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ABSTRACT OF THESIS

SPIRITUALITY AND NURSING CARE

A phenomenological study was conducted to address what Intensive Care Unit (ICU) nurses perceived as spiritual care giving in their day-to-day lived experiences. Interviews with ten ICU nurses were conducted on a volunteer basis. Data was analyzed using Colaizzi's method of phenomenology. Significant statements from the interviews were extracted and clustered into six main themes. Themes included: outlook on life, loss of connectedness, activities, psychological comfort level, attuned to the patient's/family's spirituality, and value placed on spiritual issues. After themes and their meanings were explained, an exhaustive description of spiritual care giving was formulated. Nurses in this study discussed the barriers that deterred them from delivering spiritual care. All of the nurses interviewed believed that spiritual care was an important part of the holistic role of the nurse. Findings suggested the need for nursing education to incorporate spirituality and spiritual care classes into basic nursing education curriculum and to offer in-service to post graduates. Findings also suggested how nurses define their own spirituality and how that influences their delivery of spiritual care. Nurses need to find comfort and understanding with their own spirituality in order to gain comfort in providing spiritual care to their patients and families.


Sandy J. Ruth

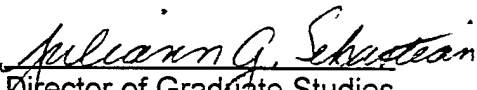
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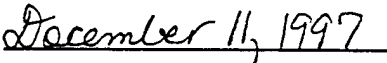
SPIRITUALITY
AND
NURSING CARE

By

Sandy Jo Keith


Director of Thesis


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THESIS

Sandy Jo Keith

The Graduate School
University of Kentucky
1997

SPIRITUALITY
AND
NURSING CARE

THESIS

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science of Nursing
at the University of Kentucky

By

Sandy Jo Keith

Lexington, Kentucky

Director: Dr. Sherry Warden, Associate Professor of Nursing

Lexington, Kentucky

1997

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Chapter One

Introduction

Background

Nursing has traditionally valued providing holistic patient care. This implies providing for physical, psychological, social and spiritual needs. Spiritual needs involve any "essential variable required for the support and viability of that element which inspires in man the desire to transcend the realm of the material" (OBrien, 1989, p. 85). Spiritual needs of patients/families have been neglected in nursing care. Perhaps examining the concept of spirituality more closely will shed some light on why spiritual care is not routinely provided by nurses.

Spirituality is regarded as a basic component of a human being and is important in the attainment of an overall sense of health, well-being and quality of life (Reed, 1992). For many, spirituality provides a sense of meaning and purpose in life. It can provide a source of love and relatedness to ourselves, others and a higher power (Lulcoff, Lu, & Turner, 1995). Spirituality helps one develop and remain in harmony with the universe and may consist of either religious or secular dimensions or both. The religious dimension usually encompasses a supreme being, sometimes called God, Allah or Buddha and a set of codes of behavior by which one aspires to live (Harrison & Burnard, 1993). The secular dimensions follow a more humanistic perspective. Instead of having a set of standardized religious beliefs, the person chooses his own set of values and beliefs that guide life's decisions (Oldnall, 1996). Many people have integrated religious beliefs and their own set of humanistic values. Spirituality is unique to each person. It is a part of how one identifies with their individuality.

Therefore, spirituality may best be defined as an aspect of the total person that influences or acts in conjunction with other aspects of the person; "it has a relational nature which is expressed through interpersonal relationships between persons and through a transcendent relationship with another realm; . . . it produces behaviors and feelings which demonstrate life, faith, hope, and trust, therein, providing meaning to life and reason for being" (Labun, 1988, p. 314-315). In contrast, religion is defined as "an organized body of thought and experience concerning the fundamental problems of existence; it is an organized system of faith" (Dombeck & Karl, 1992, p. 267).

The concept of spirituality and spiritual care as it relates to nursing practice has gained popularity in nursing literature since the 1980's (Reed, 1992). Spiritual care is the use of simple ways of helping a patient find meaning and purpose in life; supporting the faith needs of a patient; supporting and furthering the patients appreciation of spiritual values. The goal of this care is to decrease spiritual distress, that is the "disruption in life principles that pervades a person's entire being and that integrates and transcends one's biological and psychological nature" (North American Nursing Diagnosis Association, 1992, p. 46). Another goal of spiritual care is to increase spiritual well-being, defined by Mickley, Soeken, and Belcher (1992) as the affirmation and satisfaction with life and a relationship with God, as well as, the perception that one's life has meaning. The reasons for this increase in interest are that many nurses have been reexamining the meaning of providing holistic care and have concluded that nurses are providing inadequate spiritual care to their patients/families (Carson, 1989; Morrison, 1990; Piles, 1990). Another reason for the increased interest in spirituality in nursing is due to the growing literature on how spirituality can help

patients cope with illness. This focus on holism has prompted the nursing profession to study how spirituality affects a person during illness and what nurses need to know to provide better spiritual care. The purpose of this study is to address what nurses perceive as spiritual care giving in their day-to-day lived experiences.

Need for the study

Belief systems can influence patients' perceptions of health and illness and direct the use of traditional or nontraditional alternative therapies. For example, religious beliefs and practices have been found to affect patients' experiences with cancer (Jenkins & Pargament, 1995; Mackey, Koopermieners, & Gutknecht, 1996). Mackey, et al. (1996) asked cancer patients what gave them hope. Almost two thirds of the patients mentioned faith, spiritual strength, religion and belief in life after death, as helping them find meaning with their illness. Studies with HIV patients and their coping strategies (Hall, 1994; Jenkins, 1995) found that spiritual experiences helped them find hope and meaning with their illness, strengthened their love of self and others, and renewed their belief in the support of a higher power. Other studies with patients diagnosed with coronary artery disease (Agrawal & Dalal, 1993), alcoholism (Uva, 1991) and diabetes mellitus (Landis, 1996) resulted in similar findings that patients' spirituality helped them find meaning and hope in dealing with illness. As people age, the need for meaning in life becomes more important and spiritual beliefs can offer a means of understanding life's experiences (Forbis, 1988). According to Erickson (cited by Forbis, 1988), a primary developmental task for elderly adults is to resolve conflict between spiritual integrity and despair before achieving life satisfaction in later life. Nurses who are able to recognize and attend to spiritual needs may help

alleviate their patients'/families' suffering, restore a sense of meaning, meet developmental needs, and ultimately patients/families will attain greater life satisfaction.

Nurses need to know how to assess spiritual needs and intervene appropriately. Even though the topic of spirituality has increased in popularity in the nursing literature, there still has been little attention given to methods of assessing and delivering spiritual care. The reason for this lack of interest may lie with the lack of nurses' personal understanding of spirituality (Oldnall, 1996). In order to understand spirituality, one must explore one's own beliefs, values and thoughts about the meaning of life. Nurses need to understand how spirituality can transcend the self in a way that is empowering and not devaluing. This transcendence may be experienced intrapersonally (how one is connected to oneself), interpersonally (how one is connected to others and the environment), and transpersonally (how one is connected to the unseen God, or power greater than the self)(Reed, 1992). By developing awareness and positive insights into one's own spirituality, nurses may gain comfort in offering positive spiritual support to their patients.

Another reason why nurses may not incorporate spiritual care into their practice may be due to fear (Granstrom, 1985). Examples of fears that may interfere with the provisions of spiritual care include: fear of getting into a situation that nurses may not be able to handle or being asked questions they don't know how to answer, fear of intruding on patients' privacy and fear of being converted or confused with their own belief systems. To alleviate some of those fears, nurses need to know that they are not solely responsible for meeting patients' spiritual needs. Support from clergy, family and friends should be

utilized as well. Other reasons for spiritual care being overlooked, may be that spirituality cannot be easily quantified. No step-by-step interventions exist for spiritual care (Prail, 1995). Delivering spiritual care needs to be explored and understood so that nurses can provide holistic care.

This study will focus on what intensive care unit (ICU) nurses experience in their effort to deliver spiritual care. ICU nurses are challenged with the responsibility of helping patients/families find hope and meaning in their lives during times of physical and emotional crisis. The nurse, as primary care giver, is ideally placed to help patients/families who are in spiritual distress.

Review of literature

The Role of Spirituality in Nursing

The majority of nursing theorists do include spirituality in their theories, but the concept is not well explained. However, Watson, Neuman, and Henderson have integrated spirituality into their theories. Watson (1988) acknowledges that spiritual and religious awareness is a nursing responsibility. Nurses should seek opportunities to become familiar with religious and spiritual influences in a person's life at home or in the community. Neuman refined her theory to include reference to the spiritual variable being present in every client system; "the spirit controls the mind, and the mind consciously or unconsciously controls the body" (Neuman, 1989, p. 29). Henderson (1967) believes illness has spiritual as well as physical and emotional components. All three theorists support the view that a therapeutic environment is one where not only physical and psychological needs are met, but, where a person's spirituality can grow and spiritual healing can take place.

The nurse's role is to allow persons to express their spirituality in a

nonjudgemental environment by showing genuine concern, trust and promoting a sense of security (Narayanasamy, 1996). The nurse's role is to assess the patient's/family's spiritual needs and intervene to help the patient/family meet those needs. Skills that may be helpful for nurses in assessing and providing spiritual care include self awareness (Narayanasamy, 1991); communication skills such as listening (Burnard, 1990), observing, building trust (Narayanasamy, 1991), and giving hope (Herth, 1990). Self awareness requires nurses to acknowledge their own values, beliefs and attitudes. Communication includes verbal and nonverbal skills that show genuineness and acceptance. Some writers recognize the most essential way nurses show genuineness and acceptance is called 'presencing' or being there. This is enhanced by empathetic listening (Carson, 1989; Shaffer, 1991). In addition, therapeutic touch may provide emotional comfort and support during spiritual distress for some patients and their families (Shaffer, 1991). Observations include: watching if the patient prays, having religious ornaments in the room or wearing them, observing patient's behavior with family and friends, and if the patient demonstrates any behaviors that may indicate spiritual distress, such as showing despair or anger (Harrison & Burnard, 1993). Giving the patient/family hope includes: helping them reaffirm their faith, encouraging them to focus on memories that are uplifting (recalling happy stories can serve to renew hope), and empowering patients/families to live their life to the fullest (Narayanasamy, 1996). Many of these skills such as empathetic listening, giving hope and communicating acceptance are already part of the concept of caring and should not be feared or considered optional (Harrison & Burnard, 1993).

Codes governing nursing practice acknowledge nurses responsibility to respect

patients' values and beliefs (International Council of Nurses, 1973). These statements are usually interpreted as requiring nurses to passively avoid offending patients/families. These codes can also be interpreted in a more active role for the nurse to intervene and encourage their patients'/families' belief system.

Spirituality and Practice Setting

Most of the literature found on spirituality and health care deals with two broad areas: 1) the importance of spirituality to patients for coping with illness, and 2) health care provider interventions that can assist patients toward spiritual well being. Only a few articles were found dealing with spiritual care in the critical care setting. Two of those articles discussed which nursing interventions were needed to provide spiritual care. The first study (Clark & Heidenreich, 1995), found nursing interventions supporting spiritual care in 62 critical care patients. These included establishing trusting relationships, providing in-depth spiritual assessments and acting as a facilitator among family, clergy and other providers. The second article (Harrington, 1995) described factors that influenced acute care nurses in their delivery of spiritual care. In this descriptive study, 10 nurses working in an acute care setting and 10 nurses working in a hospice setting were interviewed. The results indicated three things that influenced the provision of spiritual care. The first was the comfort level of nurses with their personal meaning of spirituality. The more uncomfortable nurses were, the more reluctant they were in initiating spiritual care. The second factor was the nature of the practice setting. Nurses in the acute care setting found it difficult to provide spiritual care due to the focus on disease rather than on the person. Hospice nurses found greater opportunities to discuss spirituality with their patients

because they worked in an atmosphere that encouraged and supported that type of care. The third factor was nursing education. The respondents felt their original nursing training did not prepare them for delivering spiritual care.

Barriers to Spiritual Care

Other studies (Narayanasamy, 1993; Taylor, Amenta & Highfield, 1994, 1995; Piles, -1990) found that nurses were aware of the presence of spiritual needs and their importance in nursing care, but did not feel comfortable with, or competent in delivering spiritual care. Narayanasamy (1993) studied 33 first level general nurses (RGNs) by using a questionnaire on awareness and preparedness of nurses in meeting patient's spiritual needs. Two reasons were found explaining why nurses were unable to give spiritual care. First, nursing education did not adequately prepare nurses for this task. Second, spiritual care was seen as a chaplain's responsibility and therefore, not within the domain of nursing.

Piles (1990) used stratified random sampling (300 registered nurses) to study the type of spiritual care that was provided and factors that hindered the nurses from providing spiritual care. The amount of attention that was given to spiritual care by the nurses was positively related to: the nurse's perceived ability to provide care, educational exposure in the nurse's basic nursing program, and the importance the nurse placed on the value of spiritual care. The obstacles that deterred nurses from delivering spiritual care were lack of knowledge and time. In another descriptive study (Taylor et al., 1994) an investigator - designed questionnaire was mailed to a stratified random sample of 700 oncology nurses. The study addressed spiritual care attitudes, beliefs and practices. Results indicated many of the nurses struggled with the meaning of spirituality. Many of these participants' attitudes and beliefs were associated with their own sense of

spirituality. Those nurses who perceived themselves as very spiritual were those who attended religious services frequently, were Asian and Latino, were clinical specialists, and held a more positive attitude toward spiritual care than the other nurses who participated in this study.

Purpose of this study

The purpose of this study is to address what ICU nurses perceive as spiritual care giving in their day-to-day lived experiences.

Chapter Two

Methodology

This chapter will discuss qualitative research using a phenomenological design, data collection procedures, and trustworthiness of the study.

Phenomenology as a Research Design

Qualitative research involves an interpretive, naturalistic approach. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meaning people bring to them (Denzin & Lincoln, 1991). This study reports on the meaning of spirituality among ICU nurses who deliver spiritual care.

Phenomenology has its roots in philosophy and psychology. Martin Heidegger, a philosopher, developed the method known as existential phenomenology or philosophical hermeneutics.

The existential perspective considers that an understanding of the person cannot occur in isolation from the person's world (Dreyfus, 1987). Heidegger thought that understanding the meaning of being is needed before all else can be understood about ourselves and the world (Mulhall, 1996). To understand the meaning of being, Heidegger suggests exploring the meaning of human existence. He refers to human existence as "Dasein" or being there. Dasein emphasizes the internal relationship between being and world. It is a relationship of unity that cannot be dissolved (person-world). Heidegger's analysis of human existence is that people are in and of the world, rather than subjects in a world of objects (Koch, 1995). One's culture and history influences a persons Dasein, Being-in-the-world (Dreyfus, 1987). Everyday experience as it is lived is the focus of attention; the concern is to understand lived experience because this is

the place where meaning resides. Yet, because our lived experience is everyday and seems ordinary, much of its meaning remains hidden. Phenomenology attempts to uncover and describe that which is hidden and find the internal meaning. This is known as finding the essence of an experience. Heidegger feels that our foundational mode of existing as persons is in interpretation and understanding. Understanding is grasping one's own possibilities for being within the context of the world in which one lives, our Dasein. Our understanding is rendered by our interpretation of lived experiences.

Hermeneutics means interpretation. Heidegger stated (Mulhall, 1996), that everyone exists hermeneutically, finding significance and meaning everywhere in the world. Every encounter entails an interpretation based on the person's background. It is something we cannot eliminate or bracket, it is already with us in the world. As an alternative to bracketing, Heidegger introduced the interpretive approach of the hermeneutic circle, where pre-conceptions or pre-understandings are recognized as an integral relationship with the world. Within the hermeneutic circle one moves back and forth between overall interpretation and interpretation of details. As the process continues, a richer understanding (Dreyfus, 1987), of the phenomenon is uncovered. In other words, new discoveries of preconceptions brings new conclusions and each set of conclusions brings a deeper meaning.

The aim of hermeneutics is to increase our understanding of our everyday lives, transform our thinking and create for us a future of new possibilities (Mulhall, 1996).

In this study, the researcher was seeking to understand spiritual care giving from the perspective of ICU nurses lived experiences.

Subjects

In contrast to quantitative research, the number of subjects in a qualitative study can be small and a random sample is not needed (Polit & Hungler, 1997). Many qualitative researchers use the principle of saturation, which occurs when themes and categories in the data become repetitive and redundant. Redundancy can typically be achieved with a fairly small number of cases (Polit & Hungler, 1997). A sample of ten ICU nurses participated in this study. All of them work at a tertiary care hospital in the southeastern United States, in various adult ICU settings. The adult ICUs included: Surgical, Neurosurgical, Trauma, Medicine, and Coronary Care. Eight females and two males volunteered to be interviewed. Ages of the participants ranged from 26 to 45 years of age. The amount of experience in the adult ICU setting ranged from 1 to 9 years. Religious backgrounds included: Catholic, Baptist, Lutheran, Disciples of Christ, Christian and Presbyterian. All participants identified with religion. See Table 3 for example of demographic survey.

Data Collection Procedures

Approval from the university's Medical Institutional Review Board and the hospital's Research Review Committee was given to start the data collection. Contact with the adult ICU nurse managers was made by telephone by the researcher. Permission was given by the nurse managers to speak to their staff and ask for volunteers to participate in the study. The study was verbally explained to each of the participants either during staff meetings or one-on-one meetings. A designated date and time were scheduled. The respondents were reminded of the interviews the day before by a telephone call. Before each interview began, the study was explained again to the participants. It was

stressed that there were no right or wrong answers, not to be rushed, and they could withdraw from the study at any time. Confidentiality also was emphasized. In order to protect the participant's identity, each person was given a letter coinciding with that taped interview. The women were given a single letter and the male respondents were given a double letter. For example; Woman: A; Man: AA. -

After the study was explained, each participant filled out a demographic information sheet and signed a consent form. See appendix A for the consent form. All interviews started with the question: "What does spirituality mean to you?" From that point the interviews became more of a dialogue conversation between the researcher and the participant. This developed into an exchange of stories on the subject of spirituality and spiritual care using a few lead in statements. Mulhall (1996) states that such conversations can become a mutual search for understanding the meaning of the experience for both the participant and the researcher. See appendix B for interview questions and lead in statements used in the interview.

Interviews were tape recorded and transcribed. Tapes were destroyed after analysis of the data and trustworthiness were examined. The same researcher conducted all of the interviews. The length of time of the interviews ranged from 30 to 45 minutes. Timing constraints of the study allowed the researcher one interview with each participant.

Trustworthiness

Effort was made to create an informal, relaxed, quiet environment. Many of the interviews were conducted away from the unit. Some were conducted in the unit, but in a closed door conference room. Only two of the interviews were

interrupted and had to be continued in another room. The researcher attempted to develop a relationship where the respondent felt comfortable talking, while at the same time maintaining a certain degree of formality. McCracken (1988) argues that the balance between informality and formality is essential if 'rich' reliable data is to be obtained. A certain amount of formality helps to reassure the respondent that the researcher can be trusted to maintain confidentiality.

To establish trustworthiness in qualitative inquiry, Polit and Hungler (1997) suggest the criteria of credibility, transferability, dependability, and confirmability. Credibility refers to confidence in the truth of the data. Peer debriefing was one technique used in this study to establish credibility. Peer debriefing sessions were held with the chairman of the thesis committee to review and explore the interview guide and questions, techniques of interviewing and any other aspects of the study. Another technique, member checking, was used to support credibility by having the respondent verify what had been said at the interview. Three respondents were contacted and asked to verify the interpretations of their statements they made during the interview. There were no changes made to the interpretations.

Transferability refers to the generalizability of the data. It is the responsibility of the researcher to provide sufficient descriptive data in the research report so that consumers can evaluate the applicability of the data to other contexts (Polit & Hungler, 1997). In this study, the researcher has provided thorough descriptive data that potentially can be transferred to other settings or groups. The researcher believes that the readers of this study will view the findings as meaningful and applicable in terms of their own experiences.

Dependability refers to the stability of the qualitative data over time.

Confirmability refers to the objectivity of the data in a way that two or more people would be in agreement on the data's relevance. One way to test dependability and confirmability is to have the study audited. Sandelowski (1986) states that a study and its findings are auditable when another researcher could arrive at the same or comparable but not contradictory conclusions given the researcher's data, perspective and situation. Once the documents are assembled, the inquiry auditor proceeds to audit (similar to a financial audit) the trustworthiness of the data and the meaning attached to them (Polit & Hungler, 1997). The data collection and analysis were audited by a participant not involved in this study, but knowledgeable on the phenomenological method of inquiry. Interview transcripts, process notes, observations made, findings from member checks, and drafts of the final report were given to the auditor and discussed with the researcher. See Table 1 for a summary of trustworthiness techniques.

Table 1**Trustworthiness Techniques**

Technique	Application in Study
Peer Debriefing	Use of others, who are experienced in in the study of spirituality and nursing, to review and explore the interview techniques, interview questions, and any other aspects of the study. This technique establishes credibility.
Member Checking	Feedback on results of the study will be provided to the participants after data has been collected and analyzed. This technique establishes credibility.
Inquiry Audits	Once the interviews are: transcribed, notes from peer debriefings and personal notes are gathered, then the researcher will verify the data for trustworthiness and the meanings attached to them. This technique establishes dependability and confirmability.
Thick Description	The researcher will provide thorough descriptive data that can be transferred to other settings or groups. This technique establishes transferability.

Chapter Three

Analysis of Data

Method of Analysis

Each transcript of the nurses' descriptions of spirituality and spiritual care was analyzed using Colaizzi's (1978) phenomenological methodology. The steps to the Colaizzi technique are as follows:

- 1) Read all of the subject's descriptions in the transcribed transcripts. This helps the researcher obtain an overall feeling of what was said and experienced during the interview.
- 2) Statements or passages revealing something significant about the phenomena were extracted from each transcript.
- 3) Meanings were formulated from these significant statements and passages. This is an important step, where the researcher must use creative insight.
- 4) The formulated meanings were organized and clustered under identified themes.
- 5) A return was made to the original protocols to validate. The respondents were asked to verify if the interpretations of their statements were correct.
- 6) The last step was to formulate a clear and exhaustive description of the phenomenon, spiritual care giving as experience by ICU nurses.

Analysis and Results

Each transcript was read several times to familiarize the researcher with the content and acquire an overall feeling of what was happening during the interview. After reading through each transcript several times, significant statements and passages that directly pertained to spiritual care giving were extracted. Meanings were formulated from these statements and passages.

These statements were read through again and clustered under identified themes. The themes identified included: outlook on life, loss of connectiveness, activities, comfort level, reception of patient/family, and value placed on spiritual issues. Table 2 contains the themes, their meanings and significant statements taken from the transcripts. The meanings were referred back to the original transcripts to validate. Member checking was accomplished at this time as well. Following Table 2 will be the last step of the analysis, formulating an exhaustive description of the phenomenon, spiritual care giving.

Table 2

Themes, Meanings, and Significant Statements of Spiritual Care Giving

Themes	Meanings	Significant Statements
Outlook on life	Being centered, focused, at peace, confident, at ease with self and others, and having a sense of purpose and direction in life are all influenced by a higher power that controls the energy of the universe and are reflective in spiritual care giving.	<p><i>I think if I come to work with that 'centered' mind set that I feel after I pray, I think my spiritual care is better than when I have 'burned-out' days. I think it has to do with the energy of the nurses that determines what kind of spiritual care a patient may receive. *(F)</i></p> <p><i>How I do spiritual care hopefully comes through me as a person. That I do have a spiritual background, that my patients can see that by my conversation, by actions... A spiritual being that is created in us or a generalized power that flows throughout the universe. *(BB)</i></p>

(table continues)

Themes	Meanings	Significant Statements
		<i>I think I've grown myself more spiritually as I've gotten older. I have found the greater importance of that (spirituality) hence the more involved in it I've become. *(E)</i>
Loss of Connectedness	Feelings of detachment, frustration, loss of interest, being unaccepted and inadequate resulting in the use of spiritual care substitutes or avoidance of spiritual care.	<i>You could tell the family kept asking for chances or blaming the surgery. They just could not reconcile the fact that we all die and that this woman was going to die. Nothing I said or did helped, they were not hearing anything. They didn't like my care. They thought I was trying to actively kill her, but I would say there is nothing more we can do for her medically. I offered them a chaplain.</i>

(table continues)

Themes	Meanings	Significant Statements
		<p><i>I got tired of dealing with them.</i></p> <p><i>*(AA)</i></p> <p><i>I don't know how to relate to them</i></p> <p><i>I can't know what they are feeling,</i></p> <p><i>I really don't. I feel that I am a</i></p> <p><i>very compassionate person, but</i></p> <p><i>I don't warm up to people right</i></p> <p><i>away. I do provide care through</i></p> <p><i>other people. *(H)</i></p> <p><i>The biggest barrier would be</i></p> <p><i>people that I feel I can't relate</i></p> <p><i>to on that level. People that I</i></p> <p><i>don't feel that closeness with, I</i></p> <p><i>may refer them to the Bible. But</i></p> <p><i>then, I will generally offer those</i></p> <p><i>people a chaplain. *(E)</i></p> <p><i>There was nothing I could do</i></p> <p><i>after that to make life any better.</i></p> <p><i>I mean I did everything. I got</i></p>
(table continues)		

Themes	Meanings	Significant Statements
		<p><i>our nurse liaison involved, the family became offended. They just didn't like me...Finally, we decided the most spiritual caring thing I could do at this point was to just withdraw and not take care of this lady anymore. *(D)</i></p> <p><i>I don't know enough about Jehovah Witness beliefs to know what kind of spiritual care to offer or give this patient. I just provided the best care possible. I explained that I am here for you without touching on the spiritual subject. *(B)</i></p> <p><i>I'll get someone else because there are other nurses here that have a strong spiritual relationship and it would be very easy to get someone else. *(G)</i></p>

(table continues)

Themes	Meanings	Significant Statements
Activities	Interventions including: providing privacy, praying, listening, and 'presencing' followed by feelings of accomplishment, acceptance, usefulness, but also for some, inadequacy.	<p><i>I've led the prayers before many times... One of my patients came back to the ER dying. Her mother called me and asked , "will you go and whisper a prayer in her ear before she dies?" I mean in one way it makes you feel good that this lady thinks you are special enough to say the last prayer to her dying daughter.</i></p> <p><i>*(D)</i></p> <p><i>There was a patient, he had a CABG... He was telling me about that he didn't know if people would go through this procedure if they realized all the suffering they would have. He said this was his second time and all the life style changes</i></p>

(table continues)

Themes	Meanings	Significant Statements
		<p><i>he had to go through. He emphasized the word suffering numerous times. Beyond just listening to him, I didn't know what else to do for him. He wasn't asking me for a major spiritual intervention but I feel that part of that is. *(A)</i></p> <p><i>I guess I feel many of us can and many of us already give spiritual care. I think you don't have to realize that your doing it. It is more of a presence of being. For me, I have to strive to achieve. *(F)</i></p>
Psychological Comfort Level	Spiritual care giving is experienced by some as uncomfortable feelings of vulnerability, insecurity, and frustration	<p><i>I am not overly comfortable, so there are times when I don't know what to say, except I understand. I am worried about making them uncomfortable and</i></p>

(table continues)

Themes	Meanings	Significant Statements
	but by others as comfortable feelings of confidence and determination.	<i>that makes me uncomfortable.</i>
Attuned to the Patient's/Family's Spirituality	Cautious and tactful observation for signs of the patient's/family's experience of spirituality with the desire to provide non-offensive care to promote spiritual well-being.	<p><i>I usually wait and see before I offer spiritual care. *(E)</i></p> <p><i>You can get vibes from people. People who believe turn to God in times of crisis. They bring it up and then you are free to bring it up... *(C)</i></p> <p><i>I usually try to feel a person out and their beliefs because I don't want to offend a patient or family. I did deal with one family that were atheist and I tried to show them respect without intruding on their grounds, but at the same time, I have my relation-</i></p>

(table continues)

Theme	Meanings	Significant Statements
		<p><i>ship with God and I am a very proud Christian. If I see the distress or the need, I will ask if I can help them with that need.</i></p> <p><i>*(G)</i></p> <p><i>If people are more open, you are more likely to pause and explore that area (spiritual needs), just like any other of your assessment that you find a problem in. But if your patient is not receptive to what you are doing, you're not going to explore any further. It is hard because sometimes you don't know how spiritual that they are and you're afraid that you may offend the patient or family. *(A)</i></p>
Value Placed on Spiritual Issues	Recognition of the importance of meeting	<p><i>I had this patient...was going to be busy. This lady was going to</i></p>

(table continues)

Theme	Meanings	Significant Statements
	spiritual needs and the positive feelings of certainty and satisfaction which followed the giving of priority to these needs.	<p><i>die. I mean did it really matter if her bed got changed on day shift or evening shift? Her mother showed up and she was crying. I sat down and looked up at the clock after we had been talking for an hour and a half. My first thought was I have all these tasks that I did not accomplish. Then I thought it didn't really matter because this lady needed to talk...I just sat down and she did most of the talking. I just kind of sat there and held her, let her cry. *(D)</i></p> <p><i>I can think of so many times when I have a patient filling my ear and I'm listening but I know I have ten other things to do and I'll tell my patient I'll be right</i></p>

(table continues)

Theme	Meanings	Significant Statements
		<p><i>back and pat them on the arm.</i></p> <p><i>But, even though I am busy with a task, I will take at least a spiritual moment and let the person know that I do care about them and what is going on. *(F)</i></p> <p><i>I think we both got something positive out of our time together, but her physiological problems were things I could not do anything about, so my focus got shifted. I met a need, spiritual need that she had because I didn't have any other direction to go in at the time. *(A)</i></p>

* The participants code name

Description of Phenomenon

The last step of Colaizzi's method was to formulate an exhaustive description of the phenomenon, spiritual care giving, from the meanings of the themes.

According to the sample, spiritual care giving is controlled in part by one's personal experience of spirituality, a force that influences one's sense of inner peace, direction and focus of life. It is expressed by how connected one is to a higher power, another person, or themselves. Spirituality is an energy that flows throughout the universe and affects the way we live our lives. Feelings of separation are felt when there is no spiritual connection. Spiritual care giving can be manifested by, for example, praying, listening, presencing, and holding hands to name a few. It may be seen as an enlightening experience shared when the nurses are able to connect on a spiritual level with their patients/families.

There appears to be a commonality that runs throughout all themes related to spiritual care giving. It is the effect of how nurses view their own spirituality on their delivery of spiritual care. If they were comfortable with their own spirituality, they expressed it as having an inner confidence and felt secure in delivering spiritual care. If they are uncomfortable with their own spirituality, they feel inadequate and insecure in delivering spiritual care to their patients/families.

Other Findings

The interviews revealed other information that did not seem to fit within any of the themes, but could influence the delivery of spiritual care. This information included barriers and the importance of spiritual care to the nurses role.

Lack of time and training were identified as barriers preventing ICU nurses from delivering spiritual care and nurses expressed frustration and disappointment when discussing these conditions. The following are excerpts

from the transcripts.

*I don't remember spirituality or spiritual care being taught in my undergraduate program. *(D)*

*I could of benefited from a class on spiritual care because we as nurses deal with that everyday. *(H)*

*Time is a big problem for ICU nurses. We often don't have an allotment of time with patients to look at all those kinds of things. *(A)*

The importance of spiritual care being part of the nurse's role was seen as very important and was positively expressed. Statements included:

At least 50% of my job is related to comforting these people and their families.

**(D)*

*I feel that is a part of my nursing as well as dressing a wound. *(G)*

Observations during the Interviews

The majority of the participants responded to explaining their meaning of spirituality with ease. Surprising, only two had some difficulty with their explanations. Spirituality is not an easy concept to understand. According to Rowan (1990),

one of the difficulties in defining and describing spirituality is the resistance to language. When the researcher introduced this study to the nurses, it was mentioned that spirituality and spiritual care would be discussed in the interview.

The nurses were told not to discuss their views with anyone else until their interviews were completed. The researcher feels that the prior notification of the topics could be one reason why most of the participants had no difficulty defining spirituality. Another reason could be the way the question was stated. Instead of asking what does the word spirituality mean, the researcher asked what does

spirituality mean to you, personally?

Many of the participants commented or implied that being older and having more life experiences made them look more closely at what spirituality meant to them. This way of thinking follows Maslow's Hierarchy of Needs (Maslow, 1970) for self actualization. Self-actualization means that the individual is relatively satisfied with most aspects of their life. This includes what individuals think of themselves and the level of achievement reached or the ability to fulfill their purpose in life. Out of the ten nurses interviewed, eight implied that understanding their own spirituality had affected their purpose in life. It should also be noted when the researcher approached younger nurses (early 20s) to volunteer, they felt they didn't know enough about spirituality and declined to participate.

It should be noted that the other demographic variables (gender, nursing education background, number of years as a nurse and working on the ICU) did not have an impact on the participants responses, according to the observations of the researcher. See Table 3 for demographic information format.

Another observation made when interviewing the nurses was how they felt about giving spiritual care to their unconscious patients. Five of the nurses verbalized focusing their spiritual care on the families when the patient was unconscious. The researcher was surprised at how many nurses felt that way. It was the researcher's impression that these nurses need to understand that many of these unconscious patients may still hear voices by the bedside.

Table 3

Demographic Information Format**Variables**

Gender

Female

Male

Age in years

18 - 25

26 - 35

36 - 45

46 - 55

56 - 65

Nursing Education

associate

diploma

baccalaureate

master's

Number of years in Nursing

Number of years in ICU Nursing

Religious tradition identified with

Church/synagogue

attendance per month

0

1

2

3

4

>4

Chapter Four

Discussion

Present Results Related to Review of Literature

The theme, outlook on life is similar to Murray and Zentner's (1989, p. 259) description of spiritual dimensions which is a quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning and purpose. The spiritual dimension tries to be in "harmony with the universe, strives for answers about the infinite and comes into focus when the person faces emotional stress, physical illness or death. Reed (1992) suggests that only by developing awareness and positive insights into one's own spirituality, will nurses gain comfort in offering spiritual support.

The second theme, loss of connectedness, made nurses feel unaccepted and detached. Watson (1988) recognizes the importance of connectedness in fulfilling human needs such as acceptance and unconditional love from others or a higher power. According to Reed (1992) intrapersonal relationships provide an avenue for expressing connectedness with others. When the loss of connectedness occurred, nine of the ten nurses in this study involved chaplains or other nurses to meet the patient's/family's spiritual needs.

Activities of spiritual care were easily identified by most of the participants. Eight of the nurses interviewed felt useful and confident in performing the activities. The other two nurses felt inadequate. Studies (Narayanasamy, 1993; Piles, 1990) found that lack of spiritual care training is one reason why nurses feel inadequate. Piles (1990) reports that many nurses who are not trained in spiritual care will either offer a chaplain or avoid the subject completely. The nurses in this study agreed that

spiritual care training would be helpful in providing spiritual care to their patients/families.

The literature supports the meaning of the psychological comfort level of the nurses in delivering spiritual care. Harrington (1995) found that the more uncomfortable nurses were with their own spirituality, the more reluctant they were in initiating spiritual care.

Attuned to the patient's/family's spirituality created caution and a desire not to offend them. Granstrom (1985) found that fear and concern about patient's reactions were the reasons why nurses were reluctant to become involved in spiritual care. The fear of intruding on a patient's privacy was a common fear found among nurses in that study but not in the present study. The nurses in this study desired to support their patients'/families' beliefs and not offend them with unwanted spiritual care.

The last theme, value placed on spiritual issues, was important to many of the nurses interviewed. Nurses that recognized and acted on the spiritual needs of the patient experienced feelings of satisfaction. No studies from the literature review specifically addressed the meaning of this theme, except for Piles (1990) and Taylor, et. al (1994) found that the amount of attention given spiritual care depended on the value that nurses place on spiritual needs.

Limitations

After reading the transcripts, some of the participants' meanings on the phenomenon, spiritual care giving, were not completely clear. A second interview would have developed a richer and deeper understanding of the phenomenon through their lived experiences. Time constraints on the study prohibited the researcher from conducting a second interview. Another limitation was the

researcher's inexperience with interviewing in a phenomenological study.

Implications for Nursing

This study revealed that the nurse's personal meaning of spirituality has an effect in their spiritual care giving. The way they gave spiritual care was influenced by their own belief systems because nine of the nurses interviewed had no nursing training on how to give spiritual care.

Eight of the ten nurses recognized that listening, presencing, and holding a patient's/family's hand was giving spiritual care. Even though the majority of nurses in this study understood some aspects of spiritual care giving, doesn't mean that all nurses know how to deliver spiritual care.

All the nurse in this study mentioned religious affiliations when describing their own spirituality. This may imply that religion and spirituality are seen as the same. This issue may need to be further investigated possibly through another research study.

The findings of this study could implicate that the nursing education community may need to take a closer look at how spiritual care is being addressed in the nursing curricula.

Finally, the information provided by this study could be used by nurses to enhance the quality of spiritual care that they deliver.

Recommendations for Future Studies

Additional studies need to be done on spirituality, nurse's provision of spiritual care, and the importance of spiritual care to patients/families. Studies on nurses' perceptions between religion and spirituality may help clarify some misunderstandings between the two terms. Educating nurses on giving spiritual care may be another area to study. These studies could answer such questions

as: What format could be used to educate nurses? What type of classes should be taught, religious, philosophical or both? And what data is needed to develop class curriculum. The researcher suggests that more studies on the health care professionals' perceptions of spiritual care be done because of the important impact it has on patient care.

Final Comments

Nursing has traditionally valued providing holistic care. This implies caring for the mind, body, and spirit. It has been documented in the literature and confirmed by patients that spiritual needs are a real concern. The nurse, as a primary care provider, is ideally placed to help patients/families who are in spiritual distress.

It is the hope of the researcher that this study will be meaningful and useful to all nurses from staff nurses to nurse administrators, that it may enhance the quality of spiritual care given by nurses, and inspire nurse educators and administrators to incorporate spirituality and spiritual care classes in nursing curricula.

APPENDIX A

Consent to Participate in a Research Study at the University of Kentucky Medical Center

Title of Study: Spirituality and Nursing Care

Investigator Information: Sandy J. Keith, R.N., Graduate Student and Sherry Warden, R.N., Ph.D., Faculty member, College of Nursing at the University of Kentucky. Phone number (606) 323-6640.

Purpose: The purpose of this research, as explained by Sandy J. Keith, R.N., a nurse in the graduate nursing program at the University of Kentucky, is to describe what ICU nurses perceive as spirituality and spiritual care.

Duration, Location and Procedures:

All nurses who work in adult ICUs with at least one year of adult ICU experience will be invited to participate in this study. Between 8 - 10 nurses will be interviewed one time. To participate in this study, I will be asked questions by Ms. Keith concerning my feelings on the meaning of spirituality. I will be asked to give examples of spiritual care interventions that I have been involved in and barriers I have faced in delivering spiritual care. I will be asked my opinion of the nurse's role in spiritual care. The interview will be tape recorded to assist Ms. Keith in coding my responses. The tape will be destroyed after data has been coded. The location of this interview will be held at the University of Kentucky Medical Center in a private room. My conversation with Ms. Keith should last approximately 30 minutes.

Benefits:

There will not be any benefits to me personally from participating in this study, but the information gained may help nurses to give better spiritual care to patients. There will not be any costs incurred from my participation in this study.

Risks/Discomforts:

I have been told that the only possible risk to me at this time in participating in this study could be a minor degree of psychological stress as a result of feeling uncomfortable with the subject of spirituality.

Confidentiality:

Ms. Keith has assured me that every effort will be made to maintain the confidentiality of my interview. The data from the study may be published; however, I will not be identified by name. My identity will remain confidential unless disclosure is required by law. Agents that include the investigator, Ms. Keith, and her research committee at the University of Kentucky, will be allowed to inspect sections of the interview related to this study.

Right to Refuse or Withdraw:

I understand that I do not have to take part in this study and my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may withdraw from this study at anytime without penalty or loss of or other benefits to which I am entitled.

If I have any questions about this study, I may call Ms. Keith at (606) 323-6640.

Signatures:

I understand my rights as a research subject and I voluntarily consent to participate in this study. I understand what the study is about and why it is being done. I will receive a copy of this consent form.

Signature of Research Subject

Date

Signature of Witness

Date

Signature of Investigator

Date

APPENDIX B

Interview Guide

Introduction

- Explanation about the study.
- Explanation about the tape and its relevance.
- Give format of interview.
- Stress confidentiality.
- Stress no right or wrong answers.
- Stress no rush.

Demographic Information Format (Table 3)

Interview Questions

1. What does spirituality mean to you?
2. Tell me a story about when you delivered spiritual care to a critically ill patient.
3. Tell me a story about when you assessed a patient who needed spiritual care but you did not provide it.
4. Tell me a story about when you intervened with spiritual care.

Any further points

Thank respondent

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VITA

1. Date and place of birth: April 4, 1962, Akron, Ohio.
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