2018

A Grounded Theory Study Exploring Spiritual Care in Nursing Practice

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A GROUNDED THEORY STUDY EXPLORING SPIRITUAL CARE IN NURSING PRACTICE

DISSERTATION

Presented in Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy in Nursing

Barry University

Janice Lowden-Stokley

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by

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Abstract

Background: Currently in nursing practice, the standards require a holistic approach to nursing care, and this includes caring for the physical, psychosocial and spiritual components of the patient (American Nurses Association [ANA], 2010). Addressing a patient's spirituality, which is defined as an individual's search for meaning and purpose in life and death, is a fundamental component of holistic care but it is likely the least comprehended aspect of holistic nursing care (Vachon, Fillion, & Achille, 2009). Even though nurses understand that addressing a patient's spiritual needs can provide comfort and healing, many nurses report feeling uneasy and unprepared in addressing this component of holistic nursing care.

Purpose: The purpose of this qualitative grounded theory study is to generate a substantive theory explicating the nurses' role in providing spiritual care.

Philosophical Underpinnings: The grounded theory is based within the constructivist paradigm and has philosophical underpinnings of symbolic interactionism and pragmatism.

Methods: The research approach was qualitative using grounded theory to discover a substantive theory to understand the critical factors that affect attitudes, perceptions and behaviors of holistic nurses providing spiritual care in their practice.

Design: The study utilized an adapted approach of Strauss and Corbin's grounded theory methodology. Sampling conducted was purposive, theoretical, and snowball. Semi-structured interviews with individual participants and an expert group were conducted. Data analysis and collection occurred simultaneously, and data was coded, categorized,

and compared through open, axial, and selective coding. Main categories emerged from the data and were conceptualized, linking the categories into a substantive theory.

Results: The main categories of *becoming aware*, *caring for the spirit*, and *embodying praxis* emerged from the voices of the participants. Relational statements and intersection of categories and subcategories supported the core category, revealing the basic social process of living spiritual care praxis. Living spiritual care praxis identified and explained the meaning ascribed by holistic nurses providing spiritual care in their nursing practice.

Conclusions: The theoretical framework developed from this study provides needed information about spiritual care in nursing practice. This theoretical framework can be used to guide nursing education, research, and practice, thereby strengthening the profession's ability to provide holistic care and include spiritual care in nursing practice.

ACKNOWLEDGMENTS

First, I would like to thank God for giving the will and the desire to pursue and complete my doctoral degree. I would also like to express my sincere gratitude to my committee chair, Dr. Colin for her continuous support, patience, guidance, and vast knowledge she provided me during my doctoral study at Barry University. She continually guided me during my research and the writing of my dissertation. Additionally, I want to thank my dissertation committee members, Dr. Robin Walter and Dr. Ronica Subramoney, for their guidance and encouragement throughout this challenging and transformative process. I also want to express my appreciation to Dr. Carolyn V. Fore, Dr. Janice Preston, and Dr. Len Archer who have continuously encouraged me to keep going and finish my doctoral studies and dissertation especially when my life literally fell apart. A very special gratitude goes out to Gould Family Nursing Foundation for providing the funding for this study.

Finally, I want to thank my daughter, Andrea, son, John, my brothers, Paul and John, and sisters JoAnn, Debby, Donna, Trisha, and Dee, for always being there to help me pick up the pieces and put it back together. It has been a long journey and you have been the only ones to stick with me all the way through. I am forever grateful for your unconditional love and support.

DEDICATION

This work is dedicated in memoriam to my mother, Joan, father, Jack, and first nursing mentor, Dr. Jacqueline Byers. It is from their constant encouragement and support that I was able to finish this endeavor. I could not have made it without each of you. Even though all three are not here physically with me to see me finish this degree, I can feel your presence and your support. It was their encouragement and belief in me that gave me the strength to continue and finish even after the loss of each of you in my life.

LIST OF TABLES

LIST OF FIGURES

TABLE OF CONTENTS

CHAPTER ONE

Problem and Domain of Inquiry

Current standards in nursing practice require a holistic approach to nursing care, and this includes caring for the physical, psychosocial and spiritual components of the patient (American Nurses Association [ANA], 2010). Addressing a patient's spirituality, which is defined as an individual's search for meaning and purpose in life and death, is a fundamental component of holistic care but it is likely the least comprehended aspect of holistic nursing care (Vachon, Fillion, & Achille, 2009). Even though nurses understand that addressing a patient's spiritual needs can provide comfort and healing, many nurses report feeling uneasy and unprepared in addressing this component of holistic nursing care. Additionally, many patients often express dissatisfaction with the spiritual care provided within healthcare facilities (Balboni et al., 2013; Carr, 2010; Puchalski, Lunsford, Harris, & Miller, 2006).

The identification of how nurses develop the skill to provide spiritual care remains unknown. This proposed grounded theory study seeks to develop a substantive theory regarding the spiritual care development in nursing practice and contribute to the knowledge of spiritual care practice provided by nurses.

Background of the study

Nurses are holistic health care providers and are required to care for the person's mind, body and spirit. Caring for the physical and mental needs of their patients do not often create any difficulties for nurses. Even though nurses are aware of the spiritual

dimension of nursing care, uncertainty in how to provide spiritual care is often expressed. One issue is that that nurses are often unsure how to define spirituality and spiritual care (Taylor, Maimer, Bahjri, Anton, & Peterson, 2009).

The interconnectedness of the mind, body and spirit is the essence of holistic care. It is necessary that the spiritual component of the individual and healer be recognized in order for the healing process to occur. The expression of spirituality is comprised of the shared relationship recognizing the common humanity and connectedness between the nurse and the individual (Dossey and Keegan, 2016). Spiritual care of the whole person mandates attention to the individuality and uniqueness of each person and their interconnection (O'Brien, 2011).

Defining Spiritual Care

There are multiple interpretations for defining spiritual care found in the literature (Narayanasamy & Owens, 2001). According to Sawatzky and Pesut (2005) spiritual care is defined as "an intuitive, interpersonal, altruistic, and integrative expression that is contingent on the nurse's awareness of the transcendent dimension of life but that reflects the patient's reality" (p. 23). Taylor (2002) defines spiritual care as "the activities and ways of being that bring spiritual quality of life, well-being, and function-all of which are dimensions of health-to clients" (p. 24). Ferrell & Baird (2012) state "Spiritual care addresses the thoughts, feelings, and experiences of being human" (p. 258). Baird (2010) additionally defined spiritual care as "allowing our humanity to touch another's by providing presence, deep listening, and compassion" (p. 663).

Hospice and Palliative Nurses Association (HPNA) (2010) defines spiritual care as "assessing, monitoring, and responding to the spiritual and religious issues that concern patients and families" (p.1). HPNA requires both the appreciation of the significance of presence and a willingness to be fully present with the patient. Effective spiritual care requires recognizing spirituality as an integral component of patient's experiences related to illness, healing and health and listening reflectively with a compassionate presence. Additionally, effective spiritual care requires creating a therapeutic and healing environment for spiritual expression, demonstrating empathy, and journeying with others in their suffering. Other required skills include offering appropriate prayer, music, readings meaningful to the patient and their family, supporting the patient's and their family's sources of spiritual strength, and seeking additional resources such as chaplaincy and other spiritual advisors as needed (HPNA, 2010).

For the purpose of this proposed research, the definition of spiritual care developed by HPNA (2010) will be used to define what is meant as spiritual care in nursing. This definition allows for a broad, holistic, and non-exclusive view of spiritual care.

Professional Standards

The International Council of Nurses (ICN) is a federation made up of national nurses' associations (NNAs), representing the more than 16 million nurses worldwide from over 130 nations. ICN works to ensure quality nursing care for all, sound global health policies globally, the advancement of nursing knowledge, and the presence

worldwide of a respected nursing profession and a competent and satisfied nursing workforce (ICN, 2015). The *ICN Code of Ethics for Nurses*, revised in 2012, is a guide for nursing behaviors based on social values and needs. The ICN Code of Ethics serves as the standard for nurses worldwide. The first element of the ICN Code of Ethics states that the main responsibility of the nurse is to provide nursing care to all persons in need. This care is to be provided in an environment that respects "human rights, values, customs, and spiritual beliefs of the individual, family and community" (ICN, 2015 p. 2).

The American Nurses Association has developed the *Scope and Standards of Nursing Practice* (2010). This document describes the duties all nurses are to perform competently regardless of their role or specialty. Among other requirements, nurses are to collect data related to a patient's spiritual orientation in a continuous manner based on their patient's individual needs. The ANA *Scope and Standards of Nursing Practice* (2010) also direct nurses to provide appropriate holistic care to individuals from different cultures and throughout the lifecycle. It is a professional obligation that nurses; who are present with patients during life threatening situations, with chronic illness, and with those who are dying, have the capability to provide spiritual care to their patients (ANA, 2010).

The Code of Ethics with Interpretive Statements (2015) written by the ANA is a guide for nurses to provide ethical and quality care to their patients (ANA, 2015). Each nurse is to be aware of the Code of Ethics and to incorporate in it into their everyday practice. Spirituality and spiritual care parameters are addressed in Provision 1.3. In this

provision, it is stated that “Optimal nursing care enable the patient to live with as much physical, emotional, social, and religious or spiritual well-being as possible and reflects the patient’s own values.” (ANA, 2015, p 2).

According to the North American Nursing Diagnosis Association International (NANDA International) spiritual distress, risk for spiritual distress and readiness for enhanced spiritual well-being are three accepted nursing diagnoses that should be identified when appropriate, and responded to with appropriate nursing interventions all of which are documented (NANDA International, 2014).The purpose of nursing diagnoses is to provide consistent and appropriate communication about the nurse’s professional assessments to other healthcare providers and to direct interventions in a team context. Nurses are required to document a patient’s spiritual assessment, interventions, and evaluation of the spiritual care provided (NANDA International, 2014).

The Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations) requires a spiritual assessment along with other assessment processes be completed on all patients admitted to a healthcare facility (Joint Commission, 2008). Another requirement is that each hospital provides a definition and the extent of the spiritual assessment. It is necessary that the credentials of the person completing the assessment be clearly delineated. In most hospitals, this is the responsibility of the registered nurse and is included in the admission assessment. The nursing assessment is only to be completed by registered nurses and includes the

evaluation of the spiritual needs of the patient. The assessment should at least include the patient's religious affiliation, beliefs, and spiritual practices (Joint Commission, 2008).

American Association of Colleges of Nurses (AACN) has developed *The Essentials of Baccalaureate Education for Professional Nursing Practice (2008)* through evaluation of nursing standards nationally and current research in nursing care and education in order to assist nursing programs in meeting the competency expectations of their graduates (AACN, 2008). *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008) is written to provide nursing programs with a guide in developing their curricula to assist the programs in meeting the high standards necessary for nursing program accreditation. In Essential IX of *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008), recommends that the nursing program educate student nurses how to perform comprehensive and focused spiritual assessments of their patients, using developmentally and culturally appropriate methods. (AACN, 2008).

Spiritual care is addressed by each of the national accrediting agencies for nursing educational programs. The Commission on Collegiate Nursing Education (CCNE) states in Standard III C (CCNE, 2013) that programs in nursing incorporate the generalist knowledge common to baccalaureate nursing education as delineated in *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008). *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008) directs nursing programs to perform focused spiritual assessments. Dedicated to

excellence in nursing, the National League for Nursing is the premier organization for nurse faculty members and leaders in nursing education. The NLN's accreditation services, represented by the NLN Commission for Nursing Education Accreditation (CNEA), and in Standard V: Culture of Learning and Diversity – Curriculum and Evaluation Processes (2016) mandates nursing programs to address six integrating concepts. These are *context and environment; knowledge and science; personal and professional development; quality and safety; relationship-centered care; and teamwork* to be brought into their curriculum (NLN, 2010). *Knowledge and science* refers to the foundations that serve as a basis for nursing practice these foundations include understanding and integrating knowledge from a variety of disciplines outside nursing that provide insight into the physical, psychological, social, spiritual, and cultural functioning of human beings.

The Accreditation Commission for Education in Nursing (ACEN) supports the interests of nursing education, nursing practice, and the public by the functions of accreditation. The third nursing program accrediting agency is the Accreditation Commission for Education in Nursing (ACEN). ACEN supports the interests of nursing education, nursing practice, and the public by the functions of accreditation. Spiritual care is assessed in Standard Four: Curriculum which states the BSN program's curriculum will incorporate established professional nursing standards, guidelines, and competencies and has clearly articulated end-of-program student learning outcomes. The

standards/guidelines include The Essentials of Baccalaureate Education for Professional Nursing Practice (AACN, 2008).

Despite the clear requirements of the professional nursing associations and regulatory agencies directing nurses to assess and respond to the spiritual aspects of care, nurses report being too busy with other patient care issues and taking care of physical needs to address the spiritual needs of their patients (Pearce, 2009). Often, the hospital chaplain is called to provide for the spiritual needs of the patient, because the nurse does not have time due to other tasks that only the registered nurse can complete (Leavey & King, 2007).

Spiritual Care Education

There are limitations and inconsistencies in preparing nurses to meet the spiritual needs of the patient in pre-licensure nursing education programs and in the professional practice setting, . In one nursing study, the lack of a consistent definition of spirituality and spiritual care was identified as one reason for the differences in the provision of spiritual care (Paley, 2007). Lemmer (2002) found in a study of pre-licensure nursing programs that many nursing education programs did not include a consistent definition of spirituality or spiritual care throughout their curriculum (Lemmer, 2002). In another study that explored barriers to spiritual care, Catanzaro & McMullen (2002) identified inadequate and inconsistent teaching methods regarding spirituality and spiritual care in nursing educational programs.

Providing spiritual care education should include the meaning of spirituality, completing a spiritual assessment, and incorporating spiritual care into clinical practice (Brush and Daly, 2000). The concepts of personal meaning, purpose, and hope for the future should be taught in nursing pre-licensure programs as they relate to an individual's spirituality. Nursing and health care students should be taught that spirituality is not only related to a patient's religion or religious practice, so the student can understand the nurse's role in providing spiritual care (Lemmer, 2002).

Nursing educational programs need to emphasize the importance of spirituality and spiritual care in order to assist new nurses in understanding the need for assessing and meeting spiritual needs of their patients. Today nurses are educated in a manner to prepare them to work in a competitive healthcare environment concerned with shortening the patient's length of stay. The nurses are required to care for an increased patient load and to delegate more of the personal patient care to non-licensed care providers. This reduces the time the registered nurse has to personally interact with the patient. The registered nurse needs to be competent in spiritual care in order to meet the spiritual needs of their clients during their patient interactions (Savel, 2014).

Spiritual Care Practice in Nursing

Nurses are expected to identify and address the spiritual needs of patients and families within their scope of practice (Puchalski et al., 2009; NCP, 2013). The nursing process provides the nurse a systematic manner to assess and identify patient problems or needs in order to plan care. Spiritual assessment is a process consisting of a spiritual

screening that assesses for spiritual distress/crisis and a history to identify a patient's spiritual needs and resources (Puchalski et al., 2009).

Nurses have access to several different assessment tools to facilitate spiritual screening and history-taking, and yet research has shown spiritual assessment is not performed consistently by nurses (Belcher & Griffiths, 2005). Patients may not discuss sensitive information until establishing rapport and a trusting relationship with their nurse therefore, spiritual assessment is an ongoing process (McSherry, 2006).

It is important for nurses to ensure that spiritual care is available to all individuals regardless of culture, faith, or religion. Holloway (2006) articulates that nurses should provide spiritual care even in the absence of a belief system. In holistic nursing practice, spiritual care is based on the unique ways that the individual expresses, experiences, and nurtures their spirit both within and outside of an organized religious framework (Burkhardt& Nagai-Jacobson, 2002).

Feeling uncomfortable in assessing spiritual needs is another issue affecting a nurse's ability to provide spiritual care (Zakaria Kiaei, Salehi, Moosazadeh Nasrabadi, Whitehead, Azmal, Kalhor, & Shah Bahrami, 2015). A lack of understanding their own spirituality, developmental stage, or previous life events of the nurse may also affect the comfort and ability of the nurse to assess and provide spiritual care (Lemmer, 2002). A nurse's awareness of her own spirituality impacts the spiritual assessment and care she provides to the patient (Chan, 2010). In a study completed with nurses in Singapore, it was found that among the nurses that were more aware of their own spirituality and

spiritual care, the more likely the nurses were to provide spiritual assessment and care for their patients (Chan, 2010).

Ability to provide spiritual care can also be affected by the nurse's personal belief practices. Nurses who described an individual approach to establishing the nurse-patient relationship were found to be more effective in assisting patients to overcome their spiritual distress (Kevern, 2012). In another study, a nurse's attitude toward spiritual care was influenced by the nurse's own spiritual well-being, and this then would affect overall delivery of spiritual care to the patient (Musgrave & McFarlane, 2003). Nurses who indicated they belonged to a religious organization were more likely to address the spiritual needs of their patient and yet these same nurses were more likely to call in a chaplain or pastor to care for the spiritual needs of their patient than nurses who indicated no religious affiliation (Ross, 1994). The religious affiliation, expectations, and spiritual philosophy of the healthcare facility also have an impact on the provision of spiritual care of the patients in the health care facility (Kevern, 2012).

Patients and Spiritual Care

What patients believe constitutes spiritual care may be different from how nurses view spiritual care. For example, McSherry (1998) found that some nurses felt that spirituality is only important to those who are religious and believe in a higher being, however, their patients may have an existential view. Most holistic care nursing definitions of spiritual care include identifying and meeting the needs of all individuals. Spirituality comprises more than just religious practices or a belief in God or a higher

power. Spirituality also includes personal meaning and purpose that can become an issue when a person confronts emotional stress, illness, or death. In one study, atheist and agnostic subjects revealed they did have a sense of spirituality that was built on the existential viewpoint (Burnard, 1988). It is necessary for the nurse to allow the patient to guide the discussion regarding spiritual needs in order to determine appropriate care to meet the individual needs of the patient. An accepting and non-judgmental approach by the nurse to the patient's personal spiritual beliefs and practices is necessary to provide appropriate spiritual care to the patient (McSherry and Ross, 2010).

Support of spiritual needs in outpatient medical settings is associated with greater satisfaction and perceived quality of care (Astrow et al., 2007), less depression (Kristeller et al., 2005), higher quality of life (Balboni et al., 2007; Kristeller et al., 2005), greater hospice use (Balboni et al., 2010) and decreased medical care costs (Balboni, Balboni, Paulk, Phelps, Wright, Peteet, & Prigerson, 2011). Meeting patients' spiritual needs through holistic care assists patient recovery and improves the quality of life while in the hospital (O'Connell and Skevington, 2005).

Spiritual care has been found to enable patients to count their blessings in life, achieve inner peace and explore coping strategies to overcome obstacles during crisis situations (Baldacchino & Draper 2001, Kociszewski 2003). Culliford (2002) also reported evidence that spiritual care has a positive effect on the physical and psychological health of patients. This includes aiding prevention, speeding recovery, and fostering equanimity in the face of ill health (Culliford, 2002). Additionally, other

benefits related to such care have been found: preventing disease, enhancing a rapid recovery and fostering the composure (Koenig et al. 2001, Culliford, 2002).

Nurses face individuals at varying degrees of stressful situations across the patient's lifetime. It is expected that nurses should have the ability to competently address the spiritual needs of all of their patients. Many nurses feel inadequate in the provision of spiritual care (McBrien, 2010). Balboni et al. (2010) conducted a study on the extent to which nurses are prepared to meet the spiritual needs of hospitalized patients, 60% to 79% of nurses indicated a need for more guidance and educational preparation. Lack of preparation and comfort may lead to hesitance in investigating patients' spiritual needs. With the increasingly multicultural characteristics of today's society, healthcare providers need to be aware of and have access to resources to assist them in meeting the diverse spiritual needs of their patients since cultural and spiritual practices can have a significant impact on a person's level of wellness.

Theory of Human Caring

The transpersonal caring relationship as described by Watson's Theory of Human Caring (2008) explains how the nurse addresses the patient's subjective meaning of the health care state. The nurse's personal caring consciousness offers a connection and understanding of the patient's perspective. The patient and the nurse mutually search for meaning and wholeness. It is important for the nurse to accept the holistic person - centered approach to care to assist the patient to achieve a healthy balance within their mind, body, and spirit.

The nurse provides this for the patient by incorporating a moral commitment to protect and enhance human dignity. The Caring Theory also provides the nurse the opportunity to demonstrate respect for the person by honoring the patient's needs, wishes, routines, and rituals. The caring consciousness of self as person/nurse and other as person demonstrates the nurse's and patient's connection as human beings. In the relationship between the patient and the nurse, heart-centered/healing caring is based on practicing and honoring the wholeness of the mind, body, and spirit interconnection in self and each other. The nurse assists the patient to maintain balance or as described by Watson as inner harmony (equanimity). Caring is the nurse's intention of "doing" for the patient and "being" with the patient when in need. The provision of care to the patient by the nurse is also demonstrated through "authentic presence" which is honoring or connecting human-to-human (Watson, 2008). The Caring Theory provides nursing a theoretical explanation of human caring as it applies to nursing practice. Additionally, the Caring Theory addresses an explanation of the uneasiness and challenges that nurses experience in the provision of spiritual care in their practice of nursing (Watson, 2008).

Statement of the Problem

The fundamental component of the practice for registered nurses is to deliver holistic, patient-focused care and this requires the nurse to treat the whole person—which includes the spiritual component as well as the physical. Many nurses express difficulty in the identification of spiritual needs and the provision of competent spiritual care to their patients and therefore, holistic care is not being provided to all patients.

Nursing's lack of an understanding of how nurses develop spiritual care skills has been suggested as a significant barrier to the provision of competent spiritual care by nurses (Keall, Clayton & Butow, 2014). Patient care outcomes may be negatively impacted unless the factors that prevent nurses from developing spiritual care skills and providing competent spiritual care are explored.

Purpose of the Study

The purpose of this qualitative grounded theory study is to generate a substantive theory explicating the nurses' role in providing spiritual care. A substantive, mid-range theory has the potential to increase the current knowledge about the nurse professional's role in providing spiritual care and provide a framework to guide nursing research, education, practice, and health/public policy initiatives related to the phenomenon.

Research Questions

Three overarching questions will guide the grounded theory research.

1. What are the critical factors that influence the nurse's perceptions, attitudes, knowledge and behaviors related to the provision of spiritual care in their practice?
2. How do registered nurses come to know how to provide spiritual care?
3. What processes do nurses use to identify the contexts in which they will provide spiritual care?

Philosophical Underpinnings

Philosophical underpinnings are defined as the "stance informing the methodology and thus providing a context for the process and grounding its logic and criteria' (Crotty, 1998, p.3) for the study. This guides the assumptions about human knowledge and realities that are experienced in the human world (Crotty, 1998). The assumptions shape the meaning of the research questions, the purposiveness of the research methodologies, and the interpretability of the findings (Crotty, 1998). The inquiry into the development of spiritual care in nursing is based in the epistemological approach of subjectivism, in which findings of the inquiry are created and co-created by the inquirer (Crotty, 1998). Interpretivism frames the theoretical perspective of the study to explore spiritual care development in nursing.

Interpretivism

The research seeks to understand the process of spiritual care development in nursing. This phenomenon is assessed through the use of an interpretive framework and addresses the meaning of individuals or groups assign to a concept or phenomenon (Creswell, 2013). The interpretivism approach, the researcher looks at the individual in the society. Researchers recognize that all participants involved, including the researcher, bring their own unique interpretations of the world or construction of the situation to the research and the researcher needs to be open to the attitudes and values of the participants or, more actively, suspend prior cultural assumptions. For interpretivists, the social world consists of and is constructed through meanings. Additionally, interpretivist seek to

understand the complex world of experiences from the point of view of those who live in the world. Interpretivist try to describe and interpret the individual's feelings and experiences in human terms rather than through quantification (Crotty, 1998).

Individual constructs are obtained and understood through interaction between researchers and participants (Guba & Lincoln, 1994) Events are not reduced to simplistic interpretations; new levels of understanding are revealed as phenomena are described in rich detail. The interpretive framework is inductive, being generated from the data, (Guba & Lincoln, 1994). Interpretivists acknowledge that value free knowledge is not possible. Interpretive methods yield insight and understandings of behavior, explain actions from the participant's perspective, and do not control the participants (Guba & Lincoln, 1994).

The focus of reality in interpretivism accepts multiple realities. The goal of the inquiry is to gain an understanding of the phenomenon. Interpretivism is often connected to the thought of Max Weber (1920) which stated that human sciences are involved with *verstchen* (understanding) (Crotty, 1998). Weber states the need for social inquiry to focus on the meanings and the values of the person experiencing reality, therefore on their subjective meaning of the reality (Crotty, 1998).

Interpretivism gives rise to two views: *constructionism* and *constructivism*. Reality or meaning in constructionism is influenced by the social or cultural derived meaning. In constructivism, the meaning or reality is constructed by the individual's interpretation.

Constructivism

Constructivism is described as "the individual human subjects engaging with objects in the world and making sense of them" (Crotty, 1998; p. 79). This contrasts with constructionism which states the person is "introduced directly to a whole world of meaning" (Crotty, 1998; p. 79). The person's culture and surrounding cultures provide the person with the meanings.

The constructivist theoretical perspective extends the interpretivist philosophy by emphasizing the importance of investigating how different individuals in a social setting construct their beliefs (Guba & Lincoln 1985). It addresses the different goals of researchers and other participants in a research setting and seeks to develop a consensus among participants about how to understand the focus of inquiry.

This perspective addresses how realities are made. Constructivism assumes that the person constructs the realities in which they are participating. In this perspective, the inquiry starts with the experience and asks how the person constructs it. Constructivists acknowledge that their interpretation of the studied phenomenon is in itself a construction (Bryant & Charmaz, 2007). This perspective indicates that there in no one true reality (Doan, 1997).

Constructionism

Constructionism is a theoretical perspective that assumes that the person creates reality through a social collective process. Constructionism regards reality as being internally-created through constructs, or internal models. Humans, therefore see the

world through created constructs and the constructs then have a substantial effect on their perceptions. There are two parts to a construction: the elements themselves and the connections/relationships between them. Construction can thus involve adding new elements or making new connections between existing elements. Reality is constructed from the world and the objects in the world (Crotty, 1998). Rather than seeing the world as a given, the constructionist will ask how is it accomplished? (Bryant & Charmaz, 2007).

Constructionists believe that knowledge is socially-created (Chen, Shek & Bu, 2011). This perspective is particularly interested in the narratives or discussions that evaluate the normative standards against which the person measures and judges himself. Constructionist research is frequently indicated as an effort to answer questions of "what is constructed" and how the construction process unfolds" (Chen, Shek & Bu, 2011).

Qualitative Approach

Qualitative inquiry is the research approach associated with the constructionist and constructivist theoretical perspective in interpretive philosophy. The identification of the richness of human experiences is the purpose of qualitative research. In qualitative research, the investigator is positioned into the research. This allows a naturalistic and interpretive approach in which the participants describe their experiences and provide meaning to the phenomenon of the study (Denzin& Lincoln, 2005). In the interpretive framework of qualitative research, understanding and meaning are sought from the experiences regarding the social context expressed by the participants (Crotty, 1998). The

research regarding the process of spiritual care development in nursing is investigated in the social context of nursing, specifically in the practice of holistic nursing where the nurse participants will bring meaning to the process of spiritual care development.

Qualitative research is grounded in the social constructivism whereby, the individual seeks to understand the world they live in and meaning is developed subjectively from objects (Creswell, 2013). The objective of qualitative research is for the research findings are to be reflective of the participant's point of view within the social setting. In qualitative research, it is important to see phenomenon from the context of the participant in qualitative research. In social constructivism, meaning is not discovered; instead it is constructed by the participants engaging and interacting in the world they are interpreting (Crotty, 1998). Meaning is constructed in the social setting through language, communication, and the community of nurses. Social interactions are an essential aspect of social constructivism. This provides the rationale for the selection of qualitative research as the appropriate choice to frame the study seeking to understand the process of spiritual care development in nursing practice.

The philosophical underpinnings of the interpretivism/constructivism perspective are the foundational material that supports the qualitative paradigm. There are several major constructs of interpretivism/constructivism that describe the paradigm. Scientific assumptions also provide a rich description of interpretivism/constructivism. Finally, the key tenets of grounded theory are also included as the philosophical underpinnings of the proposed spiritual care research study.

Scientific Assumptions

The ontological assumption of interpretivism/constructivism is based in relativism. This includes that the belief that realities are multiple, constructed and holistic. There is no single, tangible reality. Instead, there are only the complex, multiple realities of the individual. Reality is seen as individual and embedded in context (Creswell, 2013). A person determines meaning from a subjective point of view. It is necessary to understand and discover both the participants' and the investigator's view of reality. The proposed research will acknowledge that there are multiple realities and the findings will be reported through subjective views. The research seeks to explore the holistic nurses' experiences and constructed meanings from their provision of spiritual care to their patients. The epistemological assumption is transactional/subjectivist. This means that the findings of the research are created and co-created by the researcher and the participant (Lincoln and Guba, 1985). The epistemological beliefs reveal that knowledge and truth develop from within the social context and are constructed. Another belief is that truth and meaning arise from the interaction of the investigator, participants and the world (Crotty, 1998). The researcher seeks to explore the constructed meaning of spiritual care provided by the holistic nurse participants and to construct the meaning of the experiences together in the study.

Axiology is represented as the values of the researcher and the participants being acknowledged and made transparent in the data reported, to be formatively reported in the findings (Creswell, 2013). The researcher becomes the instrument, immersed in the

data gathered from the participants. An understanding of personal beliefs needs to be recognized and revealed in qualitative research. The research is recognized as value-laden for both the participants and the researcher, and this allows the data to include the views of the researcher (Creswell, 2013). Memos, journaling, and reflexivity assist in revealing the values and beliefs of the researcher as they relate to the researcher's previous personal knowledge and experiences related to spiritual care to allow for bracketing of the researcher's biases.

The rhetorical assumption is represented as the telling of the story, and the language used to describe findings. This allows for the meaning to emerge from within the social context of the collected data. Rich, thick descriptions arise from the data gathered as the voice of the participants are documented. The voices of the participants of reflect a subjective view of process of spiritual care development in nursing practice.

The methodological assumption is hermeneutic and dialectical. This allows for the centrality of the researcher to co-construct the meaning with the participants in the research being conducted (Creswell, 2013). In the proposed research, the findings will emerge from the experiences of the researcher with in the social context of holistic nurses that provide spiritual care in their practice. Questions will begin a broad and general to elicit the participant's views as meaning is constructed related to the process of spiritual care development.

Qualitative research provides the researcher with an opportunity to answer questions that address social experiences, how the experience is created and gives

meaning, explore areas not thoroughly researched, and provide a holistic and comprehensive approach to the study (Corbin & Strauss, 2015) There are several different approaches to qualitative research. Each has its own purpose and structure (Creswell, 2013). In consideration of the components discussed, the proposed study is best framed through the epistemology of interpretivism, and the theoretical perspectives of pragmatism and symbolic interactionism that support grounded theory methodology (GTM).

Grounded Theory

Grounded theory was developed by sociologists, Anslem Strauss and Barney Glaser in the 1960s. Symbolic interactionism is the philosophical foundation of grounded theory. Symbolic interactionism is described by Blumer as the subjective process in which the individual constructs meaning for their reality as a result of their interactions experiences in a social context with others as well as themselves (De Chesnay, 2015). Blumer's work is known as the Chicago school of social interactionism and later referred to as the Berkley school of Symbolic Interactionism after Blumer took a position at University of California at Berkley (De Chesnay, 2015).

Grounded Theory consists of processes that define a research area to include developing a research question that seeks to understand a phenomenon of interest. Grounded Theory is an approach for developing a substantive theory that is "grounded in data systematically gathered and analyzed" (Strauss & Corbin, 1994). This theory ultimately came into existence when there was a wave of criticism of fundamentalist and

structuralist theories that were deductive and speculative in nature. Barney Glaser and Anselm Strauss working together to complete research on dying hospital patients led them to write *Awareness of Dying* in 1965. In this research, they developed the constant comparative method, later known as Grounded Theory Method. There were three main purposes behind the publication of *The Discovery of Grounded Theory* (Strauss & Corbin, 1994):

1. Rationale of the theory to be grounded is that this theory helps close the gap between theory and empirical research.

2. Helped in suggesting the logic of grounded theories.

3. This book helped to legitimize careful qualitative research. This was seen to be the most important because, by the 1960s, quantitative research methods had taken an upper hand in the fields of research and qualitative was not seen as an adequate method of verification.

Strauss identified the richness of qualitative research regarding social processes and the intricacy of social life, while Glaser recognized the systematic analysis inherent in quantitative research through line by line examination, followed by the generation of codes, categories, and properties. According to Glaser (1992), the strategy of Grounded Theory is to take the interpretation of meaning in social interaction on board and study "the interrelationship between meaning in the perception of the subjects and their action".

Through the meaning of symbols, individuals interpret their world and the other individuals who interact with them, and through the use of Grounded Theory this is translated into new understandings of behaviors that are generated from the meaning of symbols (De Chesnay, 2015).

Grounded Theory is a term used by many researchers to describe a general method of developing theoretical constructs inductively from data sources gathered as part of a qualitative research study. Researchers conduct an inquiry to generate theory inductively from data collected, typically using a "construct oriented" approach (e.g., creating categories that describe patterns in the data). They accomplish this by using systematic and thorough procedures. As researchers collect data, they simultaneously analyze these data using induction, deduction, abductive reasoning, and verification to develop theory. This theory provides a full explanation of a process or scheme associated with phenomena. A visual model is produced from the analysis that displays a coding diagram of the theory, and the tone of the research indicates that a scientific process has been undertaken, while also being sensitive to the data and ideas generated from it (Creswell, 1998).

Pragmatism

Pragmatism suggests that various sorts of power, in our interactions and experiences with others, is unequally distributed (Addams, 2002). Crotty (1998) wrote that pragmatists are not committed to only one field of philosophy. One belief of pragmatism regarding the analysis of meaning is that ideas and concepts are to be viewed

within the context and environment in which they occur. Pragmatists see individual experience as socially-transactive and transformative processes encompassing the self and the world (Talisse & Aikin, 2008). Human experiences transform the person, the society, and the environment (for better or worse). What is important to all pragmatists is that the knowledge generated by experience be practical and useful (Corbin & Strauss, 2008; Munhall, 2007).

Pragmatists are not restrictive in the selected method to conduct the research, but instead believe that the researcher should choose the appropriate method, procedure and technique to approach their work from the standpoint that best meets the researcher's needs. Practicality and usefulness of the research findings are central to pragmatism (Creswell, 2013). Additionally, pragmatists believe that the researcher is a social human being and must interact within the environment or culture to interpret their meanings. After this, the researcher inductively identifies the emerging theory generated from the findings grounded in the social and psychosocial processes (Creswell, 2013).

In the tradition of pragmatism, it is believed that the meaning assigned by the person is unique and the participants are tightly connected to the outcomes found in within the contextual setting (Crotty, 1998). Understanding meaning is accomplished through a common-sense examination of surroundings as the person seeks to understand problems. This is accomplished by depicting elements and the relationship between them and this resulting in practical applications (Rodgers, 2005). The provision of spiritual care in holistic nursing care occurs through interactions and processes experienced within

the context of the nurse's practice in which reality and meaning are created, interpreted and assigned. Research underpinned by the philosophical approach of pragmatism is appropriate to the proposed study and supports the discovery of new knowledge essential and useful to the profession of nursing and society.

Symbolic Interactionism

The underpinning of symbolic interactionism is a social theory embedded in the beliefs of George Herbert Mead from the University of Chicago and was influenced by post positivism. This, in turn, influenced the early methods demonstrating a structured process in his methodology (Crotty, 1998). Blumer, a student of Mead, is credited with defining the concepts and is considered as the "founder of symbolic interactionism" (Berg & Lune, 2012, p. 9). Blumer (1980) asserted that meaning is fundamentally connected to phenomenon (Wuest, 2012). It is generally agreed that human interaction is necessary in a specific context in which humans develop symbols to define their environment. Humans have the ability to communicate, ascribe meanings to events, and develop meaning from experience and interaction (Baker et al., 1992).

Symbolic interactionism is the basis for the assumption in Grounded Theory that the participants in the study share a social problem or process. The assumption of symbolic interactionism is that phenomena are relational. An understanding of phenomena, interactions and the context must be considered (Wuest, 2012). Blumer provides three basic assumptions specific to symbolic interactionism to develop a pragmatic approach to inquiry (Crotty, 1998):

1. Humans act and interact with events, objects or phenomenon according to the meaning the person has assigned to the item.

2. The social interaction that the person experiences determines the meaning.

3. Through the encounters with the event, object or phenomenon the person uses the interpretive process to modify meaning.

Nursing processes and care are developed within the social structure in practice of nursing. The social context allows nurses to construct their own meaning related to the provision of spiritual care in the social environment in which they practice nursing care. The use of a research methodology based in the underpinnings of symbolic interactionism is appropriate to provide insight into the meaning assigned to spiritual care development by nurses.

Approaches to Grounded Theory

Classical Grounded Theory, also known as Glaserian, is based on the work of Barney Glaser and Anslem Strauss (1967). Glaser and Strauss proposed a systematic qualitative analysis with its own logic and this ability to generate theory. Their aim was to move qualitative research past descriptive studies into the area of explanatory theoretical frameworks. The use of Grounded Theory allows for the creation of a substantive theory with supporting theory characteristics emerging from the data and works well in the real world (Straus & Corbin, 1967). This would provide an abstract conceptual understanding of the phenomenon being studied (Charmaz, 2014).

Glaser and Strauss proposed a systematic pattern in which theory is generated through a constant comparative approach. The analysis process in Grounded Theory is indicated as the origin of the constant comparative approach (Waler & Myrick, 2006). Glaser continues to support the post-positivist influence on this approach and using Grounded Theory as a method of discovery, treating categories as emergent from the data and relying on direct, often narrow empiricism and analyzing a basic social process (Straus & Corbin, 1967).

Another approach to grounded theory was developed by Strauss and Corbin in 1990 (Corbin & Strauss, 2015). This approach differs from Glaserian Grounded Theory by using a conditional matrix that allows the researcher to reconstruct meaning during the research procedures. Glaser's classical approach is more prescriptive than Strauss and Corbin's, which forces the data (Mills, Chapmann, Bonner, & Francis, 2007). The difference between the Glaserian and the Strauss and Corbin methods lies in the how the processes are carried out (Walker & Myrick, 2011). In the original version of Grounded Theory, a limited literature review is conducted in order to maintain a stance of unknowing (Glaser & Strauss, 1967). Strauss and Corbin differ in coding by utilizing a process whereby the data is fractured, then grouped into codes that become the theory and explaining the data. The process is systematic and structured. This allows for the constant review, fracturing data, putting it back together, and personal memoing to describe the researcher's thoughts throughout the research process.

Charmaz (2014) developed another approach to Grounded Theory. This is the Constructivist Grounded Theory Method reflecting a postmodern stance versus the positivist of the original Glaserian Grounded Theory approach. The Constructivist Grounded Theory is a less structured, more flexible approach because it pieces together the meanings of a category (Charmaz, 2014). The researcher is embedded in the experience, relationships, and hidden networks with more of an emphasis on views, values, feelings, assumptions and beliefs of the individual rather than on the methods (Creswell, 2013). Charmaz (2014) moved grounded theory to a constructivist approach. This positions the participants and researcher as co-constructors of meaning where "the critical interpretivist builds on the pragmatist underpinnings of grounded theory and advances interpretive analysis that acknowledges these constructions" (p.10).

The Qualitative Grounded Theory methodology serves to frame this study exploring the social context of what is the process for spiritual care development in nursing practice. Grounded Theory allows the researcher an opportunity to live in the data obtained from holistic nurse participants in order to identify the critical factors influencing the nurse's spiritual care development in nursing practice. Grounded Theory is the most appropriate method as the process of spiritual care development in nursing practice is limited in the current literature. The data was gathered from a purposive sample of nurses who understand and practice spiritual care in their nursing practice.

The Strauss and Corbin Method was selected for study because the processes provide the structure for a novice researcher. The philosophical foundations of

pragmatism support the proposed study in that the reality of spiritual care is open to multiple interpretations. The facts and values of spiritual care are linked rather than separate as is evident in the expressions of the experiences from the holistic nurses' accounts in providing spiritual care in their practice.

Relationship of Grounded Theory to this Proposed Study

Grounded Theory supports the investigation of the research questions in this study by enabling experiences of the participants (nurses) related to providing spiritual care to be connected to analytical findings and data collected through the interviews. The social interaction being investigated in this study is the interaction of the nurses with their patients during the provision of spiritual care. The researcher will be exploring the meaning that the nurses assign to this social process.

Grounded Theory will support the analysis of the interrelationship between the nurses meaning related to spiritual care to their practice of nursing. The researcher will explore the symbols and meanings of spiritual care as expressed by nurses. Through the use of grounded theory, the researcher is able to translate the collected data into new understandings of behaviors generated from the meaning of the nurse's experiences with providing spiritual care in their practice of nursing. Grounded Theory Methodology provides an opportunity for the researcher to demonstrate the value placed on the participants as a contributor to the reconstruction of the final grounded theory generated from the study.

Significance of the Study

Nursing research incorporates a holistic approach and regards the treatment of the patient, family members, and care providers as a whole. By developing healing methods to focus on the whole community involved in the patient's care, there is a greater level of effectiveness when new techniques are implemented. Important improvements in the health treatment of the patients are indicated as science unfolds and expands the boundaries of holistic health care promoting treatments that will ultimately bring faster healing and better quality of life to the patients who need them most. These therapies are not only for the improvement of the individual patient but also for the community as a whole.

Significance of the Study to Nursing

Spiritual care is essential to the healing process of the individual and nurses need to understand how to identify and provide spiritual care to their patients. The research also indicates that nurses would benefit from support for their spiritual caring and addressing the perceived barriers to providing spiritual care. It is also important for nurses to understand that their perception of spirituality can affect how they behave and communicate with their patients while providing spiritual care.

Implications for Nursing Education

Research related to spiritual care has explored several issues in nursing education. Nursing education curricula should enhance a student’s awareness and knowledge of spirituality. Nursing faculty should become more proficient and comfortable in working

with spiritual issues of nursing students and the recipients of their students' care. Another issue addressed is that nursing faculty needs to assist students in understanding the spiritual care skills needed to provide holistic nursing care.

After reviewing the current research on spiritual care, the investigator found that additional research is needed related to spiritual care development of nurses. Additional research is needed on how undergraduate education could be further enhanced relative to palliative and spiritual care.

Implications for Nursing Practice

Nursing is a holistic practice. Nursing care includes providing for the needs of the whole person; mind, body, and spirit. In nursing practice, spiritual care helps to treat illness and prevent poor health. Meeting the spiritual needs of the client through the delivery of holistic nursing care assists a client's recovery and improve the client's quality of life. It was found that continued nursing research on the identification of barriers to spiritual care in the acute care setting should be explored. This study will assist the nursing profession to better understand how nurses understand and develop their skills related to spiritual care.

Implications for Research

Research has supported the concept that meeting the patient's spiritual needs have improved patient outcomes and enhanced nursing practice. However, it is reported by many nurses that they do not understand what spiritual care is and how to provide it for their patients. Nursing research is needed to fill the gap with evidence-based strategies to

assist nurses in understanding spiritual care and how to provide for their patients. Prior research indicates that additional qualitative studies in other specialty nursing fields and in different cultures would address this gap on nurses' perceptions of spirituality and spiritual care. Additional research will assist in the development of guidelines for educating nurses about spiritual care and effective spiritual care interventions.

Implications to Health/Public Policy

The Affordable Care Act of 2012, addresses the need to reduce health care costs through competent and innovative health care procedures and ensuring that competent professionals are employed. Providing appropriate healthcare delivered by a competent and inter-disciplinary healthcare team is the expectation of the federal government in order to meet the healthcare needs of the country. Nursing educators and leaders need to assist in developing healthcare policies that will improve the delivery of healthcare in this country. This research can help provide insight to guide nursing leaders in the development of necessary policy changes.

Scope and Limitations of the Study

This study will explore the nurses' experiences with providing spiritual care in order to better understand the essence of the lived experiences of nurses. The nurses interviewed for this study have provided spiritual care in their current nursing practice and voluntarily consented to sharing their experiences with the researcher. The sample was limited to limited to registered nurses who self-identified as practicing spiritual care in their current practice. Their conceptualization of spirituality and their ability to express

this must be viewed within this context. There is also the potential contributing factor of the social desirability effect during the participant interviews. A final limitation of the study was the researcher's inexperience with grounded theory methodology.

Chapter Summary

This chapter has discussed the problem, purpose, research questions, philosophical underpinnings, significance, scope and limitations of the proposed study which seeks to explore the lived experience of nurses who provide spiritual care in their practice. The background presented the lack of consisted spiritual care in nursing due to several barriers. The barriers include lack of understanding of spiritual care and needs, lack of time and lack of support. Grounded Theory approaches and underpinnings of symbolic interactionism and pragmatism were discussed as the framework for the proposed study. Grounded Theory is presented as the appropriate qualitative choice to gain an understanding of the holistic nurses meaning of the process of spiritual care development in nursing practice. A grounded theory study using Strauss and Corbin (1990, 1998) will be used to identify the process of spiritual development in nursing practice. The findings of the proposed study will provide significant information to nursing, nursing education, implications for nursing practice, research and for public policy. Additionally, the scope and limitations of the proposed study are discussed. A gap in the literature was identified regarding the process of spiritual care development in nursing practice. Chapter Two will discuss the literature review related to spiritual care in nursing.

CHAPTER TWO

Review of the Literature

The purpose of this qualitative grounded theory study is to generate a substantive theory describing the nurses' role in providing spiritual care. A literature review is completed for a qualitative research study to provide a systematic identification, location, and analysis of material related to the research problem of spiritual care in nursing practice. This section presents a review of the research literature that summarizes what has been published on spirituality and spiritual care as it relates to nursing. The following databases were accessed: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Dissertation Abstracts, EBSCOhost, Medline, ProQuest, PubMed, OVID, and Science Direct. Key words include *nursing, spiritual care, holistic care, spiritual care interventions, spiritual care development*, and *spiritual care competency*. The search was further limited to English and by subject to the investigated concepts citations published from 2000 to 2016. This allowed for review of seminal works published at that time. The review of literature includes historical context, competency issues related to spiritual care and barriers to spiritual care. Synthesis of the literature reveals what is known and not known about this phenomenon of interest and provides a rationale for the proposed project. Finally, the experiential context is discussed.

Historical Context

Among the oldest Indo-European nurse type images symbolized nutrition and protection of life (Gimbutas, 1974). Approximately 5000 years ago, in Greek mythology

nurses also were portrayed as caring for the spirit and healing the sick and injured (Jobes, 1962). In just over 200 years ago, with the start of Christianity, the compelling force of nursing was recognized especially among the poor and less fortunate, the intrinsic dignity and spiritual needs of all individuals (Lebech, 2009). In more than 7000 years, the major aspect of nursing have been described as spiritual, initiated by the vulnerable individuals' need for nutrition and protection. This has been supported by the nurses' objective to help and promote healing as displayed in nursing relationships (Nutting & Dock, 2000). Physicians existed in ancient Egypt as early as 1100 BC. It is believed that during this period, many practical therapeutic remedies used to care for the sick were developed. It is also believed that a primitive form of nursing care also existed in Egypt at this time (Dietz & Lehozky, 1967).

In ancient Greece, nursing care was largely the responsibility of the family of the ill person or the slaves who were employed to provide this care. The spiritual aspect of care was born out of duty to and love for their relative (Swaffield, 1988). It was at this time that Hippocrates encouraged caregivers to attend to the spiritual needs of their patients and to do no harm (Frank, 1959). Nursing was considered a noble role in ancient Greece and nurses were to provide care in a loving, devoted manner (Gorman, 1917).

In the Roman Era, there were few great advances in nursing or medicine. Health care at this time depended upon the knowledge founded by the Greek physicians. Nursing care was heavily influenced by religion. Prayer to a god or to several gods was a major adjuvant therapy in caring for an ill person in Rome (Pavey, 1952).

In Israel, the Hebrew people followed the Mosaic Law, which identifies the provision of nursing care for the ill person. There were religious prescriptions for general health and hygiene, rules concerning diet, and laws for work and rest. (Sellew & Nuesse, 1946). Rules for public health as the rules were written for the community and not the individual. It has been stated that the people of Israel developed the foundations for public health nursing in terms of a responsibility of visiting the sick as a religious duty (Robinson, 1946). Another religious tradition of nursing at this time included the concept of hospitality and charity for anyone in need (Pavey, 1952).

Early in the beginning of Christianity, nursing care of the sick or injured was occupied a place of honor and respect as one of the primary messages of Christ: to love one another. Anyone identified as providing nursing care to the sick held a diaconal role in the early Christian church (Dolan, 1973).

In the 16th Century, more than 100 female religious affiliated groups were founded specifically to provide nursing care including meeting the spiritual needs of their patients (Donahue, 1985). Nursing communities continued to grow in the following centuries including a few new groups into the mid-20th century.

Florence Nightingale and her nursing community, although not formally constituted as a religious order, served in the Crimean War and undertook their work out of spiritual motivation (Donahue, 1985). Among the first to combine spiritual care and nursing was Florence Nightingale (Maher, 2006). Nightingale felt spiritually called to model the greatness and generosity of God to the individuals she cared for as a nurse

(Selanders, 1993). One belief of Nightingale was that spirituality is an essential aspect of being human and is required for healing to occur (Macrae, 2001). Nightingale believed nursing to be mystical work similar to a religion and that spiritual experience was found in actively living in the world. The spiritual responsibility of the nurses was not to pray that God would act, but instead for the nurse to work to reduce sickness and injury. This would assist in improving the health of society (Macrae, 2001).

In reviewing spiritual care in nursing theories, Oldnall (1995) found that many nursing theorists have either omitted discussing the spiritual aspect of the patient or only discussed it very briefly. Since this time there has been an increase in the inclusion and the discussion of importance of spiritual aspect in nursing theories. Barbara Barnum (1995) wrote of three reasons for the increased attention to the spiritual care in nursing. The three reasons are; "a major shift in the normative world view," "a spiritual focus in the growing self-help movement," and "a renewed drive on the part of traditional religious groups and individuals in nursing" (Barnum, 1995, p.25). Barnum (1995) suggests that the holistic health care approach to nursing is a significant catalyst for nursing's interest in spirituality.

Neuman's Systems Model is a conceptual framework that addresses the spiritual dimension and the spiritual needs of the ill person. This model addresses the person from a holistic approach by assessing the physiological, psychological, psychosocial, developmental, sociocultural, and spiritual dimensions of an individual (Neuman & Fawcett, 2002). In the third edition of *The Neuman's System Model*, the spiritual variable

is described as the pivot on which the framework centers and as having an important implication from many different world cultures (Neuman & Fawcett, 2002).

Sister Calista Roy (1999) addressed in her Roy Adaptation Model the adaptive needs of the ill person and their family. She included a self-concept adaptive mode that emphasizes the psychological and spiritual characteristics of the individual. Religion and religious practices are considered among the significant cultural practices of the person, and she also notes that the cultural category includes spiritual beliefs, practices, and philosophies that are not necessarily connected to an institutional form of religion (Roy & Andrews, 1999). Roy states that religiosity or religious practices influence the person's life view and functional capacity especially related to health behaviors and attitudes (Roy & Andrews, 1999).

Many contemporary nurses find assessment and interventions relative to a person's spiritual needs to be a cherished and essential part of their nursing care. Other nurses do not feel competent or comfortable in the provision of spiritual care (O'Brien, 2008). O'Brien states that all nurses should be sensitive to the importance of the assessment of a patient for spiritual distress, interventions to meet the patient's spiritual needs and appropriate referral to a pastoral caregiver for support.

Challenges in Providing Spiritual Care

Spiritual care is an important aspect of holistic nursing care. Copper, Gables, Mason and McGlinchey (2014) completed a descriptive quantitative study to explore the confidence levels of nurses who care for patients with learning disabilities, including

their palliative care needs. Out of the 111 surveys mailed to nurses who worked at hospitals in England, 33 responded to the survey. The survey was divided into three sections. The first addressed demographics, the second section collected information related to patient care including questions specific to patients with learning disabilities, and the final section asked questions related to hypothetical situations involving patients with learning disabilities (Cooper et al., 2014).

The participants with various levels of experience reported they were less confident in their capability when providing spiritual and psychological care related to aspects of general care (37%) and more confident when providing spiritual and psychological care related to aspects of end-of-life care (60%) (Cooper et al., 2014). The researchers reported that reasons indicated for lack of confidence in providing spiritual and psychological care were related to lack of training (Cooper et al., 2014). The researchers of the study recommended additional research related to the effect of educational sessions related to palliative care. They also recommended exploring other settings, such as hospice facilities (Cooper et al., 2014).

Attard, Baldacchino, and Camilleri (2014) explored the predictive effect of pre- and post-registration education on the spiritual care competency of nurses and nurse midwives in Malta. There were 99 nurses and 75 nurse midwives who participated in the quantitative study. There were two groups in the study: a control group and treatment group that received the spiritual care education program (Attard, Baldacchino, and Camilleri, 2014). All of the nurses and 11 of the nurse midwives received the education

unit. Data were collect through the use of the Spiritual Care Competency Scale (SCCS) (Van Leeuwen et al., 2008). The SCCS is a 27 item Likert Scale survey. The overall score ranges were between 27 and 350. The responses were analyzed for descriptive and inferential statistics (Attard, Baldacchino and Camilleri, 2014).

The findings indicated that the control group nurses and both treatment groups scored higher in the overall spiritual care competency score than the midwives who did not take the course. No statistical significance was detected in the scores between the control group nurses and midwives ($p=0.437$), nor was there a statistically significant difference between the control groups and the treatment groups ($p=0.054$) (Attard, Baldacchino, and Camilleri, 2014). Although the difference in competency scores was not statistically significant, the participants who took the educational session scored higher in all six dimensions of the competency in spiritual care. A regression analysis was used to determine the predictive effect of two variables, education, and profession, on the overall competency in spiritual care derived from the SCCS survey (Van Leeuwen et al., 2008). Education was found to be the stronger predictor of the two variables ($p=0.089$) (Attard, Baldacchino, and Camilleri, 2014). The researchers recommend a trans-cultural longitudinal study to evaluate the influence of life experiences on the spiritual care between undergraduate and post graduate nurses and nurse midwives (Attard, Baldacchino, and Camilleri, 2014).

Ebrahimi et al. (2017) completed a cross-sectional descriptive quantitative design to investigate the perception of competence of spiritual care provision in Iran. The study

population was 555 nurses who were working as nurses or nursing managers at one of the medical-educational centers in Tabriz, Iran. The demographic characteristics of the study subjects were 491 females (88.5%), 64 males (11.5%). The educational level breakout of the subjects included 17 Associate Degree Nurses (ASN) (3.1%), 508 Bachelor of Science in Nursing (BSN) (91.7%), 25 Master of Science in Nursing (MSN) (4.5%). The level of employment positions for the subjects included 480 staff nurses (86.5), 48 head nurses (8.7%), 22 supervisors (4.0%), and three education supervisors (0.5%) (Ebrahimi et al., 2017). The demographic questionnaire also asked if the subject had participated in the workshop on spiritual care. There were 496 (89.4%) that had not attended the workshop and 59 (10.6%) who attended the workshop (Ebrahimi et al., 2017).

The nurses completed a two-part questionnaire including demographic information and the Spiritual Care Competence Scale (SCCS) (Leeuwen, 2009). Back translation to Persian was performed by two English language experts. The Persian translation was retranslated into English. The Cronbach *alpha* score for the scale was 0.93. The survey consisted of 27 items with a 5-point Likert Scale divided into six categories. Data analysis was performed using descriptive and inferential statistics using SPSS (Ebrahimi et al., 2017).

The results demonstrated a significantly different score of nurses' understanding from their competence in spiritual care in hiring and workshop attendance ($p \leq 0.05$) while in gender, marital status, shift, income, and position there was no significant difference ($p \geq 0.05$) (Ebrahimi et al., 2017). Results for each category on the competence

scale for spiritual care was significantly higher than average for the items. Individual support, professionalism, evaluating, and implementing spiritual care categories each included 6 questions. The subjects' score range is 6 to 30 with a mean of 18. Attitude towards religious states category has four questions ranging from 4 to 20 with a mean of 12. The section on communication had two questions with a range of 1-10 and a mean of 6 (Ebrahimi et al., 2017).

Analysis of the results revealed that providing spiritual care to patients is influenced by personal, cultural, and educational factors. The scores for nursing spiritual care competence were between 38 and 135 with a mean of 95.2 $\pm$. This indicates that the perception of the nurses regarding providing spiritual care to their patients was average. Most nurses who participated in the study scored in the average range. The mean score for each category was higher than the average. Future studies are recommended to focus on other qualitative research studies exploring the spiritual care experiences of nurses from different cultures and religious beliefs (Ebrahimi et al., 2017).

Baldacchino (2006) completed a mixed-methods descriptive exploratory study investigating nurses' competencies in the delivery of spiritual care to patients with myocardial infarction (MI). The sample was selected from two general hospitals in Malta on the islands of Malta and Gozo. The response rate was low 36% (N=77). Of the nurses who responded, 75 were Roman Catholic, and two indicated Christian, other denomination. There were 45 males and 32 females. The units were designated as either caring for females or males only. Four of the MI units were designated for males. Only

male nurses could work on the male coronary care units and females could only work on the female units. There was a higher percentage of male patients in this area who experienced an MI.

There were 20 open-ended questions, and the data underwent thematic analysis guided by the framework of Burnard (1991). Four main themes were identified; 1) role of the nurse as a professional and as an individual person; 2) delivering spiritual care by the four stages of the nursing process; 3) nurses' communication with patients, inter-disciplinary team and clinical/educational organizations; and 4) safeguarding ethical issues in care. This study demonstrated the complexity of spiritual care, which requires nurses to increase their awareness of the uniqueness of each individual patient with regard to connections between mind, body, and spirit (Baldacchino, 2006).

According to the researchers, the results should encourage nurses to consider the importance of spiritual care and assist them to empower the patients to find meaning and purpose during illness and crisis. Further research was recommended to continue to identify specific competencies to guide spiritual care in nursing (Baldacchino, 2006).

Nardi and Rooda (2011) completed an exploratory mixed methods study to examine the nature of awareness and ability to provide spiritual care among senior nursing students in two baccalaureate degree nursing programs in the Midwest region of the United States. A sample of 86 senior level nursing students in their final semester participated in the study. Independent *t*- tests, stepwise regression analysis and factor

analysis methods were used to determine the nature of the spiritual care practices of the participating students (Nardi & Rooda, 2011).

The study sample consisted of 50 students from the private school, and 36 were from the public nursing program. Both schools were similar in location and student demographics. The mean age was 27.98 years and 89.5% were female. A majority (56.9%) were married or in a relationship. There were 43% Roman Catholic, 36% were Protestant, 15.2 % did not identify themselves with a religion, and 3.6 % indicated either Hindu, Muslim or Mormon. The majority of the subjects were Caucasian (68.6%), African/Caribbean American (11.6%), Pacific Islander (4.7%), Hispanic (3.5%), Asian (3.5%), and South Asian (3.5%). There were only 9.4% that indicated that they belonged to a holistic nursing society or professional organization (Nardi & Rooda, 2011).

A combined mean spirituality score was 128.76. The scores for the two groups were not significantly different ($t = 64$; $p = 0.507$). Factor analysis extracted five dimensions of spirituality-based nursing 1) valuing and supporting others; 2) use of spirituality-based nursing process; 3) use of metaphysical self; 4) Individual spirituality-based actions and 5) Spirituality based outcomes. Three themes were identified from the qualitative data1) metaphysical dimension; 2) awareness of the metaphysical self - dimension and 3) experiencing the emotional dimensions of spiritual care.

This study explored the meaning and use of spiritual care by nursing students. The results revealed five dimensions of spiritually-based nursing care. This study also identified the perceptions of the student nurses' ability to provide spiritual care.

It is evident from the research that to nurses need to understand their role in providing spiritual care. The studies reviewed explored issues in nurses' perceived level of understanding in the provision of spiritual care in their practice. Each study indicated that additional research was needed to evaluate how nurses learn to provide spiritual care in their nursing practice. The research undertaken in this study intends to generate a substantive theory explicating the nurses' role in providing spiritual care.

Barriers to Spiritual Care

In a descriptive correlational, quantitative study, Balboni, Sullivan, Enzinger, Epstein-Peterson, Tseng, Mitchell, Niska, Zollfrank, VanderWeele, and Balboni (2014) evaluated nurses and physicians' desire to provide spiritual care and identify potential barriers to spiritual care. The participants were nurses and physicians from the northeastern United States who care for patients with incurable cancer (Balboni et al., 2014). There were 322 participants, 204 physicians, and 118 nurses. The survey used included five sections to explore the study subjects' demographics, religiousness versus spirituality, desire to provide spiritual care and actual frequency; medical professional barriers to spiritual care and desire to receive spiritual care training (Balboni et al., 2014).

Chi-squared statistical tests were used to evaluate the demographic information between the nurses and physicians. Perceptions of spiritual care frequency, desire to provide spiritual care, and spiritual care barriers were analyzed through the use of *chi-square* statistical test analysis (Balboni et al., 2014). Univariate and multivariate linear and logical regression parameters were used to identify predictors of spiritual care barrier

ratings for nurses and physicians; predictors of actual spiritual care provision for nurses and physicians; and predictors of lack of desire for future spiritual care training. Significance was set at a *p* value less than 0.05 (Balboni et al., 2014).

The results revealed that a majority of the nurses and physicians desired to provide spiritual care at least "occasionally" for their incurable cancer patients (74% vs 60% respectively, p=0.002) (Balboni et al., 2014). There was a significant difference between desire to provide spiritual care and reported provision among nurses (p<0.001) and physicians (p<0.001) (Balboni et al., 2014). Lack of time was reported as the most frequently reported barrier to providing spiritual care by both of nurses and physicians (71% and 73% respectfully). Inadequate training was reported as 60% of the nurses and 62% by physicians (Balboni et al., 2014). The belief that spiritual care would be better done by others was reported as 31% by nurses and 62% by the physicians. The multivariate analysis linear and logistic regression identified inadequate training, belief that spiritual care is not part of the medical professional's role and worry that the power inequity between patient and clinician makes spiritual care inappropriate as the major barriers to providing spiritual care (Balboni et al., 2014). A minority of the nurses and physicians (21% and 49% respectively; p=0.003) reported that they did not desire future training in spiritual care (Balboni et al., 2014). This study supports the additional spiritual care training for nurses and physicians. Lack of training was the only barrier identified by the majority of both nurses and physicians. Additional research was recommended to

study the barriers to spiritual care among healthcare providers of other diseases and stages of illnesses (Balboni et al., 2014).

A phenomenological qualitative study completed by Noble and Jones (2012) investigated the oncology nurses' understanding of spirituality. The participants for the study consisted of seven nurses working at a regional oncology unit. Data collection was completed through a focus group and one-to-one semi-structured interviews. The data were then analyzed by using cross-sectional analysis to develop themes. Analysis of the qualitative data revealed five themes; understanding of the term 'spirituality,' 'nurses' own spirituality, skills required, constraints and barriers, education and support (Noble and Jones, 2012).

Participants differed in their understanding of spirituality. Most saw it as being individual to each person and related to wellbeing (Noble and Jones, 2012). There was wide variety in participants' reports about their own spirituality. Concern was expressed for the nurses' own spirituality and coping skills, as it was felt that the difficulty in assessing and addressing patients' spiritual needs can cause feelings of stress and guilt (Noble and Jones, 2012). Participants regarded good communication as essential in tending to patients' spirituality. The use of reflection was considered important, and it was stated that nurses do not always have to do a great deal to address spiritual needs (Noble and Jones, 2012) Time was clearly the major barrier in helping patients with their spiritual needs. Areas found lacking were the amount of training and education devoted to spiritual issues (Noble and Jones, 2012). The researchers recommended a larger study

and a broader spectrum of participants to further explore if the results are replicated (Noble and Jones, 2012).

Keall, Clayton, and Butow (2014) explored the barriers and strategies that Australian palliative nurses identified in providing spiritual care in a qualitative phenomenological study. The participants were 20 palliative care nurses from a cross-section of practice settings, years of experience, spiritual beliefs, and importance of those beliefs in their lives. Questions focused on their current nursing practices and provisions of spiritual care, identification of barriers, facilitators and strategies to assist in providing spiritual care (Keall, Clayton and Butow, 2014).

The demographic data revealed ages ranged from 25 to 65. There were 19 females and one male in the study. Practice settings included community (nine), inpatient unit (six), acute hospital (four), and area (one). Twelve nurses reported identifying with a spiritual or religious belief, 11 stated Christianity and one with Buddhism (Keall, Clayton and Butow, 2014).

Three themes were identified as facilitators to spiritual care. The first was development of the nurse-patient relationship, and the following were sub-themes; confidence and experience; walking alongside the patient; and patient openness. The second theme was communication skills and was supported by active listening; being genuine/human/know your limitations; allowing silence; compassion; and body language/reading clues. The final facilitator theme was the questions palliative care nurses use to facilitate conversation. The barriers identified were time, fear of what may

be uncovered, unresolved symptoms, lack of privacy, lack of skills of others and differences of belief. Strategies identified were making appropriate referrals, maintaining realistic expectations, setting the scene, undertaking a counseling course, and completing documentation (Keall, Clayton and Butow, 2014).

This study provides support for the education for nurses both academically and in practice for the nurses to provide competent spiritual care. Additional research related to developing evidence-based practices for competent spiritual care and identifying how nurses learn best to provide spiritual care was indicated (Keall, Clayton and Butow, 2014).

Iranmanesh, Banazadeh, and Forozy (2016) conducted a cross-sectional descriptive quantitative study using data collected from the National Survey of Critical Care Nurses Regarding End of Life questionnaire to determine pediatric nurses' perception of intensity, frequency of occurrence and barriers in providing pediatric end-of-life care. Spiritual care was identified as a major component of end-of-life care or these patients and their families (Iranmanesh, Banazadeh, and Forozy, 2016).

The study subjects were 151 nurses working in pediatric units in two hospitals in southeast Iran. Their ages ranged from 20 to 65 years of age with a mean of 32.7 years of age. Females made up 98.7 of the sample, and 80.1% were married. The subjects had a range of 0.5 to 30 years of experience in nursing with a mean of 8.7 years. All of the nurses had provided care to dying pediatric patients in their practice (Iranmanesh, Banazadeh, and Forozy, 2016).

The highest perceived barrier magnitude core among all items was “families not accepting poor child prognosis” Discussions of death and dying in Iran are still considered inappropriate conversations due to lack of education and understanding among the county’s population (Iranmanesh, Banazadeh, and Forozy, 2016). The second highest reported barrier was “available support person for family such as a religious leader.” The nurses perceived that the most important barriers were family issues (Iranmanesh, Banazadeh, and Forozy, 2016). One issue identified was a lack of education and knowledge on the part of the nurses regarding the Iranian culture. Additional research was recommended to help determine the best approach to educating the nursing staff regarding end-of-life pediatric care and cultural practices (Iranmanesh, Banazadeh, and Forozy, 2016).

These research studies revealed several barriers to nurses providing spiritual care to their patients. In addition to educational levels and curriculum in nursing time constraints, perception of competency and adequate resources were identified as variables affecting how nurses approach spiritual care. A gap was identified in the current literature regarding the need for additional research to generate a substantive theory explicating the nurses’ role in providing spiritual care to provide guidance to nursing as to what their role is and how spiritual developed. The proposed research study will seek to generate a substantive theory explicating the nurses’ role in providing spiritual care.

Experiential Context

My nursing career started over 30 years ago, as a wide-eyed and naïve registered nurse excited to help others who are suffering. I believed my nursing education had prepared me to accomplish this. Reality shock set in as I started working full-time in the hospital and I felt so unprepared. I was responsible for the total care of my patients, and I was struggling. I remember knowing that nursing was supposed to be holistic care, but I was only able to address physical issues for my patients during my shifts. I believed that the chaplain would address the spiritual issues and I did not even ask if there were any spiritual issues affecting my patients.

As I continued in my career, my practice focused on addressing the physical needs of my patients as was also true of the nurses with whom I worked in the unit. We felt that calling the chaplain, or other designated religious leader to talk to the family and patient was sufficient when a patient was critically ill.

Just seven years ago, I experienced the worst time in my life, and I learned through personal experience what spiritual distress was and how nurses might address these issues. Several of my family members were entered into hospice care, and my entire family was the recipient of holistic care from the hospice team.

Once hospice care was initiated for each member, the family and patient were better prepared for the medical care and health changes ahead. It was at this time that I realized the need for additional related to how nurses know how to provide spiritual care This researcher is aware of projecting her personal experiences on the data, and the

researcher is aware of the necessity to bracket or "epoche" the personal influences and experiences through self-reflective journaling.

Qualitative researchers participate in the process of *epoche*. The researcher must acknowledge the need to set aside the preconceived ideas related to the phenomenon of the study to allow the substantive theory to emerge (Creswell, 2013). Acknowledging my own beliefs and judgments was the first step to "set aside previous habits of thought" (Crotty, 1998; p. 80). Bracketing then became a continuous process throughout the research study so that an ongoing cycle of feedback to verify if the data outcomes could be attained without judgment. In grounded theory research, every attempt should be made to allow the theory to emerge solidly from the data.

Reflexivity provides a means for the critical analysis of self-reported assumptions, and emerging data are compared. My personal biases and influences were assessed using reflective journaling throughout the research study. In the reflective journal my beliefs and biases surfaced during the interviews, data collection, and data analysis (Dowling, 2006). In the proposed study, *epoche* will allow me to suspend my beliefs that the solution is easily assessed in the literature.

Chapter Summary

This chapter presented a review of the literature relating to the history of spiritual care in nursing, competency perceptions, and barriers to provision of spiritual care in nursing. A gap in the research is identified as the need for studies related to the nurses'

experience in the development of providing spiritual care. The purpose of this study is to assist in developing new knowledge related to nursing spiritual care development.

CHAPTER THREE

Methods

The purpose of this qualitative grounded theory study is to generate a substantive theory explicating the nurses' role in providing spiritual care. The aim of this study is to contribute to the knowledge of registered nurses and provide an understanding of the developmental skill processes nurses use to provide spiritual care to their patients. There is a lack of a theory to understand how nurses develop the skill to provide spiritual care in their nursing practice. Chapter Three discusses the research design of grounded theory, sample and setting, access and recruitment strategies, and inclusion and exclusion criteria. In addition, ethical considerations for human protection are presented. Data collection procedures, data analysis, and research rigor are discussed.

Research Design

A study to explore the meaning that the nurses assign to the social process of the providing spiritual care in their nursing practice is appropriate using a qualitative approach and a grounded theory design. This approach is best guided through the methods designed by Strauss and Corbin (2008). This method utilizes a systematic set of canons and procedures. A researcher begins the study with general questions to guide the initial and subsequent data collection processes. This was an essential step to direct each additional interview. Grounded theory analysis begins with the first data collected and continues until the completion of the research study. Analysis is done to search for cues and will incorporate all relevant issues into subsequent sets of interviews and

observations. Both experienced and novice researchers may be guided by this research process.

The adapted grounded theory model supports an interactive process in which constant comparison, memoing, journaling, and the use of field notes are used throughout the study. The processes inform the analysis process as data results are constantly compared, moving back and forth from data, interviews, and coding, as the researcher living in the data, records thoughts, impressions, and reflexivity during analysis. Data collection begins with purposive sampling in which semi-structured interviews are conducted with participants thought to have knowledge of providing spiritual care. Snowball sampling was also used. This was accomplished by participants identifying others who meet the inclusion requirements to participate in the study. Data analysis and data collection occur simultaneously with the first interview using the constant comparative process. Open coding is the first phase during which concepts are identified with associated properties and dimensions. The use of procedures such as word-by-word analysis, flip-flop techniques, and comparison allow codes to emerge and categorized. Next, axial coding will break the data apart and put the data together in alternative ways, considering how emerging categories and subcategories relate to one another. This analytical process and emerging categories will direct theoretical sampling in which participants with knowledge unique to the findings are sought for data saturation and to uncover new data. Selective coding is the final step of data analysis, when saturation of data is recognized. During selective coding, the intersection of categories,

conceptualization, and the linking of the categories into a theory explaining the basic social process are developed from the data.

The adapted, structured, and systematic pattern of grounded theory by Strauss and Corbin (1990, 1998) will be used to develop a theory regarding how nurses develop the skill to provide spiritual care in their nursing practice. Using the grounded theory approach allows the meanings and explanations of what is going on to emerge from the data. With limited literature and nursing knowledge regarding process of how nurses develop the skill to provide spiritual care in their nursing practice, this approach provides a substantive theory to gain important nursing knowledge regarding the meaning of how nurses develop the skill to provide spiritual care in their nursing practice. A model is depicted in Figure 1 of the methodology used to research the phenomenon

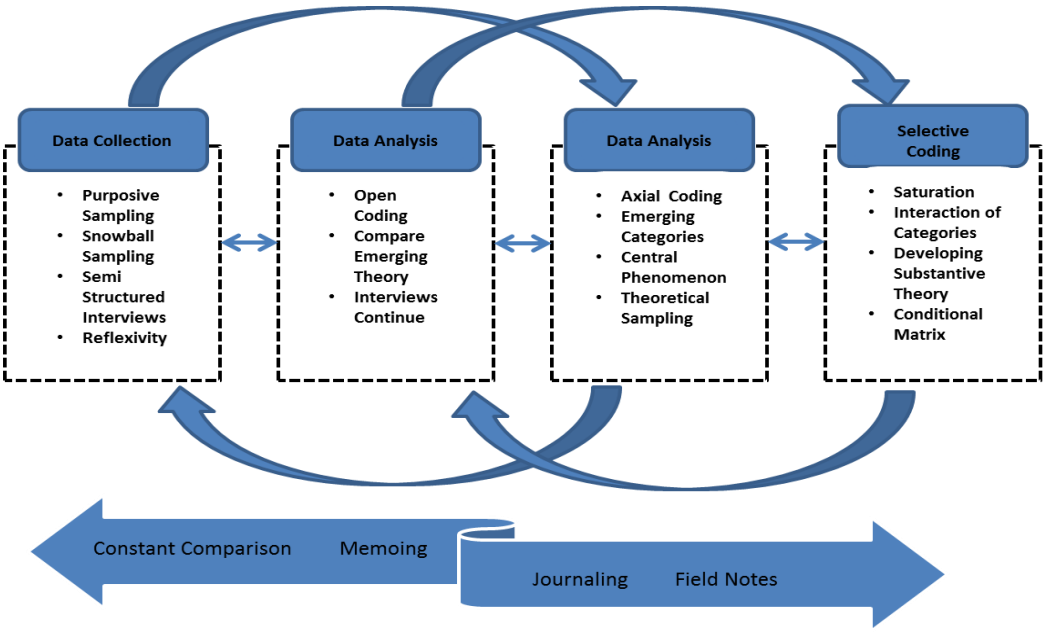

Figure 1. Grounded Theory Method (Lowden-Stokley, 2017, adapted from Strauss & Corbin, 1990)

Sample and Setting

The purpose of sampling is to allow the researcher to make informed decisions about when and how to collect data in terms of number and population (Corbin & Strauss, 1998). The sample is achieved in two phases to include purposive and snowball sampling. The investigator uses purposive sampling to select the participants for the study who will best help to understand the phenomenon which is usually done in a naturalistic research frame to maximize the range of specific information.

Phase One of the study, purposive sampling will be achieved by recruiting a maximum of 30 individual nurse participants from the American Holistic Nurses Association who practice spiritual care. Additional participants will be obtained through snowball sampling. This approach to recruitment occurs when participants willingly suggest others with similar characteristics to participate. The maximum size of the purposive sample will be 30 individual nurse participants.

The second phase of the sampling is theoretical sampling in which the researcher seeks participants to illuminate and define the boundaries and relevance of emerging categories (Bryant & Charmaz, 2007). This will be driven by the emerging concepts, seeking participants with unique characteristics who provide information for comparison and confirmation and to enrich data among the emerging concepts (Strauss & Corbin, 1998). Theoretical sampling allows for rich, thick data to emerge into a cohesive theory embedded in data. A theoretical sampling method is systematic and cumulative and is carried out carefully during the constant comparative process. In this phase, a sample of a

maximum of 9 expert spiritual care nurses known to have significant knowledge of the topic, have previously completed research and published their finding will be recruited for a focus group interview. The use of a focus group is used for concept clarification and confirmation of the findings. Participants in both phases of the study must have the ability to communicate through a computerized system and will be interviewed via Skype®, telephone, and/or face-to-face meetings. Decisions as to whom to include in the study will be made by the researcher based on the inclusion criteria.

Sample size and the approach to interviews in a grounded theory study is based on the accumulation and analysis of information to produce theoretical saturation and the emerging substantive theory (Wuest, 2012). This does not provide an exact measurement, because it includes a broad domain such as attitudes and perception of role amongst the nurses: therefore, a larger sample may be required. Sample size to achieve saturation in grounded theory research using the systematic procedures of Strauss and Corbin is usually achieved with 20-30 interviews (Creswell, 2013). The maximum sample size for Phase One, purposive and/or snowball sampling, will be a maximum of 30 individual participants, and for Phase Two, theoretical sampling, will be a maximum of nine participants interviewed as a focus group.

Access and Recruitment of the Sample

Upon IRB approval, permission to access participants for Phase One of this study will be obtained from the Administrators of the American Holistic Nurses Association (AHNA) (Appendix C), Access to these participants will be through an email distribution

list of AHNA members provided by AHNA. In addition, other holistic nurse participants may be obtained through snowball sampling. The recruitment flyer (Appendix D) will be sent via email to potential participants.

In Phase Two of this study, recruitment of participants will occur using two approaches: 1) the researcher will contact a prominent nurse researcher, Elizabeth Taylor, PhD, in the area of spiritual care who has agreed to distribute the recruitment flyer (Appendix D) to experts in the phenomenon of interest; 2) recruitment approach will include participants identified by searching the published literature in CINAHL database for published spiritual care nurse researchers. Those nurses will be sent a recruitment flyer by the researcher.

All study participants will be given a $25 gift card as a token of appreciation for their participation in the study.

Inclusion Criteria

The participants for phase one in the proposed study will be registered nurses who:

1. Provide spiritual care in their practice in their inpatient or outpatient professional practice:
2. Are willing to discuss their experiences in the interest of nursing research;
3. Are 18 years old or older;
4. Currently residing in the continental United States;
5. Able to read, write and understand the English language;

6. Are available for a face to face, Skype® or telephone interviews;
7. Be fluent in the use of video conferencing, Skype®, if opting to video conference the interview
8. Agree to be audiotaped and willing to review and return the transcribed interview as part of the "member check" procedure;
9. Have access to a computer and an email to complete the transcribed interview verification;

No limitation will be placed on the number of years of experience in providing spiritual care.

The participants for phase two of the proposed study will be registered nurses who:

1. Are considered experts in the context of spiritual care.
2. Have completed research in the field of spiritual care in nursing practice.
3. Have published in peer-reviewed nursing journals and/or presented their research at a professional nursing conference regarding spiritual care in nursing practice.

Exclusion Criteria

Anyone not meeting the inclusion criteria will be excluded from the proposed study. Licensed Practical Nurses (LPN), anyone under the age of 18, anyone unable to speak, write or understand the English language, and anyone not providing spiritual care in their nursing practice is excluded from the proposed study.

Ethical Considerations/Protection of Human Subjects

The proposed study requires approval from the IRB at Barry University and access to their members from the Administrators of AHNA prior to the start of the study. This qualitative study involves human subjects – mentally responsible adult registered nurses who meet the inclusion criteria and voluntarily choose to participate in the study. Prior to collecting data, participant nurses will be informed of the purpose of the study, assured that participation is voluntary throughout the research process, and assured that there would be no pressure or coercion to sign the consent form or to remain in the study if the participant decides to drop-out of the study. The participant can refuse to answer any question without consequences. Details of the study will be explained before the interviews and all questions regarding the study and the informed consent will be answered and clarified. Participants will be assured of confidentiality and security as an integral part of the procedure of obtaining the informed consent. There are no identified risks attributed to the study.

Procedures to protect the confidentiality of the participants will be implemented to meet legal requirements. Focus group participants will be informed that due to the nature of the group process confidentiality cannot be guaranteed; however, the investigator will maintain confidentiality to the extent provided by law. Participants will be asked to select a pseudonym that cannot be traced to their actual identity. All records, including audio recordings, scanned documents, disseminated findings, transcriptions, and demographic sheets will be identified with the pseudonym and retained in a locked

drawer in the researcher's office. Hard copies of signed consent forms will be secured in a locked drawer separate from all other documents, materials, and data related to the study. The electronically signed consents forms that are sent and returned through DocuSign.com will be encrypted, authenticated and made accessible only to the investigator. Electronically signed consent forms are to be kept on a secured password-protected personal computer. Confidentiality is to be maintained by secure storing of digital recordings, transcriptions, electronic records, and records of personal information such as names, demographics, email addresses, photos, postal addresses, telephone numbers, and all other forms of information and communication. A personal, privately-secured and password-protected computer will be used to store all relevant materials and data. It will be locked in a file cabinet drawer in the investigator's office, accessible only to the investigator. All other data, including demographics, consent forms, and transcripts will be maintained for a minimum of five years, then indefinitely by the researcher after the completion of the study. The audio recordings will be destroyed upon data clarification and member check. Findings of the study will be reported in the aggregate form to further protect participant confidentiality.

Data Collection Procedures

Data collection will occur in two phases:

Phase One

Data collection will begin after the investigator receives approval from Barry University IRB and permission to access members of AHNA by the Administrators of

this group. The email list of members of AHNA provided by the administrators of the organization will be sent the recruitment flyer. Although information about the study and criteria for participation in the study are included in the flyer, participants who contact the researcher will be provided with additional information about the study to include the purpose, criteria for participation, and number and length of time of interviews. Participants meeting inclusion criteria will be interviewed by the principal investigator using face to face, or Skype® and will be mutually agreed upon by the participant and researcher. The meeting will be scheduled at a mutually agreeable time and setting.

Face-to-face interviews will be held in safe locations. The meeting will open with a welcome and thank you to the participants. Next, this study's protocol, recordings, and informed consents will be discussed with the participants, questions will be answered and clarification of the purpose of the study will be reviewed. If the participant agrees to proceed, then, before the interview, the informed consent will be signed (Appendix B) and the $25 gift card will be given as a token of appreciation for participation in the study. Then the demographic questionnaire, which will take 10-minutes to complete. If this is a Skype® interview, the consent will be sent to the participant electronically via Docusign.com. The demographic questionnaire will also be sent electronically to the Skype® participant and returned via email before the Skype® interview is started. Once the consent and demographic questionnaires are received, the mailing addresses will be obtained for Skype® participants and the gift card will be mailed to the participants as a

token of appreciation for participating in the study. Once the investigator receives the signed consent, both the investigator and the participant will be ready to proceed.

Face-to-face interviews were conducted using semi-structured open-ended questions (Appendix H). In order to maintain confidentiality, the participant will select a pseudonym or have one assigned by the investigator. Follow up and probing questions will be used to gather the data from the participants. This will be used to describe meaning and essence of the attitudes and perceptions about the practice of spiritual care to produce a rich description that may lead to an emerging theory. The interview will last 60 minutes. At the end of the planned interview, the investigator will ask the participant if he/she has any additional comments or information to offer relating to their provision of spiritual care experience. The participants will be informed that the interview is being audio recorded. The audio recorder and back up audio recorder will be visible to the participant throughout the interview.

The Skype® interview will be conducted through semi-structured open-ended questions (Appendix H). In order to maintain confidentiality, the participant will select a pseudonym or have one assigned by the investigator. Follow-up and probing questions will be used to gather the data form the participants to describe meaning and essence of the attitudes and perceptions about the practice of spiritual care in an effort to produce a rich description that may lead to an emerging theory. The interview will last 60 minutes. At the end of the planned interview the investigator will ask the participant if he/she has any additional comments or information to offer relating to their provision of spiritual

care experience. The participants will be informed that the interview is being audio recorded. The audio recorder and back up audio recorder will be visible to the participant throughout the interview.

Interview procedures are outlined in Appendix F. All interviews will be conducted using a digital recording device. Digital recordings will be transcribed by a transcriptionist who will sign a third-party confidentiality agreement (Appendix E). Transcribed data will then be transferred and maintained on the personal computer of the principal investigator. All data, demographics, recordings, and transcriptions will be labeled with the participant's pseudonym and kept in a separate locked file drawer in the researchers' office for a minimum of 5 years, then indefinitely. The informed consent will be kept separate from the other data in a locked file in the researcher's office for a minimum of 5 years then, indefinitely,

Upon conclusion of the interviews, the participants will be thanked and informed that once the data has been transcribed, they will be sent the transcript via email, fax or postal service for their review and clarification (member check). The participants will be contacted for the follow-up interview which will be no more than 30 minutes. This interview will take place in person or via Skype® or telephone. Credibility of findings is a significant step that allows the participants to consider whether or not the transcription confirms their intended statements. Once member check is concluded, the audio recordings will be destroyed.

Phase Two

Phase Two focus group interview will occur via Skype®. Each of the theoretical sample participants will have met the inclusion criteria. Nine (9) qualified, expert participants will be sought to achieve a sample size of a maximum of seven. An electronic signature using Docusign.com or a signed, scanned consent will be completed by each focus group participant. The demographic questionnaire which will take 10 minutes to complete will also be sent electronically to the Skype® participant and returned via email before the Skype® interview is started. Once the consent and demographic questionnaires are received, the mailing addresses will be obtained for Skype® participants and the gift card will be mailed to the participants as a token of appreciation for participating in the study. An interview will be set at a time agreeable for the group and the researcher.

Participants will be provided a manuscript to review the emerging categories and emerging theory prior to the focus group interview A semi-structured audiotaped focus group interview will be conducted using open ended questions specific for the focus group and are identified in Appendix I. The Skype® interviews will be conducted via the Internet with the investigator and participant each in a private office for the interview on the computer. Follow-up and probing questions will be used to gather data from the participants to describe meaning and essence of the attitudes and perceptions about the practice of spiritual care in an effort to produce a rich description that may lead to an emerging theory. Interviews will last approximately 90 minutes. This group will be

informed that due to the nature of the group process, confidentiality cannot be guaranteed; however, the researcher will maintain confidentiality to the extent provided by law.

After completing the interview, the investigator records the field notes in the form of memos. Analytic memos which are unspoken thoughts in order to expand on the meanings of the outcomes will also be recorded. Self-reflecting journaling will be completed after each interview to record the investigator's insightful thoughts and reactions to the participant's lived experiences. This self-reflective journal assists the investigator in identifying personal biases and assumptions and to offer fresh insights.

After the data was verified for accuracy, it was analyzed by the investigator for emerging themes. The data gathered from observations and other documents that were provided by the participant were examined. Interviews will continue until saturation of the data is met. After the transcriptions were completed, the audiotapes will be kept in the locked file drawer in the investigator's office. The investigator will keep all documents for a minimum of 5 years then indefinitely, fully secured, including the password protected electronic file, and locked storage, after completion of the study. Collected data will be kept separately from the consent in a locked file draw in the researcher's office. The password protected personal computer will be kept in a separate locked file drawer.

Interview Questions

Grounded theory data collection uses the semi-structured interview approach (Appendix I) that begins with an overall question with subsequent probes to elicit

meaning from the participant. The first question to open the semi-structured interview will be “How would you define/describe spiritual care?” The leading question should serve as a catalyst that allows the respondent to spontaneously answer and disclose information, experience, and interpretation (Wuest, 2012). Questions in this study began with a broad leading question and proceeded with prepared probing questions to elicit information. There will be two individual interviews: the first interview used for data collection will last 60 minutes, and the second interview used for clarification and member check will last no more than 30 minutes.

Demographic Data

A researcher-designed demographic questionnaire (Appendix H) is provided by the investigator to obtain basic identifying information from the participants. The data will be used to describe the study sample. The information to be collected on the demographic questionnaire will be age, gender, ethnicity, nursing degree, years’ experience as a nurse, specialty, competent at spiritual care, years’ experience providing spiritual care (Appendix H). Once informed consent has been obtained, the demographic questionnaire, which will take 10 minutes will be completed. Data are to be collected at the beginning of the interview with the face to face participant. The demographic questionnaire will also be sent electronically to the Skype® participant and returned via email before the Skype® interview is started. This information will be reported in aggregate form and labeled with the selected pseudonym. The questionnaire is to be secured with the collected data in the locked file in the investigator’s office.

Data Analysis

The process described by Strauss and Corbin will be used in this research study. The data analysis process is embedded in grounded theory, providing a structured procedure through which data can be collected. Essential to all grounded theory methods is the researcher's participation in the constant comparative process, and coding data to uncover theory (Walker & Myrick, 2006). Each of the methods involves coding, constant comparison, questions, theoretical sampling, and memoing (Creswell, 2013). Strauss and Corbin (1990) have three phases of coding called *open, axial,* and *selective* coding. Data will be transcribed verbatim by the researcher. The interviews will be uploaded to NVivo® where the creation of open categories will begin. The constant comparative process of grounded theory integrates a cycle of data collection, data analysis, and sampling, thus returning the researcher to the participants (Polit & Beck, 2012). Constant comparison continues throughout the interviews and analysis, and the researcher will return to the participants to ask further questions to shape the axial coding phase (Creswell, 2013). As codes, categories, and the core category emerge, specific questions are developed. Theoretical sampling will be completed to seek information from those with specific, relevant experience for comparison with emerging data (Wuest, 2012). Theoretical sampling provides the researcher with confirmation of saturation, development of concepts, and an emergence of the substantive theory. Sampling continues until no new data emerges.

Open Coding

Open coding is the initial step in grounded theory analysis. Concepts and properties will be identified (Strauss & Corbin, 1990). In the first phase, data are broken down into major categories of information. A category represents a unit of information inclusive of events, happenings, and instances (Strauss & Corbin, 1990). Using the constant comparative process, categories continue to be developed as the researcher conduct interviews in an attempt to saturate the category. As the analysis continues during data collection, the data were broken down, line by line, to reveal concepts and resulting categories. Categories were fully developed in terms of property and dimension (Walker & Myrick, 2006). After each interview is transcribed and reviewed, analysis is completed through examining each word and line to uncover significant segments and ascribed meaning. The constant comparative process continues from the first interview and each subsequent interview where codes will be identified in the NVivo software. During constant comparative analysis, the first interview is reviewed, and the second interview results are reviewed while comparing to the first. Subsequent transcription review continues with back and forth reviews of data. In addition, the transcripts are also analyzed manually to verify emergent codes and group similar findings.

The codes are categorized through the linking of similar concepts. The concepts are used to create categories related to the conditions, actions, and consequences. Then the concepts are developed to show dimensions and properties of categories and

subcategories (Strauss & Corbin, 1998). A model is depicted in Figure 1 of the process of open coding. Table 1 depicts an example of the open coding from the current study.

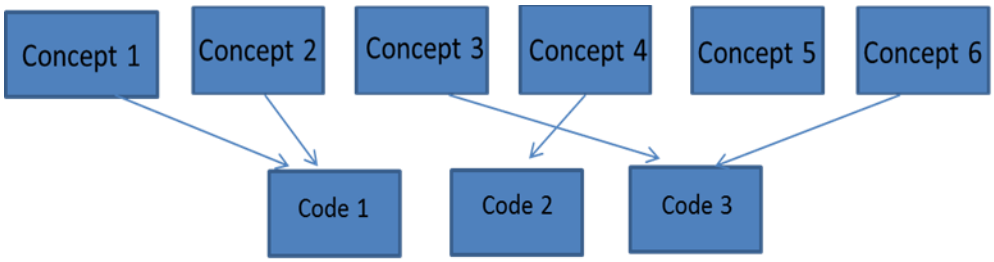

Figure 2. Open Coding

Table 1

Open Coding

Participant	Narrative	Coding
Mary 7/20/2018	I did not have any special training in school except that I was told that we are to meet the spiritual needs of our patients because as nurses we are to provide holistic care. As a new nurse and even as a student nurse I thought this meant that I was supposed to find out their religion and make a referral to their religious leader.	Training Spiritual care Personal view of role Spiritual care Provider
Field Notes	Face to face interview, Very excited, talkative, showed emotion and tears during recounting spiritual care stories but easily returned to happy mood as continued the interview. Appears interested, easy conversation.	
Memos	Thoughtful, caring, and reflective, described how she felt about spiritual care; expressed need for improved education and training for spiritual care. Concerned for future holistic of nursing and spiritual needs of patients.	

Axial Coding

The second phase in analysis is to take the resulting large amount of fractured data and put it back together. This process is necessary for the researcher to make connections between categories and permit a focus on three aspects (Strauss & Corbin, 1998). The researcher works to understand categories in relation to each other, specifically focusing on the causal conditions and situations where it occurs in each category, the context, actions of the people in response to the situation, and the consequences of the action or inaction (Creswell, 2013; Walker & Myrick, 2006). The use of axial coding allows the researcher to fully develop categories and sort, synthesize, and organize large amounts of data after open coding (Charmaz, 2014). The fragmented data is analyzed to identify the relationship of each piece to the categories by breaking the data apart; looking at the data in different ways to identify the context; and seeking to understand the who, what, when, where, why of the situated context. Relationships between the categories and subcategories emerge and are identified until saturation of categories is reached. This process helps to refine the emerging core category and subcategories. The linking and interrelation of the categories will provide a rich, thick description of the participant experiences and perceptions of nurses who provide spiritual care in their practice. The use of memoing is an ongoing process throughout this second phase.

Table 2

Axial Coding

Participant	Narrative	Coding
Mary 7/20/2018	I did not train to provide spiritual care because I was raised in a Christian environment and went to Christian schools, therefore I knew about God and God is my source of strength. That's why I try to direct my patients to realize that they can ... The experiences that they're going through, this is from what I was trained to do,	Training/Having a Foundation Recognizing/Knowing
Field Notes	Face to face interview, Talkative, excited about describing her spirituality and spiritual care practices	
Memos	Thoughtful, caring, and reflective, started singing after stating singing was a way she provided spiritual care by singing. Expressed that spiritual care was very important to her and in her practice	

Selective Coding

Selective coding is the final phase in coding, during which the emergent core category is considered based on relationship and dimensions within categories. At this time, analysis moves to a more abstract level. Categories are related back to the core categories with attention to properties, dimension, and relationship (Strauss & Corbin, 1990). Selective coding begins through the analysis of concepts, categories, and subcategories. During the selective coding process, categories are analyzed for links and a conceptualization of the basic social process is completed. An important aspect of the final

phase is the use of memoing contributes the ideas of the researcher throughout all three phases towards the developing theory (Creswell, 2013).

Development of the theory requires the researcher to step back and review memos and the researcher's interaction with the data. The use of the memos, reflective journaling, occurs throughout the data analysis of the study. Memos are documented during the analysis of the first interview and continue throughout the data collection and the analysis processes to reflect the researcher's thoughts and impressions. Field notes will be used with each interview to describe the details of the interview, the setting and to identify verbal cues and body language of the participants. The use of journaling allows the researcher the opportunity to reflect, set aside personal views and expectations, and bracket personal influences in order to allow the categories to emerge from the voices of the participants. The goal is to develop a substantive theory of the critical factors that influence the attitudes and perceptions of nurses providing spiritual care in their practice. The core category will be determined, and a theoretical framework developed. Ultimately, the researcher will complete a narrative describing the experiences that connect the categories to the core category and subsequent theory of the critical factors that influence the attitudes and perceptions of nurses providing spiritual care in their practice.

Research Rigor

Due to the emergent aspect of a qualitative design, it is critical to address rigor during the research process and in reporting the study's findings in qualitative research.

Rigor expresses the richness and depth of the study, giving the reader the ability to audit the actions of the researcher and the development of the research, building trustworthiness into the process. In an effort to minimize the biases of the researcher according to the subjective nature of the study, strategies must be used to maintain trustworthiness. These include prolonged engagement, triangulation, peer debriefing, member-check, audit trail, and reflexivity. According to Lincoln and Guba (1985), there are four components used to assess rigor and serve to establish the trustworthiness of a study: *credibility, dependability, confirmability*, and *transferability*.

Credibility

Credibility refers to accuracy in the description of the phenomenon being studied. This addresses whether or not the research is believable and answers the question: Is there consistency between the viewpoints of the participants and the interpretations of the researcher? Credibility can be demonstrated by adoption of a well-established research method, triangulation, strategies to ensure honesty in informants, audit trails, member-check, and reflexivity (Lincoln & Guba. 1985). The investigator will implement these strategies by spending time in the field with the participants, with the intent to develop an environment of trust, openness, and honesty that will result in clear and in-depth responses from the participants. Participants will be from different locations and practices and will be asked to share their practice guidelines. The investigator will use reflectivity by journaling personal preconceptions, assumptions, beliefs, and attitudes about the phenomenon, spiritual care in nursing. Audit trails will include accurate

transcriptions, clear descriptions of the process of analysis, and interpretation of data. Member-checking - an important technique for establishing credibility- will be completed with each participant rechecking transcriptions. Ongoing evaluation of data collection, analysis, and interpretation of data will be completed by the dissertation committee experts, as part of evaluating qualitative research, and to validate credibility.

Dependability

Dependability is an integral component of rigor and involves the researcher providing the reader with sufficient information to determine how dependable the study and the investigator have been (Ryan et al., 2007). The process of the research study will be reported in detail, so that future researchers may repeat the study process. The research report will include the research design and its implementation, operational detail of the data collection process, and a reflective appraisal of the completed study. An audit trail for each stage of the research will be traceable with detailed documented steps so that it can be replicated by another researcher.

Confirmability

Confirmability refers to the degree to which the results can be established or confirmed by another researcher. This is accomplished through demonstrating how conclusions and interpretations were reached. The investigator's description of the nurse participants' experiences in providing spiritual care in practice must accurately reflect that of the participant and not the interpretations of the researcher. Confirmability will be accomplished by peer review, member-check, and reflective journaling in order to ensure

that the researcher's biases do not alter the results. Triangulation will be used to assist in reducing the bias of the researcher. An inclusion of a detailed methodological description permits the reader to determine how far the data and emerging constructs from the data can be accepted. An audit trail provides a step-by-step account of the decisions made and procedures used will be included. An auditor will be able to clearly determine whether the conclusions, interpretations, and recommendations can be traced to their sources and if they are supported by the inquiry (Lincoln & Guba, 1985).

Transferability

Transferability is the ability of the reader to make a transfer of the findings from the study to other situations. It is the degree to which the findings of the study can transfer beyond the research project. Through purposive sampling to data analysis, the researcher can ensure transferability by providing a detailed, thick, rich, and vitalized description of the process and a database that makes transferability judgments possible by the potential appliers (Lincoln & Guba, 1985). The method, sample selection, inclusion and exclusion criteria, and data collection and analysis clearly described in this study provide an evident audit trail. The investigator's use of experts in the field and the dissertation committee will assist in ensuring the transferability of the research. The study is deemed transferable if others can fit the meaning in the study and the findings into their contexts as applied to their own experiences.

Chapter Summary

This chapter has discussed the research methods and process applicable to this study. The research design is Strauss and Corbin's (1990, 1998) Grounded Theory, and the rationale for this approach is demonstrated as appropriate. A detailed discourse of the research design, sample and setting, access and recruitment of the sample, participation criteria and ethical considerations, along with data collection procedures, interview questions and data analysis, was presented. Research rigor is discussed with a focus on trustworthiness, credibility, transferability, dependability, and confirmability.

CHAPTER FOUR

Findings of the Inquiry

The purpose of this qualitative research using grounded theory approach was to develop a substantive theory about spiritual care development in nursing practice. The lack of a theory to understand the spiritual care development in nursing practice has created a lack of understanding about how nurses develop spiritual care skills. Patient care outcomes may be negatively impacted unless the factors that prevent nurses from providing spiritual care are explored.

This study aimed to contribute to the knowledge of spiritual care development in nursing practice. Through the use of open, axial, and selective coding, data were constantly compared and analyzed. The concepts and categories that emerged were reviewed to determine relationships among them and to identify a core category explaining the attitudes and perceptions of nurses who provide spiritual care in their nursing practice. The data collection involved two phases, Phase One; the individual (N = 27) participant interviews, and Phase Two; the focus group (N = 4) interviews. The aggregate description of data from these two phases is presented in this chapter. This chapter will present a demographic description of research participants, the results gathered from the data and verbatim interviews of the participants.

Overview

The application of the grounded theory approach as described by Corbin and Strauss (2008), informed individual and group interviews to reveal data that resulting in a

basic social process. A core category emerges supported by three categories. Each category includes subcategories rich with examples providing dimensions and attributes. During the first phase of the data collection process, 27 individual interviews were conducted. The participants in the individual interviews were protected through the use of pseudonyms. Each participant was provided the opportunity to review the interview through member-checking. This phase included participants who are registered nurses with at least three years of experience in providing spiritual care in their nursing practice. The second phase of the process included a group interview of four participants. These participants who served as the theoretical sample were identified as experts in the field of spiritual care practice who have published or presented on this issue. Group and individual demographic descriptions of both groups are presented in the sample characteristics sections.

Barry University IRB approval was obtained before any data collection occurred. No other institutions required IRB approval, although IRB approval documents were provided to the research Chair and Committee members at the American Holistic Nurses Association (AHNA) before they shared research flyers with association members for potential volunteer participants. In an effort to obtain the initial purposive sample, the American Association of Holistic Nurses was contacted regarding the study (Appendix C). Access was granted by Chair of the Research Committee at the American Holistic Nurses Association. The first participants responded to the email posting of the research flyers. Sampling was purposive with participants located throughout the United States,

including California, Florida, New York, Colorado, and Pennsylvania. Snowball sampling was utilized for additional participants. Individual participants who met inclusion criteria but could not meet face-to-face were interviewed using Skype® at a mutually-agreed upon time. Several individual interviews were conducted via telephone due to participant preference. Seven interviews were held face-to-face with the researcher. The interviews were conducted using a semi-structured interview approach. Iterative questions were broad based and included probes to elicit participants' thoughts and views, meanings, perceptions, and attitudes about spiritual care development in nursing practice. In ongoing individual interviews, questions were adapted to enrich the emerging concepts, categories, and subcategories. All individual interviews were audiotaped and subsequently transcribed verbatim by a third-party transcriptionist. Each interview transcript was reviewed while listening to the audiotapes by the researcher to ensure the accuracy of the transcription. Member-check of each individual interview was conducted.

Data were reviewed and analyzed continuously through the constant comparative process to identify similarities and differences and was then categorized (Strauss & Corbin, 1998). Analysis was initiated during open coding through a line-by-line approach to the data from the first individual transcript, and multiple concepts emerged (Strauss & Corbin, 1998). The concepts were developed as the properties and dimensions that subsequently described them were identified. Then, the categories were reassembled as relationships connected the main categories and subcategories through the properties and

dimensions that described their meanings (Strauss & Corbin, 1990). Relationships were identified by diagramming the conditions and consequences of categories and subcategories. The categories are phenomena defined by the participants as significant and explain "what is going on" (Strauss & Corbin, 1990, p. 125). Categories were refined and integrated, producing a core category representative of the data. The categories that emerged from the data were *becoming aware, caring for the spirit* and *embodying praxis*. The core categories were then conceptually linked to describe a basic social process. The basic social process that emerged from the data was *Living Spiritual Caring Praxis*.

Upon saturation of the categories, the data collection moved to the theoretical sample, Phase Two, which included four participants. A theoretical sample is formed to select a population where the researcher believes the people can assist in discovering the variations and densify categories both in dimension and property (Strauss & Corbin, 1990). The participants in the group interview served to verify the emerging categories and subcategories from Phase One of the data collection process.

A constant comparison process was used from the initial interview through the analysis process. A developing theoretic sensitivity allowed the researcher to move from concepts to categories and subcategories. As relationships, dimensions, consequences, and properties emerged, the conditional matrix was sketched. Returning to the data served as an additional sampling method to examine and identify any further information to refine conditions of the emerging categories. Saturation occurred after 21 interviews and six more interviews were conducted to verify saturation. Determination of saturation

was verified when no new relevant data emerged, properties and dimensions were well developed, and relationships were apparent between the categories (Strauss & Corbin, 1990). One abstract, explanatory category emerged as the core category that links the categories explaining the basic social process of the critical factors influencing nurses' attitudes and perceptions related to providing spiritual care in their practice.

The use of bracketing by regularly recording preconceived ideas and biases in a journal throughout the research process provided a means to maintain theoretical sensitivity. Field notes and memoing conducted with each interview allowed the researcher to document thoughts about context, dimensions, properties, and links in categories. Transcriptions and data were entered into NVivo® to provide a visual collection of data augmenting categories and subcategories. Reflexivity in the journaling process allowed the researcher to set aside beliefs and journal reaction sto interviews, analysis, and explanation of the emerging theory.

Ongoing analysis of data, field notes, memos, and journals resulted in links between categories. Strauss and Corbin (1998) described the creation of a core category with the "greatest explanatory relevance and potential for linking categories … and has analytical power" (p. 104). The basic social process of *Spiritual Caring Praxis* emerged from the refinement and integration of categories serving as a logical and consistent core category explaining the main theme of the research findings. The following is a description of the individual participants who provided the data from which the theory evolved.

Sample Description

Two groups of participants were interviewed for the completion of this research. The first group was made up of 27 nurses purposively sampled who had a minimum of at least three years of providing spiritual care in their nursing practice. The initial participants responded from flyers and notices posted electronically on the American Holistic Nurses Association website. Additional participants were obtained through snowball sampling. The theoretical sample group was sought through a review of the literature of spiritual care in nursing. Four nurses were selected based on their expertise in spiritual care demonstrated scholarly publications or presentations regarding spiritual care. All participants in the study completed a demographic questionnaire and informed consent form. Table 3 contains the demographic characteristics of the participants from Phase One of the study and who completed the individual interviews. Table 4 contains the nursing experience demographics of the phase one participants.

Table 3

Demographic Characteristics of Phase One Participants (N=27)

Phase One Demographics			
Gender	**Male**	**3**	**11.1%**
	Female	24	88.9%
Age	18 - 25	0	0%
	26-35	1	3.7%
	36 - 45	6	22.2%
	46-55	13	48.1%
	56-65	4	14.8%
	Over 65	3	11.1%
Race/Ethnic Background	African American	7	25.9%
	Asian Pacific Islander	2	7.4%
	Caucasian	9	33.3%
	Latino	6	22.2
	Other	3	11.1%
Religion/Spiritual Belief	Christian	22	81.5%
	Jewish	3	11.1%
	Muslim	1	3.7%
	Buddhist	1	3.7%
	Agnostic	0	0%
	Atheist	0	0%
	Other	0	0%
Employer Type	Faith-Based	19	70.4%
	Non-Faith-Based	8	29.6
Education Level	Diploma	0	0%
	ASN	0	0%
	BSN	8	29.6%
	MSN	11	40.7%
	ARNP	1	3.7%
	PhD	4	14.8%
	EDD	1	3.7%
	DNP	2	7.4%

Table 4

Nursing Experience of Phase One Participants

Phase One			
Years' Experience as a Nurse	>5 – 10 years	1	3.7%
	>10 – 15 years	5	18.5%
	>15 years	21	77.8
Nursing Specialty	Cardiac	3	11.1%
	Critical Care	4	14.8%
	Dialysis	1	3.7%
	Hospice	2	7.4%
	NICU	1	3.7%
	Obstetrics/ Women's Health	3	11.1%
	Emergency Room	2	7.4%
	Nursing Education	4	14.8%
	Pediatrics	2	7.4%
	Post-Anesthesia Care	1	3.7%
	Mental Health	2	7.4%
	Oncology	2	7.4%
Years' Experience in Providing Spiritual care	>3 – 6 years	2	7.4%
	>6 – 9 years	4	14.8%
	>9 years	21	77.8%

Demographic Characteristics

This section discusses the demographic characteristics of the Phase One participants presented in aggregate format. The Phase One participants included 27 registered nurses who had a minimum of three years of providing spiritual care in their

nursing practice. The Phase Two focus group included four registered nurses considered experts in the field of spiritual care. The phase one participants were interviewed individually. The individual participant's demographics are presented next in aggregate.

Among the participants in Phase One, 11.1 % (*n*=3) were males and 88.9% (*n*=24) were females. The age range of 46 – 55 was mostly represented with 48.1% (*n*=13) participants, in the 26-35 age group, 3.7% (*n*=1), 36 -45 age group, 22.2% (*n*=6), 56-65 age group, 14.8% (*n*=4), and 11.1% (*n*=3) being over the age of 65. All participants reside in the United States representing Florida, New York, California, Colorado and Pennsylvania. Participants self-identified as 33.3% (*n*=9) Caucasians, 25.9% (*n*=7) African Americans, 22.2% (*n*=6) Latinos, 7.4% (*n*=2) Asian Pacific Islanders, and 11.1% (*n*=3) indicating as Other. Phase One participants reported 81.5% (*n*=22) as Christians, 11.1% (*n*=3) as Jewish, 3.7% (*n*=1) Muslim and 3.7% (*n*=1) as Buddhist. Phase One participants reported 70.4% (*n*=19) working in faith-based institutions and 39.6% (*n*=8) working in non-faith-based institutions. The majority of participants held graduate degrees with 40.7% (*n*=11) MSN, 3.7% (*n*=1) ARNP, 14.8% (*n*=4) PhD, 3.7% (*n*=1) EDD, 7.4% (*n*=2) DNP and 29.8% (*n*=8) BSN. Among participants of Phase One 77.8% (*n*=21) reported greater than 15 years' experience as a registered nurse, 18.5% (*n*=5) greater than 10 years and up to 15 years and 3.7% (*n*=1) less than 10 years. Table 5 presents the Phase One participants by their pseudonym and years of experience in providing spiritual care in their nursing practice.

Table 5

Phase One Pseudonyms and Years' Experience in Providing Spiritual Care

Participant Pseudonym	Years' Experience in Providing Spiritual Care
1. Coach	>6 - 9 years
2. Straight	> 9 years
3. Diana	> 9 years
4. Rebecca	> 9 years
5. Lacey	> 9 years
6. Miss Holmes	> 9 years
7. Seven	> 9 years
8. Mingy	> 9 years
9. Betty	> 9 years
10. Rabbi	> 9 years
11. Riches	> 9 years
12. Rachel	> 9 years
13. DK Nurse	> 9 years
14. We La	> 9 years
15. Butterfly	> 9 years
16. Polly Pockets	> 9 years
17. Nancy	> 9 years
18. Gigi	> 9 years
19. Beth	> 9 years
20. Estella	> 9 years
21. Wrestling Mom	>3 - 6 years
22. Julia	>3 - 6 years
23. Betsy C.	>6 -9 years
24. Dally	>9 years
25. Sally	>9 years
26. Mary	>6-9 years
27. Eleven	>6-9 years

Individual Characteristics

This section reports the actual data from the participants, providing a view of the unique characteristics of each participant. In addition, to preserve participants'

anonymity, they used a chosen pseudonym, or one was chosen for them. Data used to describe the individual characteristics include the demographic information and information gleaned from the interviews.

Coach is a 46-55-year-old, Christian, African-American female, Master's-prepared nurse. She currently works at a Christian facility and has more than 15 years' experience as a registered nurse and has been providing spiritual care in her nursing practice for more than six years. She reports self-spiritual care practices as prayer, devotional time, meditation, books, church attendance.

Straight is a 46-55-year-old, Christian, African American, female, Master's-prepared nurse and with an EdD. She currently works at a Christian facility and has more than 15 years' experience as a registered nurse and has been providing spiritual care in her nursing practice for more than nine years. She reports self-spiritual care practices as reading the bible, meditation, attending church regularly, prayer.

Diana is a 56-65-year-old, Christian, Caucasian, female, and currently enrolled in a PhD program. She has been in nursing for more than 10 years and has been providing spiritual care in her nursing practice for more than nine years. She is currently employed at a non-faith-based facility. She reports self-spiritual care practices as meditation, therapeutic massage, breathing exercises for relaxation and concentration, communion with nature, aromatic kinesiology with essential oils, prayer, singing and energy work.

Rebecca is a 46-55-year-old, Christian, African American, female and she is a BSN prepared registered nurse. She currently works at a faith-based facility. She has

more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as **r**egular church attendance and prayer group meetings.

Lacey is a 46-55-year-old, Jewish, Caucasian, female and she is a MSN prepared registered nurse. She currently works at a non-faith-based facility**.** She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports meditation as her self-spiritual care practice.

Miss Holmes is an over 65 -year-old**,** Christian, African American, female and she is a PhD prepared registered nurse. She currently works at a faith-based facility. She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as daily devotion, prayer, meditation, meditation and music.

Seven is a 46-55-year-old, Christian, Asian/pacific Islander, male and he is a BSN prepared registered nurse. He currently works at a faith-based facility. He has more than 10 years' experience as a nurse and more than nine years providing spiritual care in his practice. He reports self-spiritual care practices as meditation, personal devotion, education, parish involvement, ministry, retreats, and conferences.

Mingy is a 46-55-year-old, Christian, Latino, male and he is a MSN prepared registered nurse. He currently works at a non-faith-based facility. He has more than 10 years' experience as a nurse and more than nine years providing spiritual care in his practice. He reports self-spiritual care practices as prayer and listening to music.

Betty is a 46-55-year-old, Christian, African American, female and she is a BSN prepared registered nurse. She currently works at a non-faith-based facility. She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as meditation, prayer, singing, and walking on the beach.

Rabbi is a 36-45-year-old, Jewish, Latino, male and he is a BSN prepared registered nurse. He currently works at a non-faith-based facility. He has more than 10 years' experience as a nurse and more than nine years providing spiritual care in his practice. He reports self-spiritual care practices as prayer, meditation, and reading music.

Riches is a 56-65-year-old, Christian, West Indian, female and she is a PhD prepared registered nurse. She currently works at a faith-based facility. She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as prayer, devotional readings, meditation, and CREATION Health.

Rachel is a 56-65-year-old, Jewish, Caucasian, female and she is a BSN prepared registered nurse. She currently works at a non-faith-based facility. She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as meditation, prayer, singing, and walking on the beach.

DK Nurse is a 46-55-year-old, Christian, African American, female and she is a DNP nurse educator. She currently works at a faith-based facility. She has more than 15

years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as prayer and listening to music.

We La is a 56-65-year-old, Christian, Latino, female and she is a MSN prepared registered nurse. She currently works at a faith-based facility. She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as a daily devotion guide for morning and one for bedtime.

Butterfly is a 46-55-year-old, Christian, Latino, female and she is a MSN prepared registered nurse. She currently works at a faith-based facility. She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as meditation, yoga, and practicing all of CREATION Health principles.

Polly Pockets is a 56-65-year-old, Christian, Caucasian, female and she is a MSN prepared ARNP. She currently works at a faith-based facility. She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as a prayer, meditation, journaling, select topic readings, spiritual (Christian) music, church related-attendance

Nancy is a 56-65-year-old, Muslim, female and she is a BSN prepared registered nurse. She currently works at a non-faith-based facility. She has more than 10 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as meditation, yoga, and prayer.

Gigi is a 46-55-year-old, Christian, Latino, female and she is a MSN prepared registered nurse. She currently works at a faith-based facility. She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as meditation, praying 3 times daily, reading devotionals, reading the Bible, reflexology, listening to Christian music.

Beth is a 36-45-year-old, Christian, Caucasian, female and she is a MSN prepared registered nurse. She currently works at a faith-based facility. She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as a prayer, worship (music & devotion), and church membership/fellowship.

Estella is an over 65 -year-old, Christian, West Indian, female and she is a PhD prepared registered nurse. She currently works at a faith-based facility. She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as Bible readings, daily devotions, and prayer.

Wrestling Mom is a 36-45-year-old, Christian, Caucasian, female and she is a MSN prepared registered nurse. She currently works at a faith-based facility. She has more than 10 years' experience as a nurse and more than three years providing spiritual care in her practice. She reports self-spiritual care practices as weekly rest time, meditation, prayer, and quiet time for reflection.

Julia is a 26-35-year-old, Christian, Asian/pacific Islander, female and she is a BSN prepared registered nurse. She currently works at a non-faith-based facility. She has more than 10 years' experience as a nurse and more than three years providing spiritual care in her practice. She reports self-spiritual care practices as meditation, therapeutic massage, nature, essential oils, prayer and singing.

Betsy C. is a 36-45-year-old, Buddhist, Caucasian, female and she is a MSN prepared registered nurse. She currently works at a faith-based facility. She has more than 15 years' experience as a nurse and more than six years providing spiritual care in her practice. She reports self-spiritual care practices as meditation, exercise, positive affirmation, healthy diet, yoga, and laughter.

Dally is an over 65 -year-old, Christian, Caucasian, female and she is a PhD prepared registered nurse. She currently works at a faith-based facility. She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as daily devotion, bible study, prayer group, spiritual associations (church, friends) and music.

Sally is a 46-55-year-old, Christian, Latino, female and she is a DNP prepared ARNP. She currently works at a faith-based facility. She has more than 15 years' experience as a nurse and more than nine years providing spiritual care in her practice. She reports self-spiritual care practices as meditation and prayer.

Mary is a 46-55-year-old, Christian, Caucasian, female and she is a MSN prepared registered nurse. She currently works at a faith-based facility. She has more than

15 years' experience as a nurse and more than six years providing spiritual care in her practice. She reports self-spiritual care practices as prayer, reading, music, reflection, yoga, and attending Mass.

Eleven is a 36-45-year-old, Christian, African-American, female and she is a MSN prepared registered nurse. She currently works at a faith-based facility. She has more than 15 years' experience as a nurse and more than six years providing spiritual care in her practice. She reports self-spiritual care practices as prayer, devotional time, meditation, books, and church attendance

Conceptual Categories

Three conceptual categories were co-constructed from the data: *becoming aware, caring for the spirit,* and *embodying praxis*. There were three subcategories for *becoming aware*; *having a foundation, knowing there is a need*, and *being reflective*. *Caring for the spirit* has three subcategories; *connecting, separating*, and *enduring*. The final category, *embodying praxis*, has two subcategories; *transforming* and *self-understanding*. These categories and their subcategories are presented in this section. Quotes from the Phase One participant interviews (identified by pseudonym) are included to provide a rich description of their experiences and perceptions of spiritual practice. The inclusion of quotes provides the reader an opportunity to confirm the initial findings.

Becoming Aware

Duchscher (2008) described, the process of *becoming aware* as "both a personal and a professional journey, participants evolve through three stages identified as doing,

being and knowing" in the *Stages of Transition Theory* (p.449). This journey is not linear or progressive, rather, it is evolutionary and transformative (Duchscher, 2008). According to Parse (1992) human becoming is described as personal meaning is freely selected and the person's reality meaning is derived through their lived experiences. This is the connection of the conceptual category of *becoming aware* to the current study: It is a transformative, foundational process that includes both personal and professional components. The concept of *becoming aware* was explored in this study by discussing the participants' earliest memories and perceptions of spiritual care in the nursing practice. Three subcategories emerged from the concept of *becoming aware were*: having a foundation, knowing there is a need, and being reflective. *Becoming aware* was described in the data as a foundational process. Having a foundation in spiritual care included the experiences and beliefs the nurse brought to their practice from earlier family and personal spiritual experiences and beliefs. Early educational experiences also assisted in the development of the nurse's foundation in spiritual care. Another component of *Becoming aware* was described as knowing there is a need. This is described as understanding and recognizing when the person needed spiritual care, and how the person defines and expresses their spiritual beliefs. The final component of *Becoming aware* is being reflective. This was described as the nurse reflecting on and looking back at the spiritual care experiences and outcomes of those experiences. Together the subcategories create the design of the concept *becoming aware* – how one utilizes their own foundation, comes to know, and reflect upon the experience of spiritual

care. The process of *becoming aware* of spiritual care provides the nurse the skills to provide spiritual care.

The participants described *becoming aware* in their interviews. **Riches** described *becoming aware* as “Probably from meeting my own ... through thinking, and focusing on my own spiritual needs, then you become more aware that there’s ... there is that aspect”.

Additionally, **Rebecca** expressed similar experiences in *becoming aware*.

> I think it first started as my background being a Christian, knowing that even throughout high school I was a very caring person. I've been a Christian all my life. When I became a nurse, I knew that my call of duty to care for the body was not just for the body. As a Christian, we're called to not only care for the body, and Christ even said it, "As I have done to you, I want you to do to others." When we love each other, when we care for them in a way that the sense we don't just care for them to get well physically but we also care for them spiritually, again as I mentioned. It helps them to heal faster. So, I think not only from my upbringing but also, it's a call of duty for a Christian to be able to care for that body, mind and spirit as one.

Gigi described a strong familial connection to becoming spiritually-aware and how this had influenced her nursing practice.

> Yes. It's basically part of my family because I belong to a family of 6 nurses and we, when I was young, one of my best auntie wants to be a nurse wanted before to

> be a nun, so that hospital belong to a convent. When I grow, I felt really close. It was part of my background and then, when I came here and started as a nurse, I have the privilege to be part of the spiritual ambassador group and I get more education and mentoring. However, I worked with was also interested in how we nurses are for their own spirit and how we can be more peaceful and to find more tools to heal, to be themselves every single day.

Betsy recalled that her foundation in spiritual care had been built through personal experiences.

> I learned how to provide spiritual care through personal experience, where we did not receive spiritual care. I started doing more research into it and more life experiences. Instead of going into the patient room or into someone's life and thinking of physical, strictly physical, I started looking back and realizing that the emotions are just as important.

DK Nurse reported that she had strong familial and early life experiences and formal educational experiences that helped shape her spiritual care foundation. She stated, "Initially, just from my upbringing. I was born into a very religious and spiritual family. And my education, my upbringing as well as my religion."

We La reported that she developed her foundation in spiritual care later in her career after she began working at a Christian facility and she was encouraged to provide spiritual care.

> I went to a public university and that was not an emphasis, and it was not really brought out that spiritual is needed. Again, I've been a nurse for 40 yours, so the training was a little archaic in that part. Then at this Hospital, with its Christian based belief system, they brought it out more and more, and also holistic care became something that was looked at."

Mary described her first thoughts of spiritual care as:

> As a new nurse and even as a student nurse I thought this meant that I was supposed to find out their religion and make a referral to their religious leader. So, it was not until I was working in the emergency room that I really found out more of what I believe spiritual care to be now.

Having a Foundation

Riches discussed how her family experiences and early life experiences related to spiritual issues helped to shape her ability to become aware of spiritual needs and to address them in her nursing practice.

> Mind, body ... I always looked at everyone as mind, body and spirit. So, having looked at myself that way, I think I'll be more apt to think. I won't say I was trained in any way, it's probably more instinct because of your own background.

Mrs. Holmes stated that she also had similar foundational experiences and added she did not receive formal training related to spiritual care.

> I did not train to provide spiritual care because I was raised in a Christian environment and went to Christian schools, therefore I knew about God and God

> is my source of strength. That's why I try to direct my patients to realize that they can ... The experiences that they're going through, this is from what I was trained to do, not trained but just going to church, that believing in the Bible, believing that there is someone that knows about my pattern of life and my way of life, that I'm going through this situation, then I can help my patient with the situation that they're going through. I've used this, actually. It's not the physicians that are doing the surgery, it's God that's doing the surgery. He's directing their hands and helping them go through the situation they're going through. I didn't really actually get "training," I developed it from reading my Bible, connecting with God with prayer and devotion and meditation music.

Many of the participants indicated that spiritual care was a part of their early nursing education and this supplemented their personal and familial experiences related to spiritual care. **Rabbi** discussed how his education and experiences helped to form his foundation of spiritual care.

> This was part of my curriculum for the BSN. I graduated from a BSN college and started the holistic approach of what's that to approach their spiritual need. Not only that but because of my personal background, which I'm a Rabbi. I always try to fill that gap. Once again, of course, I will wait for the sign for the patient to start talking about that spiritual gap and then that will be my opened door."

Polly Pocket described a formal spiritual care educational experience provided in her nursing education.

> All of my AS degree and my BS degree I took at ... As was at Southern Adventist University, which, when we graduated, we actually got a certification as a missionary nurse for ... I'm going out and doing mission outreach. The spiritual thread was embedded in every nursing course that we took and our prerequisites. It was part of our requirement.

Mingy reported a similar experience as Polly Pocket. He stated "It happens from school, studying in school. I graduated from a Seventh Day Adventist college, and that is in the curriculum. After that I continue the tradition, and I have always included it in my patient care." **Estella** described her foundational experience as occurring after she was first employed and had received formal training from her employer. She states "Well I'm a spiritual ambassador for Florida Hospital, so we had a day's training, and then there's also, like once a year there's a refresher. And mentoring new nurses and others wanting to learn more about providing spiritual care."

Some of the participants described their foundational experiences related to spiritual care as occurring through a mentoring relationship. **Diana** discussed her experiences working with a Chaplain where she was employed. **Diana** stated "The one that I've had in hospital was provided by the chaplain where I was working at the time. And he was very disturbed that we didn't have a holistic nursing program."

Mary explains her foundational experiences grew from by working with different role models in her early years as a nurse.

> I did not have any special training in school except that I was told that we are to meet the spiritual needs of our patients because as nurses we are to provide holistic care… I learned through other role models that provided spiritual care. When a patient came in and received devastating news this nurse would sit and talk with the patient about how they felt after hearing this news and also asked what she could do to help them to answer their questions. Many times, the patient would be in shock and so would their family.

Nancy described her awareness of spiritual care in her practice as:

> In the beginning, I was only offering to call a chaplain for my patients. I really did not asses their level of spiritual pain or to try to find out what they felt about their spiritual needs. Now after working with Chaplains in Oncology for the past several years, I start by identifying what the patient reveals as their spiritual needs and how they identify they would like to address their needs.

Estella described *becoming aware* of her beliefs first before providing spiritual care:

> First of all, you have to know yourself as a spiritual person or know if you have any barriers to providing that care, and how you can work through those barriers. So, the materials that you would need is, basically what helped me is when I studied religion in my BSN program because everybody's spiritual needs are not the same. So, depending on what their religion is they may need something different. So, it's not cut and dry; it's not the same for every patient.

Knowing There is a Need

The second subcategory of *Becoming aware* was knowing there is a need for spiritual care. *Becoming aware* was expressed as the nurse needing to recognize that a person needed spiritual care and what the person's individual spiritual needs were. The nurse had to understand that they needed to separate their spiritual beliefs from that of their patients. **Beth** described her experience in identifying the need for spiritual care in her practice:

> Well, it's funny because sometimes you can tell right away. Sometimes it's just presented, the way that their effect is, the way that there's something they are presenting. You can sense it right away. Other times, it's hidden. They might be very angry, and you have to be able to look past those things and ask the right questions. And sometimes that's difficult, because they're lashing out. But a lot of times, for me, the assessment comes within the interaction

Betsy responded that knowing when there is a need for spiritual care is:

> First of all, everyone is in need of spiritual care all the time. I think you can always help them spiritually, but maybe emergency spiritual care, like drug overdoses, suicide attempts, someone who's angry. I think anger is a big one. When someone is angry, it's really they're not happy with themselves. When they're mean, someone is really mean, they need spiritual care.

Rabbi reported that to be able to know when there is a need, the nurse needs to follow the lead of the patient.

> By experience maybe 80% of my patients, they will in one way or the other start the spiritual part of the conversation. I am rarely proactive unless once again I go into a patient that is in the last days of his life. Most likely they are the ones who start, and if they don't I can always have clues like a picture on the wall, a book, a rosary, a prayer shawl. It depends on the religion, but there's always something in the home that I will identify that person as a spiritual person or as a religious person. Once again, will be the piece that will open the doors for a mutual approach occasion.

Additionally, **Wrestling Mom** stated that reaching out and talking with a patient helped her to know when there is a need for spiritual care:

> if you see the person and they look like they just need some help then even just talking to them and finding out you know, are you doing okay, is there something I can do for you, how can we meet your needs. But like I said you know, I work in mental health, so a lot of it is assessing your patient's nonverbal cues.

Being Reflective

The final subcategory of *Becoming Aware* was being reflective. Participants expressed changes in their spiritual care practice after reflecting back on their experiences over time. **Straight** stated she felt she was able to identify the need for spiritual care in her practice:

> As I have gained more experience, I'm more discerning. Before, you do it because it's something that you need to do, but now I would be purposeful to go on the

> unit and say, "Lord, who do you need me to speak to now? Who do I need to?" Sometimes it could be even a fill-in nurse, or patient care, somebody needs something from you. I'm just a conduit, so who do you need me to touch? I can walk in a room, and I'm talking to a patient, and it's their family member. I'm looking for the opportunity. It's not just a regular day. There's no such thing as a regular day when I go on the unit because there's always somebody that needs the word.

Additionally, **Butterfly** reflected on her practice and stated:

> In the beginning, I started with listening, and therapeutic communication and working in a non-faith-based institution where praying was not necessarily an option. In addition to building on that. And then, of course, once CREATION health ... The first time that was introduced to me, my mind was blown, in a good way. And I use that all the time. I introduce that to patients, I introduce that to family members, or I attempt to. And I introduce it to co-workers or friends. Even friends. I have a friend that's a lawyer, and I have introduced her to CREATION health. So that piece of it, plus praying. And even just in my own self-evolving.

Rachel reported that her journey in providing spiritual care has been rewarding:

> At first, I would offer prayer and chaplains to my patients. I had no idea that there were so many other ways to meet the spiritual needs of my patients. It has been a very rewarding journey.

Several participants described what they had learned as being important to know about spiritual care during their reflective processes. **Beth** reported that reflecting on her spiritual care reminded her that nursing care is holistic.

> When you think about spiritual, what people believe, whether it be after this life or even the comfort that's brought within this life, whatever it is that their belief system is, to me that is at the heart of the most important thing a person holds to themselves. So, if we're not touching that, then the other things, I don't know, in medicine, we see the physical is the most important thing. But honestly, I just feel like spiritual's at the heart, and the rest revolves around that…

Straight reflected on the importance of the support needed in her practice of providing spiritual care:

> An environment that promotes that, so whether it's a chaplain that comes on the unit and offers his or herself in that time. It could be a manager that also promotes, insists, not even promotes but insists that this happens. Those are the main resources that you need, and if you have that, everything else will come naturally 'cause people are gonna want it, right? And you want people to want it not because you're telling them, but because you've created the environment that they can't do without it.

Caring for the Spirit

Watson (2012) defines the caring moment as “Two persons (nurse and other) together with their unique life histories and phenomenal field in a human caring

connection comprise an event" (p. 71). The concept of caring in this study emerged from the data collected from the 27 participants. Two subcategories of caring were identified from data as: *connecting and enduring*.

Caring for the spirit was described as a journey and connection with the person needing spiritual care. The first subcategory of caring for the spirit described was connecting with the person which included building a relationship and social interaction between the nurse and the patient. *Enduring* was the second subcategory of caring for the spirit identified from the data. The sub-category of *enduring* was described as the overcoming of barriers that may prevent the nurse from providing spiritual care. A third sub-category was added after the completion of the Phase Two interviews. The final category was *separating*. *Separating* is the need for the nurse to separate their personal spiritual beliefs from the patient's.

Caring for the spirit was reflected in the participant interviews. **Coach** described an experience that caring for her patient and then identifying the spiritual needs of her patient.

> I had a patient when I was doing home health, and this was a family who they were probably close to poverty level. They didn't live in the best neighborhood. They didn't always have everything that they needed, but there were certain things that we required they do because these nurses are coming into the house. In my interactions with the mother, I would often talk about or we would have conversations about, "I know you have to go to work and I know you have two

> other kids." At that time, she had something going on with her shoulder. I was like, "You have to take care of yourself, otherwise you can't take care of either one of these kids." The father was in the home. I don't think they were married, but they had a roach infestation…After a number of conversations she was able to see that yeah, "I got to stop this." In the hospital, it was always about being compassionate and trying to do what was accommodating for the patient. I would always ask about, "How are you doing?" Not just the regular how are you doing, like how are you really doing? "What can I do for you today that would make a difference for you?" Of course, I would pray with patients if they wanted it.

Additionally, caring for the spirit was described by **Diana** as beginning with focused listening.

> The first thing is really listening. With what I would call focused listening so that the person that you're caring for knows that they have your undivided attention. Listening. And just with an open heart. And only guiding them when they need guiding. Which can offer some challenges for some. But being mindful of each being that you interact with. And that's really, really hard outside of the room, or when you've got a Spectralink hung on your scrub pocket. And I personally got to the habit of the phone when on the chart outside the door, yes and I got in trouble with that. But I can't be answering the phone in one room while I'm trying to take care of a patient. That's splitting my allegiance. Because when I go into a room,

> and I'm working with a patient, they're my focus. They've gotta be my focus, or they don't feel cared for.

Rebecca recounted an experience that depicts an example of how she cared for the spirit of a dying patient.

> This one sticks with me because this patient was young, she was dying, she had cancer. This was in critical care, even though my background is cardiac, I guess they probably didn't have room on the medical side. She was with us on the critical care side. She was also a Christian, but after the physician spoke with her and the news was grim, she wasn't going to make it, and she didn't have any family there. I walked in the room, and she was crying. I pulled up my chair, and I sat with her. As we sat, and we talked she started to really cry because she had two kids and she knew she didn't have much long, and she was talking about the kids and what can be done. Not only did I offer to pray for her, she wanted the prayer, but she wanted me to reassure her that when the kids come in I would come in to sit with her, so she could talk to them as well. They didn't come that same day. The day that's in question, I sat and prayed with her, and as we're praying we both were crying together. To me, that made all the difference in this lady's life. And yes, when the kids came in the following day, I sat with her, we all sat together and prayed about it again. She was ready, she felt ready to go, but the fact that I was there to support her, and the kids meant a lot.

Connecting

The subcategory of *connecting* was identified from the interviews of the participants. *Connecting* was described as the journey or social interaction between the nurse, patient and their family. The connection was indicated as necessary by the nurse for the caring relationship to occur. **Coach** recalled an experience that identified her connection with her patient that helped her identify the spiritual needs of her patient.

> Then I would try to be an advocate for them. Some patients, they take a blood pressure pill once a day. Hospital, once a day is 9:00 in the morning, but they don't want it at 9:00 in the morning. Can we give it to them at 11:00 when they normally take it? Is there a reason why we can't do that? I would try to do things like that to try to change the system so that we're really thinking about that these are real people. They're not cookie cutter boxes. We could do something to make them feel a little bit more human, and just everything happens to everybody at the same time.

Gigi described the need to connect to the parents of her pediatric patients.

> In my work at Peds, basically for one example. My patient was a tiny toddler, was going to surgery, rapid in and out for surgery. The parents, unfortunately, are divorce. Both parents are in the room. Very, very concerns of their little one. When, as a spiritual ambassador, I'm thinking in both parents need, both caregivers need, and the patient need by the training that I have, the guidance, I was able to guide both of them to be together for their concern as a couple for the

> immense love because prior they have this little child and after this intervention, both spirits, both parents feel united by the crisis and was unbelievable how they hug each other before surgery and how they pray each other.

Enduring

The second subcategory identified in the data supporting the caring relationship was *enduring*. *Enduring* is described as how the nurses overcame barriers and obstacles to be able to provide spiritual care in their practice. Many of the participants reported facing and having to overcome barriers in their practice that have prevented them or could prevent them from meeting the needs of their patients. **Wrestling Mom** discussed time issues as a barrier to spiritual care in her practice.

> A lot of times it's just not having the time to do that. We don't have time to interact with our patients on a day to day level, on a basic level, you know. Healthcare has become almost like a drive-thru service so not having the time to provide basic care much less the holistic patient approach is a problem. The nursing shortage again, you're not having the staff to care for your patients. Even, you know, where I worked we only had three chaplains, for the whole hospital.

Straight also discussed time issues as a barrier to spiritual care.

> The barriers are the time that we have. The lack of time that you have with patients. I think we've become so inundated with paperwork, or should I say now computer work that you miss that time that you could be working with, not could be, should be working with your patients.

Lacey also reported time and prioritization as barriers to overcome in providing spiritual care.

> I think sometimes there might be. Again, there's always that prioritization of what those tasks we have to do for patient care. Does praying take priority over medication or procedure or something like that? Sometimes from a time management perspective or volume of patients. Could we dedicate that same amount of time to each one of our patients? I think those are challenges that we face.

Sally described fear as a barrier to spiritual care in nursing practice.

> Fear of being rejected. Saying no, I don't want to or they themselves are not spiritual and don't believe in it, so they do not offer it. I mean, I can think these are the reasons 'Cause I've asked my colleagues. Why don't you do this? And they say, "Well, I don't dare." And "What if she doesn't' want me to?" Or "Well, I'll just call the chaplain if they want something," so it's. I don't know that they do it viciously. They just don't.

We La discusses how pressure from co-workers can be a barrier to spiritual care.

> It's not always cool to be the one that brings up the spiritual. I think that they themselves need to tell people how good it feels. It's like a big secret, so if they talk about it a little more, and again, in our environment with the energizers, and prayer within our own peers and all that, it helps to establish and maintain the ability and encouragement of providing spiritual care.

Rebecca talked about nurses not seeing spiritual care as necessary and how nurses need to support each other.

> I don't think most see it as a priority. I do think some definitely see it. We can do a better job at assisting and empowering our nurses to provide spiritual care. I think creation health getting embedded into what we're doing right now is helping. But I don't think it's most. I think we have a lack of enough nurses to provide that spiritual care. I don't think we have enough. I do think spiritual care plays a major role in someone's life. The way they cope with illness, and even death. In a moment of desperation, my response having had spiritual support or having a strong belief is definitely going to be different than someone who doesn't have that spiritual care at all. How we embed it so that the patients can feel it and see it around them is multifaceted but is definitely a valuable part of what we should have in nursing to support our patients and their families as well.

Separating

A third sub-category was added after the completion of the Phase Two interviews; *separating*. *Separating* is the need for the nurse to separate their personal spiritual beliefs from the patient's. **Beth** described in her interview:

> But when you think about spiritual, what people believe, whether it be after this life or even the comfort that's brought within this life, whatever it is that their belief system is, to me that is at the heart of the most important thing a person holds to themselves.

Dally also expressed separation in her interview:

> But I think you also are mindful and respectful of the patients and not be intrusive with yours, but you assess or evaluate your patient or whoever you're working with, in our case, maybe a student here, and understand that not everybody is accepting of that. You give it as you know it wants to be received.

Embodying Praxis

Kyle (2013) defines praxis as "standing at the intersection of theory, practice, and reflection for the purposes of transformation" (p 13). Praxis is also defined by Paulo Freire (1970) as concurrent "reflection and action upon the world in order to transform it" (p.33). The act of reflecting by the nurse allows for a collaborative reconstruction of their beliefs and attitudes that generate new meaning in practice. The concept of *embodying praxis* emerged from the data collected from the 27 participants. Two subcategories of embodying praxis were identified from data: *transforming and self-understanding*.

Seven described an experience of how he was able to find meaning and feeling complete after a spiritual care experience:

> It's a humbling one. The locations that I tend to feel proud that I prayed with a patient. Then I realized this is not the right path. I cannot provide spiritual care because I need one myself. It's only when I realized that I am the one benefiting, that in my encounter I'm spiritually enriched in a manner that I get to find meaning in what I do when I find I belong to a bigger reality or I belong to this

> patient. I had that connection. Usually, the strongest spiritual ... What's the word? I did a spiritual care ... Sorry. What was it again? When I really failed a patient. When I failed a patient and reconciled and admit, "I missed to give your pain med. I really get caught up." Really use the word forgive so that they will allow themselves the reality that may need one too. That actually is a good idea of spiritual care.

Straight discussed feeling fulfilled and accomplishment after an experience in providing spiritual care:

> Oh my gosh, it's fulfilling. You feel like you've accomplished not what you wanted to do, but what he wanted you to do. There's a song that says, "Lord don't let me leave behind an unfinished task." So what task do you need me to do to let people see you, not me. However, I do it or however he allows me to do it, I'm good. I've done what I've been told to do or instructed to do.

Sally talked about feeling complete in her nursing care.

> Very complete. I feel like I've done this circle. I've performed all these patient's needs. I've been there. I feel like I've done my good work. Whereas before I felt incomp'. There's something missing. I don't, and I couldn't really pinpoint, but now, when I leave that bedside and I've done the physical need ... all those needs, and then, you know that you provided spiritual care, oh, my word, you feel so. I don't, any other word than complete.

Rebecca expressed a similar experience.

> Twofold. It humbles me to know that I could be in that same situation as that person, but I'm not there now. It also makes me feel that what an opportunity and a blessing for me to show that person there is more to what they're going through right now and supporting them through prayer, meeting those needs whatever they might be, and letting them know that God sees them through a different light regardless of what's going on with them.

Additionally, **Mingy** described a feeling of satisfaction and accomplishment in his nursing care:

> Actually, it made me very happy. Because I know that I have given my best. And I see the difference at the end of the shift. You know? We come in, we get a report. Oh, this patient, she's not doing well, this and that. Not communicating, not doing, you know, the treatments right. But once you come in and work with them, at the end of the shift they are smiling, and they are moving, and they are doing what they need to do for themselves.

Transforming

Transforming was one of the sub-categories of embodying praxis. Transforming was described by data as changing and altering the way the nurse approached spiritual care. The participants also described how other healthcare professionals were affected by and the nursing practice of spiritual care. **DK nurse** described how her spiritual care impacted students and other nurses:

> I think I've made more of an impact on students, more than maybe other nurses unless I was orienting a nurse and training a nurse with me. Then they would say, "Oh, wow," that would only happen with my experiences in the community because I was a community health nurse. So, when I take the new employees out with me, or the new nurses with me they'll say, "Oh wow, that was so nice, that was so special I have to do that." But that's the role modeling.

Eleven described a similar experience:

> It's kind of like a domino effect. They see you providing it, and especially where we're not going to be reprimanded or getting written up, if it's not outside of our scope or outside of what the policy and procedure is, it's contagious. Everyone is onboard. Everybody's happy…

Seven reported that she is seen as a resource for the other nurses and that they look for him to help them.

> When one of my colleagues approaches me and opens up and really allow a conversation that cannot be just done in a casual way. Then I know I made my presence real in the sense that I am available. It's a challenge actually. How do I say it? Although you want to bloom where you are planted, sometimes you are planted in the desert, and you have to bring your own bucket of water.

When reflecting on the spiritual care experiences in their nursing practice, several nurses described how they had to step back and adjust their approach to their patient and the patient's family. The nurses had to transform their care in order to meet the needs of

the patient at that time. **Nancy** discussed how she was unsuccessful a first, but when she redirected her approach appropriately to meet her patient's needs, she met with success.

> I approached my patient by asking if I could pray with her and she refused. I felt terrible and I wanted to do more. She had just been told she had terminal cancer. I knew I needed to redirect my approach. I asked her if I could sit with her and she nodded. After a few minutes of silence, she looked at me and asked "How do I tell my family? What do I do?" I looked at her and stated I am here for you and whatever you need. I will be with you when you tell your family if you like. I can also ask the Chaplain to be here with us, and you can meet him before if you like. She reached out, and I held her hand as she cried. She said thank you.

Rachel described and experience in which she was wrong in what she thought the patients' needs were and had to quickly adjust to what he really needed.

> My patient was depressed and angry after his stroke. He was 60 years old was a very strong man and supported his family financially. Now after his stroke that was all going to change. I was focusing on his recovery, and he seemed to not want to work on it. His speech was slurred, but I could understand him. He hated to talk because it was frustrating for him to get the right words out. I had to find out how to address this with him. One day he told me he wished he had died. I was stunned. He said he was useless now to his family and he had not purpose in life. I sat there and listened and finally said we will talk to your doctor and your family and you can express your concerns. I am here for you, and I will help you

> as you need. We will talk about what you can expect from your recovery and what you will be working to be as you recover. He looked at me and slowly said thank you.

Betty had a similar experience and discussed how she had to adjust.

> I was totally off in working with one patient. I kept trying to speak with her regarding her diagnosis and prognosis, and she kept dismissing me. I finally waited for her family to arrive and went in to see her then and then she asked me to sit with her and her family to discuss her diagnosis and prognosis that the doctor talked with her about that morning. I had to change my approach from trying to be with her when she was alone to addressing her needs when her family was there. She then opened up, and we all were able to discuss our feelings and concerns together.

Self-Understanding

The participants also reported the experiences related to how their patients and their families responded to the spiritual care provided by the nurses. This provided a sense of self-understanding of what spiritual means to the patient and their families. **Coach** described the emotional responses displayed after providing spiritual care.

> I've had people cry in my office. I've had parents come and tell me, "I don't know what you did to my child, but it's been amazing. They're different because of it." I've had them come tell me, "They talk about you all the time." I'm like, "What did I do?" Because sometimes I don't recognize the impact that I'm having on

> lives. When a parent comes and tells me that their child said something to them about me, that is huge for me because they don't have to talk about me. I'm just a regular old person around here. They rub shoulders with you all the time, but that tells me that I made an impact on that life. Yeah, I've had them cry. I've had them smile when they came in, and they were not smiling. I've had them come back and thank me for things. The other day I simply provided a piece of information that this student needed, and she saw that it would be helpful to her. She just lit up. It was like a totally different person. Then she was like, "Can I hug you?" "Well, sure you can hug me." She has continued to be different. That was a five or ten-minute encounter. Yeah, those are the kind of things that I have happen. For me, those things, those moments are moments that I live for. I recognize that they're not a common practice. When they happen, they're to be cherished.

Mary expressed a similar experience:

> Many of the patients that I have prayed with have stated that they were very appreciative that I took the time to pray with them, also when I would sit with a patient or just touch them in a comforting manner, I would usually see a decrease in their stressful appearance, and they would appear to relax. I did pray with a family whose father was dying from cancer and man of the family members cried but stated they were thankful for the acknowledgment of their pain by me.

We La talked about an experience in which her patient was surprised about how the spiritual care affected her.

> I think that you see relief in their face. Some will express verbally, some will not, but most will say something "Thank you. I didn't realize how much this is going to mean to me." I've heard that. Or family members will come back after you leave, and come back and tell you, "Oh, thank you. That was wonderful." So, yeah. Usually, you get a lot of gratitude that's expressed.

Julia discussed her experience with a couple who were new parents of a baby in the NICU. She understood that they were experiencing spiritual distress, but they were not ready to work with the nurses. Julia reported how she had to understand their needs and adjust her care appropriately.

> As a NICU nurse, you have to wait for the parents to be ready to talk about any issues regarding their baby. They need time to accept the fact that they did not have that perfect child, perfect outcome that they planned on for the past 8-9 months. I approached one set of parents, and they waved me off and said I was wrong. I kept my distance and waited allowing them to have time to themselves, but I stayed in view. I allowed them to come to me to discuss what the plans would be now for discharge and care for their newborn after they had finally accepted that their original plans were not appropriate. We all cried together and then we worked with the team to make the new plans."

All of the participants described a transformation and self-understanding that was the effect of the *embodying praxis* after contemplative reflection. The nurses indicated

that it was necessary to reflect on their previous experiences and theoretical information and have transformed their spiritual care practice.

Phase Two: Focus Group Participants

Phase Two participants (*N*=4) comprised the theoretical sampled focus group interview of nurse experts in the field of spiritual care and nursing. After reaching saturation of the conceptual categories and the development of the initial draft of the theoretical framework, the focus group was convened. The purpose of the focus group was to confirm the conceptual categories and the proposed theoretical framework. Focus group members were given the option of anonymity or to be known to each other. All five focus group members agreed to be publicly identified. The following is a brief description of each of the individual characteristics of the focus group participants.

The focus group was comprised of nursing experts in the field of spiritual care in nursing. The focus group interview was conducted after saturation of the conceptual categories and development of the initial draft of the theoretical framework. The purpose of the focus group was to confirm the conceptual categories and the merit of the proposed theoretical framework. Focus group members were given the option of being known to each other (in the dissertation and in future publications or presentations related to this study). Each of the four participants in the focus group agreed to be publicly identified and attested to this individually at the beginning of the audio recording of their interview.

The focus group interview was scheduled to occur via conference phone call, and it was postponed twice due to the participants' work schedules, professional and personal

time constraints. Finally, after three weeks of trying to reschedule the focus group interview, each participant was able to complete an individual interview. After each interview, the audio recording was transcribed and reviewed with each successive focus group participant interview so that each participant was aware of the other participants' responses. The following is a brief description of the individual characteristics of each Phase Two member.

Iris Mamier, Ph.D. is a 45-55-year-old, currently an Associate Professor, working as full-time faculty in the School of Nursing at Loma Linda University. She has more than 15 years of experience in nursing. Her primary area of scholarship centers on spirituality and healthcare with a specific interest in patients' spiritual needs and spiritual care in nursing. She is involved in collaborative research in this area and is a Research Associate to the Center for Spiritual Life & Wholeness at Loma Linda University.

Sara L. Horton-Deutsch, Ph.D., RN, FAAN, ANEF, is currently the Watson Caring Science Endowed Chair at College of Nursing, University of Colorado. She was appointed as a Research Fellow at the University of South Africa-UNISA College of Human Sciences, Department of Health Studies, Johannesburg, South Africa and the 2nd Edition of her co-edited text Reflective Practice: Transforming Education and Improving Outcomes was published in 2017.

Deborah Laughon, Ph.D., RN, DBA, CCRN, is currently the Director of Professional Development & Clinical Excellence. She has more than 30 years'

experience as a nurse. One area of research interest is holistic and spiritual care. She has published spiritual care research findings in peer-reviewed journals.

Karen Avino, EdD, RN, AHN-BC, HWNC-BC, is currently an Assistant Professor, University of Delaware, School of Nursing and Associate Faculty, Energy Work, HeartMath Interventions Trainer, Holistic Nurse Consultant, Holistic Nurse/ Wellness Coaching, Guided Imagery, Meditation, Nutrition, Reiki, Stress Management. She has also spoken about spirituality in courses and conferences and written about spirituality textbooks.

Confirmation of the Conceptual Categories by the Focus Group

The purpose of the focus group was to confirm the conceptual categories and subcategories that were co-constructed during Phase One of the data collection and analysis process of the study. Four focus group participants of nurse experts from the field of spiritual care in nursing practice supported the conceptual categories. Three weeks before the scheduled date of the original focus group meeting, the participants were electronically sent a copy of the mode and explanatory narrative of the conceptual categories and conditional contexts. The matrix graphic that was sent to the focus group participants can be found in *Figure* 3 below. This section provides an overview of the key comments that made by the Phase Two participants.

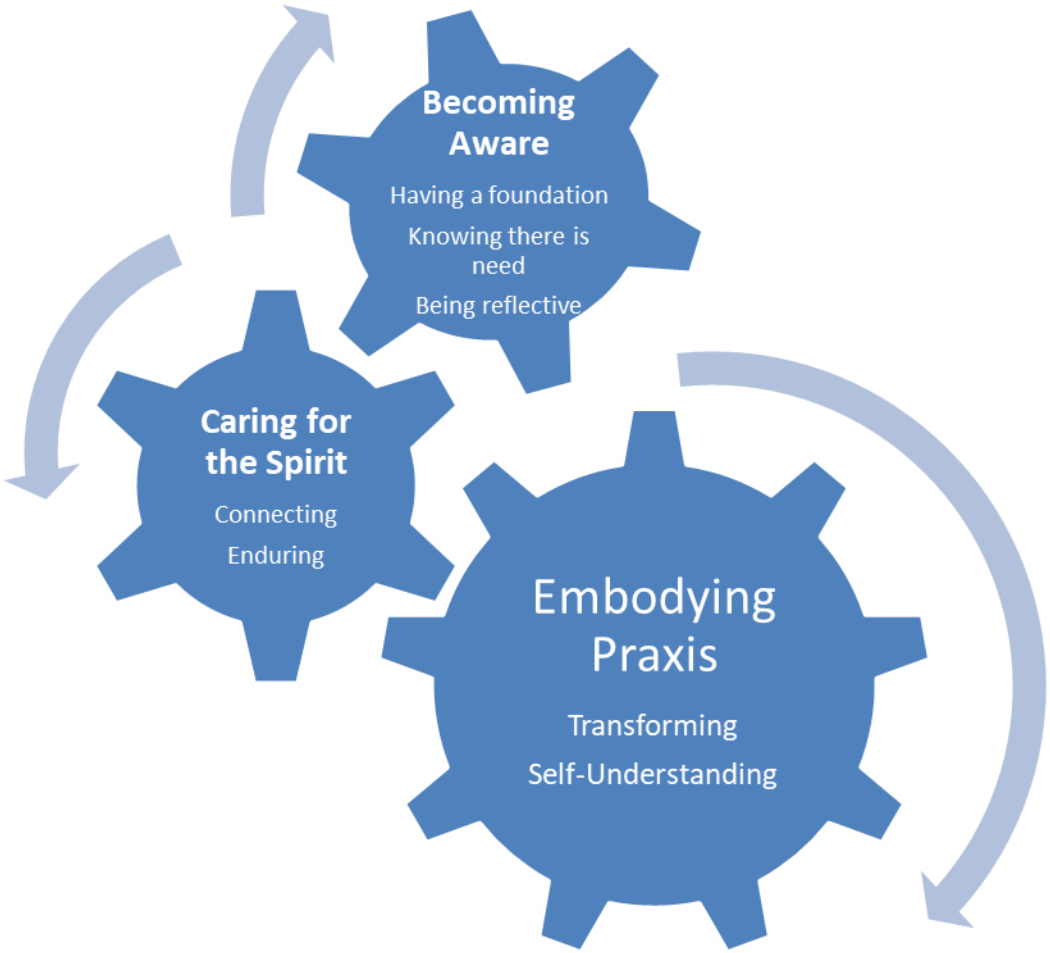

Figure 3. Lowden-Stokley (2018) Conceptual Model of Living Spiritual Care Praxis

Becoming Aware

The focus group participants confirmed the concept of *becoming aware*. The general discussion with each of the participants was agreement related to *becoming aware* as the first step in providing spiritual care. The participants discussed the importance of nurses needing to understand how their foundation in spiritual care affects their nursing practice. There was additional consensus that the nurse needs to understand and recognize when a person is in need of spiritual care, and how the person defines and expresses their spiritual beliefs. Dr. Avino stated related to awareness:

> That's great. Yeah, it makes sense certainly when you look at it that way because everything starts with awareness. If we don't create awareness within ourselves, we can't help others to also create the awareness within themselves.

Dr. Laughon discussed the importance of the self awareness component of the *becoming aware* concept:

> You know the interesting point that I think there's a reason to be self-aware because often your own experiences shape how you approach a situation, but sometimes you have to be careful about that. Cases that come to my mind are the unusual relationships, the Jehovah's Witness, and some other religions who may not have the same beliefs that you do. So, you could almost think that they were wrong. And they're not wrong, they're different.

Dr. Mamier also discussed the importance of *becoming aware* of patient's beliefs regarding spiritual care and spiritual needs:

> And it has been, I think again, also the questions and the concerns have been raised. Are they doing it right? Are they good enough? Are they even prepared to? The patients are actually our teachers. Yes, we can do quite something. We can give tools. We can raise awareness even in nursing, and so forth. You know, if that's what we want, if that's the ultimate goal of our education, yes, then we need to put forth our best efforts to teach it.

Caring for the Spirit

The focus group participants confirmed the concept of caring for the spirit. Recognition of the importance of the nurse establishing the connection with the patient was described by the focus group, in alignment with the proposed spiritual care framework. The sub concept, enduring (recognizing and overcoming barriers) experienced by nurses in the provision of spiritual care was also confirmed as important by the members of the focus group. Dr. Mamier discussed:

> We want nurses to be knowledgeable and to be skillful as spiritual care providers, we want them to embrace this dimension, and incorporate that in their care, And the connection allows for this to happen. Then, of course, that raises questions of, "How do we education nurses?". I think from the get-go, it's not just enough to pay lip-service to whole person care, or holistic practice. I think, for example, when you go with them into the clinical context, is there a debriefing on this virtual dimension at post-conference, about what was going on in this patient's life. And the connection allows for this to happen.

Dr. Avino talked about the process of caring for the spirit:

> When we care for the spirit, we then are better able to make a connection with the spirit of the other person even that we're caring for. That's when those caring moments come in that Jean Watson talks about, a sacred moment. It's a sacred moment because you know that some sort of transformation has occurred. If we bring these activities in, then we're more likely to experience those other components that really continue to feed that spirit in a way that we're caring for ourselves and caring for the patients.

Dr. Horton-Deutsch replied:

> The concept of caring for the spirit as described in the proposed framework absolutely fits in the practice of nursing. Again, it's that piece of helping nurses know that they're being is as important as their doing. And this model really emphasizes that piece. The balance of the being and the doing.

Dr. Laughon added regarding the concept of caring for the spirit:

> Well, we talked about awareness, and listening I thought was really a skill there, so that makes sense to me. And then again that underlying foundation, a relationship with the person. If you don't have that I'm not sure you would connect. And you know interesting, the self-understanding it's hard to say, which comers first. In my experience it might have been through the care of others, I became more aware of myself. But it's hard to say that, that didn't occur first.

> So, I don't see anything here that doesn't make sense, that's not logical. The arrows indicate that it's dynamic.

Additionally, Dr. Laughon suggested the addition of separating as an aspect of caring for the spirit:

> It is interesting that I think the word of separation is also important because there are times that you can't agree because it's not aligned with your own values. But how do you still support the person in that situation without sharing your disagreements?

Embodying Praxis

The focus group participants confirmed the concept of *embodying praxis*. Each of the focus group participants agreed that the contemplative reflection on theoretical information and prior spiritual care experiences was very important. Dr. Mamier described the importance of praxis as

> I can see that it could guide developing awareness, and caring for the spirit, particularly, if we find ways, for example, to make room for clinicians to share their stories, and to debrief them, and to be blessed by them. But, I'm even wondering, can we find ways for reflective practice in the hospital environment.

Dr. Laughon added about praxis:

> The assessment skills and the emotional and things that require reflection and more time are often pushed to the back burner. It is very interesting.

Dr. Avino also stated:

> That's the praxis is where you have, if that's your philosophy of practice is that where you have embodied, maybe that's it, where you have transformed yourself really into a place then where you're able to walk, talk, and breathe it. It becomes natural to you.

Dr. Horton-Deutsch also stated about the concept of *embodying praxis* and the proposed theory:

> It's that piece of helping nurses know that they're being is as important as their doing. And this model really emphasizes that piece. The balance of the being and the doing.

The comments provided by the theoretical sample of the focus group confirmed the categories and supported the subcategories. A discussion point alternative to the model was the addition of separating as a subcategory under the concept of caring for the spirit. After evaluating the data from the Phase One interviews, separating would follow as a component of engaging in spiritual care as the nurse being able to separate the nurse's own beliefs from that of their patients. The basic social process that emerged from the data that links the other main categories is *Living Spiritual Care Praxis*. The data revealed the holistic nurses' spiritual care practice attitudes and perceptions was influenced by the basic social process, *Living Spiritual Care Praxis*. The next section will discuss the core category of *Living the Spiritual Care Praxis* and the theoretical framework used to describe the model.

The Basic Social Process: Living Spiritual Care Praxis

Throughout data collection and ongoing data analysis, three main categories were revealed. The core category that emerged from the open, axial and selective coding process was *Living Spiritual Care Praxis*. Within the participant data, there was a continual expression of reflection and transformation by the nurses when describing their spiritual care practice. Living Spiritual Care Praxis consisted of three implementing processes, *becoming aware, caring for the spirit,* and *embodying praxis*.

The relationships between the nurse and the nurses' reflexivity regarding their spiritual care practice were the two contextual conditions in *Living Spiritual Care Praxis*. The relationship context consisted of the type of relationship that is developed between the nurse, other healthcare providers, patient and the patient's family if they are present. Reflexivity also affected the process of *living spiritual care praxis*. Four dimensions of reflecting, thinking back (connecting to memories and experiences), thinking forward (considering future implications), thinking inward (recognizing feelings and emotions), and thinking outward (considering other's point of view and reactions) determined the nurses' experiences of living spiritual care *praxis*.

Restatement of the Research Questions

Three overarching questions will guide the grounded theory research. As the attitudes and perceptions regarding spiritual care in nursing practice emerged from the data, the main categories of *becoming aware, caring for the spirit*, and *embodying* praxis

were theoretically defined by the basic social process of *living spiritual care praxis*. The research questions that guided the study were:

1. What are the critical factors that influence the nurse's perceptions, attitudes, knowledge, and behaviors related to the provision of spiritual care in their practice?
2. How do registered nurses come to know how to provide spiritual care?
3. What processes do nurses use to identify the contexts in which they will provide spiritual care?

Evolution of Theory

The analytical process involved moving and shifting back and forth through the data and revealed a feeling of movement and interconnectedness of the three main categories that emerged from the participants' voices. The participants expressed the necessary aspects and commented on the context whereby nursing practice occurs in providing holistic care. They also described how the movement to deliver holistic care was occurring within the profession of nursing. Each participant shared different examples with similarity in their stories reflecting their beliefs of what is going on in holistic nursing care. The nurses described how they are committed to continuing to provide spiritual care, engaging in collaborative efforts through a transformed self and environment to move holistic care forward. The practice of spiritual care in holistic nursing practice continues to move transform. The conceptual core category of Living Spiritual Care Praxis was revealed as the basic social process that influenced the attitudes

and perceptions of spiritual care in nursing practice. The factors of how nurses become aware, care for the spirit and embody spiritual care praxis integrate into the basic social process. *Figure* 4 depicts the process of Living Spiritual Care Process.

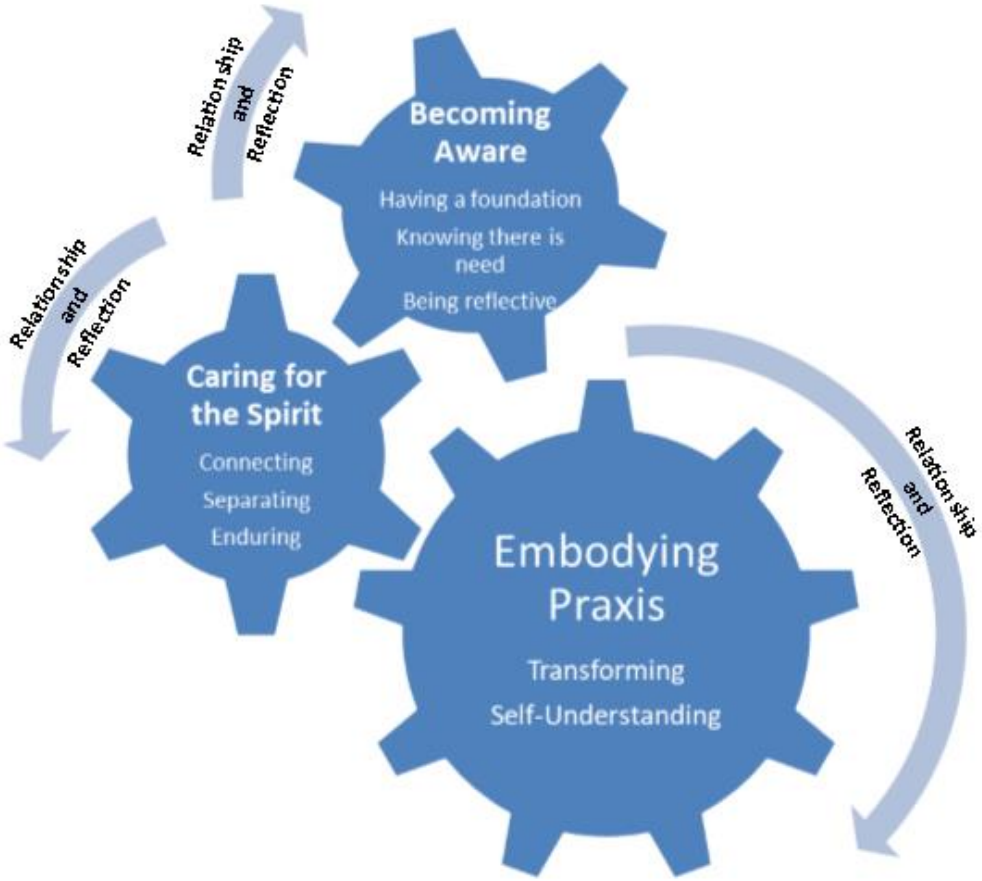

Figure 4. Lowden-Stokley (2018) Conceptual Model of Living Spiritual Care Praxis

The Conceptual Model of Living Spiritual Care Praxis provided a visual of the interactive processes used by holistic nurses engaged in spiritual care in nursing practice were represented in the main categories of *becoming aware*, *caring for the spirit*, and

embodying praxis. Within each category were the subcategories that provide dimension and descriptors where individual and group participants ascribed meaning to spiritual care in nursing practice.

The wheels with the interlocking cogs (Figure 3) depict how the interaction of each category interlocks to turn and move with each other category. The interlocking of the wheels allowed for a depiction of action between the categories and how each category is necessary to allow the basic social process of living spiritual care to occur. If one category stops then the entire process grinds to a holt.

The first wheel to move is *becoming aware* as the foundational process. Having a foundation in spiritual care included the experiences and beliefs the nurse brings to the practice from earlier family and personal spiritual experiences and beliefs. The nurse must be able to understand and recognize when a patient is in need of spiritual care, and how the person defines and expresses spiritual beliefs. Reflection also occurred in this component as the nurse is required to reflect on and look back at the spiritual care experiences and outcomes of those experiences. The category of *becoming aware* interlocks with caring for the spirt and starts to turn this wheel. Caring for the spirit is described as journey and connection with the person needing spiritual care. The first component of caring for the spirit includes building a relationship and social interaction between the nurse and the person during the spiritual care connection. *Enduring*, to overcome barriers, is another component of caring for the spirit. The turning of the wheels of *becoming aware* and *caring for the spirit* create the necessary action to turn the

embodying praxis wheel. After contemplative reflection on theoretical information and prior spiritual care experiences, to transform the knowledge and theory into action, self-understanding of what the spiritual care experiences mean to the nurse and how the transformation and understanding of the experience continue to affect the spiritual care by the nurse have occurred, the three wheels will continue to move each other. This continual and simultaneous movement of the three wheels has provided the mechanisms necessary for the social process of living spiritual care praxis.

The core category of living spiritual care praxis answers the question of how holistic nurses provide spiritual care in their practice. As the holistic nurses engaged in *becoming aware, caring for the spirit* and *embodying praxis*, their actions resulted in meeting spiritual care needs of their patients. As they live spiritual care praxis, the holistic nurses demonstrated an ongoing movement towards furthering understanding spiritual care in the nursing profession. Adding to the understanding mitigates a potential lack of understanding of spiritual care both within the profession and for how society views spiritual care.

Chapter Summary

Chapter Four has provided the results of the inquiry. Demographic information was provided on all participants and presented in aggregate form for the individual participants. Individual characteristics provided descriptive information to support the purposive and theoretical sampling of the participants. The emerging categories of *becoming aware, caring for the spirit*, and *embodying praxis* were presented with

supporting data from the voice of the participants. Relational statements and intersection of categories and subcategories supported the core category. The core category of Living Spiritual Care Praxis was identified.

CHAPTER FIVE

Discussion and Conclusion

The purpose of this qualitative, grounded theory study is to develop a substantive theory about attitudes and perceptions of nurses regarding spiritual care in nursing practice. This study aimed to contribute to the knowledge of spiritual care in nursing practice. There is a lack of a theory to understand how nurses provide spiritual care in their practice of nursing. Using an adapted grounded theory method based on that of Strauss and Corbin (1990), the basic social process of Living Spiritual Care Praxis emerged from the data and was supported by the categories of *becoming aware*, *caring for the spirit*, and *embodying praxis*. Chapter Five will discuss the meaning, interpretation of the findings and relationships among the categories and explain how they are supported in the literature. The significance of the research, scope, and limitations of the research will also be presented.

Explanation of Meaning

The research was informed by grounded theory with the underpinnings of symbolic interactionism and pragmatism. Three assumptions by Blumer (1980) specific to symbolic interactionism in meaning are 1) meaning is attached to an object, event or phenomenon based on meanings held, 2) meaning is derived and arises from human social interactions; and 3) meanings are modified by the interpretive process of the person (Crotty, 1998; Wuest, 2012). In this study, the participant's viewpoints were considered as they discussed the provision of spiritual care in their nursing practice. The

personal meaning attached to spiritual care was revealed through participant dialogue in which they shared interpretations and descriptions, subsequently providing the meaning they attached to the spiritual care. Interactions in their professional settings provided rich examples through which participants could clearly share meanings about spiritual care in nursing practice. The nurses shared their views, thoughts, and interpretations of just what is going on in the practice setting related to spiritual care through attachment of meaning and symbols. Nurses were given the opportunity to interpret and subsequently use the meanings they ascribe to their spiritual care in their everyday practice.

The structured grounded theory methodology used was one developed by Corbin and Strauss (1990), which provided the rich, thick, descriptions, of spiritual care in nursing practice from the voices of the participants. The analytical process revealed the three main categories of *becoming aware*, *caring for the spirit* and *embodying praxis*. These categories support the core category which is the basic social process of living spiritual care praxis. The analysis was situated within the social setting of holistic nurses and considered the context, and subsequently provided a basis to understand the phenomenon and interactions (Wuest, 2012). In this study, the holistic nurses ascribed meaning and explanations about spiritual care in nursing practice, which supported the three main categories and the core category.

Pragmatism that describes the usefulness, not just meaning, must be ascribed to the theory, which should be viewed within the context and environment in which the theory is conceived. As social human beings, holistic nurses interact within their

environments of practice, academia, and health systems as functioning members of an expansive social network in which they can interpret meanings of the phenomenon. Their shared experiences are relevant and distinct as they describe unique events, encounters, and activities experience within the context of practice, teaching, and networking. The inductively based theory of Living Spiritual Care Praxis, emerged from the findings, describing the social processes ascribed by the nurses' attitudes and perceptions of spiritual care in nursing practice. Living spiritual care praxis is the core category that subsequently provides the structure or the framework of this theoretical model.

The usefulness of the theory resides in part in how it fits with other conceptual and philosophical perspectives already framing spiritual care practice in nursing. The Living Spiritual Care Praxis is based on praxis (reflection in action and action in reflection) is the catalyst for spiritual care transformation. This is consistent with the tenets of complex sciences as they apply to several nursing theories (Parse's Human Becoming Theory and Watson's Human Caring Theory): all things are interconnected in nature, connected with the environment, nonlinear, similarly structured, and constantly evolving (Parse, 2012; Watson, 2012). Living Spiritual Care Praxis is also consistent with Kyle's (2013) living spiritual praxis theory; understanding the nature of a situation, recognizing specific formative interventions, assessing various approaches, and continually reflecting, assessing and modifying these understandings and approaches.

The participant's descriptions of their perceptions and experiences related to spiritual care in nursing practice demonstrated their active involvement in the process of

reflection in action and action in reflection for the expressed purpose of the transformative change in spiritual care. All participants engaged in this process in various ways. The Living Spiritual Care Praxis theoretical framework identified and clarified the nurse participants' use of praxis (reflection in action and action in reflection) for the purpose of transforming spiritual care in nursing practice.

Interpretive Analysis of Findings

The first two chapters discussed the background and purpose of the study and the literature review. Chapter one presented the historical view of spiritual care in nursing practice and issues related to spiritual care and holistic nursing practice. Perceptions and attitudes of nurses were presented, and the findings revealed that there was confusion as to what the nurse's role is in providing spiritual care in nursing practice. A gap existed to gain understanding of the meanings ascribed by the professional nurses about spiritual care. This study focused on gaining an understanding of the attitudes and perception of professional nurses about spiritual care and the meaning they ascribe to spiritual care in nursing practice. Individual participants were interviewed, and the data were constantly compared, analyzed, and coded. After data were saturated, three main categories emerged: *becoming aware*, *caring for the spirit*, and *embodying praxis*. These categories, in turn, supported the core category of Living Spiritual Care Praxis. The model was reviewed and discussed with the expert group, and the consensus was reached that the model depicted the spiritual care in nursing practice and the core categories. Each of the core categories will be discussed, interpreted and supported by the literature as follows.

Becoming Aware

The category of *Becoming aware* emerged as the participants spoke about how they first learned to provide spiritual care. *Becoming aware* in this study was defined as a foundational process in spiritual care. Having a foundation in spiritual care included the experiences and beliefs the nurse brought to the practice of nursing from earlier family and personal spiritual experiences and beliefs. *Becoming aware* was described as knowing there is a need by understanding and recognizing when the person needed spiritual care, and how the person defined and expressed their spiritual beliefs. Finally, the data revealed that being reflective is an important aspect of *becoming aware*. In this context, the nurse reflects on and looks back at the spiritual care experiences and outcomes of those experiences. The process of *becoming aware* of spiritual care provides an important step for the nurse with the necessary skills to provide spiritual care.

There have been many studies describing the need for spiritual care in nursing and the attributes of spiritual care in the context of nursing practice throughout the last three decades. Price, Stevens, and LaBarre (1995) found in their work that the nurse does not need a perfect understanding of spiritual care but rather an openness to spiritual ideas and beliefs. Long (1997) also wrote about spiritual care in nursing and that nurses should be comfortable with their own spirituality and emotional history. Hall (1997) reported that being a spiritual care provider involves being a lifelong learner in spirituality and spiritual care issues.

Giske and Cone (2011) completed a study to explore nursing implications related to nurses identifying spiritual needs and enhancing their spiritual care to meet those needs. Understanding spirituality and paying attention to the spiritual needs is an essential component of holistic care and the promotion of quality of life. Data from this study revealed that identification and awareness of spiritual needs are important to the patient and the care provided. Additional findings indicated that making spiritual assessment and interventions more visible and explicit would facilitate the nurses' learning in clinical practice, and evaluative discussions in clinical settings that include spiritual concerns will enhance holistic care.

Nursing education should prepare nurses to recognize and act on spiritual cues. A trusting relationship and respectful and sensitive communication assist nurses in discovering what is important to patients (Giske & Cove, 2011). The findings from Giske and Cove (2011) support the concept of *becoming aware* in this study. In this current study, *becoming aware* refers to the participant descriptions of their foundational experiences related to spiritual care in nursing practice. The participants described family life experiences and early nursing practice experiences as their foundation in spiritual care and initiating their *becoming aware*. **Betsy** stated, "everyone is in need of spiritual care all the time. I think you can always help them spiritually." **Wrestling Mom** added, "if you see the person and they look like they just need some help then even just talking to them and finding out you know, are you doing okay, is there something I can do for you, how can we meet your needs."

These findings were supported by a qualitative study conducted by Luker, Austin, Caress, and Hallett (2008) who examined key factors contributing to or detracting from high-quality care for several different nursing specialties including palliative care. One of the findings of the study described the importance of knowing the patients and their families as an essential antecedent to the provision of high-quality palliative care (Luker, Austin, Caress, and Hallett, 2008). The findings of the current study were supported by the findings of Luker, Austin, Caress, and Hallett (2008). In the current study, **Eleven** expressed:

> We can't see the patient just as a patient. We have to look at them as a whole, so we have to assess, and we have to ask is spiritual care or do they believe in some type of upper being, and how does the affect their faith, how does that affect their care and what they're going through.

Additionally, **Beth** stated:

> When you think about spiritual, what people believe, whether it be after this life or even the comfort that's brought within this life, whatever it is that their belief system is, to me that is at the heart of the most important thing a person holds to themselves. So, if we're not touching that, then the other things, I don't know, in medicine, we see the physical is the most important thing. But honestly, I just feel like spirituals at the heart, and the rest revolves around that.

Lacey also discussed individual needs, “You could ask them, or you can observe it in that family dynamics or that environment when you're caring for them. Mostly it's the

communication. What's the patient preference? It's asking and providing that individual care."

Giske and Cove (2011) correspondingly found that the degree of experiences and exposure to others who are experts in spiritual caring enhances spiritual care in nursing practice. The current study also reported that nurses discussed the need for additional resources to assist them in learning an improving their practice of providing spiritual care. As stated by **Diana**, "I have had quite a bit of different trainings. The one that I've had in hospital was provided by the chaplain where I was working at the time…It was very helpful to work with the chaplain." **Mary** reported that she found mentors or role models helpful:

> I learned through other role models that provided spiritual care. When a patient came in and received devastating news this nurse would sit and talk with the patient about how they felt after hearing this news and also asked what she could do to help them to answer their questions. Many times, the patient would be in shock and so would their family.

The last component of *becoming aware* was described as how the nurse reflects on and looks back at the spiritual care experiences and outcomes of those experiences. Burkhart and Schmidt (2012) found in their nursing education study that uses of reflective practices helped to provide support during stressful times. This finding supports the reflective component of the current study. Several participants described this in their interviews. **Straight** expressed she felt she was able to better identify the need for

spiritual care in her practice, “As I have gained more experience, I'm more discerning. Before, you do it because it's something that you need to do, but now I would be purposeful.” Additionally, **Rachel** reported that her journey in providing spiritual care has been rewarding, “At first I would offer prayer and chaplains to my patients. I had no idea that there were so many other ways to meet the spiritual needs of my patients. It has been a very rewarding journey.” Reflection was found to be an important facilitator for continuing to provide spiritual care and to initiate learning more about what was spiritual care. This is seen in **Nancy’s** description of her change in spiritual care:

> In the beginning, I was only offering to call a chaplain for my patients. I really did not asses their level of spiritual pain or to try to find out what they felt about their spiritual needs. Now after working with Chaplains in Oncology for the past several years, I start by identifying what the patient reveals as their spiritual needs and how they identify they would like to address their needs.

Straight also identified the change in her practice after reflection. She said “As I have gained more experience, I'm more discerning. Before, you do it because it's something that you need to do, but now I would be purposeful.” **Eleven** also described the need for reflection in her learning process of spiritual care, “I think is, number one, nurses need to do a self-reflection of what do I believe, what do I think spiritual care is, so let's do a self-reflection, a self-assessment first.”

Caring for the Spirit

Caring for the spirit emerged from the data collected from the 27 participants. Additionally, two subcategories of *caring for the spirit* were identified from data: *connecting and enduring*. *Caring for the spirit* was described as journey and connection with the person needing spiritual care. A third subcategory was added after the Phase Two interviews, *separating*. The first subcategory, *connecting* with the person included building the relationship and the interaction between the nurse and the patient. *Enduring* was the second subcategory and was described as the overcoming of barriers that may prevent the nurse from providing spiritual care. *Separating* describes how the nurse needs to separate their beliefs from their patients and patients' family to be able to provide spiritual care as defined by their patient and their family.

Caring for the spirit has been studied for more than three decades, and many researchers have reported their findings related to spiritual care. Thomason and Brody (1999) found that all persons are valued as being comprised of mind, body, and spirit regardless of their religious beliefs or lack of beliefs. Hall (1997) strongly argued that a reliance on only on scales and labels to identify spiritual needs and beliefs limited the meaning of spirituality and spiritual care needs. She suggested that listening, engaging and being present are skills needed by the nurse to continually learn from the patient during spiritual care (Hall, 1997).

Narayanasamy and Owens (2001) found in their qualitative study that an approach on "mutuality," "equal partnership," and "feelings of trust and security" is how

spiritual care should be approached in nursing practice (p. 451). In providing spiritual care, the role of the nurse is not to be a mental health counselor or religious advisor; rather the nurse's role is to be caring and present with the patient while that patient seeks out meaning, and purpose (Narayanasamy & Owens, 2001). The results supported the findings of the current study in relation to the concept of *caring for the spirit* and subconcept connecting. The subcategory of connecting was identified from the interviews of the participants and was described as the journey or social interaction between the nurse, patient and their family. The connection was indicated as necessary by the nurse for the caring relationship to occur.

Coach described her experience with connecting with her patient in the hospital, "In the hospital, it was always about being compassionate and trying to do what was accommodating for the patient. I would always ask about, "How are you doing?" Not just the regular how are you doing, like how are you really doing? "What can I do for you today that would make a difference for you?" It was important to **Coach** to make that personal connection and move beyond just the physical needs. **Diana** discussed connecting as beginning with focused listening, "The first thing is really listening. With what I would call focused listening so that the person that you're caring for knows that they have your undivided attention." It was important to **Diana** that her patients know that she was there for them.

Earlier studies reported that spiritual care is interpersonal, and the therapeutic use of self by engaging and being present with the patient (Chiu et al., 2004; Greasly, Chiu &

Gartland, 2001). Kendrick and Robinson (2000) described spiritual care as transcending "through the extending of self for the good of another" (p. 73). Piles (1990) described spiritual care as being and doing. Being with a person in a position of hospitality, empathy, and compassion is always acceptable (Piles, 1990). The early studies support the findings of connecting. In this study, **Beth** discussed, "there's also a knowing in our own realm where we would, I think listening. I think listening and knowing when to stop talking, when to speak, when to pray, and just having that knowing that comes I believe over time."

It is important for nurses to understand that providing spiritual care requires the nurse to acknowledge their own beliefs related to spirituality and spiritual care. In delivering spiritual care, it is important for the nurses to separate themselves from their own beliefs and discover what spirituality and spiritual care means to the person and their family (Kendrick & Robinson, 2000). **Beth** talks about providing care outside of the physical realm, "providing care outside of a physical realm. Reaching in and touching someone on a different level. Touching them on a level that is outside of the physical." **Coach** also stated, "taking care of the whole person, like seeing everything as one, and really looking at the impact that the incident is having on the whole person's life. **Beth** described in her interview, "taking care of the whole person, like seeing everything as one, and really looking at the impact that the incident is having on the whole person's life." **Mary** also reported:

> Spiritual care is taking care of the spirit of the patient, and this includes assessing their connectedness with a higher being and with others, their sense of hope, belonging and purpose in life. It is intervening in however the patients indicates as helpful to protect and keep healthy all of these components of the spirit.

Eleven had also expressed similar aspects related to spiritual care:

> Spiritual care is what I do, what I believe in. It gives me a sense of hope, a sense of meaning, a sense of purpose. It gets me throughout my day. Sometimes when I'm in my own spiritual distress or kind of depressed a little bit, I can go to scripture, or I can go to a book, or I can listen to music, or even meditate, walk, just to get me back to where I'm comfortable, and I'm able to function. Spiritual care in nursing, I think, is bringing all those aspects to the individual person. We can't see the patient just as a patient. We have to look at them as a whole, so we have to assess, and we have to ask is spiritual care or do they believe in some type of upper being, and how does the affect their faith, how does that affect their care and what they're going through.

The final sub-component of the *Caring for the spirit* category was e*nduring*, defined as the need for nurses to overcome barriers present preventing the nurses from providing spiritual care in their practice. Keall, Clayton, and Butow, (2014) in their qualitative study explored current practices of existential and spiritual care, identification of facilitators of, barriers to and strategies for the provision of spiritual care. One finding was the identification of barriers and how the nurses dealt with them. Such barriers cited

were lack of time, skills, privacy and fear of what you may uncover, unresolved symptoms and differences in culture or belief. Nurses offered strategies that included the following: enrolling in continuing education programs in spiritual care and cultural applications, being self-aware and ensuring the setting is conducive to in-depth conversations, interactions, and documentation, and interdisciplinary sharing for continuity of care (Keall, Clayton, and Butow, 2014). In the current study, all 27 participants in Phase One addressed barriers to spiritual care in their practice. The most common barrier listed was lack of time as cited by Keall, Clayton, and Butow, (2014). In the current study over half (15 out of 27) of the participants listed time as a barrier. Lack of skills, differences between the nurse's and the patient's beliefs, and lack of support from the administration of the healthcare facility or company were also identified by the participants in the current study and were supported by the Keall, Clayton, and Butow, (2014) findings.

Expressions related to lack of time as a barrier made by the participants in the current study included, **Straight** stating, "The barriers are the time that we have. The lack of time that you have with patients." **DK Nurse** explained the time factor a being related to workload, "Workload prevents the delivery of spiritual care." **Riches** talked about the time issue as being related to priorities, "Time. That it's not priority. Because you're not going to be disciplined for not providing spiritual care, but you're going to be disciplined if you don't get out on time." **Mary** also discussed time as a barrier, "Lack of time

because there is so much physical care to do.” Time as a barrier to spiritual care was also supported by the findings in the study by

The participants also discussed lack of skills. Rushton (2014) conducted a study to explore why health professionals are failing to meet patients' spiritual needs while in hospital. The study found that nurses were unable to fulfill patients' spiritual needs for several different reasons. Barriers to spiritual care included a difficulty in defining spirituality; the lack of evident guidelines for the nurse's role in providing spiritual care; nurses' lack of time to provide spiritual care; and a lack of training and education on spirituality for pre- and post-registration nurses (Rushton, 2014). Rushton (2014) supports the findings of the current study. The participants in the current study also described lack of training as a barrier to providing spiritual care. **Estella** described lack of education, “It could be a lack of education. In some cases, if you don't know how to. So, there are some nurses who have said they don't know how to, so they will call me or call another spiritual ambassador.” **Diana** also talked about time and whether the nurse is responsible for spiritual care, “All kinds of barriers from not enough time, too, "Well, we're nurses, we aren't somebody's chaplain. That's the chaplain's business. If somebody needs a prayer, then they need to call the chaplain." And those were the kinds of things that were major barriers.” **Mary** also discussed time, education and role issues as barriers:

> Lack of time because there is so much physical care to do; initial education is not enough to help nurses to know what to do. Some nurses are just uncomfortable in

> dealing with the spiritual care needs of their patients and feel that that is the role of the Chaplain and not their responsibility as the nurse.

Barriers to spiritual care were also explored in a study conducted by Kroning (2017) to explore spiritual care provided by nurses to patients during all their clinical experiences. The findings included lack of time, having different religious viewpoints than their patient, and lack of education and training (Kroning, 2017). The previous findings support the categories created from the data of the current study. **Rabbi** discussed the barrier of differences in beliefs, ". I guess their personal religious practice may always be an interference to a new sense. In Christianism, lets say, if someone is Catholic and the patient is Jehovah's Witness if the nurse does not put aside their personal belief they are going to be hard to approach that." Another participant, **Eleven**, also spoke of differences in beliefs being a barrier:

> Again, your coworkers and your manager, you know sometimes people want a circle of people praying for them, and sometimes people want one-on-one, but if your circle of people are not into religion, into spiritual care, it's going to be hard to get a circle of folks. I think that's just the biggest thing, would be those big barriers.

Embodying Praxis

Embodying praxis was described in the data as the process of the nurse providing spiritual care after contemplative reflection on theoretical information and prior spiritual care experiences. Two subcategories of *embodying praxis* identified in the data were

transforming the knowledge and theory into action and self-understanding of what the spiritual care experiences meant to the nurse. Participants described personal and patient/family transformations resulting from spiritual care. Labrague (2016) explored nurse's spirituality and provision of spiritual care in quantitative correlational design study. The study findings examined the perception of spirituality and spiritual nursing care among Filipino nurses. Correlations between the nurses' perceptions of spirituality, understanding of spiritual care, and provision of spiritual care revealed that for nurses to provide spiritual nursing care, the nurse needs to care for oneself through self-awareness, self-reflection, and acquiring a sense of satisfaction and contentment.

The results of the Labrague (2016) study supports the current study's findings in which the investigator found that it is important for the nurse to reflect on the provision of spiritual care in their nursing practice. This was reported as evaluating what the responses of their patients and their families, the responses of other health care providers, their own responses to spiritual care.

Kang and Bang (2017) developed a self-reflection program for Korean nurses who have experienced the death of pediatric patients in the intensive care unit and evaluated its effectiveness. The qualitative results revealed two themes, "personal growth" and "professional growth." The self-reflection program developed by this study was effective in assisting nurses who had experienced the death of pediatric patients to achieve personal growth through self-reflection, and it was confirmed that the program could be applied in a realistic clinical nursing setting. The findings of this study

supported self-reflection and self-understanding elements of spiritual care in nursing practice.

In the current study, participant **We La** reported that the personal reflection of her spiritual care experiences was “You feel great. You feel re-energized in your spirit. That's biblical.” **Straight** also reported a similar experience:

> Oh my gosh, it's fulfilling. You feel like you've accomplished not what you wanted to do, but what he wanted you to do. There's a song that says, "Lord don't let me leave behind a unfinished task." So what task do you need me to do to let people see you, not me. However, I do it or however he allows me to do it, I'm good. I've done what I've been told to do or instructed to do.

Selman et al. (2018) completed a qualitative study to explore spiritual care needs, experiences, preferences and research priorities in an international sample of patients with life-limiting disease and family caregivers. Most patients and caregivers across sites in this study agreed that spiritual care was an essential facet of whole person care that should be addressed in healthcare when approaching the end of life. Participants largely reported good experiences of spiritual care when received (Selman et al., (2018). The participants in the current study reported similar findings when describing their patients and their families’ responses**. Butterfly** discussed, “They've always been very responsive. Very appreciative. Yeah. You can just visibly see that they calm down. That anxiety, you just see it leaving them, you know? So, it's really cool to see.” **Mingy** stated, “I have had letters from patients. They right back the manager, or the hospital

administrators, complementing the care that we provide. They'll always make you feel good and keep you going. **Sally** also described her patient's experiences:

> Some of them don't even realize what I've done. They just. This is just nursing care. This is part of my job. They don't realize that this is complete holistic care. Now it's just almost an expectation, which is great 'cause that's good, and then some of them do realize that I've gone above and beyond and they're very grateful, and they'll send me cards or letters and notes. Even with the students, I'll get cards when they graduated three years ago, and they're still sending me cards here about, in the office, just acknowledging what they're doing, they're comfort level. If they've graduated from here, they're comfortable with spiritual care.

Significance of the Study

The significance of this grounded theory study is that it served to address a gap in the literature regarding how nurses perceived spiritual care in nursing practice. There have been many studies on spirituality and spiritual care, and yet there is limited research related to the theoretical aspect of spiritual care in nursing. The purpose of this inquiry was to develop a middle range theory of spiritual care in nursing practice. The concepts of *becoming aware*, *caring for the spirit* and *embodying praxis* formed the main categories that led to the core category of *Living Spiritual Care Praxis*. This grounded theory study identified the model explaining the critical factors that influence the nurse's attitudes, perceptions, and behaviors related to spiritual care in nursing practice. This

substantive theory has timely implications for nursing education, practice, research, and health/public policy.

Implications for Nursing Education

Spiritual care is poorly defined and underrepresented in nursing education in the United States despite being a required component of holistic nursing care. Information gained from this study indicated the nursing profession should clearly identify the progressive education of the professional nurse. Specific examples from participants alluded to the responsibility for mentorship of students and the education of the future nurses. This study discussed the views of the participants about the importance of the mentoring role specific to the educational setting in the counseling of students about the advanced roles within the practice discipline. The study also uncovered a need to develop education about research pertaining to the generation of nursing knowledge and the implementation and application of research findings. This study discusses the views of the participants about the importance of education in pre-licensure programs and mentoring in professional practice specific to spiritual care provision in nursing care for all patients. A clear definition of spiritual care and an understanding of what spiritual care entails early in their professional practice was cited by many of the participants in this study. It is important to nursing education to contribute new knowledge that can be shared throughout the profession and included in educational settings to inform students and practicing nurses.

Educating nurses entering the profession and offering continued education the practice setting provides accurate and timely opportunities to educate nurses regarding spiritual care in nursing practice. Educational opportunities will assist to the increase the number of nurses with skills to provide spiritual care and improve the patient spiritual care outcomes. The educational standards presented in academia, refereed journals, educational programs, and continuing education offerings should provide a standardized platform for sharing and providing an understanding of current nursing practice, theory and role building cohesiveness to further identify the components for spiritual care in nursing. Nurse educators can make a difference in the preparedness of nurses to assess and address the spiritual concerns of their patients (Baldacchino 2011, Giske &Cone 2012). The theoretical framework emergent in this study serves as a guide for schools of nursing and professional practice educators to implement what is needed to achieve knowledge, competency, and skills needed to provide spiritual care.

Implications for Nursing Practice

The significance of this research to nursing practice is the improved insight and understanding of fundamental attitudes, perceptions, and behaviors of spiritual care. The profession continues to evolve and rely on the discovery of new knowledge (Polit & Beck, 2012). In many spiritual care research studies, the findings reveal the confusion many nurses experience related to providing spiritual care in their nursing practice. The importance of fostering a culture where nurses discuss and reflect spirituality and spiritual care in professional practice by nurses is important. Such reflections in clinical

practice, combined with continued education in the organization, might be the best way to increase nurses' expertise in spiritual care. Clinical supervision, mentorship or team coaching using case studies, articles or examples from professional practice are also valuable ways to increase excellence in spiritual assessment and care.

As a practice profession, participants in this study were clear in identifying practice exemplars and the goal of improving nursing care locally, nationally, and internationally. The participants in this study described barriers in professional practice that prevent nurses from providing spiritual care. The theoretical framework created in this study can assist nurses to identify how to incorporate spiritual care into their professional practice. With educational, peer and administrative support, spiritual care becomes holistic, individualized, appropriate, and coordinated in a manner that will influence outcomes positively.

Implications for Research

Research is necessary to build nursing knowledge and contribute to the foundations of the profession (Polit & Beck, 2012). Research about the spiritual care in professional nursing practice was necessary to provide new knowledge and provide key information regarding attitudes, perceptions, and behaviors of professional nurses from their viewpoint. This research contributes to the body of nursing knowledge but remains a starting point for further investigative efforts. The substantive theory uncovered in this study provides a basis for ongoing discovery of the evolution of the discipline of nursing.

In addition, new research may be conducted from the concepts and categories supporting the theoretical model and the core category of Living Spiritual Care Praxis.

There is a need, though, to further explore the theoretical framework, spiritual care praxis which emerged from this study and the impact it will have on spiritual care in professional nursing practice. Additional research exploring the effect on the influence the progress of any new initiative in nursing practice and patient care outcomes. The purpose of this classical grounded theory study was to understand the critical factors that influence nurse educators' perceptions, attitudes, and behaviors of related to spiritual care in nursing care practice. Additional research will assist in the development of guidelines for educating nurses about spiritual care and effective spiritual care interventions.

Implications for Health and Public Policy

The Affordable Care Act of 2012, addresses the need to reduce health care costs through competent and innovative health care and ensuring that competent professionals are employed (Walsh-Brennan & Sullivan-Marx, 2012). Providing appropriate healthcare delivered by a competent and inter-disciplinary health care team is the expectation of the federal government to meet the healthcare needs of the country (VanSant-Smith, 2014). Nursing educators and leaders should support in the development of health care policies that will improve the delivery of healthcare in this country. This research can help provide insight that will guide the nursing leaders to develop the necessary policy changes. The need to deliver quality care, identify effective models for care, and improve nursing functioning to the full extent of their training is needed to care for the mounting

number of patients in our society who require access to care after the implementation of the Affordable Care Act of 2012.

The American Hospital Association (AHA) should be made aware of the need for spiritual care and this study would support that need. Through representation and advocacy initiatives, the AHA addresses national health policy development. This study assists in providing additional evidence for the AHA to bring the need for competent spiritual care in health care facilities to the attention of legislature. Spiritual care is an integral aspect of holistic nursing and meeting the spiritual needs of the patient leads to improved patient outcomes. Improved spiritual care and improved nurse patient relationships can lead to earlier conversation related to need for hospice care and completion of advance directives.

The Institute of Medicine (IOM, 2011) calls to action and the profession of nursing is in a position to identify areas where the profession can become integrally involved in emerging health care policies and impact national and ultimately global health. Identified opportunities for policy change include ways to assist in removing barriers preventing nurses from providing holistic spiritual care to all patients in all practice settings. Nurses can increase the awareness of legislators to the impact of competent spiritual care as it relates to hospice care coverage to direct necessary changes in health care laws. In addition to legislators, nurses need to advocate to the American Hospital Association to support the need for competent spiritual care to all patients being

cared for in the hospital setting. Active participation in policy development was an important aspect discussed regarding a complex environment.

Strengths and Limitations

This section discusses the strengths and limitations of this grounded theory study. One strength of this study is that the findings were co-constructed from the voices of nurses who self-identified as providing spiritual care in their nursing practice. Data founded in the life experiences of nurses from different cultures and religions who have provided spiritual care provided an in-depth understanding of the complexity and transformation. The purposive sample consisted of holistic nurse participants with at least three years in the role who resided in different regions of the United States. The theoretical sample of spiritual care experts, with more than three years of experience, published on holistic nursing or spiritual care and participated in regional or national panels, was able to critically analyze the model and categories. The individual voices supported by the theoretical group confirmed the basic social process of *Living Spiritual Care Praxis*.

Personal experiences were expressed before the study. The researcher improved trustworthiness in the maintenance of research rigor. The faculty chair and committee members of this research provided clear guidance and suggestions when moving through the coding and analysis processes of grounded theory. Credibility was maintained as participants were informed of options to withdraw from the study at any time, and each reviewed the transcription (member checks), allowing for confirmation of accuracy and

intent of the responses. Iterative questioning was used with the participants. Triangulation was used with the inclusion of an expert group to confirm findings. Dependability was ensured when the measures to ensure credibility were taken. In addition, an audit trail, journaling, field notes, memoing, and reflexivity by the researcher contributed to dependability. Confirmability was assured through the author's self-disclosure, reflexive journaling, ongoing memoing, and the use of triangulation to gain additional sources to confirm findings. Transferability was done by proving clear demographic data, and the personal characteristics and descriptions of participants from varied geographical locations. Also, the rich, thick descriptions provided allow the reader to judge transferability.

There are limitations to this study. Although attempts were made to reach multiple areas of the United States, the southwestern and midwestern states were not represented. The lack of an available convenient date and time for all the focus group members resulted in individual phone interviews with each of the four content experts. This was a limitation to the study and resulted in a missed opportunity for the focus group and researcher to hear the group discussion of the concepts. Additionally, the interviews completed via telephone presented a limitation. Completing an interview via telephone does not allow the researcher the opportunity to see the participant's facial reactions, body language and gestures during the interview.

The inexperience of this novice researcher must also be considered as a limitation of this study. Limitations may also arise from the processes of the grounded theory

methodology which is a complex and time-consuming process relying heavily on the abilities of the researcher, in this instance a novice researcher. Other limitations could emerge using a grounded theory methodology as a novice researcher utilized theoretical analysis, which could limit the findings of this study (Wuest, 2012).

Recommendations for Future Research

There are several recommendations for future spiritual care in nursing care research. Replication of the research could be conducted to include the Southwest and Midwest states for input. Another potential study might replicate the research in five years to identify if there is any change in the barriers preventing nurses from providing spiritual care. A study to investigate the measurement and assessment of the outcomes of the collaborative activities between nursing, medical and chaplain spiritual care is another additional research study.

A quantitative research study to compare patient perspective and attitudes regarding the spiritual care provided to them and their satisfaction related to their overall hospital experience would add to patient spiritual care outcome research. Quantitative research could be conducted on interventions to overcome barriers to spiritual care in nursing. The theory emerging from this study should be further tested. Aspects of the categories, subcategories, and the core category all could be further researched independently and for relationships with each other in a mixed methods study. For example, quantitative research investigators could seek to understand the effect of a

spiritual care education program focusing on the nurse-patient relationship and the nurse's perceived spiritual care competence.

Another future study related to spiritual care in nursing practice is a case study completed at a healthcare organization that has provided the health care to the victims of any of the mass casualties in the past several years and examine the healthcare system's response to the effects of this traumatic care on the healthcare providers. A phenomenological study to explore the lived experience of recent active duty military persons spiritual care practices and needs after returning to private sector healthcare practice. Research opportunities with a focus on the nursing role in spiritual care are abundant and specific to the identity of nursing.

Summary and Conclusion

This research used grounded theory with an adapted methodology of Strauss and Corbin (1998) to discover the critical factors influencing spiritual care in nursing practice. The purpose of this qualitative research was to develop a substantive theory about the attitudes, perceptions, and behaviors of holistic nurses providing spiritual care. This study aimed to contribute to the knowledge of registered nurses and provide an understanding to the process nurses use to develop the skill to provide spiritual care to their patients. A purposive group of holistic nurses consisted of 27 participants from multiple states who completed individual interviews. A theoretical group of four experts was interviewed and confirmed the main categories along with model depicting the process. The results of the interviews provided rich, thick, data where participants

ascribed meaning to their spiritual care and subsequently allowed the emergence of three categories. *Becoming aware*, *caring for the spirit*, and *embodying praxis* emerged supporting the framework that described the basic social process used by holistic nurses to describe their spiritual care. Living Spiritual Care Praxis emerged as the conceptual model that described the basic social process as substantiated in the literature.

Strengths and limitations of the research were addressed. Implications for nursing, education, research, and public/health policy were identified. Ongoing research opportunities are identified to build on understanding spiritual care in nursing practice. Finally, ongoing research will continue to contribute to the body of nursing knowledge of spiritual care in nursing practice.

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APPENDIX A

BARRY IRB APPROVAL LETTER

Barry University
Division of Academic Affairs

[redacted]

Research with Human Subjects
Protocol Review

Date:	May 4, 2017
Protocol Number:	170413
Title:	Exploring Spiritual Care in Nursing Practice
Meeting Date:	April 19, 2017
Name:	Ms. Janice Lowden-Stokley
Address:	[redacted]
Faculty Sponsor:	Dr. Jessie Colin – Nursing

Dear Ms. Lowden-Stokley:

On behalf of the Barry University Institutional Review Board (IRB), I have verified that the specific changes requested by the convened IRB on April 19, 2017 have been made.

It is the IRB's judgment that the rights and welfare of the individuals who may be asked to participate in this study will be respected; that the proposed research, including the process of obtaining informed consent, will be conducted in a manner consistent with requirements and that the potential benefits to participants and to others warrant the risks participants may choose to incur. You may therefore proceed with data collection.

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol. These adverse events include, but may not be limited to, any experience that is fatal or immediately life-threatening, is permanently disabling, requires (or prolongs) inpatient hospitalization, or is a congenital anomaly cancer or overdose.

The approval granted expires May 14, 2018. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with an IRB Application for Continuing Review (Progress Report) summarizing study results to date. The IRB will request a

progress report from you approximately three months before the anniversary date of your current approval.

If you have questions about these procedures, or need any additional assistance from the IRB, please call the IRB point of contact, Mrs. Barbara Cook [redacted] or send an e-mail to [redacted]. Finally, please review your professional liability insurance to make sure your coverage includes the activities in this study.

Sincerely,

David M. Feldman, PhD
Chair, Institutional Review Board
Barry University
Department of Psychology
[redacted]

Cc: Dr. Jessie Colin

****

APPENDIX B

INFORMED CONSENT FORMS: INDIVIDUAL AND FOCUS GROUP

Approved by Barry University IRB :
Date : 5/9/17
Signature :

Institutional Review Board
Protocol Form
April, 17 10

APPENDIX B
INFORMED CONSENT FORMS: INDIVIDUAL AND FOCUS GROUP

Barry University

Phase I Individual Informed Consent Form

For use with Skype/Face to Face Interviews

Your participation in a research project is requested. The title of the study is "Exploring Spiritual Care in Nursing Practice." The research is being conducted by Janice Lowden-Stokley, a PhD student in the College of Nursing and Health Sciences at Barry University, and is seeking information that will be useful in the field of nursing. The aim of the research is to generate a substantive theory explicating the nurses' role in providing spiritual care. In accordance with these aims, the following procedures will be used: two digitally recorded interviews and a demographic survey. The first audiotaped interview will be conducted in a face to face meeting or Skype interview using open ended questions related to the topic of registered nurses' attitudes and perceptions related to the provision of spiritual care in their nursing practice. The first interview will last approximately one hour. The second interview will last approximately 30 minutes and will be completed face to face, via Skype, or over the phone and will not be audiotaped. The purpose of the second interview is for clarification and verification of information collected during the first interview. We anticipate the number of participants to be 30. The total estimated participation time for Phase I is 100 minutes.

If you decide to participate in this research, you must meet the following criteria:

1. Provide spiritual care in their practice in your inpatient or outpatient professional practice:
2. Are willing to discuss your experiences in the interest of nursing research;
3. Are 18 years old or older;
4. Able to read, write and understand the English language;
5. Are available for a face to face, Skype or telephone interviews;
6. Be fluent in the use of video conferencing, Skype, if opting to video conference the interview
7. Agree to be audiotaped and willing to review and return the transcribed interview as part of the "member check" procedure;
8. Have access to a computer and an email to complete the transcribed interview verification;

9. Be fluent in the use of video conferencing, Skype®, if opting to video conference the interview.

10. Agree to be audiotaped and willing to review and return the transcribed interview as part of the “member check” procedure.

If you decide to participate in this research, you will receive a $25 gift card as a token of appreciation for your participation in this study regardless if you complete the interviews or not.

If you decide to participate in this research, you will be asked to do the following: Complete a demographic questionnaire, spend one hour in an audio recorded interview at a mutually agreed location. The digital recording of the first interview will be transcribed, you will be asked to review the transcription for accuracy in a second interview during the next week. The second interview will last approximately 30 minutes.

Your consent to be a research participant is strictly voluntary and should you decline to participate or should you choose to drop out at any time during the study, there will be no adverse effects on your or your employment as a nurse.

There are no known risks to you as a participant in this research. Although there are no direct benefits to you, your participation in this study may help our understanding and contribute to knowledge related to spiritual care provided in nursing practice.

As a research participant, information you provide will be held in confidence to the extent permitted by law. As this project involves the use of Skype®: to prevent others from eavesdropping on communications and to prevent impersonation or loss of personal information, Skype® issues everyone a "digital certificate" which is an electronic credential that can be used to establish the identity of a Skype® user, wherever that user may be located. Further, Skype® uses well-known standards-based encryption algorithms to protect Skype® users' communications from falling into the hands of hackers and criminals. In so doing, Skype® helps ensure user's privacy as well as the integrity of the data being sent from one user to another. If you have further concerns regarding Skype® privacy, please consult the Skype® privacy policy. To ensure confidentiality, the researcher will establish a separate Skype® account for this research project only. After each communication, the researcher will delete the conversation history. Once this is

done, the conversation cannot be recovered. The conversation will be transcribed by a professional who has signed a third-party confidentiality form. Following verification of transcription, the digital recording will be destroyed. As stated previously, to the fullest extent of the law, the information you provide as a research participant will be kept confidential: that is, no names or other identifiers will be collected on any of the instruments used. Any published results of the research will be in aggregate form and pseudonyms will be used. Transcripts of recordings will be kept in a locked file in the researcher's office. Digital recordings will be destroyed after transcription is verified. Your signed consent form will be kept separate from the data. All data will be kept indefinitely.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Janice Lowden-Stokley, at [redacted], [redacted] [redacted]; my supervisor, Dr. Jessie Colin, at [redacted], [redacted]; or the Institutional Review Board point of contact, Barbara Cook, at [redacted] [redacted]. If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I have been informed of the nature and purposes of this experiment by Janice Lowden-Stokley and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this experiment.

_____ _____

Signature of Participant *Date*

_____ _____ _____ _____

Researcher *Date* *Witness* *Date*

(Witness signature is required only if research involves pregnant women, children, other vulnerable populations, or if more than minimal risk is present.)

Approved by Barry University IRB
Date: 5/9/17
Signature:

Institutional Review Board
Protocol Form
April, 17 13

Barry University
Phase II Informed Consent Form
Focus Group Interview
For use with Skype

Your participation in a research project is requested. The title of the study is "Exploring Spiritual Care in Nursing Practice." The research is being conducted by Janice Lowden-Stokley, a PhD student in the College of Nursing and Health Sciences at Barry University, and is seeking information that will be useful in the field of nursing. The aim of the research is to generate a substantive theory explicating the nurses' role in providing spiritual care. In accordance with these aims, the following procedures will be used: one digitally recorded interview and the completion of a demographic questionnaire. The following procedures will be used with the focus group interview: read a manuscript of an emerging theory, an audiotaped, semi-structured focus group interview will be conducted face-to-face or Skype using open ended questions related to the topic nurses attitudes and perceptions related to the nurses' role in providing spiritual care and completion of a demographic questionnaire. In addition, focus group participants will review categories and emerging theory. The estimated time to read the manuscript of the emerging theory is 45 minutes. The interview will last approximately 90 minutes. We anticipate the number of participants to be no more than seven. The total estimated time for Phase II is 135 minutes.

If you decide to participate in this research, you must meet the following criteria:
1. Are you considered an expert in the context of spiritual care.

2. Have completed research in the field of spiritual care in nursing practice.

3. Have published in peer reviewed nursing journals and/or presented your research at a professional nursing conference regarding spiritual care in nursing practice.

If you decide to participate in this research, you will be asked to do the following:
1. Complete a demographic questionnaire;

2. Review an electronic or mailed copy of the initial draft of the theory the nurses' role in providing spiritual care;

3. After reviewing the manuscript of the emerging theory (estimated time 45 minutes), you will be asked to meet with the principal investigator and other nurse experts in spiritual care in nursing practice as part of a focus group interview (Skype). This interview will last no more than 90 minutes and will be scheduled at an agreed upon date and time that will be convenient for all. The purpose of this focus group is to explore the relevance and fit of the nurse's role in spiritual care theory in professional nursing practice. Total amount of estimated time for participation in Phase II is 135 minutes.

4. scheduled at an agreed upon date and time that will be convenient for all. The purpose of this focus group is to explore the relevance and fit of the nurse's role in spiritual care theory in professional nursing practice.

Your consent to be a research participant is strictly voluntary and should you decline to participate or should you choose to drop out at any time during the study, there will be no adverse effects on your or your employment as a nurse. If you decide to participate in this research, you will receive a $25 gift card as a token of appreciation for your participation in this study regardless if you complete the interview or not.

There are no known risks to you as a participant in this research. Although there are no direct benefits to you, your participation in this study may help our understanding and contribute to knowledge related to spiritual care provided in nursing practice.

As a research participant, information you provide will be held in confidence to the extent permitted by law. As this project involves the use of Skype®: to prevent others from eavesdropping on communications and to prevent impersonation or loss of personal information, Skype® issues everyone a "digital certificate" which is an electronic credential that can be used to establish the identity of a Skype® user, wherever that user may be located. Further, Skype® uses well-known standards-based encryption algorithms to protect Skype® users' communications from falling into the hands of hackers and criminals. In so doing, Skype® helps ensure user's privacy as well as the integrity of the data being sent from one user to another. If you have further concerns regarding Skype® privacy, please consult the Skype® privacy policy. To ensure confidentiality, the researcher will establish a separate Skype® account for this research project only. After each communication, the researcher will delete the conversation history. Once this is done, the conversation cannot be recovered. The conversation will be transcribed by a professional who has signed a third-party confidentiality form. Following verification of transcription, the digital recording will be destroyed. As stated previously, to the fullest extent of the law, the information you provide as a research participant will be kept confidential: that is, no names or other identifiers will be collected on any of the instruments used. Any published results of the research will be in aggregate form and pseudonyms will be used. Transcripts of recordings will be kept in a locked file in the researcher's office. Digital recordings will be destroyed after transcription is verified. Your signed consent form will be kept separate from the data. All data will be kept indefinitely.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Janice Lowden-Stokley, at [redacted], my supervisor, Dr. Jessie Colin, at [redacted], or the Institutional Review Board point of contact, Barbara Cook, at [redacted]

[redacted] If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I have been informed of the nature and purposes of this experiment by Janice Lowden-Stokley and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this experiment.

_____	_____		
Signature of Participant	*Date*		
_____	_____	_____	____
Researcher	*Date*	*Witness*	*Date*

(Witness signature is required only if research involves pregnant women, children, other vulnerable populations, or if more than minimal risk is present.)

APPENDIX C

BARRY UNIVERSITY
LETTER OF REQUEST FOR ACCESS TO THE
AMERICAN HOLISTIC NURSE ASSOCIATION

Janice Lowden-Stokley, MSN, RN
[redacted]

March 13, 2017

Name and Address of Director AHNA

Dear_____;

I am a doctoral student at Barry University, College of Nursing and Health Sciences, conducting a study entitled Exploring Spiritual Care in Nursing Practice. The study is being conducted for my dissertation, which is in partial fulfillment of the PhD requirements. The purpose of the study is to generate a substantive theory explicating the nurses' role in providing spiritual care in nursing practice.

I am requesting your permission to distribute a flyer to the attendees at the Annual Conference in Rancho Mirage, California on June 5-10, 2017, and to members listed on the Members Directory of the AHNA website. Upon approval by Barry University's IRB, I will send you my recruitment flyers to be made available at the Annual Conference to potential participants, or according to AHNA protocol. Nurses may choose to contact me by phone and/or email provided on the flyer. Participation in this study is voluntary; and volunteers will be offered a $25.00 gift card as a token of appreciation. Interviews will be face-to-face, or by Skype®, will last no more than 60 minutes; and will be digitally recorded. There will be a follow-up 30 minutes review session to verify accuracy of the transcript. Times and locations will be mutually agreed upon.

If you are to approve and permit me access to the AHNA membership, please respond on letter head, sign, and return a scanned copy to [redacted]

Thank you sincerely for your consideration in allowing me access to recruit volunteers for this study. Please feel free to contact me at 407-247-9690 or email at janice.lowden-stokley@mymail.barry.edu.

You may contact my faculty sponsor, Dr. Jessie Colin at [redacted]. The IRB contact is Barbara Cook at [redacted]. I look forward to your response at your earliest convenience.

Sincerely,

Janice Lowden-Stokley, MSN, RN
Barry University, PhD Student

APPENDIX D
Barry University Flyer

PARTICIPANTS NEEDED FOR A RESEARCH STUDY

Exploring Spiritual Care in Nursing Practice

30 Volunteers Needed
Each participant will receive a $
$25 VISA Gift Card
as a token of appreciation

Contact Principal Investigator:
Janice Lowden-Stokley, MSN, RN
A PhD Student in the College of Nursing and Health Sciences
[redacted]

Phase I

Participant Qualifications

Interested persons must meet the following criteria:

1. **Provide spiritual care in their practice in their inpatient or outpatient professional practice:**
2. **Are willing to discuss their experiences in the interest of nursing research;**
3. **Are 18 years old or older;**
4. **Currently residing in the continental United States;**
5. **Able to read, write and understand the English language;**
6. **Are available for a face to face, Skype or telephone interviews;**
7. **Be fluent in the use of video conferencing, Skype, if opting to video conference the interview**
8. **Agree to be audiotaped and willing to review and return the transcribed interview as part of the "member check" procedure;**
9. **Have access to a computer and an email to complete the transcribed interview verification;**

Barry University Faculty Sponsor
Jessie Colin, PhD, RN, FRE, FAAN
[redacted]

Barry University Institutional Review Board
Barbara Cook
[redacted]

PARTICIPANTS NEEDED FOR A RESEARCH STUDY

EXPERT FOCUS GROUP

Exploring Spiritual Care in Nursing Practice

Phase II

Participant Qualifications

Interested persons must meet the following criteria:

1. **Are considered experts in the context of spiritual care.**
2. **Have completed research in the field of spiritual care in nursing practice.**
3. **Have published in peer reviewed nursing journals and/or presented their research at a professional nursing conference regarding spiritual care in nursing practice.**

7 Volunteers Needed
Each participant will receive a
$25 VISA Gift Card
as a token of appreciation

Contact Principal Investigator:
Janice Lowden-Stokley, MSN, RN
A PhD Student in the College of Nursing and Health Sciences
[redacted]

Barry University Faculty Sponsor
Jessie Colin, PhD, RN, FRE, FAAN
[redacted]

Barry University Institutional Review Board
Barbara Cook
[redacted]

APPENDIX E

Barry University

Third Party Confidentiality Form

Transcriptionist

Confidentiality Agreement

As a member of the research team investigating Exploring Spiritual Care in Nursing Practice, I understand that I will have access to confidential information about study participants. By signing this statement, I am indicating my understanding of my obligation to maintain confidentiality and agree to the following:

1. I understand that names and any other identifying information about study participants are completely confidential.
2. I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
3. I understand that all information about study participants obtained or accessed by me in the course of my work is confidential. I agree to not divulge or otherwise make known to unauthorized persons any of this information unless specifically authorized to do so by office protocol or by a supervisor acting in response to applicable protocol or court order, or otherwise as required by law.
4. I understand that I am not to read information and records concerning study participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.
5. I understand that a breach of confidentiality may be grounds for disciplinary action, and may include termination of employment.

6. I agree to notify my supervisor immediately should I become aware of an actual breach of confidentiality or situation which could potentially result in a breach, whether this be on my part or on the part of another person.

_____	_____	_____
Signature	Date	Printed Name
_____	_____	_____
Signature	Date	Printed Name

APPENDIX F

Barry University

Procedures for Interviews

1. Respond to potential participants who show interest in the study and agree on date, time, place and method of the interview, whether conducted face to face, by telephone or Skype®.
2. Obtain pertinent contact information including name, telephone and email contact.
3. At initial meeting, introduce the researcher and welcome participant. Offer gift card.
4. Gift card will be mailed to the participant's address when the interview is not face to face.
5. Thank the participant for willingness to participate.
6. Before interview, create a relaxed atmosphere using conversational comments and questions
7. Describe study protocol, explain informed consent, and answer questions.
8. Ask participant to read and sign informed consent.
9. Remind that participation in the study is voluntary, with the option to withdraw at any time.
10. If interview is not face to face, arrange for consent to be scanned, emailed or mailed.
11. Ask participant to choose a pseudonym as unidentifiable identifier
12. If not face to face, ask participant to complete demographic questionnaire, scan and e- mail
13. Conduct interview using guiding questions.
14. After the planned questions, ask whether participant wants to add anything else

15. Remind that audio-recording can be paused or discontinued, and offer breaks as needed

16. Conclude the interview by asking participants if they know of other nurses who would be interested in participating, and schedule second meeting.

17. Turn off the recorder.

18. Thank the participant; turn off Skype® if applicable.

19. Self-reflect and note thoughts, feelings, and observations.

20. Submit audio-recording to transcriptionist who signed 3rd party confidentiality form.

21. Save scanned documents on the personal password protected computer of the researcher

22. Review the transcribed interview and compare with audio recording

23. Provide for member check at next meeting.

24. Analyze data, memos, journaling throughout the process.

25. Schedule interviews until saturation is met.

26. Analyze data using Strauss and Corbin's methods for grounded theory until themes emerge.

APPENDIX G

Barry University

Demographic Information Form

Pseudonym_____

Instructions: Please provide a response for each of the following questions:

1. What is your age: __18-25 __26-35 __ 36-45 __46-55 __56-65 __over 65

2. What is you sex/gender: __Female __Male

3. With which racial or ethnic category do you identify?

__African American __Asian/Pacific Islander __Caucasian __Latino

Other: _____

4. Religious/ Spiritual Belief Foundation

___Christian ___Jewish ___Muslim ___Buddhist ___Agnostic ___Atheist

___Other (please list)_____

5. Type of Facility/Company you are employed with?

____ Faith-Based ____ Non-Faith-Based

6. What is your highest level of education?

___Diploma __ASN __BSN __MSN __ARNP __PhD

___Other (please list)_____

7. How many years' experience do you have as a registered nurse?

___less than2 years ___ 2-5 years ___ 5-10 years ___10-15 years ___more than 15 years

8. What is your Nursing Specialty? _____

9. How long have you been providing spiritual care in holistic nursing care?

__ 6 months __over 6 months to 1 year _over 1-3 years

__ over 3 - 6 years __ over 6 - 9 years __Greater than 9 years

10. List spiritual care interventions used for self:

_____

_____

11. List spiritual care interventions and assessments you have used in patient care:

_____

_____

Demographic Information Form

Phase Two Focus Group Members

Pseudonym_____

Instructions: Please provide a response for each of the following questions:

1. What is your age: __18-25 __26-35 __ 36-45 __46-55 __56-65 __over 65

2. What is you sex/gender: __Female __Male

3. With which racial or ethnic category do you identify?

__African American __Asian/Pacific Islander __Caucasian __Latino

Other: _____

4. Religious/ Spiritual Belief Foundation

___Christian ___Jewish ___Muslim ___Buddhist ___Agnostic ___Atheist

__Other (please lists) _____

5. What is your highest level of education?

___ Diploma__ASN __BSN __MSN __ARNP __PhD

___Other (please list) _____

6. How many years' experience do you have as a registered nurse?

___less than2 years ___ 2-5 years ___ 5-10 years ___10-15 years ___more than 15 years

7. What is your Nursing Specialty? _____

8. Have you completed research related to spiritual care in nursing practice?

__yes __no

9. Have you presented at nursing conference on the topic of spiritual care in nursing practice? __yes __no

10. Have you published in a peer reviewed journal on the topic of spiritual care in nursing practice? __yes __no

APPENDIX H

Barry University

Phase One Semi Structured Interview Questions

1. Tell about your experience in providing Spiritual Care in your nursing practice in the past, and today.

2. How would you define/describe Spiritual Care?

3. Tell me about the training you received in Spiritual Care?

4. Describe for me an example that you feel describes/represents the best example of spiritual care in nursing practice?

5. What are some of the activities that you do when providing spiritual care?

6. Tell me about your first experience in providing Spiritual Care?

7. How did you know that someone needed spiritual care?

8. What resources do you feel are needed to in order for nurses to be able to provide spiritual care in their nursing practice?

Prompt Questions

A. How does this experience make you feel?

B. Describe the response of patients and families to Spiritual Care provided?

C. What is the reaction of your peers and other healthcare professionals towards the use of Spiritual Care in your setting?

D. Are there any barriers to your practice, and how do you work with these barriers?

E. Is there anything else that you would like to tell/share with me?

APPENDIX I

Barry University

Phase Two Focus Group Guiding Questions

SAMPLE FOCUS GROUP INTERVIEW QUESTIONS

Initial Open-ended Questions:

1.What is your experience in the provision of spiritual care in nursing practice?

2.Describe for me an example that you feel describes/represents the best example of spiritual care in nursing practice?

4.What are some of the activities that you do when providing spiritual care?

5. Tell about your experience in providing Spiritual Care in your nursing practice in the past, and today.

6. What resources do you feel are needed to in order for nurses to be able to provide spiritual care in their nursing practice?

Intermediate Questions

1. What are your thoughts regarding the themes (list) that emerged during the individual interviews?

2. How closely does the theoretical framework that emerged from the individual interviews fit your understanding of the provision of spiritual care in nursing practice?

3. Does this theoretical framework align/represent with your experience as an expert practitioner with spiritual care in nursing?

4. What are your thoughts regarding the usefulness to nursing practice of the theory of spiritual care provision in nursing practice generated from this study? What about its usefulness to nursing education? Research? Policy?

5. Is there anything else that you would like to add?

VITAE

Janice Lowden-Stokely

1984	A.S. Mercer Community College Trenton, NJ
1984	Diploma Nursing Mercer Medical Center School of Nursing Trenton, NJ
1984-1986	Staff Nurse Medical Surgical Mercer Medical Center School of Nursing Trenton, NJ
1986-1988	Charge Nurse Surgical Unit Park Ridge Hospital Rochester, NY
1988-1990	Staff Nurse Emergency Room Highland Hospital Rochester, NY
1989-1990	Office Nurse Pediatric Primary Care Office Rochester, NY
1990-1994	Evening Charge Nurse Mother Infant Unit Denver, CO
1991-1995	B.S. Nursing Metropolitan State College of Denver Denver, CO

1994-1995	Office Nurse Obstetrical and Gynecologic Clinic Denver, CO
1994-1996	Office Nurse Kaiser Permanente Denver, CO
1996-2001	Quality Specialist Orlando Regional Orlando, FL
1999-2002	M.S. Nursing University of Central Florida Orlando, FL
2002-2003	Staff Nurse Urgent Care Unit Arnold Palmer Hospital Orlando, FL
2003-2005	Staff Nurse South Seminole Hospital Longwood, FL
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