolic representation takes place. Koch suggests that phenomenological research assumes a “systematic view of mental content and assumes that this is possible if symbols representing the world are manipulated in the mind, as these manipulations permit the external world to be brought into

internal consciousness by cognitive views” (pg. 828). She notes that this process allows for phenomenological interpretation to be “objective.”

Heidegger

Just as there is not one truth, or essence of research, there is not one phenomenological philosophy. Heidegger, a student of Husserl, developed a slightly different phenomenological approach. In order to understand Heidegger’s approach to the phenomenological method, hermeneutical circle must be explained. The Hermeneutical circle includes background, pre-understanding, co-construction, and *Dasein* (Koch, 1995).

According to Heidegger, background, deals with the ideas handed down from person to person. It presents a way to interpret the world. Background helps the person determine what is “real.” According to Koch, “background meanings, skills and practices cannot be made completely explicit” (p. 831) and these often unconscious or unaware constructs influence our understanding of the phenomena under investigation.

Pre-understanding is a slightly different concept describing the “meaning and organization of a culture” (Koch, 1995, p. 831). Pre-understanding involves the underlying notions humans have regarding an event or idea. The pre-understandings are already present and are brought into focus when understanding of the event occurs. Because of background and pre-understanding, we humans, we cannot eliminate or “bracket” our pre-understandings. Walters (1995) identifies that Heidegger thought it was not possible to bracket one’s “being in the world.” The essences of one’s own understanding of any topic under investigation, influences the approach to the analysis of the data. Researchers are of the world in which they choose to study, and therefore, any research is influenced by what the researcher has experienced. This is a major difference between the philosophy of Husserl and Heidegger.

Co-construction according to Walters (1995), is based on an existential perspective which considers that an understanding of the person cannot occur in isolation from the person's world" (p. 792). This co-construction implies that the world in which one lives, the culture, and background constructs the essence of the person. At the same time, the person, individual experiences, and background one brings to the experience construct the world. Heidegger (1927/1962), argued Husserl's description of every thought being formed in the conscious mind. Heidegger claimed this outlook overlooked dimensions of unconscious thought, and this impacted the way one views the world. Unconscious concepts as dread, anxiety, loneliness, and worry need to be considered. These unconscious aspects of the person are important to the understanding of the entire person. Other unconsciousness aspects of the person, such as the need to be connected to others, and relationships are often important when considering co-construction. Heidegger's phenomenological perspective allowed for inclusion of aspects of the unconscious mind. This is another difference between the two approaches.

Heideggerian phenomenology refers to the situation of "being there" which emphasizes the "situatedness" of human reality (Reed, 1994). This human existence, or *Dasein*, described by Heidegger, suggests that people are primarily "in and of the world, rather than subjects in a world of objects" (Reed, 1994, p. 337). Heidegger believed that because we are human, we are involved in activities, manage situations, and participate in relationships with others. *Dasein*, or the construct that we are in and of the world, cannot be considered in isolation of the previous constructs of background, pre-understanding, and co-construction.

Nurses find the aspect of "being in the world" an important component of co-construction. Heideggerian phenomenology and the concept of "being in the world," makes it particularly well suited for nursing research. Walters (1995) continues to note that according to

Heidegger, the most “fundamental way of ‘being in the world’ is caring” (p. 793). According to Heidegger, “to care” is “to be.” Caring about one’s self, other people, and other activities is the essence of “being-in-the-world.” This aspect of caring is very similar to the concept nursing theorists use to describe the practice of nursing. People must care about something. Some people have great capacity to care, and others lack the magnanimous nature to care. Providing care has been the focus of nursing since the beginning of the nursing profession (Hood & Leddy, 2003). As a caring profession, nurses often choose the Heideggerian method of phenomenological research because the aspect of “care” is embedded into the essence of the tradition.

All four constructs, background, co-construction, pre-understanding, and *Dasein*, when considered together, constitute the hermeneutical circle, and this is a critical aspect of the Heideggerian phenomenological approach.

Additionally, Heideggerian phenomenology is concerned with the interactions and acquisition of knowledge that are present in our everyday activities (Walters, 1995). Heidegger identifies that we all interact with the world in three “distinct and interrelated ways” (Walters, 1995). Heidegger describes these three ways of interacting with the world as the “ready-to-hand” the “unready-to-hand,” and the “present-at-hand.”

Heidegger identified the ready-to-hand form of interaction as the most basic way things are present to in everyday practical activity and the response is simply to cope. The ready-to-hand mode is the primary way of being in the world. The person is reacting to a situation. In carrying out our usual activities, the awareness of our situation is holistic. We usually do not experience any tools or equipment that we use, including our bodies, as distinct entities. This holistic approach begins to define our perception. When we engage in activities, we fuse our personhood and our attributes. These reactions are usually every-day interactions and consist of

activities that may or may not require conscious thought. These skills and practices of our everyday life are so over-practiced and familiar that we often take them for granted. This type of interaction is the starting point for Heideggerian research.

We experience the unready-at-hand interactions when things do not go as planned. We direct our attention toward fixing or improving an independent entity, which has become obvious to us. These problematic situations stand out and we attend to them because they stand out. These activities usually are conscious because they were unanticipated. The response generated was not ready-to-hand and thought was required to formulate a response.

The present-to-hand activities require some detachment and objectivity. In this mode, our perceptions of objects are broken apart and through detachment, their abstract properties are revealed. In these situations, the person needs to reflect upon it. Through reflection, the person generates a solution or response. The present-to-hand activities are different from the unready-at-hand activities because reflection and detachment are required in order to formulate a response. The person needs to separate him or herself from the situation in order to formulate a response.

Koch (1995) delineated the aforementioned differences along with other comparisons between these two phenomenological traditions (p. 832). Table 1 recreates Koch's comparison of Husserlian and Heideggerian Phenomenology

Table 1: Comparison of Husserlian and Heideggerian Phenomenology

Husserlian Phenomenology	Heideggerian Phenomenology
Transcendental phenomenology	Philosophical hermeneutics Hermeneutic phenomenology
Epistemological	Existential-ontological
Epistemological questions of knowing	Questions of experiencing and understanding
How do we know what we know?	What does it mean to be a person?
Cartesian duality mind-body split	<i>Dasein</i>
A mechanistic view of the person	Person as self-interpreting being
Mind-body person lives in a world of objects	Person exists as a 'being' in and of the world
Ahistorical	Historicality
Unit of analysis is the meaning giving subject	Unit of analysis is the transaction between the situation and the person
What is shared is the essence of the conscious mind	What is shared is culture, history, practice, language
Starts with a reflection of mental states	We are already in the world in our pre-reflective selves
Meaning is unsullied by the interpreter's own normative goals or view of the world	Interpreters participate in making data
Participants' meaning can be reconstituted in interpretive work by insisting that data speak for themselves.	Within the fore-structure of understanding, interpretation can only make explicit what is already understood
Claim that adequate techniques and procedures guarantee validity of interpretation	Establish own criteria for trustworthiness of research
Bracketing defends the validity or objectivity of the interpretation against self-interest	The hermeneutic circle (background, co-construction, pre-understanding)

Adapted from Koch (1995)

Even though this table makes the differences very clear and distinct, in reality, the differences are often cloudy. Some phenomenological studies may not even state which philosophical tradition was followed because the researcher utilized some aspects of each method. This problem however, is not unique to phenomenological research. Researchers, while attempting to be true to a particular method, find certain aspects of one tradition work for their area of research interest, and aspects of other traditions works for other aspects of their research. In reality, the researcher, his environment, and the participants of the research co-construct phenomenological research

CHAPTER 3

METHODS

This chapter is composed of six sections. The first section states the research questions and the research design. The second section identifies the researcher's subjectivities. Section three describes the selection of participants, and section four discusses the instrument and data collection procedures. Section five identifies the process of Institutional Review Board approval, and the final section describes the data analysis procedures.

3.1 Research Questions and Research Design

Nursing, like all professions, embodies a number of practices that are unique to the profession. While nursing practice and nursing knowledge are unique to nursing, many times nursing activities are so commonplace for nurses that these activities seem everyday. Providing spiritual care may be one of those commonplace activities. The American Nurses Association (1998) instructs nurses to care for patient's physical, psychological, cultural and spiritual needs. As identified in the literature review, meeting spiritual needs is often a low priority. Caring for patients spiritually should be an everyday activity in the practice of nurses. The review of the literature also noted a lack of research related to nurses' experiences while providing spiritual care. Specifically, there are no studies indicating how rehabilitation nurses use spiritual care interventions when caring for patients. Because of my interest in this everyday activity of providing spiritual care, and the current lack of research in this area, I designed a qualitative phenomenological study to obtain the actual stories of how rehabilitation nurses are providing

spiritual care. The goal of this study is to examine the lived experiences of rehabilitation nurses when providing spiritual care. Rehabilitation nurses are ideal to interview for this study because of the length of time they are with patients. Dettmore (1984) acknowledges spiritual care requires time. Nurses need time to develop the relationship necessary to provide spiritual care and the nature of rehabilitation nursing allows nurses this time.

The research questions of the study are:

1. How do rehabilitation nurses define spiritual care?
2. How do rehabilitation nurses describe their experiences providing spiritual care?
3. How do rehabilitation nurses describe their level of comfort providing spiritual care?

In order to study the lived experiences of rehabilitation nurses, I designed a phenomenological study. Phenomenology is interested in the “origin of knowledge embedded in our everyday activities” (Walters, 1995, p. 793). The purpose of phenomenological research is to identify the “structure or essence of the lived experience of a phenomenon in the search for the unity of meaning which is the identification of the essence of a phenomenon and its accurate description through the everyday lived experience” (Rose, Beeby, & Parker, 1995, p. 1124). This research study examined the lived experience of rehabilitation nurses when providing spiritual care found some “unity of meaning” among rehabilitation nurses. To examine the descriptions of times nurses provide spiritual care, I interviewed rehabilitation nurses using phenomenological techniques.

3.2 Researcher’s Subjectivities

The “everyday” activity of spiritual care is my research topic of interest. Following Heideggerian phenomenology techniques, I must first examine my own experiences with

spiritual care. I feel I have had many experiences in which I nursed spiritually. I remember times when I sat with grieving families and prayed with them after their child died. I can remember sitting with an older man whose aging wife just had a serious heart attack. I sat with him for over 4 hours and just prayed with him asking God to allow his wife to live. I think the spiritual aspect of nursing makes nursing different from other health care professions. Nurses have the opportunity to spend time with patients that other professionals do not. Nurses have the unique opportunity to interact with patients on a very personal level.

My interest in the spiritual aspect of nursing affords me insight into this research area. One aspect of Heideggerian phenomenology that particularly well suits my research interest is the researcher's inability to completely separate from the topic being discussed. As a researcher with an interest in spirituality, I will participate in formulating the shared meaning inherent in the interview. In Heideggerian research, this co-construction is necessary to understand the experience as a whole. This close association with the topic under study, allows me to understand the situations the nurses discuss. The nurses sensed this understanding and provided me with the very intimate stories of caring for people spiritually.

As stated earlier, when using the Heideggerian phenomenological technique, it is not completely possible to bracket, that is, to remove the researcher's personal experiences related to the essence under investigation. Therefore, the researcher discusses his or her subjectivities, and the reader can make a decision regarding the impact of the biases. Kvale (1996) states, "Unacknowledged bias may entirely invalidate the results of an interview inquiry. A recognized bias or subjective perspective, may, however, come to highlight specific aspects of the phenomena investigated, bring new dimensions forward, contributing to a multiperspectival

construction of knowledge” (p. 286). Just as “beauty is in the eye of the beholder,” in this study the reader must determine the potential weight of the researcher’s bias.

My close association with the topic of spirituality might also influence the data interpretation. My understanding of the topic affords me with the ability to see certain aspects of nursing care as spiritual. As mentioned earlier, sitting with a man whose wife had a heart attack might seem a natural nursing act to other nurses. However, understanding the communication, the praying with the man for the wife, made this a spiritual intervention. A nurse with a strong sense of spirituality senses this opportunity. My own perspective of spirituality allows me the opportunity to interpret this intervention as spiritual in nature.

3.3 Participants

In order to understand this unique relationship between rehabilitation nurses and patients, I interviewed a sample of nurses currently working in a rehabilitation setting. Fourteen rehabilitation nurses participated in audiotaped interviews about times they provided spiritual care to patients. Rehabilitation nurses self-selected to participate in this study, and I contacted additional nurses using a snowball technique. Self-selection and the snowball method of identifying interested nurses assured the researcher that the nurses interviewed had an interest in the topic of spiritual care. I contacted nurses during the Association of Rehabilitation Nurses 30th Annual Educational Conference held in Atlanta, GA, October 6 to 9, 2004. I posted a flyer explaining the research study on the general bulletin board at the conference for all attendees to see. The flyer contained the available interview times and the meeting place for that specific time. Nurses interested in participating in the study signed up for a particular interview time. The flyer indicated the benefit of receiving a \$20 gift certificate from a nationwide bookstore for

participating in the study. During the data collection process, the nurses interviewed had the opportunity to identify other nurses they thought might be interested in participating in the study. I asked the interviewees to request the potential interested nurses to sign up on the sheet on the bulletin board. More nurses expressed an interest in the study; however, interview times were exhausted. I obtained contact information, and I would have performed additional interviews saturation was not reached.

All of the participants were female. The age of the nurses ranged from 35 to 73 years, and they had been practicing nursing for 9 to 55 years. Eight of the nurses had Associate Degrees as their basic level of nursing education, and six of them indicated graduate degrees in nursing. All but one of the nurses had advanced certification in rehabilitation nursing. Thirteen of the nurses were Caucasian, and one identified herself as a Black Haitian. Thirteen identified the primary age of their clients as adults, and one cared mainly for pediatric clientele. All identified a religious affiliation. The descriptions of their affiliations included Catholic, Christian, Seventh Day Adventist, Methodist, Assembly of God, Baptist and Non-Denominational. Because of the confidential nature of the study, I have replaced all the nurse's actual names with pseudonyms.

I conducted all the interviews, which lasted an average of 1 hour. All interviews were conducted in the same quiet environment to assure continuity and to allow ease in transcription. The interviewer transcribed all interviews verbatim. After the twelfth interview, I found no new codes in the data; however, I coded the two additional interviews to in order to ascertain if the absence of new codes was an anomaly. Finding no new codes, I concluded I obtained saturation.

The participants provided an address to send them summaries of the coded interviews for validation purposes. I performed this validation by E-mail and regular mail, depending on the preferred method of communication the nurse indicated by the nurse. All nurses interviewed

provided this information, even though I told them I would not exclude from the research study if they choose not to provide contact information.

3.4 Instruments and Data Collection Procedures

Upon arriving at the interview location, I informed participants that:

- The interview would be tape-recorded
- The interview would take approximately one hour
- Their participation would be confidential, that is, no names or identifying information would be used in any report

The complete consent form is included in Appendix 1. After signing the consent forms, recording of the interview began. The recording began with a statement indicating the I had explained the consent, and the nurse indicated she had no further questions regarding the form.

The data collection methods included in-depth, semi-structured interviews and a researcher's log. I conducted all interviews utilizing an interview guide consisting of open-ended questions. When I needed more information related to a particular point of discussion, I used follow up questions requesting clarification or more information. The interview guide is included in Table 2.

In addition to tape recording, I created a researcher's log during the interview to improve the accuracy of the transcription of the interview data. These notes taken during the interview assured credibility of this qualitative research by capturing the non-verbal communication. During data collection, both verbal and non-verbal data were important. During the transcription process, I included as much of the non-verbal information along with the verbal data as possible. The non-verbal information helped to identify some aspects of the responses that were not

evident in the verbal responses. Within 1 month of the interviews, I transcribed the audio tapes.

Accurate transcription of the interview enhances validity and leads to reliable information.

Table 2: Research Question and Interview Questions

Demographic information	Question
<ul style="list-style-type: none"> •Length of time in the nursing profession •Initial nursing education •Highest level of nursing education •Verification of current rehabilitation employment •Age •Race, ethnicity, religion •Method of contacting after the interview to review a summary of the themes identified in the interview 	<ul style="list-style-type: none"> •How long have you been a nurse? •What is your basic level of nursing education? •What is your highest level of nursing education? •Do you currently consider yourself employed in a rehabilitation facility? •How old are you? •How do you describe yourself in terms of race and ethnicity? •What is your religious preference. •How would you like to be contacted, (mail, E-mail, or phone,) to review the summary sheets, and would you provide this contact information?
Research question	Questions and prompts
•How do rehabilitation nurses define spiritual care?	<ul style="list-style-type: none"> •What is spiritual care? •Tell me what you think “spiritual” means. •Describe spiritual care and how is it the same or different from religious care?
•How do rehabilitation nurses describe their experiences providing spiritual care?	<ul style="list-style-type: none"> •Tell me about a time you cared for the spiritual needs of a patient. •Tell me why you think you met the spiritual needs of the patient. •Tell me about another time, if possible. • How did you learn to care for patients spiritually?
•How do rehabilitation nurses describe their level of comfort providing spiritual care?	<ul style="list-style-type: none"> •Tell me about your level of comfort providing spiritual care. •Tell me how you developed this comfort level. •Tell me about the education and or learning experiences you have had regarding meeting the spiritual needs of patients.
Closure	Questions
	<ul style="list-style-type: none"> •Is there anything else you would like to tell me about providing spiritual care? •Could you suggest other nurses you think it would be good to talk to regarding this topic?

3.5 Approval to Conduct Research

The study did not change significantly since IRB approved the pilot study, which I conducted in the spring of 2003. I submitted an addendum citing applicable changes to the Institutional Review Board (IRB). Three changes were necessary to the study after I conducted the pilot study. I communicated all three changes to the IRB by means of the “Researcher Request Form.” The first change from the original pilot study was the use of incentives for nurses participating in the study. Because of the anticipated hour-long interview sessions, I offered a \$20 gift certificate from a national bookstore to all nurses participating in the study.

The second change concerned the follow up contact made with the nurse after the interview for validation of the themes. I asked the nurses to provide a contact address. I informed the nurses that if they did not want me to contact them after the interview, I would not exclude them from the research study. However, all agreed to be contacted.

The third change was the number of potential interviews. Originally, I thought I would need 10 to 12 interviews to reach saturation. However, it was necessary to increase this number to achieve saturation of the data. Eventually, I conducted fourteen interviews to reach saturation.

3.6 Data Analysis

The coding and analysis followed the Heideggerian tradition and considered the constructs of background, pre-understanding, co-construction, and *Dasein* to code the nurses’ statements regarding the phenomenon of providing spiritual care to patients. By using these constructs to guide the initial coding, the codes were, in effect, products of the statements made by the nurses through the lenses of background, pre-understanding, co-construction, and *Dasein*. The pilot study conducted in the spring of 2003 identified some of the beginning codes. These

codes were identified using the Heideggerian constructs and provided the foundations for the current interview coding.

The first construct, background, refers to the traditions handed down from person to person. When analyzing the nurses’ stories of spiritual nursing care, I examined the tradition of care, that is, how the nurses were taught to care spiritually. The study revealed codes related to formal education, informal education, and intuitive knowledge when describing how the nurses actually learned to nurse spiritually. A full list of all codes and sub-codes related to the construct of background is in Table 3

Table 3: Codes and Sub-codes Describing Background

Code	Sub-code	Meaning
Formal Education	Philosophy of nursing school	The underlying foundation of the nursing school; typically a mind-body-spirit approach or a holistic approach.
	Educational courses outside of nursing school	Any courses taken outside of nursing school. These might include courses taken as continuing education, career advancement or unrelated to nursing
Informal Education	Relationships with patients, families, or peers	The knowledge obtained during interactions with patients, families or peers.
	Personal experiences of nurses	Knowledge obtained during the normal course of life, not associated with the nursing profession
Intuitive Knowledge		The nurse states something like. “I just always knew it.”

The second construct, pre-understanding, refers to the meanings the nurse has about the subject prior to the interview. This was addressed when the nurses were asked to describe spiritual nursing and describe how spiritual is different from religious. While the nurse’s definition of “spiritual nursing” was unique to each nurse, the particular definition the nurse identified was used for the duration of the interview and analysis. This aspect of pre-understanding revealed codes related to the meaning of spirituality, religion, and nursing. Table 4

reveals all codes, sub-codes and meanings found in the interviews relating to the construct of pre-understanding.

Table 4: Codes and Sub-codes Describing Pre-understanding

Code	Sub-code	Meanings
Spirituality	Relationships	Spirituality is about relationships with others and/or a God
	Difficult to define and understand	Nurse cannot define spirituality
	Thoughts, feelings and actions	Spirituality about the thoughts and feelings one has.
	Part of life	Intrinsic to the nature of the nurse/person
	Broader than religion	Spirituality is a broader concept than religion
	Society is becoming more spiritual	Nurse mentioned society is becoming more spiritual
Religion	Formal ceremonies, place of worship, or dealing with congregation, set of beliefs, the people in a particular church	Religion in terms of the formal rituals
	Religious upbringing	Religion in terms of how the nurse was raised
	Spiritual part	Religion has a spiritual component
	Connection/relationship with God or others	Religion in terms of relationship
	Difficult to define	Nurse cannot define religion
Overlap	Spirituality and religion Overlap in construct	Religion and spirituality have some aspects of overlap
	Spirituality and religion are distinct and Separate	Religion and spirituality are distinct
Nursing	Caring nature of nursing practice	The very nature of nursing includes caring for patients spiritually.
	Making a connection	Nursing involves making a connection on a deeper level
	Challenging	Nursing is difficult and challenging
Difficult to define		The construct of religion and spirituality are just difficult to put words to

The third construct, co-construction, is the aspect of analysis that considers the culture in which the nurses practice nursing. Essences, or common threads, related to co-construction related to the nature of rehabilitation nursing were discovered as analysis occurred. The culture

and environment of rehabilitation nursing seemed to enable spiritual nursing. The nurses also mentioned times they provided spiritual care for others that were not rehabilitation patients. The nurses gave examples of times they cared spiritually for family members and friends. The nurses also spoke about times they cared for their peers, other nurses and staff members on the rehabilitation unit. These examples were coded under the construct of co-construction because the examples explained different cultures in which the nurses provided spiritual care. Table 5 contains all codes, sub-codes, and meanings found in the interviews pertaining to co-construction.

Dasein refers to the situation of “being there” which emphasizes the “situatedness” of human reality (Reed, 1994). This human existence, or *Dasein*, described by Heidegger, suggests that people are primarily “in and of the world, rather than subjects in a world of objects” (Reed, 1994, p. 337). In the analysis of the data, *Dasein* became evident as the nurses described the situations in which they provided spiritual care. The nurses’ real life examples of the times they provided spiritual care were the main aspect of the interviews and the analysis reflected the situation of providing spiritual care.

The definitions of codes and sub-codes began from the pilot study, and as the analysis of the current interviews continued, new codes were added. After saturation was reached, all interviews were recoded to verify if codes identified in later interviews were actually present in prior interviews.

Table 5: Codes and Sub-codes Describing Co-construction

Code	Sub-code	Meaning
Nature of rehabilitation nursing	Length of time spent with patient	Rehabilitation nursing affords the nurse an extended amount of time with the patient in terms of length of hospital stay
	Aware of patient beliefs, open to patient	The nurse must be aware of patient beliefs and be open to the patient
	Comfort level with patient or family	Rehabilitation nursing allows a sense of comfort to develop with the patient and family
	Holistic nature of rehabilitation nursing	Rehabilitation nursing naturally considers the holistic nature of the individual
	Functional nature of rehabilitation nursing	Rehabilitation nursing goal is to promote the highest level of function
	Relationships/Connections	A relationship must develop
	Used by God	Nurse states she feels she was used by a higher power
	Different from other nursing	Rehab nursing is unique, stressful, caring
With others	Comfort level	A sense of comfort allows the nurse to meet spiritual needs
	Making a connection	When the nurse makes the connection, spiritual care is easier to provide
Care spiritually	What is spiritual care	Caring spiritually is viewed in terms of both the patient and the nurse
	Improve Health	Spiritual care improves health
	Feelings	The nurse feels differently when caring spiritually
	Provide spiritual care for staff	Nurses care spiritually for peers as well
	Spiritual needs may be obvious	Patients and families having spiritual needs may be obviously in need
	Can lead to religious care	Caring spiritually may lead to caring religiously
	Don't push religion or your personal feelings	Caring spiritually is not pushing religion or your personal feelings
	Most important part of nursing, new dimension of care	Caring spiritually may supersede all other care
	Nurses who care spiritually are not respected	Nurses are treated poorly by peers when they care spiritually for patients
	Makes difficult patients and situations less difficult	Spiritual care helps make difficult patients and difficult situations easier.
	Limitations of caring spiritually	Limited number of nurses practice spiritual nursing and there is limited understanding, limited comfort, limited education
	Not end of life care	Spiritual care, while it may include end of life

		care, is much more than this.
	Takes time	Spiritual care requires time.
	Easier to care for spiritual patients	Spiritual patients are easier to care for, they are not as needy
	Spiritual nurses nurse more spiritually	Nurses who have a strong sense of personal spirituality, nurse spiritually more often
	Needy patients and families can be spiritual	Patients who have many needs, may have spiritual needs as well.
	Get more than you give	Spiritual care is often reciprocal. The nurse often gets more than she gives
	Non spiritual patients are more needy than spiritual patients	There are patients who are non spiritual in nature, may actually be more needy than spiritual patients
	Can change patient or family attitudes	Providing spiritual care can change patient and family attitudes.
	Respect patients	To care spiritually for patients, the nurse must respect the patient

Coding, considering lenses of background, pre-understanding, co-construction and *Dasein* began as soon as possible following the transcription of the interviews. This involved careful examination of the examples provided by those nurses interviewed. This process began with the first interview. Codes found in the pilot study were the beginning codes, and as new codes in the interviews emerged, they were added to the list of codes. The codes reflected answers to the research questions considering the Heideggerian constructs of background, pre-understanding, co-construction and *dasein*. Once the first interview was coded, an updated listing of all codes, sub-codes, and associated meanings was made. This table became the codebook and was then used to code subsequent interviews. Similar essences found any interview were coded the same. Any new essences found in subsequent interviews were added to the codebook. Previously coded interviews were recoded to look for any of the new codes. This process of forward and backward coding continued until no new coded were identified, thus saturation was reached. This method of data analysis known as the constant comparative method of data analysis developed by Glaser and Strauss, is a common form of phenomenological data analysis

(Speziale & Carpenter, 2003). No new codes were found in interview twelve; however, two additional interviews were coded to assure the absence of new codes was not an anomaly. The two final interviews elicited no new codes, and thus saturation was determined.

Once the researcher coded all interviews, careful reflection of the codes allowed similar codes to be clustered. A theme describing these clustered codes was formulated. The researcher wrote a description of the theme considering all the codes that comprised the theme. When possible, the actual theme was drawn from words used by one of the nurses when describing the experience.

I used a variety of strategies to increase the trustworthiness of the results. I sent a letter indicating the summarized codes found in the interviews to the nurses to verify the findings were supported by their experiences. These member checks are a common way to assess for credibility (Speziale et al., 2003). This procedure assures the results were actually part of the nurse's experiences. I requested the nurses to voice any concerns within two weeks of receipt of the themes. The letter sent to the nurses instructed the nurse to contact the researcher if the codes identified did not reflect her experiences. Furthermore, the letter indicated if the researcher received no response, this would be an indication of agreement. Even though no response was required, I received responses from two nurses voicing agreement with the codes found in the data. Both responses indicated the codes identified were indeed present in their experiences as rehabilitation nurses. Because the letter indicated that "no response" would indicate agreement, I inferred that the remainder of the nurses also agreed with the summarized codes. The letter sent to the nurses is included in Appendix B.

Another strategy to increase trustworthiness, described by Miles and Huberman (1994), involves the researcher becoming very familiar with the data. I conducted all interviews myself

and performed all the transcription myself, and thus became very familiar with the life experiences the nurses shared. I also coded all the interviews and therefore the meanings of the codes and sub-codes were not subject to various interpretations. This prolonged engagement with the data is one method of ensuring validity. By utilizing the constant comparative method of data analysis, I was able to note patterns in the experiences of the nurses. Finally, clustering like codes and describing the true meanings that gave common understanding, essences, allowed discovery of themes across all experiences. I compared the essences identified in the interviews to determine if similarities were present and then a description of the essences was written to describe the phenomenon.

CHAPTER 4

RESULTS

The purpose of this study was to examine the lived experiences of rehabilitation nurses when providing spiritual care. The nurses had to define spiritual care in order to describe experiences providing spiritual care, and therefore a definition of spiritual care emerged. The nurses described times they provided spiritual care. The nurses also identified how comfortable they were providing spiritual care, and if they were comfortable, how they developed this comfort. In describing spiritual care and instances in which they cared spiritually for patients, the nurses provided a glimpse into the essence of spiritual care. The term “essence” is used in a way similar to Walter’s (1995) use of the word: a fact or entity that remains unchanged over time. This chapter is divided into three sections; each section identifies themes found in the interviews, which help to answer one of the research questions of this study. The first section describes how the theme of “listening to the soft voice” depicts the nurses’ description of spiritual care. The second section identifies three themes, “little things,” “bonuses,” and “being used,” that describe nurses’ experiences when providing spiritual care. The first theme, “little things” points out how everyday activities are spiritual in nature. The second theme, “bonuses” describes how the nurses perceive they receive more than they give when providing spiritual care. The final theme for this section, “being used,” presents the idea that the nurses felt a Higher Power often used them when they provided spiritual care. The third section includes three themes, “Just Do It,” “rehabilitation helps,” and “personal spirituality” that describe how the nurses developed a sense of comfort providing spiritual care. The theme of “Just Do It” relates to the idea that the nurses felt more

comfortable providing spiritual care the more they provided spiritual care. The second theme, “rehabilitation helps,” identifies the concept that the nature of rehabilitation nursing actually enhances the comfort level of the nurses providing spiritual care. The final theme of “personal spirituality,” depicts the idea that nurses with a stronger sense of personal spirituality are more comfortable when providing spiritual care.

4.1 Participants Definition of Spiritual Care: Listening to the Soft Voice

The nurses gave a variety of definitions describing spiritual care. Two of Heidegger’s constructs, background and pre-understanding, were used to clarify the nurses’ definition of spiritual care. Background highlighted the nurses’ upbringing and schooling to assist in defining spiritual care. The nurses identified personal life experiences as the most important way they learned to care spiritually for patients. Most of the time, the nurses said it was not any big formal classroom experience that taught them how to care spiritually for patients. More often, they talked about listening to the “soft voice,” learning from the actions performed and the situations in which they found themselves. This “soft voice” was interpreted to be a type of reflective learning for the nurses. The nurses often heard the “soft voice” when reflecting on an experience in which they were somewhat surprised to experience learning. When listening to the “soft voice,” the nurses defined spiritual care as being supportive. Spiritual caring also included building a relationship with the patient and their family.

Background, or how their upbringing influenced their definition of spiritual care, was one of the elements the nurses described regarding spiritual care. I asked Ann how her upbringing influenced her ability to care for patients spiritually, she said:

It started from when I was really young, before I was a nurse. My grandmother was always caring for other people, so was my mother, always caring for other people. It did

not matter what it was about, or what it was for, especially when they were sick or dying. That was when they really came into action. Took over how and what to do, and how to care for people, what it meant to care for them. Providing, food, or driving them somewhere, or taking them you know, or just doing whatever needed to be done, to care for them at that time in that hard time in their life. And like I said at a young age I was starting to take care of my dad. Because I started taking his blood pressure when I was 8. I was the only one in the family that could actually hear his blood pressure the best. I don't know why that was, but anyway, I started taking blood pressure when I was 8 and we would record it and everything. And then, when I was 10 he was diagnosed with lymphoma. He lived with that for 22, 23 years. So there was so many incidences there.

Another nurse discussed how her spiritual upbringing shaped her perception of spiritual care. Cindy noted even in her personal life, she turns to her strong sense of spirituality to overcome trials. She talked about how trust and prayer are part of spiritual care.

I was born and raised in a Christian family, ...we believe that there's a higher power that's in charge of the healing process. So I was born like that, so I think that belief has really helped me through a lot of problems and tribulations, and even with myself, if I don't feel good, if I'm feeling sick, I always feel that prayers really help me through all sorrow, and problems, and diseases, and so forth and so on.

Emma, noted how she has a strong sense of spirituality it is because of her upbringing. She experienced a strong sense of spirituality as a child, and now as an adult, she feels her spirituality has grown. Emma identified a protective nature of spiritual care.

I would have my sense of spirituality whether I was a nurse or not. I remember growing up, my brother, was born 2 years before I was. (He) lived about 24 hours and died, hyaline membrane disease back in those days. And, about 2 years (later), almost to the day, I was born, two years and about two weeks. And, I had a book , The Littlest Angel, about this little baby that had gone to heaven, had the wings, my mom had bought it. I was raised as an only child, cause she was too old to have more children in those days. And so I always felt that my baby brother was my little guardian angel, in heaven watching over me. And that's a child's sense of spirituality, and it's grown with being a mother, with having children. It's grown with experience. It's grown as a result of my going to a church that believed very strongly in spiritual things.

Helen had a remarkable story about how she learned about spiritual care while caring for her dying mother.

But then she (Emma's mother,) got cancer. And she was terminal, and, I was waiting for her to be depressed. And I told her, "Now mom, I really don't want to talk about you

dying,” I didn’t really want to, but I didn’t want her to feel alone. And (knowing) that she didn’t have anybody to talk to. And so, I just told her, “Now I want you to know that you can talk to me about dying, how it must feel, what you’re thinking, if you’re lonely, don’t think, just because you don’t think dad can handle it, I want you to talk to me.” And she says, “You know what (name omitted)? I’m not depressed at all.” And she says, “You know, you’d think I would be, wouldn’t you?” And she says, “ I’m not, I just feel this is what God wants me to do.” And it was the strangest thing, because she inspired my whole family. Seven kids is a lot of kids, and everybody has their own agenda, and everybody tries to help in their own way, and everybody grieves in their own way. And it was very interesting because our mom taught us, so much by just letting us know just let’s do this, and God has a plan, and there is a reason. And I thought, “Boy if, if she only knew how much she taught all of us, after she passed.”

Helen actually identified the idea of “listening for the soft voice” when learning to care spiritually for patients. Later in the interview, she continued to discuss how she learned through the experience of caring for her mother during her death.

And when my mom died, you would think that would be such a horrible time, and you know what? That was like, I think the most spiritual I ever felt. That’s when it really started. Where I could really feel that, that close to God. And I learned so much from that death. And I truly feel that we just have to look for the lessons He’s trying to teach us. And we have to listen because it might be a very, very soft voice. It might be somebody we meet. It might be just sitting on a park bench and watching leaves, or whatever but there’s something there and sometimes we just have the time to, listen. And when I’m the quietest that’s when I feel the most spiritual.

The nurses were also able to identify some formal learning experiences related to spiritual care, in both nursing school and other learning environments. While some of the nurses had been out of nursing school for some time, they could still remember discussions about the topic of spiritual care. The nurses remembered a discussion related to holistic care, and another nurse remembered discussion of the mind, body, spirit connection. Interestingly, some of the nurses remembered they were told not to discuss spirituality. Barb noted, “First of all I want to tell you that when I was in nursing school, in 1949, we were told not to discuss spirituality, church and all that stuff.” Another nurse noted that even though she attended a religious based

school, she did not remember any specific course addressing spiritual care. A number of nurses said they did not have any discussion of spiritual care in their nursing program.

Some of the nurses mentioned formal learning experiences involving continuing education classes or classes associated with their church. Barb talked about a class she attended a long time ago. This particular class allowed her to view spiritual care as caring for the families of patients, as well as the patients themselves. Barb said, “Oh, there was a class, and I think I went to that one, that was so long ago. It was on death and caring for patients that were terminal or dying.

The second Heideggerian construct that helps understand the definition of spiritual care is pre-understanding. Pre-understanding refers to the underlying notions humans have regarding an event or idea. These pre-understandings are already present in the nurses’ idea of the topic under discussion and they bring them into focus when understanding of the event occurs. The nurses interviewed already had an idea of what spiritual care meant to them.

The first element of the definition of spiritual care that emerged from the interviews was support. Ann described spiritual care as being supportive to her patients. She described how support her patients is an aspect of spiritual care.

Let them understand that whatever they’re doing is right for them at that time, for that family member. Trying to be supportive to them. And, know that, going through it myself, I can understand how that works.

Deb told a story about caring for a patient who had a stroke and his family. The patient was not responsive, and the family had spent many long days sitting at the bedside of the patient in another hospital prior to their arrival on her rehabilitation unit. The family was tired, frustrated, and confused. She told the story of one of their first encounters:

So they had the nurses had already given them his education book, and I went through the book with them, and showed them different things they might be interested in reading.

And, then I explained again, about that I understood how they were feeling, about the role changes. I guess he had always been the strong one. And, his wife didn't even drive, he drove her everywhere. So, she was just you know, everything was turned around, and backwards. And um, I spent every day with them, went to the room and spent every day with them.

Some of the nurses talked about understanding supporting the preferences of patients even if the nurse did not agree with these preferences. Jan talked about a patient who needed to pray in his room a number of times a day, facing a certain direction, and how she respected this practice:

I can remember having patients, who, three times a day you didn't go in their room, because they had to be praying facing, I can't remember whatever direction, but you know, whatever direction it was they had to pray. And I'm thinking, God doesn't care where you pray, but they obviously did, and you had to respect that.

Jan also spoke about an experience she had to support a patient's wishes by caring spiritually. This particular patient had a custom of lighting candles and having prayer time every night prior to going to bed. Not only did she have to understand and respect this custom, she had to go through a complicated hospital system in order to get permission to have candles lit in a patient room, which is usually a safety hazard. The following is Jan's story:

I had a patient once who wanted candles in their room. And in a hospital that's very difficult to do, but they said, every night it was their practice before they went to bed, they'd light a candle, they had quiet music playing and they just sat for a half an hour. And the woman wasn't sleeping in the hospital. But that's what she did for I don't know, 10-15 years, that was her practice. Well, that's a spiritual occurrence in my mind, and so, we got an approval.

Mimi shared a story about not only nursing patients and families spiritually, but intervening when the current practices of the institution don't support the decisions of the patient and families. She understood and respected their beliefs, and was willing to switch jobs in order to stand up for the right to help the patient and family carry out their wishes. This situation points

to a particularly difficult issue: that providing spiritual care could potentially place the nurse's actions in conflict with ethical care or the institutional practices.

And she didn't want to eat. She wanted to die. She was ready to go. Her family were OK with all of that, and I remember having the biggest row with my head nurse because she kept saying "you have to feed her." And I said, "I'm not going to feed her. You have got to realize that she is at a place in her life where she's making a decision about what she wants to do, and you're not gonna make me do you want to do. She's got to have her right to finish her life the way she really, really wants to." Well that was not the kind of thing you tell your head nurse when you were a new grad. I got actually asked to leave the floor and go to another floor and I thought, all right, to hell with you, pardon me. But instead, and I did stay on that floor, and it got resolved and she realized eventually that that was, but I think it's being respectful, it's being respectful.

The second element of the definition of spiritual care that emerged from the interviews was making a connection and building a relationship. All of the nurses thought spiritual care involved developing relationships with patient and families. Through these relationships, the nurses became aware of the thoughts and beliefs of the patients. Spiritual care meant the nurse respected these thoughts and beliefs. Ann said that spiritual care meant making the patient "know that there is a link between themselves and someone in the world at that moment." She continued by stating: "I think it's important to make sure that when you are providing spiritual care as a nurse, or any type of practitioner, that you are aware of what that patient's beliefs are ...the best thing to be is open."

Lynn talked about making the connection with a patient who had actually been an acquaintance of her father many years ago. She knew her father had helped a man and his family, but did not remember much about the relationship. She found herself caring for this person many years later. Talking about her experiences with this patient, she spoke about how this man recognized her, and during the conversation with him, she was able to make the connection and remember the circumstance from her childhood. Lynn recounts the experience:

And he looked up at me and he said, “Oh, I’ve seen those eyes before.” And I just looked at him, and I said, “What did you say?” And he said, “I’ve seen those eyes before.” And I said, “Where did you see these eyes at?” And he said, “The kindest man that I ever met, years ago. And he helped me and he helped my family at a time when no one else would.” And I knew right then who I was talking to.

Deb recounted an interaction between her and the family of the stroke patient mentioned earlier. She talked about how this family finally accepted the status of their loved one and attributed their acceptance of the fate of their loved one, to Lynn’s caring relationship:

(The wife said,) “But you did, you helped us work through it.” And she (the wife) said, “We’re going to, we’ve made the decision that if he improves enough we’re going to take him home. But we’ve accepted the fact that if he doesn’t we can put him in a nursing home.” So it was just helping them work through it and make the decisions and looking at it.

To summarize, the nurses interviewed were able to describe times when they “listened to the soft voice” to define spiritual care. This “soft voice” was a type of reflective experience for the nurses because these instances of learning about spiritual care were not formal learning experiences. The nurses used background information of formal and informal sources to form their definition of spiritual care. Additionally, the nurses used personal experiences to help formulate what spiritual care meant. Pre-understanding helped the nurses define spiritual care as supporting patients and making a connection. These connections included building a relationship with patients and families. As nurses, they realized that they needed to be open to whatever beliefs the patients and families practiced. The nurses described this as respect. By respecting patient and their families, every other aspect of caring became spiritual in nature for these nurses.

4.2 The Spiritual Caring Experiences: The Little Things, Bonuses, and Being Used

All fourteen nurses interviewed were able to describe times when they cared spiritually for patients. However, this was expected because only nurses who self identified as providing

spiritual care were recruited for the study. These nurses' stories contained examples of what spiritual care looked like when provided. Three major themes emerged, "little things," "bonuses," and "being used." First, spiritual care was the little things such as, communicating with patients, spending time with patients and families, or performing daily tasks such as giving baths or changing bandages. Spiritual care also included other little things such as calling spiritual leaders, pastors, or ministers. At times spiritual care included praying with and for the patients, their families, and peers. While most of these little things may be performed by other nurses and not seen as spiritual, the nurses interviewed thought they were spiritual because of the attitude they had while performing the task. These little things were done for the patients in order to attempt to meet all of their needs, including the spiritual needs. Second, the nurses described the experience of providing spiritual care as a situation in which they received more than they provided. It seemed as though it was a "bonus": something unexpected or unearned. While providing spiritual care for patients, the nurse actually gained more than she felt she gave to the patients. Third, some of the nurses felt like higher power intervened and used them while providing spiritual care.

Two of Heidegger's constructs were used to understand their experiences while caring for the spiritual needs of patients. Co-construction, considers the as part of the world in which they live and work. The world of rehabilitation nursing was an ideal environment for consideration of spiritual nursing because of the extended time rehabilitation nurses care for these patients. These nurses were able to realize some of the advantages of working the rehabilitation environment. The rehabilitation nurses interviewed were able to share their experiences caring spiritually for patients, families, and even their rehab peers. The stories the nurses used to describe their

spiritual care giving experience involved examples of “being there” and the “situation” in which the care occurred, both aspects of *Daesin*, Heidegger’s fourth construct.

Little Things

The nurses interviewed often spoke about the “little things” they did for patients to provide spiritual care. The nurses noted that while these activities may not be anything extraordinary, it was because the nurses performed the tasks with an attitude of meeting the patient’s spiritual needs that made the act spiritual. One of the “little things” the nurses mentioned when describing their spiritual care giving experiences were times they communicated with patients. It was when they listened to a patient or family needs, that they felt they were caring spiritually. The following story tells how Ann began a spiritual relationship with a patient whose daughter died in the same accident that brought her to the rehabilitation unit. The patient was going to miss her daughter’s funeral.

So I went in and she was kind of anxious and upset and the first thing I did was I touched her hand, because I felt like, I introduced myself and I touched her hand. And I said who I was, and I asked how she was doing. She said she was doing pretty well considering everything. I just asked her about her daughter, because I figured she probably wanted to talk about it with someone. There was no one else in the room with her and she started to cry and talk about that. And just holding her hand through that time and trying to be a person that could listen to her needs at that time, I think, was what she needed right then. And letting her know it was OK to be upset that she wasn’t going to be able to go, (to the funeral), and letting her know that her daughter was always with her. You could tell she was a religious person, and so I tried to encourage that part of herself to come through it and being strong, and knowing that her daughter would want her to (do) the best thing for herself, at that time. So, I think that I ended with something to the effect “I hope that your pain will be eased in time, and may God be with you.”

Ann told of another time when she actually cared spiritually for the daughter of a patient who had cancer that had metastasized to the bone (bone mets), by spending time listening to her.

And, I had a patient who had bone mets, my father also had bone mets. It was more of a situation with the daughter than with the patient. She didn’t know what to do. In fact, it was to the point of crying, but (she) was trying to hold it together for her family member.

... And giving that family member the time. Just to listen to her and let her know that she was not the only person going through that experience.

Helen told a story about a difficult patient and family. She describes the act of listening to patients as an art. She noted that in this case, she actually ended up using her spiritual communication skills with the other staff that cared for this patient as well.

Cause when you really listen, I think that's when you really feel more freedom with yourself too. I think that's an art, that I have to practice. I think that is an art, and I think you have to practice it. And I think you feel more peaceful inside too. Because you really learn a lot, and you can remember, so much easier if you're really truly listening to those people. I just had another family that was there forever, like 5 weeks, that's a long time on my unit for a patient to be there. And his family was very needy. He had a terrible stroke. I don't always just think the patient is the one you have to listen to, and the one you have to pay attention to. These families, they're grieving. Cause they truly lost the person that person was. And a stroke is changing their relationship, and it's changing the roles in the family. These children were like, "come on dad," they are the cheerleader for the dad now. They had a lot of faith in God, and that mom led that family. And we would talk, and she would say, "I just don't know what people do if they don't believe in God." And excuse me, but you couldn't help but listening to that family. Because they were so needy they just needed to talk and they wanted everything their own way, and it was a lot of give and take with them. And, that was difficult because the family was trying to tell the therapists what to do, so there was a lot of constant communication even with the team, because the therapists were getting their feelings hurt. (The therapists said,) "They don't think I'm a good enough OT (occupational therapist). They're trying to tell me how to be a speech pathologist." We (the rehabilitation team), have to all talk and get back to what we're suppose to be doing is for the patient.

Another "little thing" the nurses spoke about when providing spiritual care was just spending time with patients and families. Deb told a story about a man who had been a difficult patient on the rehabilitation floor in her facility. She noted that after spending time with this patient meeting his spiritual needs, he actually became an easier patient for all the staff.

I went in and talked with him. I didn't spend long periods of time with him. I always spent short periods. I would go in and ask him how he was doing, and of course he had a long list of complaints all the time. Because he was mad at everybody, and, so I made an agreement with him, I said, "If you will just cooperate, let them do your bowel programs, let them explain to you again why we're doing it." (He said,) "I'm not going to need it. I'm going to walk out of here." I said, "I know that, but we need to do it because right at the moment you don't walk, we're going to go ahead and do it." And I asked him how he knew he was going to walk out? And he said, "Because I just know God's going to heal

me. I'm going to walk out." And I said, "Well, I believed in healing, and I believed that anything was possible," and I encouraged him to keep his faith. But, I told him to go with the program, until his healing happened. And he so, he made the agreement, with me, and every day when I checked in with him, he got less and less angry, less and less demanding.

Another nurse spoke about nursing spiritually on the evening shift at her hospital. She felt the evening hours allowed patients to express more communication needs and she thought she had more time to spend with patients. Her spiritual caring example involved discussing a stroke patient's perception of his stroke as a punishment from God.

I think it's during the night shift, the time is slower, your pace is not rushed with the patients, and sometimes that's when they I think have more time with you. They feel they can express their feelings. I think the first case that I can remember is the gentleman who had a stroke and up until his stroke he had been the primary care giver for his wife who had multiple sclerosis. And, he said to me, "I think God must be punishing me for something I've done." I said, "I don't think God punishes us. I don't think He's punishing you. In God's eyes, (you) are probably very, very special, to Him: because of how you have taken care of your wife."

Fran had another example of spending time with a patient. This example of the dialogue that goes on during the night hours talks about the "little thing" of spending time to allow patients to discuss their fears. In this situation, a patient dying of AIDS discusses some very poignant ideas with her.

He was diagnosed with AIDS. He spent a lot of time awake at night and he made many, many requests. (He) like to eat, liked to drink, and one particular night after I had first started caring for him, when I went to kind of make my break from him, he started crying. And, I of course asked him "Why are you crying?" And "Do you want to talk to me about it?" And, he was fearful of dying, and so I sat down on the bed with him, and I probably was there with him for at least for a half an hour. And I asked him what his beliefs were, and if he believed in Jesus, and (did he believe) that Jesus died for us and for our sins, and, and that he has an eternal home waiting for him? And he said yes he did.

Lynn told a told a story that described her experience with the "little thing" of communication skills. Her spiritual conversation was with a man who was burned in an electrocution accident, and in the accident, his best friend was killed. He considered this man his

brother even though not related by blood. Her spiritual communication actually began the man's road to recovery because after this talk, he began to participate more in the rehabilitation process and in the end, had a positive outcome.

I would go in there everyday. I would try get him to talking about something. One day I noticed there was a picture at his bedside of a man, and I said, "Oh, who's this, your brother?" And he said, "Yes, my brother, he's the one who died. This is my best friend." He started talking about his friend. I always look for a purpose for something. I always try to help someone see a purpose. We started talking, he started talking about what was his life worth now that he had lost an arm, that he was burned over so much of his body, had muscle loss, had suffered all this damage. He couldn't really walk very well. What good was he going to be? What was he worth to the world? Why did someone like his friend, who was such a good guy have to have died? And I said, "Have you ever stopped to think that maybe his whole purpose in this world was to be your best friend for 25 years? To bring you to a point in your life where he had to move on to a different plane, but you have stayed here? And he is helping you learn a really valuable lesson that maybe you can pass on to other people?" And he said, "What in the world kind of lesson is this?" And I said, "That someone like you who has gone through such a traumatic experience, I don't sense that you've lost your faith in God. I sense that your faith in God has been strengthened." He said, "You're right." I said, "I sense that you feel that maybe the reason you lived is because there is a greater purpose out there for you. Maybe this was the sacrifice of your friend's life. Maybe this was the whole reason that he came into the world, was to give you this increased spiritual awareness, through your powerful brotherly relationship, and that even though he's gone, you're gonna learn from this."

Many nurses felt they cared spiritually for patients when they performed ordinary everyday care such as bathing, giving a backrub, or changing bandages: more "little things." While most nurses perform these activities on a daily basis, these particular nurses thought these acts could be spiritual in nature. Deb stated, "I think it is very important that it's part of your everyday activities." When I asked her to describe her everyday activities, she responded, "Going around and talking, making rounds, speaking to patients, asking what they are doing, if there are any needs, ask if there's anything that I can do for them." Nan was more explicit. She noted:

But you can give a bath and be spiritual. I remember one time, it was father's day, and I had just had my first pedicure, and I thought, this feels great, I never had anybody massage my feet, and I thought, I'm gonna give all my father's on father's day, a foot

massage. Well you know what? They loved it. And I just was so tickled that they loved it that it tickled me. So, now that was spiritual. And, even just that little thing, now that was spiritual, because I wanted them to feel as good as I did.

Lynn, the nurse who was caring for the burn patient mentioned earlier, talked about how changing the bandages on his burns were an example of spiritual care. It was during these activities that she also served as an advocate for the patient by suggesting a change in his medication regimens to the physician. She was describing her idea of doing the everyday things: the “little things.”

Everyday I would change dressings on him. We had to do it twice a day. He had these terrible burns on his back. He got a yeast infection in them, and he was starting to lose the grafts. They were breaking down, I mean he was losing them. They called in a wound care doctor. And the doctor said, “You know, we don’t know what to do for him. He is losing these grafts.” And, I just said to the doctor one evening, “You know what? What if he’s allergic to the yeast? What if his body is having an allergic reaction to the yeast?” Because not only were all his grafts breaking down, but he had a head to toe rash that Benadryl (a medicine used to treat rashes), wasn’t touching, Atarax (an anti-itch medicine) wasn’t touching the itching. Nothing was fixing this. And I said, “What about trying some Diflucan (a medicine used to treat yeast infections)?” And he said, “Um, can’t hurt.” So, he gave him a dose of 400 mg of Diflucan. 24 hours later the rash started to disappear, the itching started going away.

I think the most eloquent description of the “little things” is also the most simplistic. Ann described her spiritual care giving experiences as:

It’s just the little things that seem to help people at the moment. I won’t say that I do any miracles. I think that it’s the little things on a daily basis. With a patient in a situation where they’re somewhat helpless.

Many of the nurses describe a relatively simple task of calling the spiritual leader for the patient and family as a spiritual care giving experience. Many of the nurses described this “little thing.” Some of these descriptions include Barb’s comment: “And she also asked that I call the bishop that she loved very much from this Methodist Church. And so I did.” Fran said, “Well, in situations like that you should refer the patient to your chaplain.” Gail spoke about making the connection between a patient requesting spiritual guidance and the hospital chaplain. She said,

“We have a priest, the chaplain, who comes and makes rounds and I make sure that they connect.” Jan mentions she often asks, “Have you seen a chaplain or has anybody called your local pastor for you?” Mini’s role as a case manager allows her to plan the meeting of all caregivers each week. In the rehabilitation setting, this is known as the team meeting. She actually asks the patient if they would like their spiritual leader to be present at these meetings.

I will often say, if that client has a spiritual connection, a group that they belong to, or if they have a priest or a rabbi, or someone like, “would you like that person to be at the team meeting?”

Nan spoke of a time when she was helping a patient prior to surgery. Acting as his advocate, she tells this story:

Before he went to into surgery, I asked him if he had a minister that he wanted me to call. I asked him if there were any relatives I could call. He did give me the minister’s name. He gave me the name of another church member. He had me make all these calls for him. I called the person at the church that he asked me to call, and let them know what was happening with him.

Additionally, most of the nurses identified times when they prayed for patients. At times, the patients asked the nurse to pray for them, and other times the nurse mentioned that she prayed for all the patients on the nursing unit. Ann, speaking about her interactions with the daughter of a dying patient, said: “And I think I ended it (the conversation) with, ‘I’ll pray for you.’ And I’ll say that if I feel comfortable enough to say it to the person. That I’ll be praying for them.” Fran spoke about prayer for patients in a more general sense. She said she prays for her patients and the staff at her facility.

I think I do it everyday I go into work, every shift that I work. I think before I even start my shift, I pray. I pray for all of the patients in our facility, and then I also pray for the nurses and the nursing staff working with these patients. (I pray) that they can do the job that they need to do.

Barb spoke about her experience with a patient this way: “I went to see her often, and she asked me to pray for her. And I did.” When I asked Barb if she was comfortable praying for

patients she answered, “When I first started doing it, I didn’t mind doing it, but I had not had a whole lot of experience doing a prayer, so, that was a growth experience for me.”

Cindy actually said she prayed for all of her patients every day. While the patients did not request these prayers, she mentioned that she rarely actually spoke to her patients about prayer. She said her prayers are usually “hoping that they feel better and they recover and go home as quick as possible.” She continued, “I think praying for someone is truly nursing spiritually.”

Gail had a couple of instances she spoke about prayer. She was talking about patients who are lonely and afraid. She said she often asks, “Would you like to pray? Sometimes they do, and sometimes they don’t. But most of the time they do. Nobody really refuses to say a prayer.”

Interestingly, Gail was one of the few who talked about group prayer. She spoke about the times when patients gather in the dining room waiting for meal trays. She said that she often asks, “Would anyone like to say grace before meals, or thanks before meals?” She said that if you have the right mix of patients, one of the patients usually begins a prayer.

Jan said that the first time a patient asked her to pray with her it was the hardest thing she ever did. The first time she prayed with a patient, was an emergent situation. She offered to pray with the patient as the patient was going to the operating room. Even though she was apprehensive about praying with a patient, the patient told her how she benefited from the experience. Jan realized it was the right thing to offer to all patients, even the difficult patients. Jan notes, they are often the ones who “need it the most.” Jan spoke about her experience this way:

I prayed with her, and after everything was all over, and I talked with her. She was like, “you know, I felt it was going to be OK then.” And I was like OK, so there was my response from a patient, it was a good thing to do. They can always say no, I guess, but it was very difficult. You know, and then after that it was like all they can do is say no. And if I do start addressing that, and make it an everyday thing, then I’m not going to forget anybody. And it gets easier the more you do it. But, it was not very easy at the beginning.

And every now and then, you get a patient where you just go, “I don’t even want to offer.” Usually they’re the ones who want it the most.

Praying with patients is not a big task. As Jan said, it may be hard at first, but if nurses offer prayer to all patients, it becomes easier. Prayer is a “little thing” nurses can offer their patients. It does not have to take a lot of time, in fact, as Cindy said, she prays for patients without them knowing it, on her way to work or on the ferry. Prayer can be with patients or for patients and yet this “little thing” is an act of spiritual care almost all the nurses interviewed mentioned.

Bonuses

A second aspect of spiritual care that did not come out in the literature, but the nurses interviewed mentioned, was the idea that the nurse often gets more than she gives when caring spiritually. Helen mentioned this aspect of “bonus” nursing a number of times. When speaking about providing spiritual care for a patient she said, “I’m trying to think if she didn’t give me the spiritual lift.” Later in the interview she said, “The more spirituality you give out, it comes right back to you. It’s freaky. But it comes to you so strong, you wonder, why don’t I do that everyday?” When ending the interview I asked Helen if there was anything about spiritual care that she would want other rehabilitation nurses to know, and she responded,

I think we always reap what we sow. And it just comes right back at you. Sometimes it’s so blatant in your face, so that’s fun. I truly feel that everything comes back to us that we give. And that’s the biggest thing. You’re going to get it if you give it.

Katy identified that maybe the give and take relationship is a reason why some people begin nursing careers. Katy said, “As nurses, that’s why we go into nursing for. We want to help others, but we don’t see that in turn by helping them, they’re helping us too. That’s a part of spirituality.”

Lynn, describing the experience taking care of the burned patient said, “Actually I was caring for his spiritual needs, and he ended up giving me a big boost.” Lynn explained the patient’s healing process and the scars left by the burn grafts. When the burns healed, the scar on his back appeared as angel wings, and the scar on the back of his head appeared as a halo. Lynn marveled at the scar the first time she recognized it. She saw her spiritual care for him this way, “I mean, it makes my hair stand up. And boy, it was a spiritual experience for him, but it was an awesome spiritual experience for me.”

Being Used

The third aspect of spiritual care the nurses discussed involved the feeling that a Higher Power was acting through them. Sometimes their actions seem guided, the words they used inspired, and the advice they gave seemed to come from another source. I did not find this description of “being used” by a Higher Power in the literature. Ora described a situation where she was taking care of a group of physically handicapped individuals on an outing. Prior to departure, she double checked all the wheelchairs and found some incorrectly locked in the van. She said that she usually does not double check, and she had no idea why she double-checked them on this occasion. She correctly fastened all the wheelchairs and began the trip. As fate would have it, they were in an accident and although they were jostled, no one got hurt. Ora said, “You know, I had to figure it’s got to be the grace of God that puts me in those places. That, that’s where I’m needed.”

Emma, talked about advice she gave to parents of pediatric rehabilitation patients. She noted:

I got bold, and I said some things that maybe I wouldn’t have said normally. The parents came back to me, because it was almost like I was talking outside of myself. And in both cases, the parents came back to me and they said, “Thank you so much for that, I think what you told me was from God.”

Emma continued to describe the phenomena this way: “I believe God uses me. I’m His servant and He uses me to serve others, through the nursing.” She also said, “You won’t believe how many times that I go to work, and I feel that I’ve had an assignment for a reason.” Fran also mentioned the aspect of “being used.” She said, “I mean I’m not saying that God is there saying, ‘You must do this.’ I think He guides me and opens the door when I need it.”

Katy had a more different concept of being inspired. She saw her calling into the nursing profession as directed by God. Nursing was a second career for her. She was a single mom with a good job. A customer spoke to her about her nursing career and Katy decided find out more about nursing school. She thought she could not afford school, and funding became available to her. She knew a Monday to Friday day shift job would be unobtainable, and one opened up just as she was ready. She knew nothing about rehabilitation nursing when the perfect job with the perfect hours on a rehabilitation unit fell into place. She said, “I felt like that was what I was meant to do.” She continues by noting, “I feel like I’m doing what God wanted me to do. What the Higher Power wanted me to do.”

Lynn used the word “vessel” to describe this feeling of “being used.” Lynn described an instance where a patient who happened to be a minister, was in a coma for a long period. The elderly father, who was also a minister, was very distressed. He was questioning his faith. She offered to pray with him at the bedside of his son. While praying she took the patient’s hand and said,

“Reverend so and so,” which was his (the patient’s) name, I said, “Your dad is here, and he wants to see you. You need to open your eyes and look at him.” At that moment, he opened his eyes and he looked at his dad. And he said, “Hi dad.” And his dad looked at him, and he looked at me, and it was, there wasn’t any big, dramatic, “Oh my God,” He was just like very calm and very serene. And he said at last, “Hello son, I wondered when you were going to wake up.” And I just think that I happened to be just a vessel that kind of passed from one person to another.

Nan described a similar experience as an instance where she was “used.” She was acquainted with a family whose loved one had died. As someone else was going to visit the family, she decided to send a tape of a spiritual song. As it turned out, when the family received the tape and played it, the song was the exact song they had been searching to use at the service. Describing the experience Nan said, “She (the family member) just knew that God had put it on my spirit to give that to her. So she could have that for the funeral. Oh it’s exciting when you’re used!”

In summary, the rehabilitation nurses interviewed had many stories of providing spiritual care. They described these experiences as very normal acts of care provided by the nurses with an intention of meeting the spiritual needs of the patients and families. . Many times the spiritual care was the “little thing.” It was often something as simple as talking and spending time with the patient and family or calling a spiritual leader. Sometimes the “little thing” of spiritual care was in the normal nursing activities that all nurses do every day. The nurses interviewed saw these experiences as spiritual in nature because the attitude they had when they provided the care made it spiritual. These everyday activities were giving baths or backrubs, passing medications, or teaching patients how to care for themselves. Some nurses discussed times when they prayed for patients, and other times when they prayed with patients. The nurses felt they often received more from the experience than the patient did. The nurses felt like they got a “bonus.” Even though she was caring for the patient, she gained something from the experience. She got a “bonus.” There were times the nurse felt as though her words and actions were inspired. The nurses felt as though they were “being used” by a Higher Power. None of the nurses interviewed had a difficult time providing instances of giving spiritual care.

4.3 Developing a Comfort Level: “Just Do It,” Rehabilitation Makes it Easier, Personal Spirituality

Three themes emerged. “Just do It,” “rehabilitation makes it easier,” and “personal spirituality” describe how the nurses developed a sense of comfort providing spiritual care. First, the nurses said they just had to “Do It.” The nurses agreed, the more often they provided spiritual care, the more comfortable they became. The nurses also agreed that the extended amount of time they experience with their patients on a rehabilitation unit assisted them in building a relationship with patients and families. When these relationships are present, the nurses reported a sense comfort providing spiritual care. Finally, these nurses thought they had an increased sense of comfort providing spiritual care when they had a stronger sense of their own spirituality. These stories included more aspects of “being in the situation,” which is Heidegger’s fourth construct, *Dasein*.

“Just Do It”

An advertisement logo says, “Just Do It.” It seems there is a similar phenomena associated with providing spiritual care. The nurses interviewed thought the more often they provided spiritual care, the more comfortable they became with this aspect of nursing. When I asked Jan how she became comfortable providing spiritual care, she answered, “repetition.” She went on to say, the first time someone asked her to pray with a patient was an emergency. She now offers to pray with patients on a regular basis and she notes, “It gets easier, the more you do it.” Fran spoke about providing spiritual care and said, “It’s a process that I’ve gradually grown into. I think it’s just grown over time.” Barb described her development of a comfort level providing spiritual care by saying that she became more comfortable by “just doing it.” Ann said her comfort level has actually developed “over years” of caring for patients. Finally, Helen

described providing spiritual care as an “art,” and noted, “I think you have to practice it.” The act of providing spiritual care for patients actually made “doing it” easier the next time.

Rehabilitation Makes it Easier

I asked the nurses if their chosen specialty lent itself to developing a comfort level when providing spiritual care more than other nursing specialties. The nurses thought there were aspects of rehabilitation nursing that made it easier to provide spiritual care. The nurses often noted the extended amount of time patients were on a rehabilitation nursing unit allowed a relationship to develop between the nurse and the patient. Once this relationship developed, spiritual issues were easier to discuss. Barb was talking about providing spiritual care to an amputee she cared for many years ago. She said, “I walked in one morning and we were talking. A friendship or a kinship developed because I had seen her so often.”

Emma, like the nursing theorist Jean Watson, mentioned earlier, thought spiritual nursing was an essence of caring. While speaking about rehabilitation nurses Emma said:

Those (the nurses) that cared got to know the family, the patient, and they could recognize subtle changes. Because they got to know them. The nurses that didn't have the caring, they could tell a patient was going bad when the monitors told them. That's how important it (caring) is. Because when you get that spiritually tuned in with a patient, you can pick up on subtle changes.

Mimi spoke about how rehabilitation nursing “made it easier” to become comfortable providing spiritual care. She spoke about developing a comfort level providing spiritual care this way:

(Rehabilitation nursing) puts us in a very special place though. I think we are very fortunate to do the work that we do. It is just amazing, to be able to be as close to people as we can. That's a gift, that's really wonderful. And maybe this is a way of being closer to them.

Deb, was telling a story about a patient who was on her nursing unit for over 2 years. Deb had worked with this patient on some very difficult issues including the patient's decision to

become a “DNR (do not resuscitate),” and then to remove her “DNR” status. DNR means that if the patient’s heart stopped, the staff would take no efforts to revive her. Deb talked about her relationship with this patient and the comfort she experienced providing spiritual care.

I just had to go in whenever I could make time. I would try to make time to go in and see her and everybody on every shift was very attached to her. (Everybody) worked with her the same way, just to give her the support, knowing that we cared. I feel that being born again is important, and I didn’t want to push my religion off on her, but I asked her if she’d had an experience (of being born again,) and she said, “Yes she had.” And so, I said, “well that’s fine.” She finally accepted whatever God wanted for her. She accepted it, and I just thank the Lord, I was not there when she died. But, she arrested and they could not bring her back.

Fran thought the “connection and the relationship that you form with your patients and families,” facilitates a sense of comfort providing spiritual care. Fran noted that rehabilitation was “different because you have more time.” She thought the more “casual” atmosphere of the rehabilitation environment promoted the development of a relationship and assisted in the provision of spiritual care.

Gail attributed her comfort level providing spiritual care with the time factor present on the rehabilitation unit as well. When talking about the extended time patient stay on a rehabilitation unit and the influence this has on the relationship, Gail noted:

Probably because our patients stay with us a little bit longer, than they do in the acute care side. So, you have the opportunity to develop a relationship and if there’s something that they want to talk about, or, that you can assist them with, you have that opportunity. And I think it’s because they’re there longer... I’m thinking it’s just the time. And, you know, you get to know people better, you’re able to be sensitive to their needs.

Ora said she thought there was a connection between developing a relationship and the length of time patients were on a rehabilitation unit. She described the relationship between time and making a connection in this way:

We become a part of their lives for a long period of time. You know, they come back, they call you on holidays, they send you a card, you become part of their family. Some of them still write me on occasion, and say would you please say a prayer for me.

The nurses interviewed talked about the benefit having an extended amount of time with patients on a rehabilitation unit. These nurses talked about how this extended time assisted them in developing relationships. They talked about how relationships promoted a sense of comfort when providing spiritual care for patients and families. The rehabilitation nursing unit environment “made it easier” to develop a sense of comfort providing spiritual care.

Personal Spirituality

The nurses agreed, the stronger their sense of “personal spirituality,” the more comfortable they were providing spiritual care for their patients. When asked about how she developed a sense of comfort providing spiritual care, Gail turned the question around and discussed why some nurses are not comfortable providing spiritual care. She said, “Spirituality is so important, and why do people feel uncomfortable? Maybe they’re not comfortable themselves, with their own spiritual needs. Maybe they have a longing and they can’t identify it yet.” Gail continued by mentioning she thought older nurses are probably more comfortable providing spiritual care because “They are becoming more spiritual as they age.” They seem to be developing a stronger sense of “personal spirituality.”

Cindy saw a connection between “caring spiritually and being comfortable in what you’re doing on a daily basis.” Cindy continued by noting that she thought she provided spiritual care on a daily basis “because she was very spiritual.” Barb said nurses who provide spiritual care do so because they are “spiritual,” because they “believe.” She thought they could not provide spiritual care if they did not believe in “miracles.” Barb mentioned that the nurse’s own spirituality was an important factor in the provision of spiritual care.

Helen talked about a special program in place at her hospital. If a nurse has a strong sense of spirituality and is comfortable sharing it with patients, she wears a pin on her lapel that depicts

a pair of praying hands. This signifies to patients a nurse who will pray with you if you request. She went on to say, “praying calms me, and if somebody wants me to pray with them, I feel very comfortable doing that.”

Mimi described her comfort caring spiritually this way: “I try to bring some form of spirituality into my practice on a daily basis with whomever I’m working with; (it) has to do with my own intrinsic spiritual beliefs.” She continued to speak about her commitment to spiritual nursing:

I think it brings a different dimension to my practice. And it’s a very settling kind of thing for me. Perhaps because I’m praying and I’m thinking about what is going to go on, what has gone on, prior to the meeting. It’s collecting your thoughts, and praying for some guidance as to how to manage some of these very difficult family situations that I deal with. So it’s been a very big part of me. Part of being Catholic is to walk the talk. I mean, you can’t just go to church and receive the sacrament on the weekend, on Sunday, or whatever, and leave and just forget it all. To me, that’s not being honest to my commitment to my faith. I bring this up everyday. I will make the sign of the cross and say a prayer on a ferry, before I eat my meal. I do it here. And I know people are looking at me and thinking, “my gosh.” But to me, it’s a way of witnessing to other people in a very unobtrusive kind of a way, but it’s important to me to remember that God is with me.

Emma described spirituality as “an essence of my being.” She said, “so much of what I do is based on who I am spiritually. She described her comfort level providing spiritual care as being rooted in this strong sense of personal spirituality.

Ora had a nice image as to why spirituality is important in her nursing practice. She told the story of the person throwing beached starfish back into the sea. When asked, “Why do this? There are so many fish washed up and throwing one back won’t make a difference.” The rescuer responded, “It makes a difference to this one.” Ora said practicing spiritual nursing is the same. Her own spiritual journey gives her the sense of comfort needed to make a difference one patient at a time.

To summarize this section, the nurses interviewed were able to identify how they developed a sense of comfort providing spiritual care. Three themes emerged that described how they developed a sense of comfort providing spiritual care: 1) “Just Do It,” 2) Rehabilitation nursing makes it easier, and 3) Personal spirituality. They thought continued use of spiritual interventions assisted in promoting a sense of comfort providing this type of nursing care. This aspect of “Just Doing It” aided in developing a sense of comfort providing spiritual care. Additionally, the extended amount of time that rehabilitation nurses spend with their patients “made it easier” to develop relationships and therefore establish a sense of comfort providing spiritual care. The nurses interviewed also thought nurses with a stronger sense of their own “personal spirituality” were more comfortable caring spiritually for patients.

In conclusion, the nurses interviewed were able to define spiritual nursing. To these nurses, spiritual care “listening to the soft voice.” By “listening to the soft voice,” the nurses defined spiritual care as making a connection and building a relationship with patients, families, and peers. As nurses, they realized that they needed to be open to whatever beliefs the patients and families practiced. The nurses described this as respect. By respecting patient and their families, every other aspect of caring became spiritual in nature for these nurses. They were able to give wonderful stories of times they provided spiritual care. Spiritual care was as evident in the “little things” the nurses did everyday. The acts included tasks as simple as communicating with patients, spending time with patients and families, or performing daily tasks such as giving baths or changing dressings. Spiritual care also included calling spiritual leaders such as pastors or ministers and praying with and for the patients, their families, and peers. The nurses described the experience of providing spiritual care as a situation in which they received more than they provided. The nurses thought this was a type of “bonus” because it was not something they

expected at first. Some of the nurses felt like they were “being used” by a higher power while providing spiritual care. The nurses thought they developed a comfort level providing spiritual care by “just doing it.” They thought rehabilitation nursing offered them some unique opportunities to develop a sense of comfort. “Rehabilitation made it easier” because patients spend an extended amount of time on the rehabilitation unit, and relationships form. This assisted the nurses in developing a sense of comfort providing spiritual care. These nurses also felt that a strong sense of “personal spirituality” allowed them to nurse more spiritually.

CHAPTER 5

DISCUSSION

The goal of this study was to examine the lived experiences of rehabilitation nurses when providing spiritual care. The three research questions were: 1) How do rehabilitation nurses describe spiritual care? 2) How do rehabilitation nurses describe experiences providing spiritual care? 3) How do rehabilitation nurses describe their level of comfort providing spiritual care? To answer these questions, I interviewed fourteen rehabilitation nurses while they attended an educational conference in Atlanta, Georgia during October 2004. This study was conducted using a qualitative phenomenological approach. The analysis of the interviews followed Heideggerian techniques considering constructs of background, pre-understanding, co-construction, and *Dasein*.

5.1 Discussion of Findings

According to Taylor (2002), Jean Watson's theory of nursing includes helping people achieve a "higher degree of harmony within the mind, body, and soul which generates self-knowledge, self-reverence, self-healing, and self-care" (p. 39). Nurses care physically and emotionally for patients, but according to Watson, nurses need to care spiritually for patients in order for patients to achieve the harmony of mind, body, and spirit. Rehabilitation nurses are an ideal population of nurses to provide spiritual care because of the holistic approach of rehabilitation nursing.

The answer to the first research question, how do rehabilitation nurses define spiritual care, provided the definition of spirituality that was used for that particular interview.

Considering the first Heideggerian construct of background, the definition of spiritual care included information related to how the nurses learned to care spiritually for patients. The first theme, listening to the soft voice, describes the nurses learning experiences through formal educational experiences, informal educational experiences, and personal learning experiences. The “soft voice” meant there was often a sense of learning through various activities. Sometimes these activities were nursing related, and, sometimes these activities were not. The nurses said that they often needed to listen to the soft voice to learn how to care spiritually. Rarely was there any formal learning exercise that taught how to care for the spiritual needs of patients, rather the nurses learned by performing activities that produced positive effects. This soft voice was interpreted to mean the learning that occurred through the relationships with others, and activities the nurses performed. Many times the definition of spiritual care was not easily achieved using words, but rather through activities they performed. This is similar to English, Fenwick and Parson’s argument that defining spirituality presumes “the experience of spirituality can be captured in words, its meaning contained, and its essence identified” (2003, p. 6).

Nurses defined spirituality as being supportive to patients and forming relationships with patients. According to Taylor (2002), Amenta (1986), defined spirituality as “connectedness.” This definition continued by noting that connectedness included aspects of intrapersonal, interpersonal and transpersonal. Amenta’s definition is similar to the nurses’ definition of spirituality, which identified the importance of support to patients as a transpersonal aspect of spiritual care. The supportive nature of spiritual care is also evident in the second component of nursing theorist Jean Watson’s theory of human caring, which addresses the aspect of the transpersonal caring relationship (2004). The nurses interviewed also recognized the

transpersonal relationship discussed in the literature, when they described their definition of spiritual care.

Spiritual care also included trusting in “something unseen,” and praying with and for the patients, the patients’ families, and their own colleagues or peers. Trusting in “something unseen” meant the nurses were providing hope and guidance during difficult times for the patients or their families. The nurses spoke about praying with the patients when they requested prayer, and praying in general for good outcomes for the patients on the nursing unit. These responses are similar to the responses by the students in Todd’s study (2003) who defined spirituality as a state of mind and as prayer. The nurses in Todd’s study also mentioned that spirituality was related to a higher power, which is similar to the rehabilitation nurses description of “something unseen.”

Some nurses described spiritual care as holistic care, and others used the definition of caring for the mind, body, and spirit which are similar to the theoretical framework described by Jean Watson (2004). Her holistic vision of nursing also includes caring for these same aspects of the mind, body, and spirit of the individual. This presents some potential questions regarding what nursing activities deal specifically with the mind, body, or spirit. The nurses interviewed discussed some activities that are unique and discrete to each of these areas. Activities such as changing bandages may seem to be nursing acts that meet physical needs. Nurses who perform these tasks with a spiritual attitude can perceive these same acts as spiritual care. Similarly, the nurses discussed acts that they thought were unique to meeting spiritual needs. These included listening and talking with patients, and spending time with patients. Other nurses may consider these activities as caring for the mind of the patient, or psychological care. The nurses interviewed did mention some acts of spiritual care that were clearly meeting the needs of the

spirit, such as prayer and calling the spiritual advisor. While there is significant overlap between physical care, spiritual care, and psychological care, some of the activities the nurses described were specific to meeting spiritual needs and others depended on the attitude or perception of the nurse.

Many nurses mentioned respect as an aspect of spiritual care. Taylor's (2003) study, did find that patients wanted nurses to be kind and respectful, but to my knowledge, no study highlighted nurses realization of the need to be respectful. O'Brien's (2000) study addressed the concept of nurses building a connection, and perhaps respect for the individual is a component of this connection.

Respecting patients may result in a conflict between the care nurses provide and the practices of the institution in which they work. This was evident in the story Mimi told about the patient who wanted to die. Mimi chose to respect the patient's wishes by choosing not to feed the patient even though her nurse manager directed her to feed the patient. The nursing manager finally agreed to abide by the patient and family's wishes, and the issue was resolved. Mimi was ready to resign her job in order to respect the patient's wishes; fortunately, she did not have to do this. Conflicts may also arise when the patient and family's wishes do not agree. The nurse then may have to decide whose wishes to respect. Sometimes these situations become difficult to resolve, and nurses may find themselves involved in difficult ethical dilemmas with the patient, family, and institution.

The nurses had no difficulty describing the times they provided spiritual care, the second research question. Many of the activities the nurses described as part of the provision of spiritual care were actually very normal everyday nursing activities. The nurses provided spiritual care in the "little things" they did every day. The participants viewed activities such as listening and

talking with patients as providing spiritual care. Simple nursing tasks such as bathing, giving a backrub, or changing the bandages of a wound were defined as spiritual. The nurses said these activities became spiritual because of the attitude of the nurse while performing these tasks. The parish nurses in Tuck, Pullen, and Wallace's study (2001) mentioned similar activities such as listening, referring, and encouraging patients, were interventions that best supported their patients. The community health nurses interviewed by O'Brien (2000) mentioned "being there," "being connected," "establishing trust," and "facilitating transitions" as spiritual care-giving activities that were similar to the rehabilitation nurses interviewed for this study. The rehabilitation nurses interviewed for this study identified some everyday activities such as giving baths, giving backrubs, and changing bandages as potential spiritual care giving experiences. The literature mentioned none of these activities as examples of spiritual care giving experiences.

Sometimes the spiritual care giving experience was more religious. This type of spiritual care included calling the spiritual leader and praying with and for the patient, family, and peers. The cancer patients and family caregivers in Taylor's (2003) study mentioned they thought calling the spiritual leader and praying were examples of spiritual care giving. While the patients in Taylor's study did mention activities of calling the spiritual leader and prayer these activities were not mentioned in the literature by nurses describing spiritual care

Two themes emerged from this study that were not, to my knowledge, described in prior research. First, the rehabilitation nurses described times when they received more from the experience than the patients did. The nurses described the times when they received more than they gave as "bonuses." Even though the nurses intended the act of providing spiritual care to benefit the patient, and actually did, the nurses felt they also benefited from the experience. This was a theme not found in the literature and further research might be able to discern if this

experience is unique to rehabilitation nurses or do other nurses providing spiritual care experience this feeling also.

The other theme that I did not find in literature deals with the aspect of “being used,” that is, they were the instruments of a higher power to provide a service. The nurses said they often did not know what to say or do in a particular situation, but were inspired once in the actual situation. There were even instances when the patients and families mentioned they thought the words of the nurse were coming from God. While the literature did not identify this theme, additional research might determine if this is a common theme among spiritual caregivers.

The participants also described how they developed a sense of comfort providing spiritual care, the third research question of the study. Most of the nurses explained that the more often they provided spiritual care, the easier it became. At first, the aspect of spiritual care seemed foreign and difficult, but after they practiced providing for the spiritual needs of patients, it became easier and more comfortable for the nurses. Many of the nurses thought that providing spiritual care was such an integral part of their nursing care, they could not imagine for patients and not meeting the spiritual needs of their patients.

These nurses also thought the nature of rehabilitation nursing made it easier to meet the spiritual needs of patients. Nurses in rehabilitation have extended contact with patients, which helped the nurses develop a rapport with the patients and families. While I found no research studies that addressed rehabilitation nurses provision of spiritual care: only O’Brien (2000) mentioned “making a connection” helped community health nurses provide spiritual care. When the nurses made a connection with the patients, it became easier to care for their spiritual needs. This study supported O’Brien’s finding of “making a connection.”

The final theme identified in the interviews was that the nurses with a stronger sense of personal spirituality found it easier to care spiritually for patients. These nurses were comfortable with their own thoughts and feeling regarding spirituality and were thus able to be more comfortable caring for the spiritual needs of their patients. One study found that mental health and parish nurses had a strong spiritual perspective compared to other nursing specialties, and all the nurses in this study indicated they provided spiritual care (Tuck et al., 2001). The current study with rehabilitation nurses supported this conclusion. The rehabilitation nurses with a strong sense of personal spirituality thought it was just part of everyday care to include spiritual care. Some even mentioned that spirituality came first: they were nurses because they were spiritual. They indicated that good caregivers had to have a strong sense of personal spirituality.

5.2 Limitations of the Study and Further Research

The nurses interviewed for this study self selected to participate. The nurses identified themselves as providing spiritual care for patients. Consequently, I expected they had examples of times they provided spiritual care. This study may be generalizable only to similar nurses: rehabilitation nurses who identify themselves as providers of spiritual care. However, phenomenological research is not generalizable. Additional studies could be designed to understand the perspective of nurses who do not identify themselves as providing spiritual care. A research study of this nature could assess if nurses who do not identify themselves as providing spiritual care are actually performing the activities the nurses in this study. If so, what are they calling these activities? In addition, quantitative studies could be designed to understand the prevalence of spiritual care giving experiences among nurses.

Another possible source of bias is that all the nurses were attending an educational conference. It is reasonable to conclude that these nurses are current in their profession and highly motivated. Nearly half of the sample, six nurses, had advanced degrees beyond the baccalaureate level. Future research in this area could investigate nurses who were not attending educational conferences or nurses who have not pursued advanced degrees. A sample of nurses practicing bedside nursing, not attending an educational conference, might produce different results.

Finally, this study is not generalizable to other nursing specialties. Additional studies might compare rehabilitation nurses to other types of bedside nurses. Several research questions still remain. Are rehabilitation nurses different from other nursing specialties? Is it the extended time that rehabilitation nurses spend with their patients the factor that makes a difference? Do other nurses develop similar relationships? Are the themes present in the experiences of these rehabilitation nurses, the little things, getting more than they give, and being used, part of the experiences of other nurses? Finally, do other health care providers participate in providing spiritual care? Are their experiences similar? All of these are potential research questions for further research

5.3 Implications for Nursing; Practice, Education, and Research

Spiritual care is not a new concept in nursing care. Florence Nightingale, in the 1800s, identified the need to include spiritual care in all nursing care (Burkhardt et al., 2002). While spiritual care is receiving more attention, more nursing research needs to address the idea of spiritual care. Numerous studies exist addressing the patients' perception of spiritual care (Boswell et al., 2001; Chapman et al., 2002; Ferrell et al., 2003; Kloosterhouse et al., 2002;

Hermann, 2001; McColl et al., 2000; Sheldon, 2000; Taylor, 2003; Theis et al., 2003). However, few articles are dedicated to actual provision of care (Greasley et al., 2001; Hoover, 2002; O'Brien, 2000; Strang et al., 2002; Tuck et al., 2001). The study by Tuck et al. (2001) focused on mental health and parish nurses. The study by Greasley et al. (2001) focused mental health nurses. O'Brien's (2000) study interviewed only community health nurses. The international study by Strang et al. (2002) did not indicate the nursing specialty of the nurses who participated. Hoover's (2002) international study was conducted among nursing students. None of the studies found focused on rehabilitation nursing. Rehabilitation nurses are providing spiritual care. Nurses need to disseminate these experiences to other nurses. Examples of spiritual care giving experiences may encourage others to provide similar care. Further research needs to consider how other nursing specialties are meeting the spiritual needs of patients.

Spiritual care is often part of ordinary everyday nursing care. Most of the examples of providing spiritual care involved spending time with the patient. When nurses spend time with patients, they develop a relationship that may be conducive to providing spiritual care. Spiritual care is being attentive to the needs the patient expresses and meeting these needs when providing care. Nurses have the unique opportunity to influence patients and families in a number of ways. Providing holistic care, including spiritual care offers nurses the opportunity to care for all of the needs of their patients. Nurses should not think of spiritual care as an "extra," but rather an essential part of the care nurses provide for all patients.

Formal and informal education may be a strategy to promote understanding of the importance of spiritual care. When I asked the nurses how they learned to care spiritually for patients, they gave examples of both formal and informal education. Formal nursing education might want to consider addressing the possibility of including information related to the spiritual

care of patients and families. Nursing curriculum could include aspects of spiritual care in the basic of nursing courses. If educators taught nursing students to consider spiritual care as a basic level of care, much like managing pain or monitoring vital signs, spiritual needs of patients would be not be neglected. Informal nursing education classes often present new trends in healthcare.

Another strategy to promote an understanding of spiritual care is continuing education courses or seminars. Many of the nurses interviewed mentioned they had attended some informal education related to spiritual care. If more continuing educational offerings included aspects of spiritual care, patients and their families would benefit, and nurses would have an increased level of comfort because of their continued familiarity with the practice. Nurses who have new and different approaches to spiritual care could share these approaches with other nurses so other nurses could benefit from their experiences. As new research concerning spiritual care becomes available, educational offerings could inform nurses of the results. When institutions develop new spiritual assessment tools, other institutions could evaluate them and decide if they would be beneficial in their environment.

5.4 Implications for Public Health

Spirituality seems to have a positive impact on health. This research, as well as other studies, highlight that health care providers can have a positive impact on the health of clients by promoting spirituality (Hummer et al., 1999; Koenig et al., 1999; Sicher et al., 1998). Many of the stories the nurses shared identified benefits the patients and families perceived after receiving spiritual care. Sometimes the nurses identified these benefits as improved health status, and others as improved mental status. In order to promote the highest level of health, practitioners

should not omit any aspect of mind, body, or spirit when caring for patients. Nurses and other public health providers should address spiritual care in order to promote health at all levels.

The nurses interviewed defined spirituality in many ways, and one definition included being respectful of others. Taylor's (2003) study of cancer patients and care-givers determined that patients want to be treated with respect, and the patients in this study thought respect was also an aspect of spiritual care. Respect for other people's world views is an important aspect of public health. People want to be treated with respect and when they are respected, their feelings of self worth are enhanced. Respect, which includes cultural sensitivity, should be an important aspect of health interventions.

To more fully understand the impact of spirituality on health, more research on how health care providers are meeting spiritual needs of patients needs to occur. As noted in the review of the literature, it is obvious patients and families recognize the impact of spirituality on their health. However, there was limited research related to the actual provision of spiritual care by health care providers. Research needs to bridge the gap between what the public wants and what health care providers are actually providing. Public health research can link the expectations of the public to the realities of practice. With this knowledge, clients will not only have their spiritual needs met, but the public health care providers will have the knowledge to meet these expectations. This study serves as a beginning glimpse into how some health care providers are incorporating spiritual care into the care they provide. Research related to spirituality may provide new approaches to health and social problems that are public health importance.

5.5 Conclusion

This study examined the lived experiences of rehabilitation nurses when providing spiritual care. The stories of these experiences provided an insight into what spiritual care is, how the nurses provide it, and how they developed a sense of comfort providing it. I hope the experiences of these nurses will help other nurses realize the importance of spiritual care when caring for patients, and how nurses can meet patient's spiritual needs during very ordinary acts of nursing care. I also hope health care providers realize the importance of including spiritual care in health promotion interventions.

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Appendix A

Consent Form for Spirituality in Nursing Care Project

I agree to take part in a research study entitled, “Nurses Use of Spiritual Interventions When Caring for Patients” that is being conducted by Mary Catherine Gebhardt (770-442-0505), doctoral student in the Department of Health Promotion and Human Behavior, University of Georgia, under the direction of Dr. Pamela Orpinas (706-542-4370), Associate Professor, Department of Health Promotion and Human Behavior, University of Georgia. I do not have to take part in this study; I can stop taking part at any time without giving any reason, and without penalty. I can ask to have information related to me returned to me, removed from the research records, or destroyed.

I understand that the reason for this study is to investigate times when nurses cared for the spiritual needs of patients, and that their stories will be audio taped. These stories will show how nurses cared for patients who had spiritual needs. The finished study will be in the form of an article, a book, a presentation and/or dissertation.

If I volunteer to take part in the study, I will be asked to: participate in one audiotaped interview about my memories of meeting the spiritual needs of patients who I have cared for. I understand that the interview will take approximately 60 minutes at a place that is convenient to me. I may be contacted by mail, phone, or E-mail after the interview to review the themes identified during my interview. Internet communications are insecure and there is a limit to the confidentiality that can be guaranteed due to the technology itself. However once the materials are received by the researcher, standard confidentiality procedures will be employed. I understand that no risks are expected. No deception will take place on the part of the researcher.

If I provide information that is used in this study, confidentiality will be maintained in the written report, as well as in any presentation of the information. Pseudonyms will be used on the audio tape and the written transcript. The transcribed interview will be analyzed by the researcher and the dissertation committee. Any written report will contain no identifying data. I understand the tapes will be destroyed by May 31, 2008. Demographic data will be presented as group data. I understand I will receive a \$20 gift certificate as a token of appreciation for my participation. Ms Gebhardt will answer any further questions about the research, now or during the course of the project, and can be reached by telephone at: 404-651-3020

My signature below indicates that Ms. Gebhardt has answered all of my questions to my satisfaction and that I consent to volunteer for this study. I have been given a copy of this form.

Signature of the Researcher, Date
Phone number of Researcher: 404-651-3020
E-mail of Researcher: mgebhardt@gsu.edu

Signature of the Participant, Date

For questions or problems about your rights please call or write: Chris A. Joseph, Ph. D., Human Subjects Office, University of Georgia, 606A Boyd Graduate Studies Research Center, Athens Georgia 30602-7411; Telephone 706-542-3199; E-Mail address IRB@uga.edu.

Appendix B

Letter Sent to Nurses to Validate Themes

January 25, 2005

Dear

It has been about 3 ½ months since we met and discussed your experiences while caring spiritually for rehabilitation patients. I hope this letter finds you well. Rest assured that I have been busy transcribing your interview and each story was inspirational. You are obviously doing wonderful work.

As promised, I am enclosing the major themes I discovered while analyzing the data. These themes are a collaboration of all the data, and while you may not have used these exact words, I think they reflect the overall ideas expressed by the group of nurses interviewed.

1. Rehabilitation nurse's definition of spiritual nursing is influenced by their nursing school education, their education outside of nursing school and their life experiences.
2. While spirituality and religion are difficult to define for some rehabilitation nurses, spiritual care involved developing relationships with patients, families and peers.
3. Spiritual care involved making a connection and respecting the patient and family and being aware and open to their thoughts and beliefs.
4. Religion, on the other hand tended to connote a more formal set of beliefs specific to a group of people.
5. Rehabilitation nurses describe their spiritual care giving experiences as making a connection with the patient and therefore respecting the patient.
6. Rehabilitation nurses describe their spiritual care giving experiences as the feeling that they were used by a higher power.
7. Rehabilitation nurses describe their spiritual care giving experiences as an activity that enhanced the patient's or family's health.
8. Rehabilitation nurses describe their spiritual care giving experiences as not only providing care for patients and families, but for co-workers and peers.
9. Rehabilitation nurses describe their spiritual care giving experiences as an activity in which they often benefited as much if not more than those for whom they provided care.

10. Rehabilitation nurses note that there are often limitations to providing spiritual care, and therefore it is sometimes difficult to provide spiritual care.

11. Rehabilitation nurses describe their level of comfort providing care as being enhanced by the extended time rehabilitation nursing allows with the patients and thus the ability to form relationships with the patient and family.

12. Rehabilitation nurses describe their level of comfort providing care as being enhanced by the holistic nature of rehabilitation nursing.

13. Rehabilitation nurses describe their level of comfort providing care as being enhanced by an attitude of openness towards the patient

14. Rehabilitation nurses describe their level of comfort providing care as being enhanced by their own level of spirituality.

I am asking you review these findings, and if there is any specific theme you feel is not accurate about providing spiritual care, please let me know by February 11, 2005. I have included both my mailing address as well as an E-mail address. If I do not hear from you, I will consider your lack of response to be a voice of agreement with the findings.

I appreciate your participation in this study. Your stories and ideas regarding spiritual care were a delight to share. Thank you again for you time and interest in this research study.

Fondly,

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