



Thesis

By

Mrs L V MONARENG

**UNIVERSITY OF
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**A MODEL FOR INTEGRATING
SPIRITUAL NURSING CARE IN
NURSING PRACTICE: A
CHRISTIAN PERSPECTIVE**

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Mrs L V MONARENG

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DECLARATION

I declare that the study on A MODEL FOR INTEGRATING SPIRITUAL NURSING CARE IN NURSING PRACTICE: A CHRISTIAN PERSPECTIVE is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

SIGNATURE

(Lydia Vangele Monareng)

DATE

A MODEL FOR INTEGRATING SPIRITUAL NURSING CARE IN CLINICAL NURSING PRACTICE: A CHRISTIAN PERSPECTIVE

STUDENT NUMBER : 702-525-4
STUDENT : LYDIA VANGELE MONARENG
DEGREE : D LITT et Phil
DEPARTMENT : HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA
PROMOTOR : PROFESSOR MS MOGOTLANE

ABSTRACT

A qualitative, grounded theory study was undertaken to explore and describe how nurses conceptualise spiritual nursing care, and how they integrate spiritual nursing care in practice. An in-depth literature review through concept analysis on the phenomenon was conducted to assist the researcher with theoretical sensitivity and theoretical saturation. In-depth Individual interviews and focus group interviews were conducted to generate data. Interviews were audio-taped and transcribed by the researcher verbatim. Symbolic Interactionism was the philosophical base for the study. Data analysis was done through the use of the NUD*1st computer software programme version 4.0. The direct quotes of participants were coded and arranged into meaning units for analysis. A constant comparison method of data analysis was applied by following a process of open, axial and selective coding. Tech's (1990:142-145) eight steps of analysis to analyse textual qualitative data was used until themes, categories and subcategories were identified and developed. Data analysis revealed that nurses had difficulty to differentiate spiritual nursing care from emotional, psychological or religious care. Nurses still felt inadequately prepared educationally on how to integrate spiritual nursing care in nursing practice. A Humane Care Model and practice guidelines were developed to guide nurses in clinical practice on how to provide such care. Recommendations proposed that the matter be taken up by nurse managers, educators and nurse clinicians to guide nurses in this regard.

KEY TERMS

Clinical practice, Christian perspective; Integrate; model, nurse; nursing practice; spiritual nursing care.

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Dedication

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CHAPTER 1

Research problem and overview

1.1 INTRODUCTION

Spiritual nursing care is re-emerging in the health care context of both public and private environments as a vital and essential component of holistic patient care (Taylor 2002:290). According to Taylor (2002:49), the need to render spiritual nursing care is grounded in the nursing history and theory as will be discussed in the text later on. Florence Nightingale (1820-1910) was a primary proponent of health care reform during the 19th century in the United States and Europe (Taylor 2002:50). Nightingale was a deeply spiritual nurse and a Christian woman who helped to reform nursing practice. Nightingale advocated holistic nursing care, asserting that as the spiritual dimension is an integral part of being human, spiritual nursing care is essential to healing. She advocated that patients who are ill and injured be treated with compassion and that high standards of morality should be maintained at all times. During the Florence Nightingale period, implicit and explicit attempts were made to treat patients holistically (Taylor 2002:51).

Historically the notion of approaching individuals as bio-psychosocial and spiritual beings has been recognised within the nursing profession. Twenty-six nursing theories were examined by Taylor (2002:38-39) to determine whether nurse theorists actually acknowledge the spiritual domain in their conceptual frameworks. The investigation revealed that 12 of the 26 theories appear to acknowledge the impact of spiritual nursing care in the dynamics of holistic nursing care. Taylor (2002:38) asserts that a common thread in these nursing theories is the assumption that human beings can be divided into various dimensions and that each dimension is related to health and well-being. The published works of many of the prominent nurse theorists of the 20th century (Peplau 1952; Henderson 1966; Orem 1985) highlight nurses' responsibility for the provision of holistic nursing care. Many of these nurse theorists recognise whole person care as the essence of nursing care (McSherry & Draper 1998:687; Taylor 2002:38). There is literary evidence that historically nurses incorporated "attention to the soul" included the spiritual dimension, as part of their practice (McSherry & Draper 1998:687; Taylor 2002:38).

Therefore, this study intends to conduct an in-depth literature review through concept analysis, investigate the phenomenon of the provision of spiritual nursing care in nursing practice empirically, and then develop a model to guide such care.

1.2 BACKGROUND INFORMATION TO THE STUDY

The background discussions on the integration of spiritual nursing care to nursing clinical practice commences with reflection on the fact that humans are characterised by four essential domains which are biological, psychological, social and spiritual.

1.2.1 Introduction to humanism

The background to this study introduces humanism. The humanism school of thought according to Young, Van Niekerk and Mogotlane (2003:84-85) emphasises humankind, human worth, ideals, beauty and the importance of humankind existence. Every person is valued as a unique individual who has freedom to make own choices. Every unique person is influenced and is part of the environment. Although humanistic existentialism differs in some approaches from the Christian tradition, however its value system that affords high priority to caring and attentiveness to people is similar. The school of thought has a definite holistic view of humankind, which is inclusive of spiritual care. (Young et al 2003:84-85).

1.2.1.1 The holistic nature of human beings

Holism relates to the study of whole organisms or whole systems. Its spelling is derived from the Greek word 'holos' meaning whole (Narayanasamy 1998:118). Holism asserts that an integrated whole has a reality that is greater than the sum of its parts (Callister, Bond, Matsumura & Mangum 2004:160). According to O' Brien (2002:9), the concept 'holism' undergirds the understanding of human beings as beings connected in body, mind and spirit. In applying it to the western health care context, it supports a health care approach that incorporates all aspects of bodily, psychosocial and spiritual human functions (Narayanasamy 1998:118). The dimensions of body, mind and spirit are

depicted in a model developed by Stallwood (1975:1087) and described by Carson (1989:8-10). This model is depicted in figure 1.1 below:



Figure 1.1: Conceptual model of the nature of humans
 ((Adapted from Stallwood (1975), in Carson (1989:9-10))

Carson (1989:9-10) explains that this model is presented in circles that demonstrate the interrelatedness of the various dimensions. The outer circle represents the physical body, which allows the person to be in touch with the world through the senses of touch, taste, hearing, sight and smell. The body is the person seen and experienced by others.

It is the house of the spirit because a person's human spirit does not reside in a vacuum. According to O'Brien (2002:9), the body is the physical substance of a person that can be perceived in the empirical reality. The second circle represents the mind, which is that part of a person that gives oneself consciousness, self-identity and personality through emotions, the intellect, moral sense and the will. The innermost circle, the spirit, is that part which is described as affecting all other dimensions in one way or another. Within this spiritual part lies the potential to be conscious of God or some other deity (McSherry 1998:39). The spirit is the life principle that is shared with all humanity and with God. The human spirit is the dimension of personhood that drives human beings to create, love, question, contemplate and transcend. It is the soul of a person. The holistic nature of human beings mandates attention to the problems and concerns of the spirit as well as to those of body and mind (Govier 2000:32; McEwan 2004:323; O'Brien 2002:10). The spirit is described as pervading all other dimensions as alluded to in the description of the model (Carson, 1989:8). The human person according to Carson (1989:9) is and functions as a dynamic whole. This is explained in the model by the arrows that demonstrate the interrelatedness of one dimension with the other.

Importantly, Frankl (2004:22, 41, 52, 54) states that humans are somatic, psychic and spiritual (noological) beings. Nursing scholars (Cavendish, Luise, Russo, Mitzeliotis, Bauer, Bajo, Calvino, Horne & Medefindt 2004:196; Taylor 2002:39) concur with the premise that human beings function as integrated bio-psycho-social and spiritual beings. While such a distinction seems to be reductionistic, it is nevertheless necessary to use the descriptors of body, mind and spirit to indicate these well-defined and distinct human dimensions that give rise to human needs that must be met equally. Taylor (2002:39) recommends that patients should be provided with nursing care that caters for the needs that are related to all these human dimensions. A crisis or illness affecting our physical body will invariably affect the other dimensions as well.

The central principle of holism is unity of all aspects that constitute a human being. Mahlangu and Uys (2004:15-16) state that every aspect of the total human being is inseparably integrated into all other aspects of the being. Smith and McSherry (2004:308) posits that the human spirit unifies the whole person and potentially promotes health in a very real sense, by ensuring inner harmony or shalom, a feeling of

peace caused by God-centred human wholeness. Frankl (1969:22, 41, 52, and 54) regards the spiritual dimension of humans as the integrating core of their beings, and the existential core of their existence. The author further argues that being human means living in the face of a meaning to fulfil and a purpose and values to realise. The satisfaction of physical and psychological needs is not the ultimate aim of human striving, but rather to find the means to become free to strive towards achieving spiritual goals.

1.2.1.2 *Spiritual nursing care as an integral part of holistic nursing care*

The concept of holistic nursing care requires that nurses should understand the interconnectedness of the physical, psychological / emotional, social, cultural and spiritual realms and treat their patients accordingly (Freshwater & Maslin-Prothero 2005:278; Govier 2000:32; Meyer 2003:185). Nurses who appreciate this interconnectedness are likely to ensure that the spiritual component is evident in their patient care practices (Callister, Bond, Matsumura & Mangum 2004:160). Spiritual nursing care represents the essence of holistic care practice and becomes the integrating factor that holds the physical, psychological and social care together that nurses and others provide (Milligan 2004:164). Koslander and Arvidsson (2007:602) state that the goal of nursing is to help patients to achieve “a higher degree of harmony within the mind, body and soul which generates self-knowledge, self-reverence, self-healing and self-care processes.”

Currently, there is a renewed emphasis on spiritual nursing care (Draper & McSherry 2002:1-2). Koslander and Arvidsson (2007:602) suggest that nurses need to adopt a caring-healing paradigm in order to move beyond its current state of high-technological curing and adopt a spiritual nursing care focus. In order to meet the needs of patients holistically and to assist patients in making sense of their circumstances, spiritual nursing care should be considered as important as physical, emotional and social care interventions. Therefore, spiritual nursing care is a valued and an integral component of quality, holistic nursing care for both acutely and chronically ill patients (McEwen 2005:161).

1.2.1.3 Justification of the importance of providing spiritual nursing care as an integral part of holistic nursing care

Certain life events such as pain, illness (acute or chronic), impending surgery, death or illness of a loved one, are examples of crises that render humans unable to regain their spiritual equilibrium (Villagomez 2005:288). According to O'Brien (2002:10), people may also experience serious physical, psychosocial and spiritual challenges as a result of an emergency room or critical care experience or having to cope with an incurable condition such as the Human Immunodeficiency Virus (HIV) infection and the Acquired Immunodeficiency Syndrome (AIDS). This may be compounded by inner conflict and guilt feelings, which are the results of a belief that God is punishing them for their sins, or their lifestyles that are contrary to God's standards (Koenig, McCullough & Larson 2001:210; Loh, 2004:131). These experiences evoke spiritual distress especially if mechanisms to meet spiritual needs are not in place.

The North American Nursing Diagnosis Association (NANDA) (2001-2002) defines spiritual distress of the human spirit as the "disruption in the life principle that pervades a person's entire being and that integrates and transcends one's biological and psychosocial nature." Spiritual distress is referred to by McGrath (1997:10) as a state of conflict between one's belief system and current reality. According to O'Brien (2002:10), unrelieved experiences of spiritual distress can lead to some form of disability.

According to the NANDA (2001-2002), various negative emotions are indicative of spiritual distress, 2004:131). The medical diagnosis of this could be non-responsive depression. Spiritual pain is the experience of conflict and disharmony between a person's hopes, values, beliefs and their existential experience with life (McGrath 1997:10). Villagomez (2005:288) explains that during spiritual distress, patients question their belief systems or feel separated from their personal sources of comfort, strength and support.

Relieving patient's spiritual distress is a compassionate and fundamental goal of quality patient care (Baldacchino & Draper 2001:833-834). Therefore, nurses should be aware of the possibility of spiritual distress, in addition to physical suffering. They ought to be able to guide patients through self-exploration and reflection and see patients' problems

clearly, without compromising their own spiritual integrity or violating patients' spiritual views (Macrae 1995:9). Nurses must devise creative strategies to intervene spiritually for persons who may be experiencing a crisis of faith when confronted with illnesses or traumatic experiences. To achieve this, nurses require a sound understanding of their patients' spirituality and the manifestations of spiritual distress. Even if nurses are not able to provide spiritual nursing care in a broader sense, they could meet patients' spiritual needs by being present, providing compassionate care and listening to their concerns and fears associated with illness, pain and suffering (Baldacchino & Draper 2001:833-834).

Research indicates that providing spiritual nursing care in times of need is a powerful source of general well-being. Reviews of nursing research studies have consistently revealed a positive association between meeting the spiritual needs of patients and their spiritual well-being (Koenig *et al*, 2001:210). In examining the relationship between spirituality and spiritual well-being, various authors (Baldacchino & Draper 2001:836; Brome, Owens, Allen & Vevaina 2000:479; Tanyi, 2002:505) confirm that spiritual well-being is indicative of the presence of spiritual health. It is an affirmation of life in a relationship with God, self, others, community and the environment that nurtures and celebrates wholeness. People who enjoy spiritual well-being tend to feel generally alive, purposeful and fulfilled.

Spiritual well-being improves the quality of life and reduces loneliness and anxiety (Callister *et al* 2004:160; Dossey & Keegan 2002:15). However, how spiritual nursing care works to produce these improved health outcomes is still not well understood (Coyle, 2001:594). The point that is made by research studies, as Taylor (2002:44) also mentions, is that spiritual well-being is often positively correlated with physical and mental wellness.

Spiritual nursing care aimed at meeting patient's spiritual needs contributes to their ability to cope when they are faced with distressing and serious health- challenging circumstances (Baldacchino & Draper 2001:26; Brome *et al* 2000:470-486). Importantly, it allows patients to confront and reconcile crises. Attending to the spiritual dimension of patients provides health benefits in terms of disease prevention, improved health status, recovery from illness or enabling people to cope with illness and other adversity (Coyle,

2001:594). Dossey and Keegan (2002:3) contend that the core aspect connected with treating patients is to care for the spiritual dimension of patients and it is essential for them to cope with ill health as well as to transcend pain, suffering and despair.

Meeting people's spiritual needs also contributes towards a restored sense of well-being and recovery from psychological conditions such as sexual abuse, substance abuse and homelessness (Brome *et al* 2000: 478; Tanyi 2002:504). People need to find relief from fear, doubt and loneliness, which are often associated with adversity and suffering. It may also foster peace and the ability for individuals to face difficult health situations with a positive attitude and grace. Similarly, human spirituality as applied in Henderson's model enables those who cannot be cured from their physical ailments, to die in hope, peaceful and assured of a blissful eternity (Mahlungulu & Uys 2004:15).

1.2.2 Challenges that hamper spiritual nursing care

The moral, legal and ethical nature of nursing calls for spiritual nursing care to be part of nursing interventions. According to Kozier, Erb and Wilkinson (2008:201), the moral nature of a situation usually refers to personal standards of right and wrong. It denotes what is right and wrong in conduct, character and attitude. The moral nature of nursing is concerned with values and norms, which are usually, defended in daily patient care practices. One need to distinguish between the moral and the legal nature of nursing. Laws often reflect the moral values of society. In nursing, some actions may be moral but not necessarily legal. For example, to perform full resuscitation for a terminally ill patient may be legal, but may still be questioned whether it is acceptable moral behaviour (Kozier, Erb & Wilkinson 2008:201). On the other hand, the ethical nature of nursing refers to the type of situations of enquiry which nurses use to understand the morality of human behaviour. When used in this sense, it is viewed as a way of looking or investigating certain issues in nursing about human behaviour. Nurses in this instance are expected to maintain certain ethical standards as described in their professional code of conduct (Kozier, Erb & Wilkinson 2008:201). Yet, many nurses seem to lack the ability, professional background and confidence to commit to holistic practice that is inclusive of spiritual care for their patients (Emblen & Pesut 2001:42; Milligan 2004:162). However, according to Govier's (2000:33) findings, many nurses claim to have a commitment to the concept of holistic care, which requires that the

patients' physical, psychological/emotional, social, cultural and spiritual needs should be met in an integrated manner. There is, however, evidence to suggest that the first four of these needs are recognised, taught and practiced in the care of patients, but the area of spiritual care is frequently overlooked (McSherry 2004:41).

Nurses often fail to recognise and appreciate needs of a spiritual nature and therefore fail to address this dimension adequately (Loh 2004:132; Taylor 2002:16). Consequently, a cycle of spiritual distress and unmet spiritual needs may occur. Research involving a case study on spiritual distress as experienced by a terminally ill patient with breast cancer revealed that the patient often avoided opening discussions about her illness, fearing that the nurses might not be interested in listening to her or that they might even ignore her (Loh 2004:132). Missed opportunities to talk about such experiences may result in anger, frustration, helplessness and hopelessness, thus further aggravating the patients' spiritual distress.

Various factors may contribute towards the failure of nurses to render spiritual nursing care, as discussed in the following sections:

1.2.2.1 Problems related to the prevailing health care paradigm

- **The biomedical health care paradigm**

Modern advances in technology and medical science have contributed to a shift away from considering the provision of spiritual nursing care as a vital component of holistic nursing care. The reasons for the lack of its application to nursing practice are numerous and complex. According to McSherry and Draper (1998:686), the 20th century philosophy of care has supported a scientific health care perspective. Consequently, the biomedical model of care characterised by scientific principles and practices, has been applied in nursing education and practice (McSherry & Draper 1998:686).

The biomedical health care paradigm is consistent with the western-scientific worldview. Health and disease are both considered to occur because of physical processes. Health care professionals subscribe to the laws of matter and energy and stipulate that because disease is a result of a physical process, therapy to remedy the disease must

be physical in order for it to be effective. The application of scientifically developed therapies such as surgery and pharmacological preparations characterise the practice of Western medicine (Ross 1995:461). A number of researchers (Boero, Caviglia, Monteverdi, Braida, Fabello & Zorzella 2005:916; McSherry & Cash 2004:152) report that diagnostic, curative and rehabilitation techniques are becoming more and more refined, thanks to medical research and new technological developments.

In a study by Greasley, Chiu and Gartland (2001:632), concerns were expressed that the ethos of nursing and the atmosphere in the health care setting are becoming less personal and user-friendly for both nurses and patients, with increasing emphasis on the mechanics of nursing. The biomedical model supports a biological and reductionist approach to health care. Patients are compartmentalised and in some instances, even de-humanised by being divided into mechanical units. They are sometimes viewed as cases or conditions and their signs and symptoms are categorised to produce a diagnosis (Mahlungulu & Uys, 2004:16; McSherry & Draper 1998:687). As a result, the relevance of spiritual nursing care tends to be compromised and sometimes lost.

In accordance with the western-scientific worldview, nurses claim that nursing practice is based on a rigorously tested theoretical foundation (Govier 2000:34; Van Dover & Bacon, 2001:18). The scientific principles and practices of nursing encourages nurses to think about nursing care issues systematically and within the larger context of empirical knowledge development (Sawatzky & Pesut 2005:21, 23, 29). Scientific explanations are offered for the causes and mechanics of diseases to the exclusion of metaphysical explanations (Meyer, 2003:186). In addition to this, a focus on intangible forces may be viewed as contradictory to the current nursing profession's claim to be a science and research based profession (Meyer 2003:186; Narayanasamy 1999b:123).

Spiritual nursing care would contribute towards overcoming, as Mahlungulu and Uys (2004:16) lament, the practice of fragmentation of a patient into a body in bed with no name, a case for surgery or a disease for pathological investigations. McEwen (2005:163) and Treloar (2001:16) emphasise the need to treat patients holistically rather than merely managing the disease in order to enable the patient to resolve or deal with a particular health problem. For instance, the impact of HIV/AIDS poses a great challenge to disease management and curative medical care. The lack of cure for this

disease supports the need for spiritual nursing care to enhance the patients' quality of life and restoration of hope. Van Loon (2005:266) remarks that meeting the spiritual needs of people leads to a sense of being alive in a qualitative rather than a mechanical sense.

- **The application of the nursing process**

In line with the biomedical perspective, the nursing process is applied to render nursing care that is aimed at meeting the patients' health care needs (Sawatzky & Pesut 2005:23). The nursing process generally entails formulating nursing care plan protocols based on health assessments and nursing diagnoses, which are derived from the assessment data. The nursing process therefore supports objective assessment and quantification of the needs of patients. Nursing interventions, which are in accordance with the nursing care plan, are aimed at achieving measurable outcomes, which are indicative of the effectiveness of care (Sawatzky & Pesut 2005:29).

A study by Tournier (1954:16) suggests that every illness needs two diagnoses, namely a scientific, or causal diagnosis; and a spiritual diagnosis, which accounts for the search for the meaning and purpose of the illness. Spiritual assessment needs to lead to the diagnosis of possible spiritual health care problems. Attention is to be given to aspects such as general and personal spiritual beliefs, expressed spiritual needs, indicators of spiritual distress and any spiritual or religious support systems of patients (Hodge 2004: 36). This would form the basis for planning and implementation of appropriate spiritual nursing care interventions (McEwen, 2005:163; Treloar 2001:16).

Current guidelines on how to apply the nursing process are explicit on how to address the identified physical, social and emotional needs of patients.

According to McEwen (2005:162-164), tools such as scales and labels to measure and define aspects which are related to the spiritual health needs of patients have been established. These support the formulation of spiritual nursing diagnoses such as spiritual concerns, spiritual distress and spiritual despair. In a study by Ross (1994:439), nurses identified a number of empirical indicators to evaluate the spiritual nursing care

provided. These include an improvement in a patient's mood status, an acceptance of current difficulties and verbal indication that their spiritual needs have been met.

Application of the nursing process has helped nurses to pay attention to the spiritual needs of patients in a context that is dominated by science. However, the existentialists criticise attempts to submit human spirituality and spiritual needs to the principles of science. Hall (1997:86-87, 91) criticises theories which suggest that there is a right way to provide spiritual nursing care, thus ignoring individual meaning. The said author states that measurement and labelling of spiritual human needs create a distance between nurses and the suffering of others and obscure the meaning underlying the spiritual needs of patients. In addition to this, the application of the nursing process has been criticised because it involves attempts to empirically describe or quantify matters that are inherently meta-physical, namely patients' spiritual distress, their spiritual needs and the progress towards spiritual well-being. Spiritual nursing care is therefore seen as an integrative philosophy of care rather than care provided by nurses using an outcome-oriented approach aimed at achieving pre-specified observable outcomes. Outcomes of spiritual nursing care need to be defined by the patient's reality and perspectives on spirituality (Sawatzky & Pesut 2005:29-30).

Critics further argue that the nursing process, as a scientific methodology largely depends on the skills of the nurse who must be able to discern a spiritual problem, design appropriate interventions and evaluate the care outcomes (Mayer 1992:33; McSherry & Draper 1998:685; Ross, 1994:443). By separating the spiritual component of care from the other human domains, there is a risk that complex, holistic, spiritual beings will be reduced to a collection of needs that can be objectively measured and routinely treated by implementing standardised nursing interventions. (McEwen 2005:163; Villagomez 2005:285-293; Walter 1997:25). Despite its shortcomings, the nursing process has nevertheless helped to keep visible the spiritual needs of patients during an era when science is focussing on the physical aspects of the person (Hall, 1997:83; Sawatzky & Pesut 2005:20-22).

1.2.2.2 Problems related to the health care institutions

Prevailing problems related to the health institutions, nursing education and the nurse might influence nurses' ability to render spiritual nursing care. In the health care delivery

system, these problems may work against holistic patient care, especially the meeting of patients' spiritual needs. Fletcher (2004:558) argues that nurses wrestle with the problem of how to meet their patients' spiritual needs given institutional constraints such as the lack of time and staff shortages in a cost-conscious climate. The necessity to meet the priorities as stated by management, while also attending to patients' spiritual needs provides a very specific challenge (Wright 2003:32). Research conducted by Stranahan (2001:102) on spiritual care practices among nurse practitioners revealed that current practice arrangements in health care arenas, place constraints on the time allotted to each patient-provider encounter. This leaves little time to attend to spiritual matters. According to Brooks, LeBlanc, McKenzie, Nagy, Tallon, Wilhelm and Flegel-Desautels (2005:24), rapid biotechnological advances in diagnosis and treatment have stretched resources to the limit and this compounds the problem.

Public institutions are expected to refrain from favouring one religion over another and private institutions have become increasingly profit driven (Popoola & Clinton 2001:44). To this effect, Treloar (2001:17) contends that many nurses avoid spiritual care giving because they fear discipline by management for any activity that might be construed as religious imposition or influence on patients who are in a vulnerable position. The South African constitution (South Africa 1996:57) endorses the situation as section 15 states "Everyone has the right to freedom of conscience, religion, thought, belief and opinion."

The section expands on the right to freedom of religion by stating that religious observances may be conducted at state or state-aided institutions such as hospitals, if those observances follow rules made by the appropriate public authorities; they are conducted on an equitable basis; and attendance at them is free and voluntary. Although provision of spiritual nursing care is part of holistic patient care, how nurses provide such care is challenged by observance of patients rights and legally protected choices.

1.2.2.3 Problems related to nursing education

Meyer (2003:185) reports that educational programs established during the 1870s adequately prepared nurses to display the good moral character required to "strengthen the soul" of the patient and family. This trend persisted in diploma programmes

frequently affiliated with religious institutions that served as the predominant model for nursing education for over six decades of the twentieth century. A shift away from training nurses to provide spiritual nursing care occurred in the latter part of the 20th century due to several factors. This included secularisation in the society, which resulted in spiritual nursing care no longer being openly taught or practiced. This type of care has therefore been subtly eliminated from the circles of patient care (Lindeman 2000:5).

According to Baldacchino and Draper (2001:833), nursing education presently emphasises aspects of science and technology both in the classroom and in the clinical area, while the spiritual dimension is largely neglected. Lindeman (2000:5) posits that students are prepared for employment in competitive health care systems concerned with shortening the patients' length of stay in hospitals rather than to render nursing care that is inclusive of meeting spiritual needs of patients. Currently, the training of nurses regarding their own and their patients' spirituality and meeting of spiritual needs seems inadequate. Training institutions are of the opinion that the subject 'Professional Practice' in which nurses are trained, inherently has both spiritual and morality care content (Villagomez 2005:285-293). Thus, there is no need to specify spiritual care.

Research by Meyer (2003:188) reveals that nurse educators and practitioners do not know how to exert a positive influence on the students' perceived ability to provide spiritual nursing care. Cantazaro and McMullen (2001:225) state that nurse educators are primarily responsible for integrating the provision of spiritual nursing care in the curriculum. Relevant teaching and evaluation strategies in the classroom and clinical learning opportunities can enable nursing students to reflect on the interconnectedness between the empirical care of patients and that of meeting their spiritual needs.

Hodge (2004:39) advocates ongoing formal and non-formal training of nurses to develop spiritual competency in rendering spiritual nursing care. However, until nurses explore the implications of integrating spiritual nursing care into the main stream of nursing care practice thoroughly, they cannot be certain whether they are missing out on something that is vital to their patients and crucial to the integrity of the nursing profession (Draper & McSherry 2002:1).

1.2.2.4 Problems related to the nurse

In a study conducted by Greasley *et al* (2001:632), nurses as study participants clearly indicated that their ability to provide spiritual care for patients is influenced by the degree to which they experience self-fulfilment, job satisfaction and the opportunity to achieve and be productive. All human beings, including nurses, have spiritual needs. Amongst others, they have a need to contribute positively to the world and perceive their contribution as valued. They also have a need to be respected and valued (Taylor 2002:19). People, who feel that they are being cared for, are likely to show the ability to care for others. However, nurses themselves often experience that they are not considered as whole persons in the workplace. Oosthuizen's (2007:20) study on the emigration of South African nurses to other countries points out a number of internal and external factors that influence nurses to leave the country in search of meaning, purpose and fulfilment outside their country. In this regard, nurses are disgruntled about inadequate remuneration, poor working conditions and high workloads because of staff shortages that affect their general well-being. They clearly do not feel cared for or that their needs are met, which also denotes spiritual distress.

Cavendish *et al* (2004:201) find that because many nurses are aware of their patients' spiritual needs, they have expressed a need for further education in this area. Although nurses may have a theoretical understanding of spiritual nursing care, they may still find it difficult to integrate it into their daily practice. This indicates that limited practical guidance is available for nurses who wish to meet the spiritual needs of their patients.

However, Fletcher's (2004:558) research findings revealed a reluctance to render spiritual nursing care because nurses experience discomfort when speaking about spiritual matters to patients. Some of the participants expressed fear to intrude on or embarrass the patients by asking to pray with them (Fletcher, 2004:558). According to Graber (2001:40), there is a tendency to treat spiritual aspects as private matters and nurses are hesitant to invade their patients' privacy. A number of studies confirm that nurses may find it safest to focus on science and technology, and avoid any discussion or effort about integrating spiritual nursing care into holistic nursing care (Fletcher 2004:548; O'Brien 2002:36; O'Connor 2001:40; Taylor 2002:24).

Accordingly, McEwan (2004:323) argues that some nurses will not be able to offer spiritual nursing care, as they do not have it within their mental armoury to offer this facet of care. Chiu (2000:51) comments that nurses who are uncomfortable with their own spirituality may not be able to fully appreciate and understand the spiritual needs of people they profess to serve. The understanding of the provision of spiritual nursing care is related to one's personal faith and spiritual belief system and the commitment to provide that care to others. The lack of spiritual awareness and failure to be in touch with their own spirituality by many nurses makes it difficult for them to meet other people's spiritual needs (Treloar 2001:18-19; Wright 2003:12).

To this effect, Dossey and Keegan (2000:65), Graber (2001:40), Sawatzky, and Pesut (2005:19) argue that to provide spiritual nursing care, nurses need to have spiritual self-awareness and a personal spiritual perspective. Each nurse needs to acknowledge his or her own personal spiritual understanding, for it is in the continuous meeting of one's own and others' spiritual needs that one will know the meaning of spiritual well-being or provide meaningful spiritual nursing care to others.

1.2.3 Responses to the challenge of rendering spiritual nursing care

The United States of America (USA) has established the Joint Commission on the Accreditation of Health Care Organisations (JCAHO), which is the accrediting body for all health care institutions wishing to receive reimbursement from Medicare, Medicaid, Social Security payments and many third-party payers (Taylor 2002:42-43). The JCAHO manual (2000:80) states: "patients have a fundamental right to considerate care that respects their cultural, psychosocial and spiritual values." According to the JACHO manual (2000:80), every patient should be assessed regarding their spiritual needs on admission. Health care providers need to demonstrate sensitivity for patients' spiritual needs and be able to provide such care for patients when necessary. Nurses working in hospitals and clinics are specifically challenged to respond to the spiritual concerns of the terminally ill and dying patients including their families. In addition, the JCAHO manual (2000:81) recommends that nurses should be mandated ethically to exhibit spiritual competency. Undoubtedly, this will have implications for educational institutions and programmes on spiritual nursing care in clinical practice (Lantz 2007:36).

In response to the challenge to provide spiritual nursing care by nurses, the International Council of Nurses' (ICN) Code of Ethics (1973) incorporated provision of spiritual nursing care as part of the nurses' responsibilities. Greasley *et al* (2001:630) point out that the importance of addressing the spiritual needs of patients has also long been acknowledged in the British educational guidelines for nursing education. The ICN (1973) and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC 1984) both declare that health professionals should take account of the customs, values and spiritual beliefs of patients and promote an environment in which these are respected.

The nursing profession in the Republic of South Africa (RSA) has not yet formalised the intention to promote spiritual nursing care. The South African Nursing Council (SANC) in the guidelines on the number of hours required to register a nurse stipulates a total of 20 hours for professional practice. It is in these 20 hours that all aspects of legislation, ethics, culture and spiritual aspirations are addressed in nursing. In the face of much litigation that is being brought against the SANC, legal aspects are brought to the attention of nursing educators. Further, the Scope of Practice for Professional Nurses (Regulation R2598, 1984, paragraph 3(1) (a)) states that, "The Scope of Practice of a Registered Nurse shall entail the following acts or procedures, which may be performed by scientifically based physical, chemical, psychological, social, educational and technological means applicable to health care practice." The exclusion of the spiritual dimension is evident and it gives the impression that rendering spiritual nursing care, as an integral component of holistic nursing care is not essential. Similarly, the 'Rules Setting out the Acts and Omissions in Respect of which the SANC May Take Disciplinary Steps' (Regulation R387, 1985, Paragraph 4) do not make any reference to omission of care that is spiritual in nature as a misconduct.

The regulation relating to the approval of the minimum requirements for the education and training of a nurse (Regulation R425, 1985, Paragraph (b)) includes a programme objective, which states that man should be treated with dignity in his socio-cultural and religious context. However, as explained in section 1.2.3.2, spirituality and religion are not synonymous. This programme objective may leave the impression that spiritual nursing care does not have statutory recognition.

1.2.3.1 Confusion about the meaning of the concepts spirituality and spiritual nursing care

The ability of nurses to render spiritual nursing care to meet patients' spiritual needs is dependent on a sound understanding of what is meant by these terms. However, an important obstacle for nursing research and practice in the area of spiritual nursing care has been the lack of conceptual clarity of the terms "spiritual," "spirituality" and "spiritual nursing care" (Martsof & Mikley 1998:298; Narayanasamy 2004:1143). There is still evidence of a prevailing conceptual disparity, vagueness and ambiguity in the descriptions given by authors about spirituality or spiritual nursing care (Villagomez 2005:287). McSherry and Draper (1998:683) conclude that there is little universal consensus about the meaning of these concepts.

According to McEwan (2004:324), definitions of spiritual nursing care are sparse. Carson (1989:18) points out that the varied themes of spiritual nursing care in the literature represent a variety of worldviews and the opinions of people from diverse backgrounds. The descriptions of spiritual nursing care in the literature range from general conceptions of a caring presence to religious orientated interventions such as prayer or reading religious texts in relation to God's will and His healing powers (Narayanasamy & Owen 2001:448; Sawatzky & Pesut 2005:20). McSherry and Ross (2002:480) contend that this lack of definitions is the greatest dilemma associated with nursing practice and education and it hampers nurses' efforts to meet their patients' spiritual needs effectively.

Draper and McSherry (2002:1) on the other hand, contend that an adequate conceptual vocabulary on spiritual nursing care already exists in the literature, but it seems to be another matter for the concept to be applied in practice. According to McEwan (2005:165), and Sawatzky and Pesut (2005:19-20), there is confusion, among nurses; about the nature of the spiritual nursing care they need to give. There is a need for nurse practitioners to develop consensus on what constitutes quality spiritual nursing care and its application to the practical day-to-day nursing care of patients.

The confusion about the nature of spiritual nursing care is partly due to a restricted view of human spirituality and partly to the nurses' training, which imparts the western-

scientific worldview to students (refers to section 1.2.2.1). Greasley *et al* (2001:629) conducted a qualitative study to obtain the views of mental health nurses about their understanding of spiritual nursing care. Researchers concluded that the perceived failure to provide meaningful spiritual nursing care may be symptomatic of a medical culture in which the more readily observable and measurable elements in care practice have assumed prominence over the more subjective and deeply personal components. As a result, spiritual nursing care remains poorly understood and patients' spiritual needs are neglected within the context of health care.

According to Koslander and Arvidsson (2007:598), professional care and a holistic view of nursing care require that concepts such as 'spiritual nursing care' be clarified for better understanding and application in nursing practice. Nurses should consider their own definitions of spirituality and spiritual nursing care, identify their own values, beliefs and attitudes about the nature of human beings, and recognise their spiritual human needs before attempting to arrive at generally applicable definitions of the concepts (O'Brien 2002:9; Sawatzky & Pesut, 2005:20; Taylor 2002:50). The challenge for nursing is to provide a definition of spiritual nursing care, which is universal in its approach, taking into account the importance and relevance of the phenomenon in clinical practice, while allowing for the uniqueness of individuals (McSherry & Draper 1998:685; Stranahan 2001:103; Villagomez 2005:287).

1.2.3.2 Confusion about the distinction between spirituality and religion

The confusion about the meaning of the concepts 'spirituality' and 'spiritual nursing care' is compounded by the interconnectedness between spirituality and religion and the tendency to equate spirituality with religion. Graber (2001:40) posits that while religion may inform and offer direction to an individual's spirituality, the two concepts are not necessarily synonymous, although they are often used interchangeably. Religion is defined by Ingersoll (1994:98) as a unified system of beliefs and practices relative to sacred things forming the basis or medium for organised worship and fellowship. Spirituality is much broader than religion and is at the core of all religions. Emblen (1992:43) adds that "spirituality" is used to refer to a quality beyond religious affiliation that is used to harmonise answers to questions regarding infinite subjects such as meaning and purpose of life and one's relation to the universe.

According to Graber (2001:39), spirituality is a dimension within every person – religious, atheist, humanist or Christian. Under the overall umbrella of spirituality (which includes most religions of the world), humans seek to integrate the values of life, namely trust, hope, meaning, love, caring and forgiveness (Burkhart & Solari-Twadell 2001:46). In nursing, an existential approach exists towards human spirituality values, individuals as spiritual beings irrespective of a presence or absence of a belief in the Supreme God or membership to a particular faith community. Likewise, sick persons are valued as spiritual beings regardless of their religious orientation or affiliation (Sawatzky & Pesut 2005:21, 29).

Narayanasamy (1998:120-121) points out that spiritual nursing care should be considered to be care that is beyond the realm of religion because even those who may see themselves as not religious, will, as human beings do, seek origin of meaning and purpose of sickness or suffering, which is essentially a spiritual activity. It is therefore necessary to distinguish between spirituality and religion, and spiritual nursing care and religious or pastoral care.

Religious origins of nursing

This confusion between spirituality and religion is understandable considering the religious roots of the nursing profession. According to Carson (1989:77), there are three major religions with a western philosophy, which are Judaism, Islam and Christianity. *Judaism* is described by O'Brien (2003:121-123) as one of the oldest religions and the foundation on which Christianity is built. Jewish people held a belief that the occurrence of illness is not an accident but rather a time given one to reflect on life and future. *Islam* is viewed as having been founded by the prophet Mohammed in the seventeenth century. Important religious practices for Muslims include ritual prayer, prayed five times a day, which historically had an influence on the practice of nursing. Spiritual nursing care for hospitalised Muslim patients had thus to be focused on providing the time (about 15 minutes) and setting (a quiet private place) for the five-times-daily ritual prayer (O'Brien 2003: 123). However, the context of this study is Christianity, which is the largest of the world religions. Modern nursing, according to Hurley (1999:8), originated in the Judeo-Christian tradition, which asserts that Christ and his followers

modelled care of the whole person and advocated for those who were less fortunate. Lane (1993:30) states that the care of the sick is a gospel imperative, which has been the hallmark of Christianity throughout the ages. Nurses were called to express their devotion to God by caring for the sick and the indigent (Sawatzky & Pesut 2005:19, 29).

It was from this religious foundation that early conceptualisations of nursing care were derived. Nursing care was understood as a calling to care for others out of a sense of duty and for the glory of God. The words 'gospel' or 'Christian' were never mentioned, but the essence was implied. Nurses operated under the banner of a motto, 'Caritas Christ Urget Nos' (the love of Christ drives us (McSherry & Draper 1998:685). Christian attitudes and values such as caring for the poor, the needy and the sick, and enabling people to suffer or die with dignity, served as a basis for the provision of spiritual nursing care (Lane, 1993:30). Virtues such as benevolence, compassion and altruism permeated all aspects of nursing care (McSherry & Draper 1998:685).

The early religious nursing orders implemented various religious interventions to meet the patient's spiritual needs. Prayer to God was considered an essential part of nursing care (McSherry & Draper 1998:685). This tradition is still evident today. Participants in a study of HIV-positive people saw praying, reading the Bible and sharing values such as receiving and giving love, forgiveness and hope as profoundly meaningful and healing (Benzein, Norberg & Saveman 1998:1063).

The question arises whether spiritual nursing care should be viewed according to the Judeo-Christian perspective or whether broader perspectives on religion and spirituality should be maintained. Van Loon (2005:267) contends that unilateral Christian definitions viewed from a Christian perspective in a modern, pluralistic society would be an infringement of human rights and would most likely curtail current nursing practice. Narayanasamy (1999b:278-279) explains that this stance may limit spiritual nursing care to Christian patients and nurses only. Some people have their own form of religion that may not always be encapsulated within institutionalised religions such as Christianity, Judaism, Islam or Buddhism. This requires that nurses should seek to listen to and respect the spiritual views and practices of patients, without necessarily agreeing with them (Govier 2000:32).

On the other hand, a number of authors (McSherry 2004:43; Van Loon 2005:266) voice their concerns that broader inclusive definitions of spirituality dislodge the concept from its predominantly Judeo-Christian interpretation, which may compromise nurses' capacity to provide spiritual nursing care to patients as mandated by God. To protect against this possibility, the authors appear to tighten definitions of spirituality to represent the Judeo-Christian worldview of a 'God breathed spiritual life'. They explain spiritual nursing care as care provided by nurses who recognise that patients have an inner sense which is the animating force in their lives; which makes them feel alive, fosters hope and helps them to ascribe meaning and purpose to their lives. This brings to the fore the possibility that such perspectives may result in ethnocentrism among nurses. Providing spiritual nursing care to people who differ in terms of culture and religion, using one's own religion such as Christianity without practising cultural imposition or serving one's own needs, therefore provides a challenge for Christian nurses (O'Brien 2002:2-4; Sawatzky & Pesut 2005:20-21; Taylor 2002:12-13). Hegarty (2007:42) posits that rather using a single approach to care, such as Christian perspective, to meet the needs of all patients in a pluralistic setting other practices such as meditation, contemplation and introspection as spiritual practices should be considered. These practices are also believed to lead to God-awareness. This is also because spirituality is the innermost belief of all human beings regardless of religion and/or culture or philosophical tradition.

1.2.3.3 Problems related to recognising the spiritual needs of patients

Human spirituality gives rise to spiritual human needs. Florence Nightingale (1946:10) recognised the importance of meeting patients' spiritual needs through spiritual nursing care in health undermining circumstances. Narayanasamy and Owens (2001:447) explain that meeting the spiritual needs of patients is fundamental to patient care and is essential to helping patients to attain optimal health. A qualitative study by Hermann (2001:67) involving terminally ill patients identified six areas of spiritual need, all of which could potentially be met through care provided by nurses. These areas of need are the need:

- For spiritual care
- For companionship

- For involvement and control
- To finish business
- To experience nature
- For a positive outlook

Findings of the research conducted by Greasley *et al* (2001:632) revealed that spiritual needs are associated with the need for 'inner peace and hope,' in terms of the primacy of interpersonal values. Watson (1988:29) identifies the need for a spiritual search for meaning and purpose. People need to discover the meaning in adversity, illness and disease in order to cope with their pain, spiritual distress and possible death. Especially in times of illness, suffering and disease, humans need to maintain a positive outlook and to live a life according to a set of values (Hermann, 2001:69). They need to have purpose in life, to have hope and to transcend challenges. However, nurses may mistake these needs for psychological needs. Sawatzky and Pesut (2005:23) indicate that nurses struggle to differentiate between patients' spiritual needs and the need for psychosocial care. Narayanasamy and Owens (2001:450) confirms this in their research that revealed that, although nurses displayed some knowledge and ability to identify the concrete spiritual aspects of patients needs, they tended to describe these needs in psychological terms.

Human beings need meaningful companionship, which would enable them to express their feelings of sadness and joy. Their needs at interpersonal level include the desire to forgive and be forgiven, to give and be given (McEwen 2005:162; Milligan 2004:164; Taylor 2002:16).

Stallwood and Stoll (1975:1088) define spiritual needs as factors necessary to establish and/or maintain a person's dynamic personal relationship with supernatural beings. A fundamental spiritual human need is therefore the need for religion, namely to strengthen one's belief in God and to relate with God or an Ultimate other in times of spiritual distress. Fletcher (2004:548) reports that nurses typically document their patients' religious affiliation when they conduct nursing assessments and that they do not move beyond this in terms of identifying their underpinning spiritual needs. Consequently, chaplains or other religious agents are often called in to perform the required religious rituals (Van Dover & Bacon (2001:18). While this is an important

intervention, it does not constitute spiritual nursing care in the broader sense of the word (Narayanasamy 1999:123).

Narayanasamy and Owens (2001:447) continue to argue that nurses' understanding of patient's spiritual needs will influence how they could meet them. According to Ross (1997:38), spiritual nursing care is rendered sporadically. A lack of understanding of human spirituality and the meaning of people's expressions of their spiritual human needs hamper nurse's efforts to provide spiritual nursing care. Greasley *et al* (2001:632) indicate that nurses may fail to address patients' spiritual needs if they do not express any religious affiliation. Whilst participation in matters of religion satisfies the existential needs for the meaning and purpose of some people, the existential concerns of others who do not identify with a particular religious creed may remain unresolved (Post, Puchalski & Larson 2000:580; Sawatzky & Pesut 2005:20; Taylor 2002:20).

An existential perspective on spiritual nursing care goes beyond religious perspectives to a universal human dimension. The spiritual needs of both religious and non-religious patients are regarded to relate to a personal search for meaning and purpose. This perspective acknowledges that non-religious people also exhibit the characteristics of serenity and inner peace, traditionally attributed to committed religious people. It recognises that all persons have spiritual needs or hold some sort of moral position irrespective of their religious or non-religious orientation, and that some people explore beyond the concept of God for meaning and purpose (Narayanasamy 1999a:279; Sawatzky & Pesut 2005:23).

On the other hand, Milligan (2004:164) questions whether nurses are regarded by patients as suitable to meet their spiritual needs. The response to this is provided by Taylor (2002:16) who is of the opinion that nurses are in a position to meet patients' need for personal dignity, assist them to cope with life transitions or make important decisions related to their health. Whether this is spiritual nursing care, remains to be proved.

1.2.3.4 Factors that hamper research to explicate the meaning of the concept spiritual nursing care

While there is general agreement in nursing that greater attention should be paid to the spiritual dimensions of human beings in the context of patient care, very few research studies have brought clarity on the subject (Van Dover & Bacon 2001:18). One reason may be the fact that science and spiritual matters have become dichotomous concepts in the health care environment (McSherry & Draper 1998:686). Both science and the spiritual realm are seeking answers about the nature and mystery of life. Science focuses primarily on temporal, tangible and materialistic facets of human nature and desire. It seeks to clarify by establishing empirical evidence whereby normal and abnormal natural processes can be understood and managed (Brown, Crawford & Hicks 2003:4). According to Greasley *et al* (2001:634), the spiritual realm involves subjective matters such as the quality of interpersonal care, expressions of compassion and love and a caring attitude towards those for whom they care. These intangible qualities make it difficult for scholars to attain conceptual and theoretical unity.

While spiritual nursing care could contribute towards the humane treatment of people in need of sophisticated health care, knowledge about its nature and dimensions based on in-depth, contextualised research is lacking. This lack of consensus may be attributed to the research tradition in the medical sciences in general and nursing profession in particular (Govier 2000:34; Van Dover & Bacon 2001:18). The western-scientific paradigm supports research, which is based on the positivist research tradition, which supports empirical research, which dictates that phenomena can be reduced to their components, observed through the senses and quantified to establish cause and effect relationships to yield verifiable results. This poses limitations with regard to studying spiritual nursing care (Young, Van Niekerk & Mogotlane 2004:135).

Spiritual nursing care is irreducible and unquantifiable in nature (Brown *et al* 2003:4; Fawcet & Noble 2004). As Mayer (1992:33) rightly points out that, spirituality and by implication spiritual nursing care, cannot be classified, controlled, quantified, recorded and processed in the same way as physiological phenomena such as fluid balance, bowel function and body chemistry. It would therefore be counterproductive to attempt

to clarify the meaning of spiritual nursing care by means of quantitative research approaches, which employ the logic, and the methodology of the natural sciences.

Research on the phenomenon of spiritual nursing care requires a holistic worldview, which supports value bound inquiry, accounting for multiple constructed realities and generalisations that are bound by time and context (Burns & Grove 2007:62). McSherry and Draper (1998:686) argue that metaphysical phenomena require qualitative research methodologies that focus on people, their experiences (an insider - emic perspective)) and their life worlds. Qualitative research approaches are amenable to investigations of human experiences, including spirituality. Qualitative methods are most appropriate to investigate this subjective dimension of people's existence (Babbie & Mouton 2001:27). Without the depth of understanding detail that is available using qualitative methods it is difficult to get a picture of the "whole" of what is happening in spiritual nursing care encounters between nurses and patients.

1.2.3.5 Concluding remarks

It is therefore clear that, while patients should be managed holistically to enable them to cope with their health problems, spiritual nursing care is often a neglected component of holistic nursing care. Nurses' ability to render spiritual nursing care may be hampered by their scientific worldview, practices and definitions of health, which exclude the spiritual dimension. Insufficient statutory endorsement of spiritual nursing care and inadequate educational preparation of nurses also contribute to the state of affairs.

Human spirituality is expressed in terms of spiritual needs and requires spiritual nursing care to promote spiritual health and well-being. However, the nurses' ability to meet their patients' spiritual needs is hampered by confusion about the meaning of the concepts, human spirituality and spiritual nursing care and the practical implications of the latter. While viewing spirituality in terms of religion may be simplistic, the importance of religion as a useful means for expressing human spirituality cannot be ignored or undervalued. It is therefore necessary to explore the meaning of these concepts, with specific reference to spiritual nursing care.

The western-scientific perspective is based on the epistemology of positivism. This hampers efforts to understand human spirituality and spiritual nursing care. In this current study, the researcher conducted qualitative research to clarify the meaning of the provision of spiritual nursing care for patients in a particular context.

The study therefore, aims at clarifying the need for spiritual nursing care in clinical nursing practice by accounting for its complexities and developing a model to guide nurses on how to provide spiritual nursing care in practice. The researcher intends to facilitate the integration of spiritual nursing care without devaluing the scientific care principles and practices of care.

1.2.4 Problem statement

The problem statement of this study relates to the nursing programmes and the curricula, which do not include spiritual nursing care as an entity, and the definition of health by the WHO, which does not include spiritual needs, the poor understanding of the concept by the nurses themselves and the lack of integration of this concept in practice.

Therefore, the renewed emphasis on spiritual nursing care as an inherent facet of holistic nursing care presents nurses with a significant challenge to understand what this care entails. This understanding is necessary in the light of the confusion about the meaning of the concepts 'spirituality' and 'spiritual nursing care' and the practical implications specifically of the latter concept. Oldnall (1996:141) contends that if the nurse educators and researchers do not attempt to make the existence and importance of spiritual nursing care explicit in the domain of holistic nursing care, the nurse practitioner in practice who is directly involved in the delivery of patient care, will not do so either.

A restricted view of human spirituality is also a contributing factor regarding the problem under discussion. It is a notable fact that religion provides a useful means for expressing human spirituality for both the nurse and the patient, a reality that cannot be ignored. However, there remains a difficulty with distinguishing between human

spirituality and religion, pastoral care and spiritual nursing care. The commonalities and differences of these concepts need to be explored.

Influential international bodies such as the World Health Organisation (WHO) have a great impact on health and health provision across the globe. According to the WHO (1948:100), health is defined as "...a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity.

This definition has raised much debate over decades. When it was first put forth, it was marked as the most complete definition of health. Saracci (1997:1-3) points out that this definition widened the conception of health as the absence of disease, to include its mental and social dimensions, in addition to physical integrity. However, this definition has been found to be inadequate in supporting spiritual nursing care as an integral part of holistic nursing care, as the absence of a reference to spiritual well being thus far is significant.

Saracci (1997:2) continues to argue the failure to identify the spiritual aspect in the WHO definition explicitly as an important component of health that has had serious consequences, because firstly, disturbance to the health of individuals, however minimal, has a bearing on the spiritual well-being of the affected people. Secondly, the quest for spiritual health is inherently essential whether there is disease or not and therefore, spiritual nursing care becomes an essential service to assist individuals to achieve an optimal state of health. Thirdly, trying to guarantee 'health for all citizens of the world' with an obvious disregard for care of the spiritual dimension jeopardises the chances of gradually attaining or practically applying the concept of holistic care in nursing.

In 1984 a WHO resolution invited Member States to include the spiritual dimension in their health care strategies (Boero *et al* 2005:316). In 1998, the WHO Executive Board recommended a review of the WHO constitution to add the spiritual dimension to its definition of health. According to Boero *et al* (2005:916), this proposal has not yet been endorsed. It is therefore understandable why nurses fail to place significant and meaningful emphasis on attending to the spiritual needs of their patients. The necessary and formidable task of the provision of spiritual nursing care by nurses needs to be

underpinned by the re-definition and reformulation of the concept 'health' by the WHO and other important statutory bodies in health care.

Although there is an ongoing debate around these issues, McSherry and Draper (1998:691) are of the opinion that these debates do not provide solutions to the issues to be addressed. The authors challenge the nursing profession to refine and clarify the phenomenon of spiritual nursing care with further and ongoing research. The personal meanings that people attach to issues of a spiritual nature influence how they perceive spiritual nursing care and the expected outcomes to be achieved. It seems therefore necessary to obtain a contextualised view of spiritual nursing care by drawing upon the views of those persons who render spiritual nursing care in a specific context.

Nurses often experience difficulty with conducting spiritual assessments and with meeting the spiritual needs of patients, possibly due to a lack of knowledge about spiritual human needs, spiritual well being and spiritual distress. Although nurses increasingly realise that spiritual considerations cannot be ignored when adopting a holistic view of the person as the foundation of nursing practice; nurses in practice are still confused about the nature of spiritual care they need to give (Sawatzky & Pesut 2005:19).

It is a noted fact that technological and scientific advances in medicine have increased the quality and effectiveness of health care. However, the focus on science and technology has increasingly overshadowed the concerns for spiritual and humanitarian needs, and this increases the risk of de-personalising the ill individuals. Walter (1997:25) is of the opinion that separating the spiritual component of care from other domains, provides a risk that complex, holistic, spiritual beings will be reduced to a collection of needs that can be measured objectively and treated routinely by implementing standardised nursing interventions. With the numerous advances in scientific and medical technology, nursing has become more complex and sometimes even mechanistic. As a result, the relevance of spiritual nursing care tends to be compromised and lost sometimes (Sawatzky & Pesut 2005:21).

On the other hand, cultural and religious diversities in health care settings complicate spiritual nursing care as an individual's culture influences his or her spiritual expression

or involvement. Many nurses' values and beliefs differ from those of their patients. Furthermore, individuals entering the nurse-patient relationship interface with their own values, but these espoused values are not always congruent with the nursing culture, which bears evidence of the influence of the western-scientific worldview and the biomedical health care paradigm (Graber 2001:40; Sawatzky & Pesut 2005:19). In multicultural health care settings, nurses may experience fears and anxieties to engage in a spiritual dialogue with patients of faiths they do not understand. Fear of imposing their own religion or religious preferences on patients who are vulnerable while they are in times of crisis, may prevent nurses from rendering spiritual nursing care. Sawatzky and Pesut (2005:19) argue that it may be risky to discuss spiritual matters when those involved have different belief systems or struggle with their own unresolved personal spiritual issues. It becomes critical to demonstrate respect for different spiritual beliefs, values and practices.

Research reveals that, although nurses are in a better position to provide spiritual nursing care than any member of the health care team is, many do not provide this care because of a perceived limited ability to do so (Stranahan 2001:101). One of the greatest barriers to spiritual nursing care may be a limited understanding of how to provide that care and inadequate appreciation of the spiritual journeys of patients. The spiritual journey of each person is unique and may not be understood fully or readily understood by those standing from the outside (Sawatzky & Pesut 2005:24; 30).

In view of the above discussions, the researcher conducted a grounded theory study to enhance the understanding of spiritual nursing care by accounting for its complexities in a particular nursing care context and by developing a model to guide nurses in practice regarding the phenomenon of spiritual nursing care. In addition, the researcher to narrow the gap between the recognised need to provide spiritual nurses care in meeting the spiritual needs of patients and the nurses' ability to render such care in their daily practice. The central theoretical question, which guided this study, was:

What does it mean to provide spiritual nursing care to patients?

The specific questions, which arose from the central question, were:

- How do nurses conceptualise spiritual nursing care?
- How do nurses render spiritual nursing care in their daily practice?
- What theoretical framework or model can be developed for integration of spiritual nursing care in practice?

1.3 SIGNIFICANCE OF THE STUDY

This study will highlight the understanding of spiritual nursing care not only in nursing but also in all other related professions thereby enhancing holistic care. The study will also advance scientific knowledge in nursing practice. The development of the model will serve to integrate spiritual nursing care without devaluing the physical, social and mental care, as we know it. Pastoral care will find meaning within the legitimate curriculum. In addition to this, the model will serve as a framework for incorporating spiritual nursing care in the curriculum as well as in-service education programmes not only for nurses, but for other health professionals as well.

1.4 AIM OF THE STUDY

The aim of the study was to enhance and contribute towards nurses' understanding of spiritual nursing care and its implications for nursing practice.

1.4.1 Research purpose

The purpose of this study was to explore registered nurses' conceptions and their experiences of rendering spiritual nursing care and inductively develop a model of spiritual nursing care.

1.4.2 Research objectives

The objectives of this study were to

- Analyse the concept 'spiritual nursing care.'
- Explore registered nurses' conceptions of spiritual nursing care.

- Explore how registered nurses apply the emerging concepts to render spiritual nursing care.
- Develop a model to guide integration of spiritual nursing care to nursing practice.

1.5 CONCEPTUAL AND OPERATIONAL EXPLANATIONS OF KEY CONCEPTS

The explanations of concepts as used in this research are provided below.

1.5.1 Clinical nursing practice

Clinical nursing practice refers to a clinical practice area, which may be private or public, where nurses provide nursing care to individual patients, their families and communities (Buys & Muller 2005:51). It includes a setting where nurses of all levels provide patients with preventive, promotive, curative and rehabilitative services together with other health care team members.

In this study, clinical nursing practice refers to a hospital or clinic setting where professional nurses are expected to provide holistic care to patients.

1.5.2 Christian perspective

Christianity is defined by The *Concise Oxford Dictionary* (1983:164) as a religion that is based on the life and teachings of Jesus Christ and His Apostles. Most proponents of this perspective are called Christians and are members of three major groups – Roman Catholic, Protestant or Eastern Orthodox. These groups have different beliefs about Jesus and His teachings, but all consider Jesus central to their religion. Christianity teaches that humanity can achieve salvation through Jesus.

Perspective refers to aspects of a subject and its parts as viewed by the human mind (The *Concise Oxford Dictionary* 1983:765). Bezuidenhout (2009:61) defines perspective as a way of looking at things. People who share a common perspective usually have a greater sense of mutual understanding and ease of communication than those who do not.

In this study, the *Christian perspective* is defined as a religious tradition or framework according to which data on spiritual nursing care can be interpreted. It relates specifically to the doctrine of Christ, prayer and application of Biblical texts in the understanding of spirituality and the provision of spiritual nursing care.

1.5.3 Integrate

Integrate means to complete by addition of parts. It includes making a whole or combining parts into a whole (The *Concise Oxford Dictionary* 1983:521). It means putting different parts, activities, programmes, plans and services together to form a whole. Integration is designed to bring together a collection of separate and independent units and programmes, which previously tended to pursue their own objectives, into a cohesive and unified structure (Monekoso 1994:139).

Applied to this study, the term “integration” refers to incorporation of spiritual nursing care into holistic nursing care practices.

1.5.4 Holistic care

Holistic care, according to Freshwater and Maslin-Prothero (2005:278,) refers to acknowledging all an individual’s physical, mental and social conditions, not just physical symptoms, in the treatment of illness.

In this study, holistic care refers to caring for or attending to the body, mind and spiritual needs of patients with special emphasis on spiritual nursing care needs.

1.5.5 Model

Freshwater and Maslin-Prothrero (2005:365) define a *model* as a simplified representation of a phenomenon. A model is the way in which a researcher or scientist views and presents his or her material within a certain paradigm (Polit, Beck & Hungler 2001:146). According to Polit and Beck (2008:116-117), a model is often used in connection with symbolic representations of some aspect of reality. A visual or symbolic representation of a theory or conceptual framework helps to express abstract ideas in a

concise and readily understandable form. Other authors view it as a symbolic representation of concepts or variables, and the interrelationships among them (De Vos, Strydom, Fouche & Delport 2005:39; Polit & Beck 2008:758). For the purposes of this study, a model refers to a schematic representation of the themes, categories and the defining attributes, which integrate spiritual nursing care.

1.5.6 Nurse

A nurse is a person who is specially prepared and registered to provide care for both well and unwell individuals as well as their families and their communities. Only those whose names appear on the register maintained by the Nursing and Midwifery Council are legally entitled to be called nurses (Freshwater & Masli-Prothero 2005:400).

In this study, nurse refers to a nurse registered with the SANC under section 31(1) of the Nursing Act (No. 33 of 2005:34) who provides care to patients in the wards in a public hospital.

1.5.7 Nursing care

Nursing care refers to all activities performed by nurses to the benefit or to help the patient, which involve observing, diagnosing, treating, evaluating, counselling and serving as an advocate for the patient (*Blackwell's Nursing Dictionary* 2005:401).

In this context, nursing care refers to care provided by nurses directed at meeting the spiritual needs of patients

1.5.8 Spiritual nursing care

The *Concise Oxford Dictionary* (1983:1023) defines *spiritual* as, of the spirit as opposed to matter, or of the soul proceeding from God, holy, divine and inspired. *Spiritual care practices* are those actions that are intended to promote spiritual well-being, coping, growth or relationships (Taylor, Amenta & Highfield, 1994:35).

Henderson (1977:4) defines nursing as the responsibility of nurses to assist individuals, sick or well, in the performance of those activities contributing to their health or recovery (or to a peaceful death) that they would perform unaided if they had the necessary strength, will or knowledge. Central to this definition is the nurse's role in assisting patients to achieve their maximum health potential and spiritual well-being.

Spiritual nursing care entails activities that facilitate a healthy balance between the bio-psychosocial and spiritual aspects of the person, thus promoting a sense of wholeness and well-being (Taylor, 2002:180). Applied to this study, spiritual nursing care encompasses activities, which will empower both nurses, and patients with spiritual coping strategies to transcend the present situation, discover meaning and purpose, and experience connectedness with God, self, other human beings and the environment.

1.6 FOUNDATIONS OF THE STUDY

This study is based on the grounded theory design and the interpretative framework of the symbolic interactionism philosophy.

1.6.1 Symbolic interactionism underpinning grounded theory

Grounded theory (GT) is the research design of choice for this qualitative study. It is based on a *philosophical orientation known as symbolic interaction theory*. This approach helps qualitative researchers to describe and understand key social, psychological and structural processes in social settings (Polit & Beck, 2008:223). Holloway (2005:295) defines symbolic interactionism as an approach in sociology that focuses on symbols and meaning in interaction. The term was used in sociology and the social psychology perspectives of Mead (Burns & Grove, 2007:66-67). Glaser and Strauss (1967:42) accept the fundamental principles of Mead's perspective of symbolic interactionism. The assumptions on which grounded theory is based are thus derived from the symbolic interaction school of social psychology, which focuses on the manner in which people make sense of their world. This theory explores how people define reality and how their beliefs are related to their actions. Reality is created by attaching meanings to situations. Meaning is expressed in such symbols as words, religious

objects and clothing that shape their appearance (Burns & Grove, 2007:66). Applied to nursing, meanings are shared by groups and are communicated to new members through the socialisation process. The approach is used in this study because interaction with patients in the context of spiritual nursing care, may lead to a redefinition and new meanings of the concept 'spiritual nursing care.'

Symbolic interactionism (SI) will serve as a broad framework for data collection and analysis from the empirical point of view especially in the evaluation of the behaviour of nurses when confronted with patients who experience spiritual distress. The major constructs of the symbolic interaction theory of self, mind, society and role taking, as proposed by Mead (1934), cited by Blumer (1969:12-13), will be considered during the interaction process with the participants and presentation of data. In this study, interactions between nurses and patients in relation to meeting the spiritual needs of patients are the areas of focus. Grounded theory, according to Streubert-Speziale and Carpenter (2003:107), speculates on issues related to human behaviour. The behaviour of patients as they express or manifest spiritual needs, and how nurses recognise and appreciate these expressions or symbols of spiritual nature is the area of interest for the researcher. Polit *et al.* (2001:216) add that symbolic interaction also looks at the manner in which people make sense of social interactions and the interpretations they attach to social symbols.

Grounded theory research is aimed at exploring the social processes involved in human interactions. In doing so, grounded theory makes explicit the reality of how individuals perceive their world and the way they interact with others (Blumer 1969:13; Griffin 1997:35; Holloway 2005:149; Van der Wal 1993:38). Referring to this study grounded theory research enabled the researcher to investigate the social process and meaning dimensions of spiritual nursing care.

This study aimed at investigating how people make sense of the world around them and how they create meaning during social interaction with people and objects. Subjective and objective reality (Timasheff & Theordorson 1976:299) experienced by the participants as they provide spiritual nursing care to patients were explored.

1.6.2 Assumptions

Assumptions are basic principles that are assumed to be true based on logic and reason, without proof or verification (Mouton & Marais, 1994:11; Polit & Beck 2008:13-14). Sources of assumptions include universally accepted truths such as theories, previous research and nursing practice experiences. In research studies, assumptions are embedded in the philosophical base, study design and interpretation of findings (Burns & Grove 2007:37). Assumptions influence the logic of the study and their recognition leads to more rigorous study development. To this end, epistemological, ontological and methodological assumptions were posited in this study.

Epistemological assumptions are statements that embody the ideal of science, namely the quest for truth and knowledge (Mouton & Marais 1994:14-15). In this regard, the epistemological assumptions are as follows:

- Multiple realities exist with regard to spiritual nursing care and this can be captured by means of qualitative research.
- Narrative data can elicit an understanding of the meanings that nurses attach to spiritual nursing care.
- Although it is difficult to ascertain when the truth has been attained, it is, however, necessary to strive for reality as close as possible.
- Theories inductively generated from data are likely to offer insight, knowledge, enhance understanding and provide a meaningful guide to action, including nursing practice.

Ontological assumptions, according to Mouton and Marais (1994:11-12), refer to the study of being or reality. The ontological assumptions underlying this study are as follows:

- Humans are essentially holistic beings.
- Human nature has a spiritual dimension, which encompasses the need to find meaning and purpose in life as well as a relationship with a supreme being (God), others, self and the environment.

- Spiritual needs are often fulfilled within an organised system of beliefs and values, or framework whether formal or informal.
- Spiritual nursing care is an essential component of holistic nursing practice, which serves to meet human spiritual needs in times of illness, suffering and distress.
- All persons are valued as spiritual beings regardless of their religious orientation or absence thereof (Sawatzky & Pesut, 2005: 22).
- The meaning attributed by patient and families to pain, suffering and death impacts heavily on their demands on the health care services, and the nurses' approach to care.

Methodological assumptions, according to Mouton and Marais (1994:15-16), provide the 'how' of research. In other words, how should research be planned, structured and executed to comply with the criteria of science. It refers to the logic of implementing scientific methods in the study of reality. Methodological assumptions regarding this study are as follows:

- Human beings use language to attach meaning to phenomena and communicate the meanings to others.
- Qualitative research supports naturalistic inquiry to collect narrative data on reality, which is constructed by people.
- Grounded theory research supports inductive reasoning to develop a model, which is based on the data.

Burns and Grove (2007:37) conclude that assumptions are embedded (unrecognised) in thinking and behaviour, and uncovering these assumptions requires introspection and a strong knowledge base in the particular field of study.

1.7 RESEARCH DESIGN AND METHODOLOGY

Empirical qualitative research, involving professional nurses, was conducted to gain an insider (emic) view on spiritual nursing care. Empirical research in terms of grounded theory, related to the challenge of observing as a nurse in the role of 'etic' researcher, that is the outsider (Cutler 2004:132-133). This approaches had to be employed in a grounded theory rule governed way. The researcher had to listen carefully at what the

participants said they do when providing spiritual nursing care and the meaning attached to those social processes. The researcher in this paradigm had to strike a balance between observation and interviews as to identify social complexities, contradictions and paradoxes for better understanding of the phenomenon under investigation (Cutler 2004:132-133). Observation was done during data collection using both in-depth and focus group interviews. Therefore, qualitative research enabled the researcher to obtain an in-depth understanding on how nurses conceptualise spiritual nursing care and its practical implications in nursing practice. The grounded theory research design enabled the researcher to develop a model inductively for integrating spiritual nursing care into holistic nursing care practices.

Purposive, snowball or network sampling techniques were employed to select the participants and identify relevant data gaps. Data collection occurred by means of unstructured in-depth individual and semi-structured focus group interviews. Specific concepts, which emerged from the unstructured interviews, guided the semi-structured focus group interviews. Interviews were audiotaped and transcribed by the researcher verbatim. The transcribed data was imported to a computer software programme known as NUD*IST power version 4.0. Data was categorised with the assistance of the computer into themes, categories and sub-categories. The direct quotes of participants were coded and arranged into text units for analysis. A constant comparison method of data analysis was applied to follow a process of open, axial and selective coding. The researcher, for data analysis triangulation purposes engaged in a systematic data analysis process suggested by Creswell (2003:190-195) and integrated with Tesch's (1990:142-145) eight steps of analysis to analyse the textual data as cited by Creswell (2003:190-195) until themes, categories and subcategories were also identified and developed. Variations were noted on the identified subcategories, but the themes and categories were similar. The SI theory served as an interpretative framework for the study. The process led to the development of a substantive theory or model on the provision of spiritual nursing care in clinical practice as presented in chapter 6.

1.8 PLANNING PHASES OF THE STUDY

The study was planned and implemented according to phases as exhibited on figure 1.1.

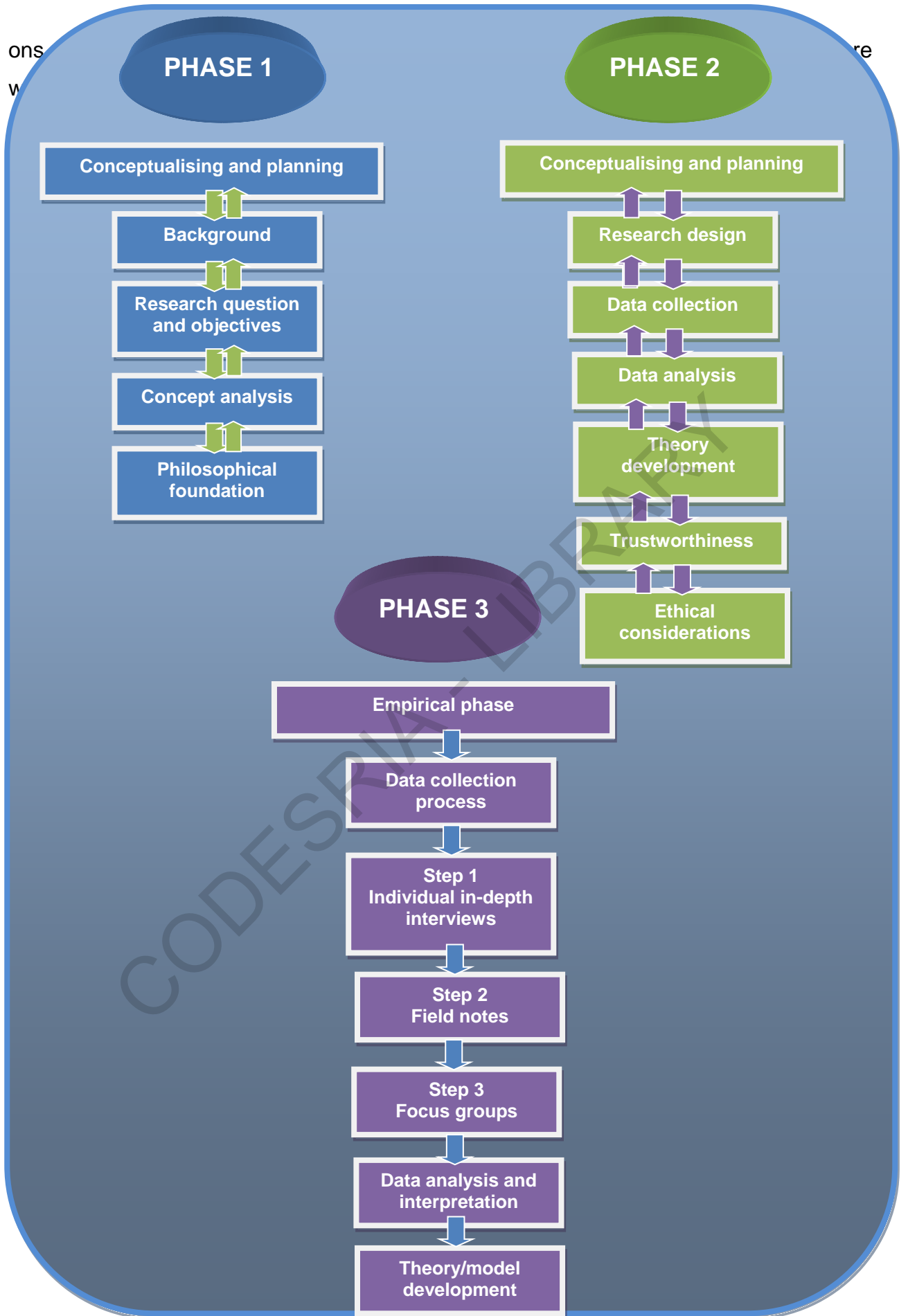


Figure 1.2
Phases of the research process

The *first phase* was that of conceptualising and planning the study as outlined in Chapter 1. This stage involved the development of the research problem, purpose, research questions and objectives. The researcher needed to enter the field of spiritual nursing care with a clear conception, while identifying and accounting for her misconceptions and preconceived ideas about spiritual nursing care, which necessitated a concept analysis. All the possibilities and vocabularies about the phenomenon of interest were described and communicated through the process of concept analysis. It also enabled the researcher to demonstrate theoretical sensitivity during sample selection, data collection and data analysis. This phase was concluded by outlining the philosophical foundation of the study, namely symbolic interactionism and developing the research method.

The *second phase* entailed the empirical phase or the research methodology of the study, which focussed on the research design, population and sampling, data collection and data analysis, which the researcher applied to identify the themes, categories and sub-categories leading to theory or model development.

During the *third phase*, the researcher engaged in the development of the theory/model based on the findings.

Table 1.1 Overview of the thesis

CHAPTER	TITLE	CONTENT
1	Overview of the study and the research problem	This chapter presented the background information about spirituality and spiritual nursing care, reasons for selecting this research problem and the rationale for the study.
2	Concept analysis: Spiritual nursing care	A theoretical conceptualisation of spiritual nursing care based on a concept analysis exercise is presented. This conceptualisation represents existing theory on spiritual nursing care.
3	Theoretical foundation to the study	An overview of symbolic interactionism is presented and how it connects with the study as its philosophical base.
4	Research design and method	In this chapter the design and methods, which the researcher applied, are discussed.
5	Data collection, analysis and presentation	The qualitative data that were generated are analysed and presented in this chapter. A literature control served to link the data obtained to existing theory.
6	The model for integrating spiritual nursing care in nursing practice	This chapter presents the Model for Integrating Spiritual Nursing Care in Nursing Practice. This Model depicts the relationship between and amongst the concepts, which emerged from the study.
7	Discussions, conclusions and implications	Discussions in this chapter focus on conclusions made and what implications the findings have on clinical nursing practice, education and research

1.11 CONCLUSION

This chapter provided the relevant comprehensive background information to the study title, outline of the problem of nurses not being sure about what spiritual nursing care is, when, and how this is rendered. The background information and discussions focused on the holistic nature of human beings, challenges and problems, which make it difficult for nurses to provide spiritual nursing care in clinical practice. The problem statement, significance, purpose, research question/s and objectives of the study were indicated. Conceptual and operational definitions of concepts were presented. The foundation of the study based on the grounded theory design and the philosophical tenets of symbolic interactionism were introduced. In addition, assumptions with regard to the 'spiritual nursing care' concept were stated. Furthermore, a summary of the qualitative, grounded theory research design and methodology with regard to sampling, data collection and analysis methods was given. A plan of how the study will be carried out was presented in terms of different phases. Finally, an outline of the structure of the chapters of the thesis was presented.

A literature review in the context of concept analysis is presented in chapter 2.

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CHAPTER 2

Spiritual nursing care: a concept analysis

2.1 INTRODUCTION

Concept analysis is an essential element of theory development and new research directives. It is a reasonable and logical method that has served the development of science in many disciplines over time (Walker & Avant 2005:78). It is a rigorous and precise strategy, which is applied to examine the major attributes or characteristics of a concept and it delineates those attributes that are relevant to the concept from those that are not (Walker & Avant 2005:63). During this process, the concept is brought further down to its refined components. In this chapter, the concept 'spiritual nursing care' is described from various perspectives to clarify its conceptual meaning in preparation for a grounded theory approach to data collection and analysis aimed at developing a model for integrating spiritual nursing care to nursing practice. This chapter contains an overview of the various methods of concept analysis, which were used to analyse the concept, 'spiritual nursing care.'

2.2 CONCEPT ANALYSIS METHODS

Chinn and Kramer (2008:187) define a concept as a complex mental formulation of experience. McBrien (2006:42) adds that a concept is a unique and wholly individualistic phenomenon, essentially based on one's personal observations or experiences. According to Polit and Beck (2008:749), a concept is an abstraction based on observations, characteristics or behaviours. Wilson (1963), as cited by Walker and Avant (2005:66), defines concept analysis as a process of isolating a concept and examining its significance in relation to various contexts, boundaries and relevance to practice.

The concept, 'spiritual nursing care,' had a bearing on the choice of the title. The researcher's Christian background, theological training and pastoral position influenced the interest in the current study. The researcher had her own preconceived ideas and

misconceptions about spiritual nursing care as a concept. The researcher experienced difficulty with distinguishing between the meanings of spiritual nursing care and religious care which could have been due to her theological background. Through the process of reflexive analysis and self awareness the researcher was able to bracket her feelings, experiences and knowledge concerning Christian values and attitudes that may influence the findings. These were recorded in a reflexive journal which enabled the researcher to collect and analyse data without bias, especially because the study is based on a Christian perspective.

The aim of this chapter is to enable the researcher to explore concepts in the literature on spiritual nursing care comprehensively. It also assisted in clarifying the researcher's position on spiritual nursing care and enabled her to adopt a neutral stance, particularly during data collection, analysis and interpretation.

Concepts often have many and vague meanings. Chinn and Kramer (2008:192) contend that there are various deliberate and disciplined methods for creating conceptual meaning. These methods include producing tentative definitions of the concept and a set of tentative criteria to determine if the concept exists in a particular situation. The methods assist researchers to discover interesting information about a concept and an understanding of its application in practice. A number of such methods or techniques are discussed below with the view to coming developing a useful or applicable method for this study (Chinn & Kramer 2008:192:57; Du Toit 2003:34; Walker & Avant 2005:63).

2.3 ANALYSIS OF THE CONCEPT 'SPIRITUAL NURSING CARE'

The techniques presented by Walker and Avant (2005); Chinn and Kramer (2008); and Du Toit (2003), were combined to structure a plausible framework to guide the concept analysis process for this grounded theory study on spiritual nursing care. The following ten modified steps were then followed for the analysis process in this study, namely:

1. Presentation of the selected concept: spiritual nursing care
2. Type/s of questions to ask during data collection

3. Purpose of analysis.
4. Uses of sources of evidence
5. Exploring current uses of the concept:
 - Dictionary definitions
 - Synonyms
 - Antonyms
 - Theoretical definitions
6. Determining the defining attributes.
7. Antecedents and consequences of spiritual nursing care
8. The social context of spiritual nursing care
9. A case study to summarise the defining attributes of spiritual nursing care
 - Case study 1 Exemplar case
 - Case study 2: Contrary to spiritual nursing care
 - Case study 3: Related case study depicting pastoral care
 - Case study 4: Related case study depicting psychological care

The ensuing discussion presents the process followed in analysing the concept, spiritual nursing care, by explaining the steps as set out above.

2.3.1 Presentation of the selected concept 'spiritual nursing care'

Selection of the concept, 'spiritual nursing care,' was guided by the purpose of the study. It was a process that involved a great deal of ambiguity. Its choice was influenced by the researcher's beliefs, values and attitudes about the nature of the discipline to which the concept applies, which is, in this instance nursing. Referring to the nursing discipline, spiritual nursing care as a concept was selected for clarification as it justifiably relates to the practice of nursing and demonstrates evidence of importance to the health care outcomes for patients. Although there is much debate going on in the literature about spiritual nursing care, little is known about how to apply it in practice. It was therefore a concept appropriate for analysis (Chinn & Kramer 2008:192-193).

Although the concept 'spiritual nursing care' appears to be difficult to manage in practice, it is critical and relevant to patient needs. It also has potential for further theoretical developments and contributes significantly to knowledge development (Walker & Avant 2005:66).

2.3.2 Type/s of question/s to ask during data collection

This concept analysis exercise was aimed at answering a conceptual question, which had a normative component. The concept spiritual nursing care, which is underpinned by a value system related to human spirituality, required conceptual clarification. The types of questions asked were aimed at providing clarity with reference to the concept 'spiritual nursing care.'

The following questions were asked during the individual interviews:

- What do you understand by spiritual nursing care?
- How do you provide spiritual nursing care to patients?

Questions asked during the focus groups were generated from the individual interviews and included the following:

- What do you understand to be the difference between your role and that of the chaplains in providing spiritual nursing care?
- What is your understanding of the difference between religious care and spiritual nursing care?
- What difficulties or barriers (if any) do you experience when providing spiritual nursing care in the units?
- What does humane nursing care mean to you?

According to Du Toit (2003:23), concept analysis is the process that follows a conceptual question. A conceptual question in this study was 'what do you understand by spiritual nursing care,' which called for the clarification of its meaning (Du Toit 2003:26-27).

However, many questions that the researcher asked through probing seemed complex for the participants and comprised more than a conceptual question.

However, a combination of different types of questions asked, made the questions interesting. Because of the abstract nature of the concept, the questions were broken up into their constituent parts before an answer was expected. (Du Toit 2003:27). The first technique applied was to scrutinise the conceptual issue and to isolate it from other types of issues. It was important for the participants to answer the conceptual question first, the answer to which was necessary for answering subsequent questions.

2.3.3 Purpose of analysis

Analysis of the concept 'spiritual nursing care' was necessary for this grounded theory study to provide the researcher with as a sense of direction. One major purpose was to set boundaries or limits so that one should not get lost in the process. Another reason for creating conceptual meaning about spiritual nursing care was to examine ways in which the concept was used in existing writing. The analysis helped the researcher to become aware of these meanings in order to explore the extent to which the meanings are consistent with the application of the concept in nursing practice (Chinn & Kramer 2008:195).

According to Du Toit (2003:35), concept analysis contributes towards constructive proposals for the better use and application of the concept in the context of interest, which, in this instance, is nursing practice. The concept 'spiritual nursing care' was analysed prior to data collection to provide guidance regarding the focus during the process of data collection and analysis and to address bias and enhance the theoretical sensitivity of the researcher. The analysis of the concept also contributed to the development of a standardised language in its description.

The reasons for analysing spiritual nursing care in this study were to:

- Distinguish between the relevant and irrelevant defining attributes.

- Arrive at operational and conceptual definitions of the concept and to ensure that the concept is used unambiguously in theory and in practice.
- Provide information necessary for focussed data collection, analysis and interpretation of the findings.
- Add to existing theory and related studies by using the data provided to develop a model to guide nurses in the clinical environment on the provision of spiritual nursing care to patients.
- Distinguish colloquial terms from scientific language (Walker & Avant 2005:65).

This process enabled the researcher to especially conduct member sampling for the focus group interviews.

2.3.4 Use of sources of evidence

Chinn and Kramer (2008:195) explain that once a concept has been selected, the sources of evidence will be examined. The type and number will be determined by the purpose of conceptual clarification.

2.3.4.1 Visual images

Existing visual images, such as photographs of nurses caring for patients, uniforms of nurses that exemplified nobility and respect for those cared for, paintings and drawings of patient care scenarios in nursing text books, were useful sources for creating meaning about spiritual nursing care. Some artists labelled their pictures with concepts that were linked to the visual image which validated the meaning of the concept, enriched the range of its meaning and helped to minimise any bias inherent in the researcher's views of meanings regarding the concept. This visual imagery highlighted important aspects of the concept, although some of the images were difficult to interpret and express their meaning linguistically (Chinn & Kramer 2008:198).

2.3.4.2 Popular and classical literature

A variety of literature sources provided valuable information about the conceptual meaning of spiritual nursing care. The literature reflected meanings arising from experiences of people in similar conditions. An example of a useful reported story in nursing is the experiences of Florence Nightingale and her team during the Crimean war in 1854 (Chinn & Kramer 2008:198-199; O'Brien 2003:45).

2.3.4.3 Professional literature

The meaning of the concept 'spiritual nursing care' pertinent to practice was explored in the context of professional literature, such as research journals and peer reviewed articles. Meaning found in literature across disciplines contributed to the clarification of the concept under scrutiny (Chinn & Kramer 2008:199).

2.3.4.4 People

Direct participants in this study included professional nurses with advanced training in their areas of speciality. The indirect participants were patients, the researcher's church members and the study promoters who provided valuable information on the concept under consideration (Chinn & Kramer 2008:200).

2.3.5 Exploring current uses of the concept

'Nursing care' is a well defined concept in a vast amount of existing nursing literature. The theoretical, philosophical and clinical foundation of the concept 'nursing care' is well established and documented. However, there is still a need to develop the concept 'spiritual nursing care' further to improve the quality of holistic patient care. One prerequisite for doing this successfully was to spell out what is meant by "spiritual" or "the spiritual dimension" of nursing care.

Usage of the concept was identified by consulting dictionaries, thesauruses, colleagues and available discipline specific literature. These sources assisted the researcher to identify definitions, relevant synonyms and antonyms of the concept under study. The theoretical definitions were specified according to the religious and existential perspectives of the concept. The search for the use of this concept was not limited to the nursing or medical field only. Its use by other disciplines, especially theology, was explored for a better understanding of the nature of the concept. Both the ordinary and scientific usages of the concept were identified (Walker & Avant 2005:67).

General definitions, synonyms and antonyms

Chinn and Kramer (2008:197-198) state that existing definitions often do not give a complete sense of meaning of the concept, but these help to clarify usages and ideas commonly associated with the concept. Existing definitions often help to identify core elements about objects, perceptions or feelings that can be represented by a word.

Existing theories and the literature provide a source of definitions that sometimes extend beyond the limits of common linguistic usages. Theoretical definitions and the way concepts are used in the context of the theory convey meanings that are related to the domain of the discipline from which the theory comes (Chinn & Kramer 2008:198).

Therefore, focus of this section was to report on the uses of the parent words such as 'spirit,' 'spiritual,' 'spirituality,' 'care' and the main concept 'spiritual nursing care.' Definitions, synonyms and antonyms of each related concept are given to assist the researcher to formulate and portray the exemplar and additional cases distinctly (Chinn & Kramer 2008:197).

2.3.5.1 Spirit

The word 'spirit' is a concrete noun. 'Spirit' is the parent word for spiritual. Villagomez (2005:286) states that spirit (a noun) can typically be traced to the Latin word 'spiritus' - soul, courage, vigour, breath or vital principle. In Greek culture, spirit is opposed to the bodily and material reality. In the Hebrew culture, spirit is opposed to death, destruction

and the negative aspects of the law, such as imposition, fear and punishment. 'Ruah', the Hebrew word for spirit translates as wind, breath and exhalation. Thus, spirit is the life force which motivates people (Bradshaw 1994:55).

Narayanasamy (2004:1142) argues that there is no authoritative single definition of the concept 'spirit,' since it is beyond the realm of subjective explanation and humanly speaking, indescribable. Reed (1992:355) adds that the phenomenon is beyond the sphere and realm of the human finite mind. It is difficult, if not impossible, to measure, explore and investigate a phenomenon which is both transcendent and a mystery.

Generally speaking, 'spirit' is considered to be the life principle that is shared with all humanity and with God. The human spirit is the dimension of personhood that drives human beings to create, love, question, contemplate and transcend. It is the soul of a person (Govier 2000:32; McEwan 2004:323; O'Brien 2002:10). The concept is further defined as exhibited in table 2.1

Table 2.1 Definitions of the concept "spirit"

MEANING DIMENSION	DEFINITION
A human attribute	<ul style="list-style-type: none"> • The essential nature of a person (Collins Essential Thesaurus 2006) • The quality of mind enabling one to face danger or hardship resolutely; a prevailing quality, as of thought (Collins Essential Thesaurus 2006) • The part of a human associated with the mind, will and feelings (Encarta World Dictionary 2007) • The principle of conscious life, mediating between body and soul (Villagomez 2005:286). • The life force manifested in love, passion, and inspiration, which motivates and connects people with the world and one another (Villagomez 2005:286)
A supernatural being or essence	<ul style="list-style-type: none"> • The soul, considered as departing from the body of a person at death (Collins Essential Thesaurus 2006) • Specifically a disembodied soul; the human soul after it has left the body (Webster Dictionary 1913)

- **Synonyms and antonyms**

Dictionary definitions and thesauruses provide synonyms and antonyms that convey commonly accepted ways in which words are used (Chinn & Kramer 2008:197). Antonyms provide contrary meanings of a concept (Chinn & Kramer 2008:197-198). They are words of opposite meaning and assist to bring about better clarity of what a concept does not mean (The Concise Oxford Dictionary, 1983:38). In an effort to explain and analyse the word 'spirit' further, synonyms that provide commonly accepted ways in which the word is used, antonyms, which express the opposite, are outlined in table 2.2.

Table 2.2 Synonyms and antonyms for the word "spirit"

Word	SYNONYMS			ANTONYMS
	Noun	Adjective	Verb	
Spirit	Life	Creatively	Purport	Body
	Morality	Essentially	Feel	Death
	Soul	Enthusiastically		Flesh
	Supernatural being	Humorously		Immorality
	Temperament	Intentionally		Inactivity
	God	Instinctively		Insignificance
	Will	Significantly		Materialism
	Heart			Natural being
	Character			Senses

Sources: *Encarta World English Dictionary 2007; Merriam-Webster Online Dictionary 2008; The American Heritage Dictionary of the English Language 2003; The Concise Oxford Dictionary 1983:1023; The Norwegian Thesaurus 1995.*

The list of words presented here above is not exhaustive.

- **A religious perspective**

In this study all discussions on religious issues allude to the Christian perspective as it is the focus of the study. However, the author acknowledges that most of the cited values and defining attributes are commensurate to other well meaning religions and belief systems.

In Christian theology, the concept Spirit is used to describe God or aspects thereof, as in Holy Spirit, referring to a Triune God (Trinity). In religious terms, the individual human 'spirit' is:

... A deeply situated aspect of the soul subject to spiritual change and growth" or "... the very seat of emotion and desire, and the transmission organ by which human beings can contact God, and relate with others, self and the environment" (O'Brien 2003:286).

The Christian Bible provides a particular perspective on "spirit". God himself, being a spirit is able to relate with man through the human spirit. The Bible text explains:

And the Lord God formed man from the dust of the ground, and breathed into his nostrils the breath of life – spirit – and man became a living soul" (New King James Version, 1994:5 - Genesis 2:7).

When a human being dies "the dust return to the earth as it was, and the spirit shall return unto God who gave it" (New King James Version 1994:365 - Ecclesiastics xii: 7).

There is no man who have power over the spirit to retain the soul, neither hath he power on the day of death" (The spirit in this perspective is seen as a gift of life from God – who has power to give it and power to take it when a person dies) (Ecclesiastics 8:8).

- ***Existential perspective***

It is generally agreed that the Danish theologian and philosopher, Soren Kierkegaard, is the first person for whose system of thought the word 'spirit' applies properly (Narayanasamy 2004:1143). Proponents of this perspective point out that it is extremely difficult in attempting to define conceptually what a spirit is. 'Spirit' is nevertheless used to refer to a characteristic that is inherent in human nature, namely an inner-state-of-being, rather than immaterial beings or substances beyond the self. Aurelius (1964), as cited by McEwan (2004:322), states that: "Nowhere can man find a quieter or more untroubled retreat than in his own soul."

2.3.5.2 Spirituality

Spirituality is a noun which denotes the essence of people's being and the purpose in being. This permeates how people live, and it brings awareness of who and what they are, what their inner resources are which shape their life journey (Dossey, Keegan, & Guzzella 2004:91). It is a personal quest for understanding answers to ultimate questions about life, meaning about relationships that are sacred or transcendent (Koenig *et al* 2001:18).

- **General definitions**

The general definitions for spirituality are incorporated in table 2.3 below:

Table 2.3 Definitions of the concept 'spirituality'

MEANING DIMENSION	DEFINITION
A human attribute	<ul style="list-style-type: none"> • That aspect of human existence that gives it its 'humanness'. It concerns the structures of significance that give meaning and direction to people's lives and helps them deal with the variations of existence. As such, it includes vital dimensions such as the quest for meaning, purpose, self-transcending knowledge, meaningful relationships, love and commitment and a sense of the Holy (Lovanio & Wallace 2007:43). • An element that is present in all individuals, which may itself manifest as inner peace and strength derived from a perceived relationship with a transcendent God or an ultimate reality or what is valued as supreme (Narayanasamy 1998:123-124)
Pertaining to the spirit	<ul style="list-style-type: none"> • Concerned with the things of the spirit (WordNet 3.0 2006)
Supernatural attribute	<ul style="list-style-type: none"> • The quality or fact of being spiritual; incorporeal or immaterial in nature (<i>Unabridged Dictionary</i> 2006)

According to Kliewer (2004:616), the definitions and expressions of what spirituality is, vary in different cultures, belief systems and religions.

- **Synonyms and antonyms**

The synonyms and antonyms of spirituality are listed in table 2.4 below:

Table 2.4 Synonyms and antonyms of ‘spirituality’

SYNONYMS	ANTONYMS
Devoutness	Body
Energy	Corporeal consciousness
Excitement	Earthliness
Higher frequency of consciousness	Externality
Human inner nature	Flesh
Ideological values	Immorality
Immaterial in nature	Irreligiousness
Inner joy	Lower frequency of consciousness
Internality	Materialism
Real you	Physical state
Religiousness	Practicality
Spiritual	Spiritlessness

Sources: *Collins Essential Thesaurus* 2006; *Encarta English Dictionary* 2006; *The American Heritage Dictionary of the English Language* 2003; *The Concise Oxford Dictionary* 1983:1023.

However, the list of words presented above is not exhaustive.

- **A religious perspective**

Ormsby and Harrington (2003:322) argue that one’s spirituality is dependent on an understanding of and relationship with God. Spirituality is regarded as a way of life that is in accordance with a religious tradition, namely:

...a way of life, informed by the moral norms of one or more religions, through which the person relates to other persons, the universe, and the transcendent in ways that promote human fulfilment (of self and others) and universal harmony (Cantazaro & McMullen 2001:222).

- ***An existential perspective***

Spirituality is regarded to be universal and integrated with all human dimensions as indicated in the following definitions:

... a universal human phenomenon that recognises the wholeness of individuals and their connectedness to a higher being, whether it is God or other; it is the integrative factor in the quest for meaning in life” (Cavendish et al 2004:199).

.. a universal experience that encompasses the whole existential domain and the very essence of what it means to be human” (Narayanasamy 2002:949).

2.3.5.3 *Spiritual*

The word “spiritual” in classical Latin is defined as “breath, wind or air,” or “of breathing, of the spirit” and “of concerning the church.” Spiritual in old French refers to: “of or concerning the spirit” especially in religious aspects (Villagomez 2005:286). Bradshaw (1994:55) explains that, in modern Western culture a spiritual person would be assumed to be disinterested in material gain or worldly concerns. Using the Hebrew definition, spiritual people (who are filled with the spirit) are far from being worldly, but are actively committed to life (Bradshaw 1994:55).

General definitions

The following are general definitions of the word 'spiritual'.

Table 2.5 Definitions for the concept "spiritual"

MEANING DIMENSION	DEFINITION
Pertaining to non-physical matters	<ul style="list-style-type: none">• Of or pertaining to, affecting or concerning the spirit or soul as distinguished from the body or material matters (<i>The Concise Oxford Dictionary</i>, 1983:1023)
Pertaining to the higher self	<ul style="list-style-type: none">• Of or pertaining to, emanating from the intellect or higher faculties of the mind (<i>Your Dictionary</i>, 2002)• Characterised by the ascendancy of the spirit; showing much refinement of thought and feeling (<i>Your Dictionary</i>, 2002)
Pertaining to morality	<ul style="list-style-type: none">• Of or pertaining to, affecting or concerning higher moral qualities (<i>The American Heritage Dictionary of the English Language</i>, 2003)• Devout, holy, pious, morally good, having spiritual tendencies or instincts (<i>The American Heritage Dictionary of the English Language</i>, 2003)
Pertaining to connectedness	<ul style="list-style-type: none">• Of, belonging or relating to others, in a spiritual relationship (<i>Collins Essential English Dictionary</i>, 2006)

- **Synonyms and antonyms**

The synonyms and antonyms of spiritual are listed in table 2.6.

Table 2.6 Synonyms and antonyms of the term ‘spiritual’

SYNONYMS	ANTONYMS
Affecting the spirit	Bodily
Cultural	Corporeal
Devotional	Flat
Godly	Fleshy
Inner	Irreligious
Intangible	Natural
Affecting the soul	Object
Transcendent	Sensual

Sources: *Collins Essential Thesaurus 2006; Encarta World English Dictionary 2006; The Concise Oxford Dictionary 1983:1023; WordNet 3.0 2003-2008.*

The list of words presented here above is also not exhaustive.

- **A religious perspective**

In Christian theology the word ‘spiritual’ denotes those characteristics or qualities, which humans possess and are not shared with other animals – moral and immortal dimensions which enable humans to have a conscious relationship with God, with others and the environment. According to this perspective the body die, but the spiritual (soul) aspect through the vehicle of the spirit goes to God (O’Brien 2003:284). This view is evidenced in the following quote:

The spiritual dimension is the intelligent and immaterial part of man, or the human soul in general, whether united with the body in life or separated from it in death, and especially that part of it which is concerned with the religious truth and action and is directly susceptible to supernatural influence” (*Oxford Dictionary of the Christian Church 1961:1281*).

- ***An existential perspective***

'Spiritual' is depicted as the essence of being human, namely:

... the essence of our being, which permeates our living and infuses our unfolding awareness of who and what we are, our purpose in being, and our inner resources that shape our life journey with self, others and God (Dossey, Keegan` & Guzzetta 2001:91).

The concept 'spiritual' is sometimes used to refer to transcendence.

Spiritual is:

... an individual existential relationship with God (Hodge, 2004:37).

... the inclination to make meaning through a sense of relatedness to dimensions that transcend the self in such a way that empowers and does not devalue the individual (Reed 1992:349).

The concept may be used to refer to a search for the meaning of life, namely:

... that part of being human that seeks meaningfulness through intra-, inter-, and transpersonal connection (Reed 1992:349).

... that dimension of humans that makes them to search for meaning and purpose in life. It entails connection to self-chosen or religious beliefs, values or practices that give meaning to life, thereby inspiring *and* motivating individuals to achieve their optimal being (Tanyi 2002:506).

2.3.5.4 Care

The word 'care' as a noun is defined as an act of taking serious attention or caution (*The Concise Oxford Dictionary* 1983:139). As a verb it denotes feeling concerned or interested in another person. In the context of spiritual nursing care, it denotes providing person centred care in which, through affirmation, humans are enabled to make the best use of all their personal and spiritual resources in facing and coping with doubts, anxieties and questions which arise in a health care setting when people (patients) are faced with health deviations. It is thus required of nurses to provide care that addresses spiritual needs for

those of different faith, denomination or of no particular faith (Gould, Berridge & Kelly 2003:30)

- **General definitions**

Definitions of the concept 'care' are incorporated in table 2.7.

Table 2.7 Definitions of the concept 'care'

MEANING DIMENSION	DEFINITION
'Care' is used as a verb:	
Pertaining to the provision of assistance	<ul style="list-style-type: none"> • Attentive assistance or treatment to those in need (Collins English Dictionary 2006). • Painstaking or watchful attention (Merriam Webster On-line Dictionary 2008). • The work of providing treatment for or attending to someone or something (Dictionary, Encyclopaedia & Thesaurus 2008). • Watchful oversight; charge or supervision (WordNet 3.0 2003-2008).
Pertaining to the protection of someone or something	<ul style="list-style-type: none"> • Judiciousness in avoiding harm or danger (Dictionary, Encyclopaedia & Thesaurus 2008). • Attention and management implying responsibility for safety (Dictionary, Encyclopaedia & Thesaurus 2008) • Careful or serious attention; caution (Dictionary, Encyclopaedia & Thesaurus 2008). • Caution in avoiding harm or danger (Merriam Webster On-line, Dictionary: 2008).
Pertaining to a state of mind	<ul style="list-style-type: none"> • A burdened state of mind, as that arising from heavy responsibility (Collins English Dictionary 2006). • A feeling of concern or interest; feeling of regard, affection or liking (Essential Thesaurus, 2006).
To act	<ul style="list-style-type: none"> • Provide treatment or care for (Collins English Dictionary 2006). • To look after or provide for (The Concise Oxford Dictionary

MEANING DIMENSION	DEFINITION
	1983). <ul style="list-style-type: none"> To provide needed assistance or watchful supervision (Dictionary, Encyclopaedia & Thesaurus 2008).
To mind	<ul style="list-style-type: none"> To have a great affection or liking for or feel tenderness for (Collins Essential Thesaurus 2006). To be worried or concerned (WordNet, 3.0 2003-2008)
Attitude (n)	<ul style="list-style-type: none"> Willingness to provide for or look after (Collins English Dictionary 2006).

- Synonyms and antonyms**

The synonyms and antonyms of “care” are listed in table 2.8

Table 2.8 Synonyms and antonyms of “care”

SYNONYMS		ANTONYMS	
NOUN		VERB	
		Be bothered	Care less
Action	Service	Be concerned	Disrespectfulness
Affection	Supervision	Caring	Feeling of no regard
Assistance	Sympathy	Handle	Indifference
Attention	Treatment	Look after	Negligence
Compassion		Mind	Unconcerned
Concern		Nurture	Unhelpfulness
Empathy		Nurse	Being disinterested
Help		Protect	Being insensitive
Kindness		Tend	Being unconcerned
Provision			Don't care
Nursing			Neglect
Respect			Never-mind
Responsibility			Overlook
Sensitivity			

Sources: *Collins Essential Thesaurus* 2006:76; *Dictionary, Encyclopaedia & Thesaurus* 2008; *Merriam Webster On-line Dictionary* 2008; *The American Heritage Dictionary of the English Language* 2006; *The Concise Oxford Dictionary* 1983:89; *WordNet, 3.0* 2003-2008.

2.3.5.5 Spiritual nursing care

Giske (1995:5) mentions that nurses very often think that spiritual nursing care is synonymous with religious care or (even more delimiting) with Christian care. The definitions below indicate that this is not the only perspective which exists. In this section the concept will be defined according to the religious and existential perspectives. According to Sawatzky and Pesut (2005:23), spiritual nursing care is at its foundational level where the spiritual expressions of a way of life such as love are lived out in the relationship of care.

- ***A religious perspective***

The nursing profession has a rich religious background (specifically in terms of Christianity, 1989:69; O'Brien 2003:2-4; Taylor 2002:13). As explained in section 1.2.2.1, it was against this religious foundation that early conceptualisations of spiritual nursing care were derived. Presumably, since its inception nursing has existed whenever people were too sick, poor and/or injured to care for themselves. According to the Christian perspective, nursing has been and is, regarded to be a calling, with a decidedly spiritual element underpinning its practice (Sawatzky & Pesut 2005:21).

A Judeo-Christian perspective on 'spiritual nursing care' is reflected in the following definitions:

... a matter of using simple ways of helping a patient understand better the true meaning and purpose in life; of nurturing his faith in God; of enlarging his/her capacity for love; of supporting and furthering his appreciation of spiritual values as opposed to those of material nature" (Hubert 1963:29 cited by Emblen 1992:45).

... supporting the faith needs of a patient, providing devotional opportunities, encouraging denominational connectedness and cooperating in pastoral care (Lane 1993:32).

... listening to the patient express key concerns; praying with the patient; reading favourite portions of religious texts; spending time with the patient or making a referral to a chaplain (O'Brien 2003:119).

- ***An existential perspective***

The existential perspective values all persons as spiritual beings regardless of their religious orientation (Burnard 1988:130). Some definitions depict spiritual nursing care as behavioural interventions involving an ethic of care that encompasses the therapeutic use of the self by a spiritually sensitive nurse.

At its foundational level, spiritual nursing care is an expression of the self defined as:

... the very way of love lived out in the relationship of care (Bradshaw 1996:43).

... a process that begins from a perspective of being with the patient in love and dialogue, which may emerge into therapeutically oriented interventions that take the direction from the patient's religious or spiritual reality" (Sawatzky & Pesut 2005:23).

... care that is embodied in the nurse's respect for a patient's dignity; display of unconditional acceptance and love; an honest nurse patient-relationship; and the fostering of hope and peace" (Bradshaw 1994:57; Taylor *et al* 1995:32).

Xiaoyan and Jezewski (2006:103) criticise this stance. They cite two nurse philosophers, namely Gadow and Curtin who stress that the concept 'spiritual nursing care' ought to be defined by the ideal nature and purpose of spiritual care provided rather than a specific set of behaviours.

Spiritual nursing care is also viewed in terms of transcendence, namely:

... care that is rendered to patients which inspires the nurse to desire to transcend the realm of the material (O'Brien 2003:131).

... an intuitive, interpersonal, altruistic, and integrative expression that is contingent on the nurses' awareness of the transcendent dimension of life that reflects reality (Sawatzky & Pesut 2005:23).

Spiritual nursing care is viewed by various authors as an important activity to help patients find meaning and purpose in their suffering and illness. Martsolf and Micklley (1998:294) cite Frankl (1988:44), who regards meaning and purpose as "the ontological significance of

life; making sense of life situations; deriving purpose in existence.” One of the earliest writers who alluded to spiritual nursing care, Dickinson (1975:1790), as cited by Martsof and Mickley (1998:296), equated it to an important activity during the time of illness when patients search for meaning and purpose of suffering and ask questions. Asking questions such as: “Why me? Is God punishing me through this sickness for my sins?” become of supreme importance as they pose a challenge to people providing spiritual nursing care to answer such questions.

2.3.6 Determining the defining attributes

According to Walker and Avant (2005:68), determining the defining attributes is an effort to try to show a cluster of attributes that are most frequently associated with the concept under study. Determining the defining attributes is the core to concept analysis. Therefore, the aim of the effort in this study was to try to group together attributes that were most frequently associated with spiritual nursing care. Defining attributes were also identified as characteristics of the concept that appeared repeatedly in the literature and were used as criteria in relating to the concept. The attributes allowed the analyst to develop a broad insight into the concept. However, the defining attributes can change as the researcher’s maturity and understanding of the concept and its applications to nursing practice develop during the process.

Martsof and Mickley (1998:298) state that attributes are often used when defining the word ‘spiritual’ according to a nursing perspective. In this grounded theory study, the defining attributes of spiritual nursing care have been derived from the uses of the concepts - spirit, spiritual, spirituality, care and spiritual nursing care. In addition to this, an extensive review of existing studies on spirituality and spiritual nursing care enabled the researcher to identify the common key attributes of the concept ‘spiritual nursing care. In this study defining or critical attributes were: the caring presence, guiding values, supporting the search for meaning and purpose, transcendence, self transcendence and harmonious connectedness.

2.3.6.1 *Caring presence*

Caring presence is defined as a feeling and a state of exhibiting concern, compassion and empathy for others (Dictionary, Encyclopaedia & Thesaurus 2008 sv “Caring”). Caring presence encompasses the concepts of being available, listening, touching and providing spiritual support (Kliwer 2004:623). Byrne (2002:69) states that the nurses’ ‘being’ is more important than their ‘doing.’ Sawatzky and Pesut (2005:21) suggest that the role of the nurse is to be available and provide care during the patients’ search for meaning and purpose in times of pain and suffering.

Touhy, Brown and Smith (2005:31) found that spiritual nursing care entails being present and available when patients experience a ‘personal crisis.’ Presence means physically appearing in a scene or being present in the place in question (The Concise Oxford Dictionary 1983:811). According to Kliwer (2004:623), the notion of a *spiritual caring presence* entails showing caring in executing activities that demonstrate connection both when a cure is possible and also when it is not. In a study conducted by Greasley *et al* (2001:634), the participants described spiritual nursing care as a loving presence; being available for patients; helping them to attain inner peace and spiritual well-being. It is through this spiritual caring presence that the values of compassion, empathy, care, respect, concern, trust and hope are made visible (Touhy *et al* (2005:31). Figure 2.1 depicts the values associated with caring presence.

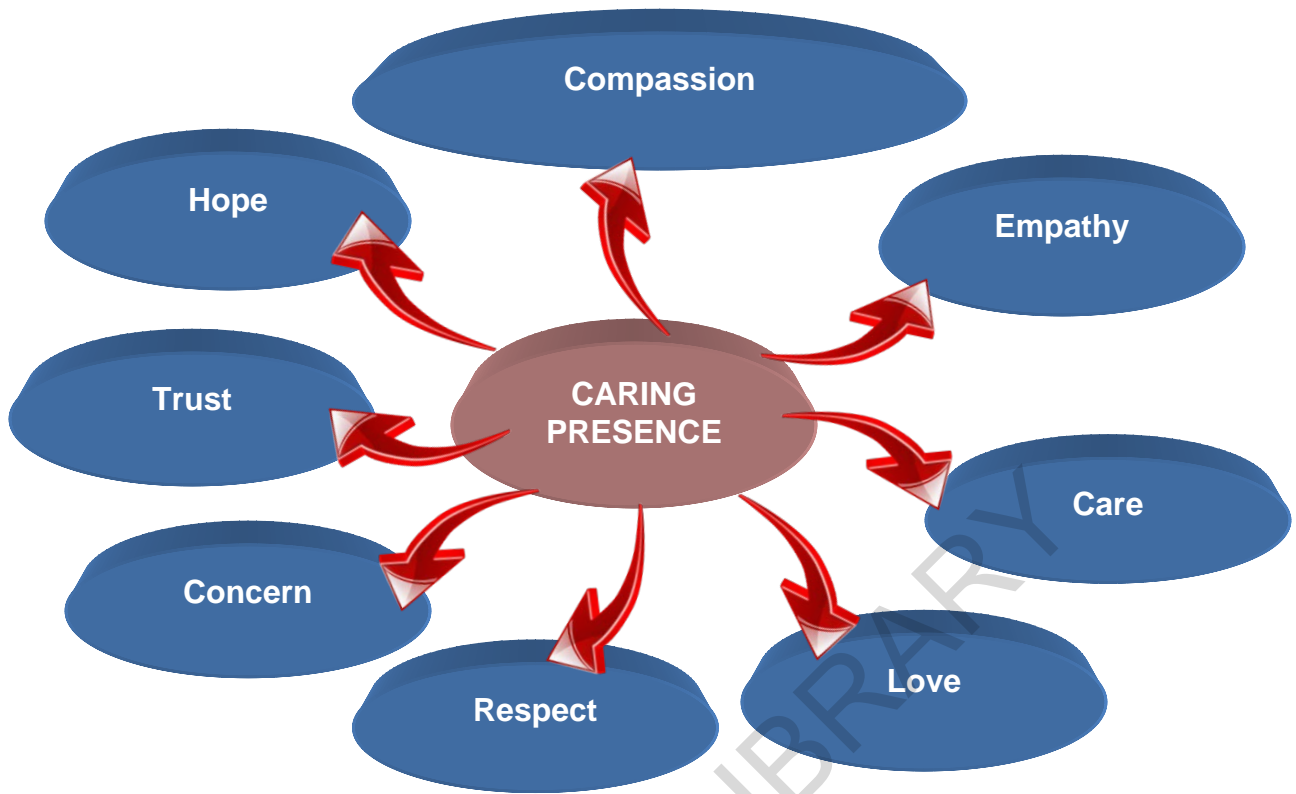


Figure 2.1 Values associated with caring presence

2.3.6.2 Guiding values

Spiritual nursing care attributes are derived from guiding values, which may apply to various belief systems or perspectives. However, the extent to which spiritual nursing care is based upon guiding values that provide hope for patients would be entirely dependent upon the content of the values (Coyle 2001:595; Stoll 1989:39; Uustal 1992:18). These values are similar to those of a caring presence, compassion, concern, empathy, care, hope, love and respect (Bradshaw, 1996:43; Greasley *et al* 2001:636; Narayanasamy & Owens 2001:451; Touhy *et al* 2005:31).

Nurses rendering spiritual nursing care express compassion, concern, empathy and interest through the care that they render (Walton 1996:240). It is through the caring presence of the nurse that the values underlying spiritual nursing care are lived out. On the

other hand, the outlined values can also be referred to as criteria for exercising spiritual nursing care. The values are discussed in the following sections.

Compassion

Compassion is defined as human quality of understanding the suffering of others and wanting to do something about it (*WordReference.com English Dictionary* 2009). According to O'Brien (2003:72), the term 'compassion,' in its Latin derivation is broadly described as meaning to "suffer" with someone, to take on the pain of their burden. Experiencing compassion entails being committed and devoted to others and refers to the sense of being truly present for the other in times of need. Compassion is demonstrated by moving physically, emotionally and intellectually closer to and spending time with the patient or family to listen to their concerns and answering their questions. The simple presence of the nurse and a gentle touch offer needed support and comfort in time of pain and suffering (Ignatavicius & Bayne 1999:210).

Empathy

According to Sawatzky and Pesut (2005:24), spiritual nursing care involves responding to patient's spiritual needs with empathy. The term "empathy" is rooted in the Greek word *empathia* which refers to affection or passion. *The Dictionary, Encyclopaedia and Thesaurus* (2008) define "empathy" as the power of entering into another's personality and imaginatively experiencing his/her feelings. It is the ability to sense and understand someone else's feelings as if they were one's own. *The Merriam-Webster Online Dictionary* (2008) defines empathy as the imaginative projection of a subjective state into an object so that the object appears to be infused with it. It further defines it as the action of understanding; being aware of; being sensitive to and vicariously experiencing the feelings, thoughts and experiences of another in the past or present, with the experience fully communicated in an objective and explicit manner. According to Bradshaw (1994:57), empathy entails being with the patient on a mental level although a physical presence is also required.

Care

Care is defined as the work of attending, helping or assisting someone or something (*WordReference.com English Dictionary* 2009). Touhy *et al* (2005:31) explain that this value is lived out as a sense of duty and devotion to God. Watson (1988:176) posits that care as a value denotes nursing practice which requires the personal, social, moral and spiritual engagement of the nurse with patients. To care for another person signifies a transpersonal process between the nurse and the patient that has the capacity to expand human consciousness and potentiate healing (Watson 1985:176).

Love

The word “love” refers to a variety of different feelings, emotional states and attitudes ranging from generic pleasure to a complexity of feelings, which makes love unusually difficult to define adequately. It is further defined as an abstract concept which refers to a deep ineffable feeling of tenderly caring for or identifying with another person. Love in its various forms acts as a major facilitator of interpersonal relationships. Christians believe that you must love God with all your heart, mind and strength and love your neighbour as yourself. God is seen as the source of this love, which is mirrored in humans and their own relationships with others. It is love that creates goodness in the world. In the context of this study, the patient is regarded as the “neighbour” of the nurse (Wikipedia 2009:1, 11). Yang, Lai and Chao (2009:102), found in their study that one of the reported spiritual needs of patients was a yearning for being with a higher being receiving unconditional love and forgiveness. Nurses are at a better position to facilitating meeting this need by utilising related spiritual nursing interventions or show that love by the way they provide care to patients.

Respect

Respect means to regard with reference, esteem or honour the other, and avoid degradation, insult or injury. It also means to treat the other person with consideration and refrain from offending or corrupting (*The Concise Oxford Dictionary*, 1983:887).

Nurses demonstrating respect accept and try to understand the patients' religious or non-religious beliefs and practices even if these differ from that of their own. Nurses regard the spiritual belief systems of their patients non-judgmentally and treat them with dignity, irrespective of their spiritual orientation. They appreciate patients' expression of their spiritual experiences and offer them support in accordance with their unique spiritual needs (Galek, Flannelly, Vane & Galek 2005:64).

Concern

According to Sawatzky and Pesut (2005:24), spiritual nursing care involves responding to a patient's spiritual needs with concern. Concern refers to marked interest or regard usually arising through a personal tie or professional relationship between two or more persons (Merriam-Webster Online Dictionary 2008 sv "concern"). Concern is also explained as a *feeling of sympathy for someone or something* (Dictionary, Encyclopaedia & Thesaurus 2008, sv "concern"). Nurses rendering spiritual nursing care to a patient demonstrate concern for patients by giving them permission to express their pain or need and respond in a nonjudgmental way. Although the nurse should show sympathy to patients, Ignatavicius and Bayne (1999:211) assert that they should not allow themselves to be overcome by their patients' suffering, but maintain the professional perspective of their involvement. When the professional perspective is lost in a nurse-patient relationship, it may encourage dependency rather than growth toward spiritual autonomy.

Trust

Trust is described by Kozier et al (2008:355) as a reliance on someone without doubt or question. To trust another person involves taking risks; patients become vulnerable when they share their feelings, thoughts and attitudes with nurses. They have to share their personal information and be touched on private parts of their bodies. Trust must therefore be an enabling value that will help patients to believe that the other person is capable of assisting in times of physical, psychological and spiritual distress (Kozier et al 2008:355)

Hope

Hope means to cherish a desire with anticipation (Merriam-Webster Online Dictionary 2008 sv "hope"). According to O'Brien (2003:179-180), hope (noun) is the anticipation that something desired will occur. The act of hoping (verb) is the "focussing of attention, affectivity and commitment to action toward a future goal of fulfilment in God and the realisation of the reign of God". A nurse rendering spiritual nursing care demonstrates this value by acknowledging the difficulties with which those patients must contend and validating their feelings and fears while planting seeds of expectation quietly and unobtrusively that the situation will improve. They help patients to believe in themselves as survivors, in the nursing and medical regimens to which they are subjected and, above all, in God or the omnipotent power who will help them cope with or overcome the distressful situation (Ignatavicius & Bayne 1999:211).

2.3.6.3 *Spiritual nursing Interventions*

Rankin and DeLashmutt (2006:282) define spiritual nursing interventions as approaches that nurses incorporate into patient care practices to nurture the spirit, such as providing care, being available, empathetic and respecting spiritual beliefs of patients, engaging in prayer, providing spiritually edifying reading material or soothing music of choice. O'Brien (2003:128) cautions that in order to minister effectively to those who are ill, two important principles pertaining to spiritual nursing intervention must be kept in mind. First, the nurse needs to understand that provision of spiritual nursing care cannot be based on a procedure book or orders because each person has a unique spirituality. Second, the nurse must be spiritually supportive, recognise the need to seek outside spiritual counselling either for his/her own personal needs or for the patient when the situation warrants.

In this study, some of the defining attributes such as the search for meaning, transcendence and self transcendence and harmonious interconnectedness provide guidance on specific nursing interventions to be employed to meet the spiritual needs of patients.

2.3.6.4 Search for meaning and purpose

According to Frankl (1969:37), meaning can be experienced through creative action, which addresses difficult situations such as health crises, pain, guilt and death. According to Burkhardt (1989:72) and Coyle (2001:594), spiritual nursing care is a sense of “unfolding mystery” related to one’s attempt to help another human being to understand the purpose and meaning of life in the midst of pain and suffering. This search focuses on the ontological significance of life, which makes sense of life situations and finds purpose in the human existence (Burbank 1992:20; Frankl 1969:38). Hall (1997:83) argues from the existentialistic point of view that nurses that render spiritual nursing care assist their patients, who may be religious or not, to seek answers for their questions about the meaning and purpose of their illness or suffering. Burbank (1992:20) adds that such an attempt assists nurses to provide care that helps patients who are sick or in pain to find a reason for living in time and space and give them hope.

Interventions depicting the type of care provided to patients who are in search of the meaning and purpose of pain, sickness and suffering refer to spiritual nursing care in the following ways:

... assisting individuals and families not just to cope with illness and suffering but to find meaning and purpose in these experiences (McEwan 2004:322).

... helping those who are suffering to reflect upon and find meaning and purpose in their experiences (Govier 2000:32).

... providing person centred assistance which, through affirmation, enables humans to make the best use of all their personal and spiritual resources in facing and coping with the doubts, anxieties and questions which arise in a health care setting and often accompany ill health and suffering”(Gould, Berridge & Kelly 2003:28).

... care that has to do with man’s need to find satisfactory answers to his ultimate questions about meaning of life, illness and death (Reed 1992:354).

Common strategies that were identified in literature that nurses can use as spiritual nursing interventions when meeting the spiritual needs of patients searching for meaning and purpose in times of suffering are spiritual dialogue, spiritual competency, self-awareness

and spiritual sensitivity.

Spiritual dialogue

Dialogue means a conversation between people or a discussion between representatives of two groups or exchange of proposals (*The Concise Oxford Dictionary* 1983:264). Mahaffey (2008:1) explains that the concept 'dialogue' comes from the Greek words *dia* and *logos*. *Dia* means *through* and *logos* mean the *mind of God*. Dialogue can be viewed as a stream of meanings that are expressed between two people engaged in a discussion as a result of which, new understandings emerge. Spiritual dialogue is the means through which patients are assisted to discover personal meaning in their circumstances of pain and suffering it is through this person-to-person conversation about God or spiritual matters that nurtures the soul that growth for both the patient and the nurse towards spiritual health occurs (Mayer 1992:27; McGrath 1997:10). Ross (1994:442) explains that spiritual nursing care entails engaging in spiritual dialogue with patients who are experiencing spiritual distress.

However, Tanyi, Recine, Werner and Sperstad (2006:537) are of the opinion that when patients desire to engage in spiritual dialogue, nurses should be encouraged to feel comfortable with addressing the topic irrespective of religious orientation. Some nurses, according to the study findings, were reluctant to do so because they regard spiritual issues as sensitive and private matters.

Byrne (2002:69) states that the presence of the nurse and the spiritual language used whether positive or negative can influence the patients' search for meaning and purpose.

Spiritual competency

According to Hodge (2004:39), spiritual competency is understood as a more specific form of cultural competency with:

- Knowledge of one's own spiritual worldview and associated biases.
- An empathetic understanding of the client's questions and ability to answer them.

- The ability to develop intervention strategies that are appropriate, relevant and sensitive to the client's spiritual worldview.

Van Leeuwen and Cusveller (2004:237) posit that nurses need to develop spiritual competencies that will empower them on how to handle their own values, convictions and feelings in their professional relationship with patients of different cultures, beliefs and religions. Findings from a study by Labun (1988:318) revealed that most patients who come to the healthcare environment for help are often persons with no well-defined philosophical or religious beliefs. They may, however, still wish to explore their feelings, values and develop an understanding of life. To do this, they need the involvement of another person who is spiritually competent to discuss these areas of concern, answer their questions concerning the meaning and purpose of their difficult circumstances and share common experiences. The challenge is to develop spiritually competent nurses who are able to meet the unique spiritual needs of patients and handle their own spiritual concerns and questions competently.

Self- awareness

Self-awareness is defined as awareness of one's own individuality, including one's traits, feelings, and behaviours (Dictionary, Encyclopaedia & Thesaurus 2008; Merriam-Webster Online Dictionary 2008). Nurses who are required to support patients in their search for meaning and purpose are required to develop and demonstrate the ability to reflect on their own nature, spirituality and life. They need to have knowledge of own spiritual worldview and associated biases in order to provide meaningful support to those experiencing pain, suffering or terminal illness (Sawatzky & Pesut 2005:24).

Spiritual self-awareness is a transcendent awareness that entails understanding that individuals have the ability to find meaning in their circumstances in a manner that empowers them to reach beyond themselves to achieve spiritual freedom and completeness (Sawatzky & Pesut 2005:24). Through spiritual self-awareness the person's inner resources are enhanced and the self is strengthened (Sawatzky & Pesut 2005:24). This enables the person (nurse) to render spiritual nursing care from a position of inner-

strength. Hall (1997:91) adds a perspective that states that self-awareness is described as 'self-in-relation' to others.

This transcendent self awareness is developed within the context of a relationship with God and involves being a perpetual learner in spiritual things (Sawatzky & Pesut, 2005:24). Hall (1997:91) adds that self awareness is developed by loving oneself and being in love, caring, being in touch with others and giving to them.

Spiritual sensitivity

To be sensitive is to be delicately aware of the attitudes and feelings of others (Merriam-Webster Online Dictionary, sv "sensitivity" 2008). Nurses who possess this understanding are able to demonstrate spiritual sensitivity that enables nurses to deal with matters such as suffering, hopelessness and spiritual dysfunction of others competently (Burkhardt 1994:13).

Spiritual nursing care is given and received in a context in which the recipient is physically and/or emotionally vulnerable and receptive to the spiritual perspective of the caregiver (Conco 1995:262). Spiritual intrusiveness during times of patient vulnerability is always a potential risk. This can cause discomfort and hinder effective spiritual communication with the patients. While intrusiveness during times of patient vulnerability can be detrimental to spiritual nursing care, the avoidance of discussing spiritual matters with patients is equally problematic (McSherry & Draper 1998:688; Narayanasamy & Owens 2001:452). Nurses should therefore, be sensitive and recognise when the spiritual needs of patients should be attended to and also recognise the dangers inherent in spiritual intrusiveness.

A study conducted by Narayanasamy and Owens (2001:452) revealed several approaches towards developing spiritual sensitivity. The nurses who adopted a *cultural interactionist* approach recognised and respected the customs of the different cultures/religions. The patients' cultural identity gave nurses a vital clue as to what course of action should be initiated to meet their spiritual needs. A *personal approach* entailed describing religious needs in non-religious terms. Nurses who adopted this approach were willing to give time

and attention to patients and engage in all aspects of patient care. This approach helped them to invest in building a nurse-patient relationship. The *counselling* approach entailed supporting patients during the critical stages of their illness. A small number of nurses gave accounts of spiritual care incidences that could be described as an *evangelical approach*. In terms of this approach, nurses share the gospel with patients spontaneously, reading sacred texts and praying for and with those in need of prayer.

2.3.6.5 Transcendence and self-transcendence

Transcendence is the process of going beyond our current limitations and gaining a wider perspective of self and the universe. For human beings, transcendence is part of how the world is experienced (Armstrong 2008). Spiritual caregivers, as is the case in this study, experience the grace that allows them to be aware of the infinite consciousness of God's help for both themselves and their patients in times of suffering. McEwan (2004:324), states that the essence of spiritual nursing care is encouraging patients to have faith in God and to find the purpose in life in relation to their illness or disease. Spiritual nursing care enhances a transcendent relationship with the divine. In this relationship, patients become aware of a higher source of power, help, solace and intervention through faith. It is demonstrated by the use of transcendent strategies such as prayer, scripture reading or meditation. In a study conducted by Coyle (2001:595), participants stressed that transcendence and connectedness to God provided them with hope and meaning in the face of adversity. This is confirmed by Mayer (1992:31) and Touhy *et al* (2005:31) who believe that the loving and spiritually sensitive care by a nurse brings hope to the patient.

On the other hand, self-transcendence is described as an experience of growing into one's unfulfilled potential. It is the process of extending oneself both inwardly in introspective activities and outwardly in relationships with others (Reed 1992:351). Self-transcendence means to be able to reach out beyond oneself, to encounter a higher being or other human beings to fulfil meaning and purpose (Frankl 1969:18, 19, 31). Coyle (2001:594-595) explains that essence of being is self-transcendence which is the process of going beyond one's current limitations to improve and better oneself, physically, mentally and spiritually. It involves a personal journey to self-discovery. In this spiritual self transcendence, the

nurse assists the patient to practice a form of self transcendence that leads to the attainment of true satisfaction.

In the transcendence and self transcendence process and patients are assisted to reach out to God and others, grow to reach their potential and overcome difficult circumstances.

Assisting patients to reach out to God

Participants in Coyle's (2001:595) study believed that prayer and reading the Bible were fundamental ways of reaching out to God as they believed that this activity provided patients with something to work through to control their illnesses or suffering. They regarded meeting with God in this way and sharing values with those who thought the same way as themselves, as profoundly meaningful and providing purpose and healing.

Assisting patients to reaching out to others

Transcendence is seen as an experience and appreciation of a dimension beyond the self and that which expands self-boundaries (Reed 1991a:10). In the health care setting it is seen as helping patients to move beyond themselves and their circumstances by reaching out to others and participating in meaningful activities to improve and better the health and spiritual well-being of others. For example, a patient who is HIV positive and has adjusted well to treatment and general care can reach out to newly diagnosed patients to assist them to cope and have hope.

Assisting patients in their personal growth

Through the transcendence process nurses enhance the ability of patients to rise above their instincts and drives, and grow beyond themselves. In this respect, humans have an innate propensity to grow. They have a coping resource that allows them to overcome difficult circumstances by connecting with God in faith or higher power, faith in the self in a way that helps them to cope beyond what they are normally capable of achieving (Frankl 1969:88-89). This occurs because humans have the potential to self-transcend, namely to

choose their attitude towards adversity, rise above adverse conditions and circumstances and attain a sense of inner-peace (Frankl 1969:113).

To grow in difficult times requires personal effort and willingness to change. At the heart of self-transcendence is the spiritual concept that humans have the potential to change and grow into a more illuminating nature and gain a wider perspective of the true self. Growing into one's true self relates to when people are able to become what they want to be, to be fully themselves in each moment; to abide in inner stability and knowledge of one's centre and to transcend the limitations of self and self constructions. These limitations can be due to pain, sickness, disease or injury (Lloyed & O'Connor 2007:169). However, challenges experienced by patients such as illnesses or injury are seen as opportunities for spiritual growth. Inherent in those times of suffering and pain is spiritual growth and autonomy (Sawatzky & Pesut 2005:29-30). Personal growth for both patients and nurses alike, who possess spiritual integrity, is possible as they engage in honest, healthy relationships with God, others, themselves and the environment (Walton 1996:243).

Assisting patients to overcome their current circumstances

Transcendence denotes to be able to rise above adverse conditions and circumstances, namely suffering. It is the ability to think about and take a stand against suffering and do something about it (Frankl 1969:16, 74, 75). Frankl (1969:88-89) posits that humans are called upon to change themselves when faced with situations that cannot be changed. This requires self-detachment, namely to be able to joke about themselves and their own fears and choose their attitudes in the face of adversity. Findings obtained from a study conducted by Galek *et al* (2005:63, 66), emphasise the value of what he termed 'positive transcendence' for patients. Nurses are to help patients through positive transcendence to connect hopefully with possibilities and realities beyond the self; possibilities that will give them a sense of peace, contentment and a positive outlook in spite of the challenge of sickness.

2.3.6.6 *Harmonious interconnectedness*

Stoll (1989:88) suggests that a person's spirituality consists of a vertical and a horizontal dimension or axis. The vertical dimension is associated with a person's transcendent relationship with God. The horizontal dimension reflects a person's beliefs, values, lifestyle and those human environmental elements and interactions of human existence.

Burkhardt (1989:70, 72) explains that harmonious interconnectedness is manifested in healthy relationships with God, the self, others and the environment. Harmonious interconnectedness based on giving and receiving love brings about meaning and fulfilment to life and provides a purpose for living in the face of challenges (Coyle 2001:594; Harrison, 1993:213; Walton 1996:243). This relationship is further discussed as transpersonal, intrapersonal, interpersonal and environmental interconnectedness.

Transpersonal connectedness

Transpersonal connectedness refers to a meaningful relationship with God. This is made possible by creating opportunities for religious practices such as prayer, Bible reading, personal, group and corporate worship, which will enable patients to derive a sense of peace or a source of strength from their faith, beliefs and values (O'Brien 2003:128). Values such as forgiveness, love, hope and trust can be experienced in a transpersonal relationship (Miner-Williams 2005:66). The nurse acts as the key person to provide such spiritual guidance or refer patients to others in the faith community such as chaplains, pastors or recognised spiritual agents based on the patient's choice (Burkhardt 1989:72; Coyle 2001:594; Walton 1996:243).

Intrapersonal connectedness

Intrapersonal connectedness focuses on what is called the 'potentiality of the self.' This has been called the capacity for inner knowing and a source of inner strength; a resource that is always present. Intrapersonal connectedness, by definition involves religious contemplation of one's inner self and leads to developing a deeper understanding of the

self and others (Coyle 2001:592-593). Religious contemplation, as O'Brien (2003:133) suggests, is a mental prayer that helps individuals draw innate strength from God. By implication, spiritual nursing care entails assisting patients to draw on their inner strength in times of illness and referring them to spiritual workers, psychologists, social workers when necessary.

Interpersonal connectedness

Spiritual nursing care entails promoting patients' harmonious relationship with others, including the nurse. Interpersonal connectedness is a source of social support from family and friends that enhances a feeling of belonging. According to the participants in a qualitative study conducted by Narayanasamy and Owens (2001:451), spiritual nursing care involves a nurse-patient relationship which is characterised by mutuality and based on an equal partnership that prompts feelings of trust, respect and security (Narayanasamy & Owens 2001:45).

Healthy interpersonal relationships encourage patients to express their views, fears, anxieties and gain new insights and awareness about their circumstances (Narayanasamy, 1999:283). People find meaning and self-expression in their healthy relationships with others, who may be the nurse, other members of the health care team, family, friends, other patients and God (Young *et al.*, 2004:102). These relationships are characterised by patients being free to discuss their spiritual needs without fear. Nurses in such a relationship are aware of and understand their own spirituality. Both parties are able to discuss, clarify and deal with spiritual matters in a healthy and understandable way. Greasley *et al.*, (2001:636) contend that to be connected to others harmoniously, they should have excellent verbal and non-verbal communication skills as well as an attitude of warmth, respect and empathy.

Environmental connectedness

The environment refers to all external and internal factors that influence and contribute to the vulnerability of both nurses and patients in that space. The factors can be:

- physical factors such as climate, temperature, food and facilities,
- socio-economic factors such as resources, support systems, culture and
- educational, biological and spiritual factors such as spiritual language, spiritual objects or people. (Young *et al* 2004:168).

Nurses have the responsibility to integrate spiritual nursing care in a way that facilitates patients' connectedness with nature and its creator. Nightingale's theory (1957), as cited by Kozier, Erb & Wilkinson (1998:46), focuses on the environment. The five environmental factors pertaining to spiritual nursing care are fresh air, pure water, light, efficient drainage and cleanliness. These factors attained significance in the 1800s in terms of their connectedness with the spiritual health of patients. For example, a gift of fresh flowers for a sick patient brings comfort; a walk in the garden and the joy of fresh air, cleanliness of the units and warmth are soothing elements in the environment (Mayer 1992:27).

The use of symbols in the environment such as the Bible, religious soft music, religious pictures, Christian artefacts, such as the cross and spiritual language used by nurses in the wards when communicating with patients, promote spiritual connectedness with the supreme being that created the environment. This enhances the development of inner strength and peace to face the challenges of sickness, pain, suffering or even death. Findings of a study conducted by Sun, Long, Boore and Tsao (2005:87) on the connectedness of patients with the psychiatric ward environment demonstrated that a symbolic environment within the context of spiritual nursing care had a spiritual impact that helped the patients to become calm and reduce their destructive psychiatric behaviour.

Nurses who render spiritual nursing care need to be sensitive in the provision of a therapeutic environment that provides privacy. Environmental measures that are appropriate to the person or situation should be conducive to comfort and the relief of spiritual distress.

2.3.7 Antecedents and consequences of spiritual nursing care

Antecedents and consequences are said to be helpful in further refining the defining attributes (Walker & Avant (2005:73).

Antecedents are those events or incidents that must occur prior to the occurrence of the concept. Furthermore, antecedents may shed considerable light on the social contexts in which the concept is generally used. They help theorists to identify underlying assumptions about the concept being studied. Consequences, on the other hand, are those events or incidents that occur as a result of the occurrence of the concept – in other words, the outcomes of the concept (Walker & Avant 2005:72-73).

2.3.7.1 Antecedents

The events or incidents that support the search for meaning and purpose as discussed under section 2.3.6.3 and that must occur before spiritual nursing care can be realised, are discussed below. They are:

Spiritual competency which is essential as indicated earlier in the text because nurses require the necessary knowledge, skills, insight and confidence to handle the different phases of the nursing process and contextual conditions for providing spiritual nursing care.

Self-awareness, which is a prerequisite because nurses need knowledge of their own spiritual worldview and associated biases in order to develop the ability to handle the spiritual needs of those under that care.

Spiritual sensitivity that enables nurses to identify the patients' spiritual needs accurately, recognises the presence of spiritual distress and render spiritual nursing care at the right moment without imposing their views and beliefs on the patient. Nurses need to have an empathetic understanding of the patient's spiritual worldview (Sawatzky & Pesut 2005:30).

Spiritual discomfort requires the rendering of spiritual nursing care to patients who have to cope with illness, disease or injury and who express spiritual distress or spiritual pain that is beyond physical treatment.

Trust relationship is also an important antecedent so that patients may view the nurse as honest, open, and concerned about their welfare. They must feel comfortable talking to the nurse about sensitive issues and that their cultural and spiritual beliefs will be respected (Kozier et al 2008:355)..

2.3.7.2 Consequences

The consequences of spiritual nursing care are the result of the care rendered Sawatzky and Pesut (2005:29) agree that just as spiritual nursing care must reflect the patient's reality, so should the outcomes.

Consequences are useful in determining frequently neglected ideas, variables or relationships that may yield fruitful new research questions and directions, hypothesis and theory development (Meraviglia1999:25). The consequences commonly identified in literature are spiritual integrity, a heightened sense of well-being and spiritual health.

Spiritual integrity is present as an outcome when a person experiences growth in self-awareness. Labun (1988:318) defines spiritual integrity as the person's experience of wholeness within the self, with other human beings and in transcendence with God. Wholeness within the self, as explained by O'Brien (2003:9), refers to being closely attuned to the body, mind and spirit connection.

A heightened sense of well-being is characterised by specific outcomes such as spiritual well-being and spiritual health. Spiritual well-being is an affirmation of life in a relationship with God, the self, others, the community and the environment that nurtures and celebrates wholeness. People who enjoy spiritual well-being tend to feel generally alive, purposeful and fulfilled (Labun 1988:318).

Spiritual health is defined by O' Brien (2002:98) as a state of well-being and equilibrium in that part of the person's essence and existence which transcends the realm of the natural.

Although antecedents and outcomes are often dealt with in passing in concept analysis, they do shed considerable light on the social contexts in which the concept is generally used.

2.3.8 The social context of spiritual nursing care

Social context in this study refers to the social environment in which spiritual nursing care is provided. It begins with the social interaction between the nurse and the patient as they constitute a faith community within the health care context. Nurses or other religious agents provide spiritual care and the patient is the recipient of such care depending on its content and acceptability. Prayers, Bible reading and singing spiritual songs are common features of such an environment. These may be conducted by nurses who are spiritually competent to do so. Visits from hospital chaplains, Christian workers, family, friends or religious groups that visit patients in hospitals from the outside, are mostly spiritual in nature and complement the spiritual nursing care provided by nurses in the wards. Bibles and Christian literature are commonly placed in hospital wards to create a spiritually oriented context.

Patients and nurses often come from different cultural and religious backgrounds and maintain unique belief systems and values, which in some instances, complicate the context in which spiritual nursing care is to be provided. In fact their cultural and religious orientations affect how they perceive their spirituality, spiritual needs and the spiritual nursing care offered. It becomes relatively easy to render spiritual nursing care if the caregiver and patient are of the same faith or spiritual orientation. However, nurses have to respect the patient's faith and establish common ground for corporate devotional worship (Narayanasamy & Owens 2001:452-453).

Spiritual nursing care is presented in diverse health care settings. Participants in this study worked in various health care contexts such as the ICU, medical, surgical, paediatric units

and primary health care settings. They cared for patients who suffered from acute and chronic medical and surgical conditions including HIV and AIDS. The social context, values displayed and spiritual language used contribute towards clarifying the meaning of spiritual nursing care. When an exemplar case is placed in these different social contexts, avenues for perceiving the important values of care and to make deliberate choices concerning them are created (Chinn & Kramer 2008:203; Du Toit 2003:33).

2.3.9 Case studies to summarise the defining attributes of spiritual nursing care

As one examines various sources of evidence, it is essential to test the soundness of one's conceptualisation of the concept in the light of the indicated purpose. According to Chinn & Kramer (2008:204), this is done by developing an exemplar, contrary and related cases to evaluate the criteria applied to the concept.

Developing an exemplar case

An exemplar case is an example of a case where all the defining attributes, values and synonyms of the concept are applied (Walker & Avant 2005:69). Wilson (1963), as cited by Walker and Avant (2005:69), suggests that the model case is one in which the analyst may say, "Well, if that isn't an example of it, then nothing is."

An exemplar case describes or depicts a situation, event or experience that resembles the true explanation of a concept. The case may be drawn from nursing practice, literature, art, film or any other source in which the concept is represented or symbolised. Regardless of the format used for the presentation, the case is selected because it represents the concept to the best of one's present understanding of it. Some concepts are relatively easy to present; while others are abstract and difficult. Usually exemplar cases of abstract meaning are concepts that involve experiences and circumstances that are described in words.

While working with exemplar cases one may ask a question, such as, "What makes this an instance of this concept?" An answer to this question or these ideas becomes the criteria for the concept. The criteria are designed to make it possible to recognise the concept

when it occurs and to differentiate it from related concepts. In these instances, the exemplar case is similar to the definitional form of the concept (Chinn & Kramer 2008:196).

After the conceptual issue has been stated clearly, one can proceed to the investigation of model examples in the use of the concept that is to be analysed. Such a model example is a typical, classic, generally accepted, and stereotyped use of the concept (Du Toit 2003:28-30).

The following is a case study depicting the concept of 'spiritual nursing care.' The case study was adapted from that outlined in Sawatzky and Pesut (2005:24). Previous personal experiences of the researcher with neurology patients were incorporated in this case study to provide the required meaning.

Case study 1 Exemplar case

Nurse A works in a neurological unit. John, a middle aged patient, was involved in a car accident as a result of alcohol abuse. He is known to lead an irresponsible lifestyle that is characterised by heavy drinking and a disregard for his family and social responsibilities. John is currently recuperating from a severe head injury and multiple fractures. He is therefore a long term patient and is following an extended rehabilitation program.

Nurse A is committed to speaking words of encouragement that bring hope to her patients. She describes her own spirituality in terms of her Christian faith as someone who is committed to expressing love, hope, kindness and compassionate care to patients. Daily Nurse A seeks ways to connect with her patients on a spiritual level and helps them connect meaningfully with the transcendent realm to transcend their personal circumstances. She prays before going to work that God will help her to be sensitive and aware of her own spiritual beliefs as a professional nurse and that of her patients. She seeks to respect her patient's beliefs and values, while attending to their spiritual needs as part of holistic patient care competently.

On a given day, Nurse A attends to John and observes that he appears restless and anxious in-spite of all the physical and medical care given. Being spiritually sensitive, she

recognises that John may be spiritually distressed. The nurse sets aside some time to engage in dialogue with the patient. She makes John comfortable and gives him a cup of warm milk. She shows concern and touches his hand as a supportive gesture and encourages him to talk. In addition, she listens attentively without interrupting him. John shares his feelings of guilt about his drinking life style and his fears and frustrations surrounding his injuries. He also confides to the nurse about the impact this situation has on his life, family, job and beliefs: "Maybe this is how God tries to talk to me, because my reckless living has to come to a halt somehow."

The nurse shows concern for how John feels and continues to give him undivided attention. John continues by asking: "You know nurse, I feel guilty and irresponsible on how I have conducted myself and treated my family. Do you think God and my family will forgive me?" Nurse A answers John without condemning or judging him and shows him respect as a spiritual being even if the patient is non-religious, "We have the gift of life, strength and courage to make right of all the wrongs of the past and go on with life positively. God is ready to forgive you; you also should, in turn, forgive others and yourself and remember you are a valuable human being, worthy of love and forgiveness." John responded: "I appreciate the fact that you took time to listen to me sincerely, talk to me and answer my questions. I feel much better after this conversation". Nurse A makes a commitment to continue the discussion when John is ready to do so.

John asks Nurse A to pray with him. She agrees and they pray together. After this, Nurse A leaves the bedside to attend to other patients. She feels grateful for the experience. John appears to be more relaxed, and an obvious connection has developed that permeates the rest of her interactions with John. They continue in this relationship that provides growth for both the nurse and the patient regarding good health and spiritual well-being. In addition, Nurse A contacts John's family to come and see him at the hospital and facilitates the healing of the relationship of John with his family.

As the relationship of trust between nurse A and John grows over time, their discussions evolve around issues of self-forgiveness, love, hope and connection with others and the transcendent power of God. At one point, Nurse A, suggests that John joins a support

group and she also introduces him to a much younger patient with similar circumstances who is in need of support. John eventually joins the support group and becomes a mentor for this younger patient. John recovers at a remarkable rate that baffles the other members of the health team in the unit. Nurse A's spiritual interaction with John continues whenever she is on duty until the day of his discharge.

This case study contains all the critical attributes of spiritual nursing care. John clearly experiences impairment in that he experiences a sense of disconnectedness with himself, others and God. Nurse A responds spontaneously to his need for someone to listen and talk to him with a spiritual caring presence, treating him with compassion, concern and empathy. She demonstrates the ability to engage in spiritual dialogue about the spiritual issues that he raises in an effort to find meaning and purpose in his circumstances. She takes deliberate action to meet his spiritual needs as initiated by the patient, in particular regarding the need to pray. She refrains from imposing her religious orientation on him but acts on a cue from him that he is trying to find meaning in his circumstances in terms of receiving a lesson from God. There is evidence that she promotes transpersonal, intrapersonal, interpersonal and environmental interconnectedness. Transcendence is promoted by assisting John to reach out to God and others by later becoming a mentor to the younger patients in similar circumstances. Importantly, John was encouraged to move beyond himself and his circumstances.

Case study 2: Contrary to spiritual nursing care

Examining additional cases that may be contrary or related to spiritual nursing care, is another part of conceptual internal dialogue in order to rule out what does not count as a defining attribute (Walker & Avant 2005:70). This may require the application of antonyms. The basic purpose of constructing additional cases is to come to a decision regarding the attributes of the model case. Walker and Avant (2005:70) argue that teasing out the defining attributes of a model case that most closely represents the concept of interest may be difficult because the attributes may overlap with those of some other related cases. However, examining cases that are not exactly the same as the concept of interest will help the researcher make better judgments about which defining attributes or characteristics fit

best. The basic purpose of these cases is to help the researcher to decide what “counts” and what does not count. The additional cases are the contrary, related, and borderline cases.

Walker and Avant (2005:71) state that contrary cases are clear cases that do not comply with the concept. Wilson (1993), as cited by Walker and Avant (2005:71), states what can be said of the contrary case: ‘Well, whatever the concept is, that is certainly not an instance of it.’

- ***Developing contrary cases***

Contrary cases according to Chinn and Kramer (2008:201), are those that certainly do not conform to the selected concept. They may be similar in some respects, but they represent something that most observers easily see as significantly different from the concept that is examined. By comparing the differences between exemplar and contrary cases, one begins to revise and refine the tentative criteria.

Although not all concepts have natural opposites in language, it is sometimes easier to explicate the meaning by describing the opposite rather than the model situation (Du Toit 2003:30-31).

The following contrary case is indicative of a failure to render spiritual nursing care.

Case study 2

In contrast with case study 1 involving John, Nurse B is known to be hard working and has little time to talk to patients about spiritual matters. She describes herself as a very busy and competent person and believes that a nurse should always be productive. In her opinion, spiritual matters should be attended to in a church and not a hospital. Nurse B considers herself to be trained to render nursing care and not spiritual care.

On this particular day, a student nurse reports to Nurse B that John appears restless and anxious in spite of the analgesic given. Nurse B checks John’s profile in terms of his vital signs and the additional prescribed medication for pain on the computer without going to

see the patient. She then administers the additional pain medication and attends to his positioning. Her conversation with John is focussed on his physical condition and matters pertaining to the pain medication. She then asks the student nurse to tidy up his physical environment.

However, John continues to appear anxious and restless despite the pain medication. John says to Nurse B: "Maybe this is how God is trying to talk to me because my reckless living has to come to a halt somehow." Nurse B does not respond to this remark. John continues to ask "You know, nurse, I feel guilty and irresponsible because of the way I conducted myself and treated my family. Do you think God and my family will forgive me?" Nurse B answers John: "I don't believe that God has anything to do with your circumstances. You made some bad choices and your present circumstances are the consequences of those choices."

Nurse B informs John that she will ask the doctor to prescribe sedatives as well and that this will make him feel much better. She then calls the doctor to come and "see the patient in bed number four" who is very restless and to prescribe a sedative for him. The doctor complies and Nurse B commences with the administration of the sedatives. Nurse B then writes a progress report on John, referring to his pain, anxiety and restlessness and her interventions. She also reports on the fact that the doctor will prescribe sedatives to relieve the restlessness. She does not return to talk to John. John subsequently becomes withdrawn and does not give further indication of his spiritual needs. Nurse B then reports that the sedatives are effective because John appears to be relaxed.

The case contrasts with case study 1 as the nurse refrains from engaging the patient on a spiritual level or meeting his spiritual needs. She cannot answer his questions which signify a search for meaning in and purpose of his suffering. Although his physical needs are met in terms of medication, she fails to provide a spiritual caring presence through listening, kindness, compassion and mutual partnership. No harmonious connectedness with God, others, the self or environment is promoted. In short, the nurse fails to meet the spiritual needs of the patient and shows spiritual insensitivity even when the patient expresses spiritual distress.

Case study 3: Related case study depicting pastoral care

- ***Developing related cases***

Related cases are described by Chinn and Kramer (2008:201) as instances that represent a different albeit a similar concept. Related cases often share several criteria with the concept being clarified, but one or more criteria will not be associated with the selected concept.

Grey (1996:20) contends that it may not be easy to differentiate between the concepts related to psychological therapy, theological counselling and spiritual nursing care.

Walker and Avant (2005:71) explain that related cases are those cases that demonstrate ideas that are very similar to the main concept, but differ when examined closely. Related cases have names of their own and should be identified by their names in the analysis. The following related cases are indicative of this confusion.

Case study 3

Referring to case study 1 involving John, Nurse C is doing her normal ward rounds and observes that John is restless and anxious. She finishes her ward rounds and returns to John's bedside. She enquires about what is bothering him. She listens attentively without interrupting him. John shares his feelings of guilt about his drinking life style, and his fears and frustrations surrounding his injuries. He also confides in the nurse about the impact this situation has on his life, family, job and beliefs. "Maybe this is how God is trying to talk to me because my reckless living has to come to a halt somehow."

Nurse C realises that the patient has spiritual needs beside his physical needs but feels too uncomfortable and inadequate to do anything about it. She then calls a pastoral counsellor to come and listen to his story and help him, after which the nurse goes away and continues with her other duties. The pastoral counsellor arrives four hours later as he has been busy in other units. John is already distraught and withdrawn and the pastor sits down to listen to his story. He then reads the Bible and prays with John and even lays

hands on him. He places a Bible at John's bedside and recommends relevant sections, which John could read. The pastoral counsellor returns to discuss these sections with John after he has read them and tells him that God loves him.

The pastoral counsellor then arranges for regular counselling sessions with John. He invites John to contact him if he needs to further discuss faith issues arising from his circumstances. John appears visibly relieved and thanks the pastoral counsellor for making him feel that spiritual support is available to him.

Case study 4: Related case study depicting psychological care

Referring to case study 1 involving John, Nurse D is known to be hard working and has little time to talk to patients about spiritual matters. She describes herself as a very busy and professionally competent person and believes that a nurse should always be productive. In her opinion, spiritual matters should be attended to in a church and not a hospital. Nurse D considers herself to be trained to render nursing care and not spiritual care.

On this particular day, a student nurse reports to nurse D that John appears restless and anxious in spite of the analgesic given. Nurse D checks John's record in terms of his vital signs and the additional prescribed medication for pain on the computer without going to see the patient. She then administers the additional pain medication. Her conversation with the student about John focuses on his physical condition and matters pertaining to the pain medication. She then instructs the student nurse to administer the pain medication.

However, John continues to appear anxious and restless despite the pain medication given. He calls for Nurse D who comes to see him and tells her: "Maybe this is how God is trying to talk to me because my reckless living has to come to a halt somehow." Nurse D does not respond to this remark. John continues to speak to her "You know nurse, I feel guilty and irresponsible about the way I conducted myself and treated my family. Do you think God and my family will forgive me?" Nurse D answers John: "I don't believe that God

has anything to do with your circumstances. You made some bad choices and your present circumstances are the consequences of those choices.”

Nurse D informs John that she will ask the doctor to prescribe sedatives as well and that this will make him feel much better. She then calls the doctor to come and “see the patient in bed number four” who is very restless and to prescribe a sedative for him. The doctor complies and nurse D commences with the administration of the sedatives. Nurse D then writes a progress report on John, referring to his pain, anxiety and restlessness, and her interventions. She also reports on the fact that the doctor prescribed sedatives to relieve the restlessness. She does not return to talk to John. John subsequently becomes withdrawn and does not give further indication of his spiritual needs. Nurse D then reports that the sedatives are effective because John appears to be asleep.

Referring to the model case involving John, nurse D interprets John’s remarks as indicative that he is in psychological/emotional distress. She reassures the patient that he will be referred to a clinical psychologist to help him to overcome the psychological issues which underpin his reckless lifestyle. She explains to John that this psychologist will also help him to come to grips with his present circumstances. Nurse D arranges for an initial appointment with the psychologist and a series of weekly follow-up sessions. The first session occurs the following day. In addition to this, the psychologist arranges for his participation in group therapy sessions. John completes his psychology group therapy sessions and continues to be an active participant in the support group. Nurse D continues to talk with John on a regular basis. She constantly reassures him that the health care team are competent and that everything will work out well for him.

In section 1.2.2.1 it was mentioned that nurses have problems with recognising the spiritual needs of patients and tend to equate their spiritual needs with psychological/emotional or religious needs. Although pastoral care and the care rendered by psychologists or others could contribute to the spiritual wellbeing of patients to a certain extent, these do not constitute or replace the need for spiritual nursing care (McShery 2004:43). Grey (1996:23) states that although psychological care is a useful perspective to incorporate in the

understanding of spiritual nursing care; it may be difficult to differentiate between spiritual and psychological care. Spiritual needs are often mistaken for psychosocial needs.

Although Nurses C and D involve the services of a pastoral counsellor (religious care) and psychologist respectively, they do not render spiritual nursing care. The pastoral counsellor and psychologist are able to meet some of John's needs, but his need for spiritual nursing care is unmet. Spiritual nursing care is rendered during episodes of routine patient care. Nurses spend more time with patients than any other member of the health team, and ample opportunity therefore exists for spiritual nursing care.

2.4 CONCLUSION

In this chapter, the literature review was done on the basis of a concept analysis. Various methods of concept analysis were explored, described and then employed to structure an applicable strategy to analyse the concept 'spiritual nursing care.' Definitions, synonyms and antonyms of the concepts 'spirit,' 'spiritual,' 'spirituality,' 'care' and 'spiritual nursing care' were extracted from dictionaries, thesauruses and authentic discipline literature. The religious and existential perspectives of the principal concepts were outlined. The analysis process was also utilised to extract the defining attributes of the concept 'spiritual nursing care' from literature. In addition, a model and contrary and additional cases were presented to demonstrate what the defining attributes are and what they are not. The antecedents, consequences of spiritual nursing care and the social context where spiritual nursing care is provided were also discussed. Nolan and Crawford (1997:286) confirm that the task to analyse the concept 'spiritual nursing care' has already begun and it was continued in this dissertation and provided a basis for data collection, analysis and interpretation. The concept analysis process also assisted the researcher to develop a model on spiritual nursing care.

Chapter 3 discusses the philosophical base of the study.

CHAPTER 3

Theoretical foundation to the study: symbolic interactionism

3.1 INTRODUCTION

Symbolic interactionism (SI) seeks to explain relationships among human beings and human beings and their environment in this study. SI has been selected as the theoretical foundation to complement the grounded theory design used. A brief discussion on the symbolic interactionism in terms of its historical background, definitions, main focus and major concepts is presented as well as its application to this study is presented.

The philosophy was chosen by the researcher because of its social constructionist approach to understanding social life that focuses on how reality is constructed by active and creative role actors who in this study are the nurse and the patient. The researcher had interest to investigate how nurses create meaning during their social interaction with patients in the context of provision of spiritual nursing. The theory seemed appropriate to assist the researcher to identify how nurses in a health care context construct their identity ('I', 'me, and 'self') as professionals and how they define situations that impacts on the demand to provide holistic patient care. One of the central ideas of the perspective is that people act as they do because of how they define situations. It is also concerned with the way of how individuals and people from different cultures and religious backgrounds interpret symbols of communication and how behaviour is influenced towards the other (Blumer1969:7). The tenets of the philosophy are amenable to qualitative methods of research which was the research approach of choice for this study.

3.2 DEFINITIONS OF SYMBOLIC INTERACTIONISM

Definitions of symbolic interactions indicate that this concept is used to refer to a theory, a process and an investigative approach.

Symbolic interactionism as a theory is defined as:

“... a theory which focuses on the manner in which people make sense of social interactions and the interpretations they attach to social symbols such as language” (Blumer 1969:16).

“... an approach that focuses on symbols and meaning in interaction” (Glaser 1978:47; Glaser & Strauss 1967:45; Strauss 1987:78-85).

“... an interactionist theory, which helps to illuminate how human beings define their experiences and give meaning to their identities, behaviours, realities and social interactions (Hewitt 2000:49)

“... a sociological perspective that stresses the way societies are created through the interactions of individuals” (Dictionary of the Social Sciences 1987).

Symbolic interactionism as a process is defined as:

“... a process of interaction that leads to the formation of meanings for individuals” (Blumer 1969:12).

“... the peculiar and distinctive character of how humans interact with one another” (Blumer 1969:18).

“... a very complex process by which ideas are converted into social facts” (Dictionary of Critical Sociology 1989).

Symbolic interactionism as an investigative approach is defined as:

“... a study of the intersections of interaction, biography and social structure in a particular historic moment” (Denzin 1989b:15).

“... a social constructionist approach to the understanding of social life that focuses on how reality is constructed by active and creative actors through their interaction with others” (Rice & Ezzy 2002:17-18).

SI can therefore be defined as a conceptualisation of communication between and amongst individuals or individual and the environment using language, actions, behaviour, expressions and objects to create meaning. In this study, SI relates to the analysis of the provision of spiritual nursing care as a social process of interaction or relationship between the nurses and the patient in a health care environment.

3.3 HISTORICAL ORIENTATION ON SYMBOLIC INTERACTIONISM

Symbolic interactionism is one of the important theoretical perspectives in sociology and social psychology (Griffin 1997:19) which has its roots in American sociology (Rice & Ezzy 2002:17-18). It has a long intellectual history, beginning with Weber (1864-1920), who was a German social psychologist from Chicago sociological tradition, who believed that human beings are best understood in a practical and interactive relation to others and their environment (Goffman 1958:12-13). This notion is relevant to the current study that seeks to explore how nurses provide spiritual nursing care in the context of health care.

Mead (1863-1947), as cited in Jeon (2004:250), is considered to be the founder and philosophical progenitor of symbolic interactionism. Amongst the classic American pragmatists, Mead was the principal precursor of SI. Mead's (1934:7) interest in symbolic interactionism was prompted by essentially philosophical questions concerning the essence of language, its perceptual process and epistemological implications, and the prerequisites for scientific enquiry. While Mead's contribution was primarily philosophical, Blumer (1969), who further advanced SI, was more concerned with aspects of sociological theory and research approach (Blumer 1969:7; Goffman 1958:12-13; Griffin 1997:18; Jeon 2004:250; Lynch & McConatha 2006:89). Blumer (1969:1) explains that SI represents a "relatively distinct approach to the study of human group life and human conduct", and has practical consequences in its bearing to human interest and behaviour. In this instance, SI seeks to explore the conduct of nurses in nursing units as they relate with patients who experience spiritual distress.

Goffman (1958:12) used the SI approach to examine human interaction in social settings. He developed a method of analysis of the interaction order or environments between and amongst people

In his research, Goffman (1974:7) has outlined the various elements that make up the joint actions of interacting individuals. These are:

- Interaction involves two or more individuals taking one another's point of view.
- Interaction occurs in social settings which can be physically located and described.
- Social objects fill social settings and will be acted on by the individuals under study.
- When taking one another's perspective, individuals use a set of rules that guides and shapes their on-going interactions. These rules may be civil, legal or spiritual in nature. The rules are usually relational and specific to the individuals in question. People in relationships typically act in terms of rules and understandings unique to their relationship. Goffman (1974:13) also clarifies that saving face in a social setting is part of the code or rules that actors use in social interaction.
- All interactions involve relationships. These may be with strangers, friends, colleagues or civil acquaintances. The total amount of time two or more individuals spend in one another's presence is termed the *occasion* of interaction.
- Every focused exchange between these individuals is termed an *encounter*. Social situations furnish the occasions of interaction, which in turn produce the conditions for encounters.
- The interaction process is filtered through social identities.

Goffman's (1958:235) method is considered the best in the analysis of the interaction between the nurse and the patient who are in one another's space day and night during a time when patients experience pain, sickness, suffering or even death.

3.4 MAIN FOCUS OF SYMBOLIC INTERACTIONISM

SI conceptualises social reality as symbolic, communicated and subjective in both form and content (*Dictionary of Social Sciences* 1987). Theoretically, SI serves as a framework for viewing the social world. The context of health care where patients suffer

from HIV/AIDS, asthma, injuries, acute, chronic and terminal illness was identified as the social world of the participants and their patients. It clarifies the existence of a social reality but does not suggest any preconceived ideas of such a reality. It is used to evaluate human interaction, particularly the behaviour and actions and responses to the communication process involved in human interaction (Griffin 1997:27; Meltzer 1978:11). Nurses are the first point of contact for patients within the health care system. In the units nurses play a key role in meeting the patient's needs including referral to the appropriate members of the health care team such as the hospital chaplain. The fundamental theoretical concern of SI involves obtaining an understanding of human beings in interaction. Spiritual nursing care interventions include taking direction from the patient's perspective because patients come in with their own belief systems which must be respected and incorporated into their care (Denzin 1989a:5). Symbolic interactionism is therefore a perspective through which social behaviour can be studied and understood (Benzes & Allen 2000:543).

SI stresses the many ways that human and psycho-social interaction takes. These are linguistic and gestural communication and particularly the role of language (*Dictionary of Critical Sociology* 1989).

Denzin (1995:37) argues that to understand the pragmatics of human behaviour, it is important to understand the basic premises of SI. Often nurses have the ability to make sense of patient's physical ailments and to a certain extent their psychological and social experiences as a result of their illnesses but find it difficult to make sense of their spiritual distress. Blumer (1969:6) contends that the basic premises of symbolic interactionism are rooted in Mead's (1934:39) basic tenets of 'I', 'Me' and 'self' and the inner conversation that is continually occurring between people and their environments in the context of social interaction. Mead (1934:40) suggests that the premises of symbolic interactionism are as follows:

- Firstly, human beings act and react towards people and things on the basis of the meanings that they assign to those people or things.

- Secondly, the meanings which humans attach to people and things are derived from or arise out of the social interaction that they have with others and the society.
- Thirdly, these meanings are handled in, and modified through an interpretative process used by humans in dealing with the people and things that they encounter.

Although the first premise may not seem to represent a position distinct from other philosophical perspectives, Blumer (1969:2) asserts that it makes a point on its own right, especially in the context of the time when the understanding of human beings as active agents in the construction of the social world was seriously questioned. The other two premises were acknowledged as significant for SI as they specify that the use of meanings by the actor occurs through a process of interpretation (Blumer 1969:5; Jeon 2004:251).

Crooks (2001:14) have outlined other aspects that underpin symbolic interactionism where he states that:

- Human beings are endowed with a capacity for thought and that capacity is shaped by social interaction.
- Through social interaction people learn the meanings and symbols essential to the expression of thought.
- This understanding in turn allows people to carry out actions and interactions.
- As people interpret their situations, they modify their meanings and symbols used in interaction.
- Interaction within the self and with others allows people to understand a situation and make choices.

Symbolic interactionism according to Blumer (1969: 21), “provides the essentials for a provocative philosophical scheme that is peculiarly attuned to people’s social experience”. It is seen as a perspective in empirical social science designed to yield verifiable knowledge of the human group life, conduct or act (Blumer 1969: 21)

To explain this further, the premises and the core principles of SI as presented by Blumer (1969:2) and Denzin (1989a) are applied in analysing and interpreting data collected for this study.

3.4.1 Philosophical underpinnings of symbolic interactionism

The philosophical underpinnings of symbolic interactionism are pragmatism and social behaviourism.

3.4.1.1 Pragmatism

Pragmatists maintain that human beings go through a continuing process of adaptation in the constantly changing social world, and that the existence of a mind through which contemplation of a situation occurs makes this process possible (Griffin 1997:18; Jeon 2004:252). Denzin (1989a:5) claims that the pragmatism of symbolic interactionism rests on three basic assumptions, namely that:

- Social reality is sensed, known and understood as a social production. Interacting individuals produce and define their own situations.
- Humans are assumed to be capable of engaging in self-reflexive behaviour. They are capable of shaping and guiding their own behaviour and that of others.
- In the course of taking a standpoint and fitting that standpoint to the behaviour of others, humans interact with one another. Interaction is therefore seen as symbolic because it conveys messages in terms of symbols, words, gestures, meanings and languages.

In the context of this study pragmatism defines the wards where patients are cared for as the social world where they have to continuously adapt to a sick role. They interact with nurses, other members of the health team and visitors. Nurses as professionals render care which is expected to be holistic in nature.

3.4.1.2 Social behaviourism

Proponents of the SI philosophy indicate that symbolic Interactionism has evolved principally from social behaviourism (Dictionary of Social Sciences 1987). The distinction between human beings and lower animals is in the response to various stimuli in the environment. With lower animals the response is instinctive. According to psychology, the response takes place immediately without the influence of interpretation or assigning of meaning (Blumer 1969:18). Animals are unable to conceive alternative responses to the stimuli (Herman & Reynolds 1994:10). In humans, human cognition interrupts the stimulus-response process. In human life, cooperation is influenced by conscious thinking rather than instinct and biological programming. This understanding should not be taken to indicate that humans never behave in a strict stimulus-response fashion, but rather that humans have the capability of not responding in that fashion (Herman & Reynolds 1994:10). When people are sick or injured they think and attach meaning to their situation, objects and symbols such as prayer, an empathetic touch or Bible text. Therefore, the stimulus-cognition-response concept according to this theory may be influenced by interaction with the health team.

In contrast to psychological behaviourism, social behaviourists maintain that the subjective meaning of human behaviour is not determined by the objective facts of a situation, but by the meanings people ascribe to it. In other words the objective world has no reality for humans, only subjectively defined objects have meaning. This notion concurs with the arguments put forth by qualitative researchers, that naturalistic enquiry allows people to share from their life experiences, encounters and meaning they attach to these encounters or experiences. Closed ended questions in research do not allow the researchers to ask probing questions that give the participants opportunity to narrate or fully express themselves (Herman & Reynolds 1994:13).

Social behaviourists maintain that subjective interpretations of reality impact on and influence social behaviour (Herman & Reynolds 1994:13). They view individuals as active interpreters of the world around them. Individuals are seen as actors in situations, and they act on the definitions they assign to persons, objects and events that comprise the situations they experience (Dictionary of Social Sciences 1987). Behaviour is

viewed as social not simply when it is a response to others, but rather when it has incorporated in it the behaviour of others (Herman & Reynolds, 1994:13).

For this enquiry the researcher had to conduct a qualitative research, ask open ended questions that probed into the subject of interest to allow for narration and full expression.

3.4.2 The creation of meaning

SI emphasises the subjective meaning of human behaviour, and provides guidance in understanding the establishment of meaning of that behaviour in context (Griffin 1997:15). Jeon (2004:252) believes that 'meaning' is one of the major elements in understanding human behaviour. The author claims that to reach a full understanding of a social process, the enquirer needs to 'grasp' the meaning of behaviour as interpreted and communicated by participants in a particular context. Like phenomenologists, this theorist emphasises an individual's lived experience, the concept of meaning as perceived by the individual and understanding of a situation from the individual's point of view. In the health care context nurses have their own world view on spirituality which may be different from that of patients meaning or understanding of spiritual nursing care, which may be positive or negative, is created and communicated to patients through behaviour towards them.

3.4.2.1 *Meaning: the construction of social meaning*

Symbolic interactionism places emphasis on the importance of meaning and interpretation as essential human processes. This perspective is concerned with the emergence of meaning in human interaction, namely how meanings are formed and how individuals interpret these meanings and act upon them. Meanings are the definitions that individuals attach to the full range of objects, (i.e. physical, cultural, social, religious and political) and actions that comprise their life world. The meaning of objects lies in the actions that human beings undertake with or toward or against the objects such as words of hope given by nurses (Griffin 1997:28; Blumer 1969:16; Burnier 2005:502). Spiritual nursing care may involve objects such as the nurse herself,

religious books or gospel tracts, the cross, the Bible or other religious artefacts whose meaning may influence the actions of both the nurse and the patient.

Interactionists view meaning formation as a process that is ongoing, fluid and emergent as people actively engage to make sense of the world around them and the situation they find themselves in. Individuals in their social world are free to find their own meaning in interactions with other humans or objects (Denzin 1989a:5). Meanings emerge through social interaction with the self, others, and the environment (Griffin 1997:28; Blumer 1969:16; Burnier 2005:502). Meaning becomes the basis for individual and collective action. People create shared meanings through their interactions, and those meanings become a reality (Griffin 1997:28; Blumer 1969:186; Burnier 2005:502).

In interactions therefore, meanings are continually created, recreated and modified through an interpretative process (Blumer 1969:18-19). A person's formation and use of meaning in specific situations calls upon previously held meanings (Blumer 1969:13). Although individual and collective meanings change over time, they also persist over time in the form of established cultural, organisational, political, religious and societal meanings (Burnier 2005:503).

Blumer (1969:13) further argues that the interpretive process for meaning depends on the context in which it is done. Situations are the 'specific arrangements of things' that are confronted by individuals. In these situations there may be people, objects, symbols and events which are defined and interpreted in terms of place and time. In this study actors are nurses and patients in a health care facility in sickness, pain, suffering or even death. Spiritual nursing care and the related objects or symbols may be interpreted by both to have meaning or no meaning for quality health care depending on the spiritual competency of the nurse and her spiritual self awareness.

Meanings are communicated through various symbols such as words, language, actions, dress and facial expressions exemplified as gestures, location and time (Turner & Stets 2005:100). Symbols are a powerful means of communication. For example there are symbols that indicate measurements universally such as SI units, police signs, etc.

3.4.2.2 Language: the source of meaning

According to Griffin (1997:54), symbolism expressed through language is the element that differentiates humans from other species. Human language composed mainly of words and a capability to interpret these gives humans a means by which to negotiate meaning through symbols. Humans communicate meaning in speech and in actions (Turner & Stets 2005:100).

Language is the most complex social act in which people engage in (Meltzer, Petras & Reynolds (1975: 543). Language, in Mead's view, is a significant symbol which is usually vocal and calls out to make a similar response. For example in this study it is necessary for the nurse to use a language that is understood by the patient. Significant communication is achieved when people can reach one another through language (Cronk 1973:316).

Differences in language can lead to misinterpretation of meanings attached to actions or responses and can easily lead to communication problems (Griffin 1997:27).

Symbols and meaning

Human beings can communicate in a variety of ways commonly identified in SI as symbols of communication. Where word of mouth cannot be uttered, symbols such as gestures are just as good. Meaningful communication can take place through gestures. SI emphasise the mutual sending and interpreting of gestures that carry conventional meanings. Gestures are symbolic and are a form of language said through facial expressions, bodily countenance, behaviour, dress, pictures and artefacts that carry meanings. Gestures as symbols should mean the same thing to the sending and receiving parties in interaction. SI depicts the social world as individuals read the gestures of others in word or body language and communicate with one another (Turner & Stets 2005:101-102).

According to Herman and Reynolds (1994:13), there is human communication of infrahuman communication. Infrahuman refers to an organised being endowed with less perceptibility than humans, have inferior mental development and no power to articulate

speech (*The Concise Oxford Dictionary* 1983:485). The authors assert that human beings interpret and assign meaning to gestures, while infrahuman communication, although gestural, has no interpretation or assigning of meaning to it. Human communication is meaningful in that gestures are symbolic and humans interpret them and assign meaning to them. It is necessary that there is consensus in meaning. Human communication is meaningful in that gestures are symbolic and do not invoke immediate responses. Humans must interpret gestures and assign meaning to them (Herman & Reynolds 1994:10; Turner & Stets 2005:102).

The meaning of gestures must be shared and understood by the individuals involved in the interaction or as observed by others. It is through the exchange of gestures at the face to face level of communication that culture shapes how individuals define situations or react emotionally, or regulate their conduct (Turner & Stets 2005:102).

SI also highlights the significance of mutual expression and interpretation of what Mead termed conventional gestures. One person's gestures serve as a stimulus to others. By virtue of reading each other's gestures individuals can formulate a response thereby articulate a possible course of action. This notion is supported by Herman and Reynolds (1994:10), who contends that gestures by others become a kind of a mirror or "looking glass" through which people can reflect their own thoughts or frame of mind in a given situation. Further discussions on thought in relation to symbolic interactionism are integrated in section 3.4.3.1 that deliberates on the *mind* as one of the core principles of the theory.

3.4.3 Concepts related to Symbolic Interactionism

The major concepts of symbolic interactionism are "mind", "self", "society" and "role taking". As infants grow, they start interacting with significant others in a particular context or society acquire a mind of their own, develop 'self' and assume the role of others (Jeon, 2004:250). These concepts are demonstrated in figure 3.1

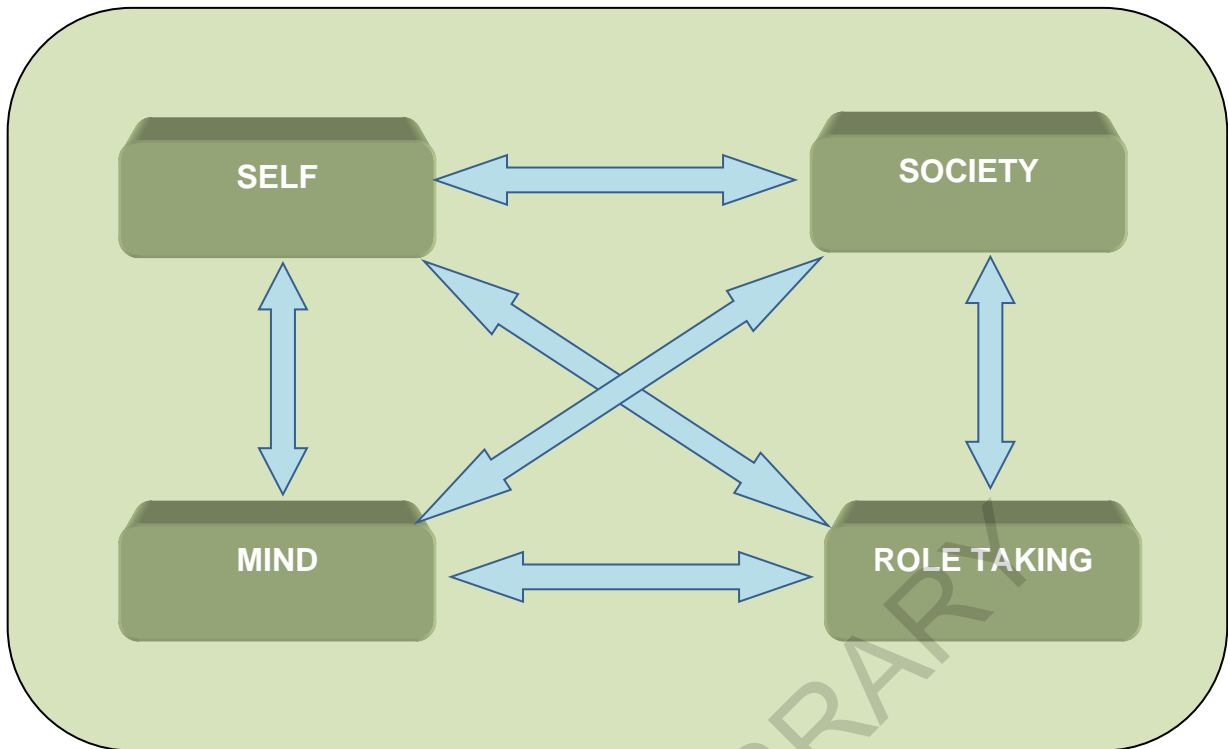


Figure 3.1 *Diagrammatic representation of the major concepts
Of SI*

(Adapted from Van der Wal 1992:38)

The arrows indicate horizontal, vertical and diagonal interplay or interlinkages between the concepts as discussed in the ensuing sections.

3.4.3.1 *Mind*

Herman and Reynolds (1994:13) state that the mind is a functional, volitional, teleological entity serving the interests of an individual. Humans are endowed with the capacity to think as determined by social interaction. According to Charon (1989:96), as cited in Herman and Reynolds (1994:13), the individual pursues interests, values and goals, in particular life situations through the use of thought. Crooks (2001:15) confirm that the action of person in a given situation is based on thought which is interactive and expending. Through the use of the mind humans develop an active relationship with the self, others and the environment. Therefore in a human being the mind develops and matures to complexity of function.

The mind uses and interprets symbols that are directed to the self, others and the environment (Meltzer 1978:20). In this sense the *mind* manifest whenever the individual is interacting with the self, others and the environment using significant symbols or gestures, interpreting these and assigning meanings (Meltzer 1978:21). Humans acquire their own mind and self while interacting with others in a given society. The self and the mind are twin emergents in the social process. They mirror others' behaviours, and develop unique ways to communicate symbolically with increasing interactions (Blumer 1969:11).

3.4.3.2 Self

The self refers to the conscious, reflective personality of the individual. Meltzer (1978:13-17) states that "self" is the entity a person envisions when one thinks about who one is. According to Goffman (1974:11-12), the self is *firstly* an image derived from the perceptions and responses of others. *Secondly* it is the individual's personal possession, in that it defines the individual and provides the individual with "security and pleasure". The concept of self is framed according to meaning, language and thought. The self is a function of a language, without talk there can be no self concept. Thought is mental conversation that requires different points of view and interpretation of what one's concept of self means to others in a given situation. Mead further develops the theory of self to state that 'self' is not merely the passive reflection of the generalised other. It is composed of two phases or poles which are the 'me' which is the socialised phase of self and 'I' which is the response phase of the 'me' (Blumer 1969:13).

To further clarify Mead's concept, the "self" is differentiated into two parts, namely a spontaneous "I" and a socially determined "me". The "I" is the initial impulsive tendency in individuals to provide an identity (similar to Freud's notion of the Id). The 'I' is the spontaneous, unorganised aspect of human existence. The 'I' in the context of this study is the identity (whether expressed or not) a patient assigns her/himself regardless of the 'me' which could be the temporary identity assigned to her/him by the nurse as bed 4 or diabetic patient. The "me" represents the expectations of others.

The self as a combination of 'I' and me is flexible but constrained by the realities of these two components (Goffman 1974:12). Action begins in the form of the "I" and ends in the form of the "me". The "I" is creative and spontaneous and contributes to change in society. The "me", being regulatory, works to maintain society. Thus in the concept of *self* is a powerful and comprehensive understanding of how humans function in a dynamic society. Goffman (1974:12) also notes that the social self is a social product because it is given by others and can be withdrawn by them.

The concept of the self arises in social interaction with others. Humans develop a sense of the self as they learn to see themselves the way they believe others see them. The self is also creative and purposive (Herman & Reynolds 1994:13; Rice & Ezzy 2002:17). Mead (1934:12) views the self as a socially emergent entity which is not initially present at birth, but develops over time. As such professions develop a sense of identity. The self of nurses as providers of spiritual nursing care is believed to develop during the education and training period. The day to day contact with patients in the context of health care exposes nurses to situations and experiences of encountering patients with a variety of needs. In the nurse-patient relationship, the self develops through the process of social experiences and nursing activities in the units and other relationships with other members of the health team or faith community within the environment of patient care (Cronk 1973:315).

Blumer (1969:12) views self as a uniquely human attribute developed through a continuous process of social interaction within a given environment and conceptualised over time. The reality of the environment and self is therefore socially constructed. The self is therefore a process, continuously created and recreated in each social interaction that one engages with. Feedback from these interactions enables individuals to be aware of how others perceive them and hence develop a perception of 'self'. Through continual patterned and regular social interaction between nurses and patients, a view on spiritual nursing care is formed based on "we" who is the nursing team, "they" who are the patients and "us" in the context of nurse-patient relationship (Lynch & McConatha 2006:89, 92).

3.4.3.3 Society

The social context for interaction is society. Society develops as a result of the interwoven patterns of interaction and action. Society is a linguistic or symbolic construct arising out of the social process and it consists of individuals interacting with one another (Herman & Reynolds 1994:13). Symbolic interactionists challenge the idea that a social system possesses structure and regularity. They argue that society has no objective reality aside from individual interaction. They consequently focus on the way that individuals, through their interpretations of social situations and behavioural negotiations with others, give meaning to social interaction and create society through this. The role of medical and nursing culture and social structure in giving shape, direction and meaning to social interaction is however acknowledged (*Dictionary of the Social Sciences* 1987).

SI perspective shares light that the individual is in some deterministic fashion shaped by the society. Its position is that individuals are a creation of society just as they are equally creators of society (Timasheff & Theodorson 1976:272).

Therefore, according to interactionists nurses are responsible for the organisation, definitions and interpretation of nursing care, holistic nursing care and spiritual nursing care and should interrogate the meaning they assign to these (Burnier 2005:503).

3.4.3.4 Role taking

Role taking is an activity, where, according to Shott (1979:1317-1334), individuals are empathetic in their relationships with others. Human beings in their interactions portray actors that put themselves in the position of the other person to become a symbolic object for people to respond to based on the meaning they assign to the behaviour. The response is usually in accordance with the interpretation and meaning assigned to the behaviour (Blumer 1969:11; Goffman 1958:11). Thus, individuals take themselves as actors in a given situation and evaluate their actions and selves through thought (Rice & Ezzy 2002:17). In this instance thought is an internalised conversation with oneself which through the process of role taking shapes ones understanding of others and oneself (Shott 1979:1324).

Role taking allows people to take the other's perspective, and to determine the meanings which other human beings whom they interact with, who are patients and other health care team members attach to their actions. The thought process modifies and develops each individual's interpretation of the role taken by the other and the meanings attached to it (Blumer 1969:12).

By role taking humans are able to obtain a certain degree of objectivity about the way others view them. In time, humans come to expect particular responses from others based on the responses of specific individuals to which they have become accustomed. These responses that can be anticipated have been organised into a system of normative standards (Blumer 1969:19).

This then provides a basis for human interaction within the context of health in particular nursing care specific to spiritual nursing care.

3.4.4 Human interaction

Human interaction is explained by the fact that humans interpret or define each other's actions and react to each other's actions based on the meaning they attach to such actions. Interaction between human beings is mediated by the use of symbols, thought, interpretation and meaning attached to actions (Blumer 1969:14).

3.4.4.1 Human action

Human action in the context of SI is defined as self directed conduct which is constructed by a human actor to cope with the world. The ongoing process of action brings meaning in relationships between people and their environment. In order to act, the individual has to identify what he wants or needs in a relationship, map out a prospective line of conduct, note and interpret the actions of others, know the rules of the group, assess the situation and know how to handle this (Blumer 1969:14, 70). The act comprises both overt and covert aspects of human action. The meaning of any significant act is given in its performance (Rice & Ezzy 2002:17).

Therefore the essence of human interaction is where people act as they do because of how they interpret or define situations they find themselves in (Lewis 1976:349). This notion is supported in the principles of symbolic interactionism as presented by Shott (1979:1321) where he states that:

- The study of the actors' definitions and interpretations of other peoples' actions is essential for an understanding of human behaviour.
- Human behaviour is dynamic and is continually constructed during its execution and can be transformed through reinterpretation and redefinition (Blumer 1969:12).
- The actions of people are influenced by their internal states in addition to external stimuli, which shape the actor's understanding, perception and interpretation of situations (Mead 1934:23-25).
- Social structures are the framework of human action which shapes behaviour without dictating it. Structural elements such as culture, religion, roles or systems shape behaviour by influencing the situation. These structures therefore influence rather than determine human behaviour (Blumer 1969:17-18).

Therefore the individual can act with a certain amount of consistency in a variety of situations because the actions are in accordance with a generalised set of expectations, definitions and interpretations which the individual has internalised (Meltzer 1978:14).

3.4.4.2 Interaction

Interaction refers to creating and recreating the patterns and structures that bring society to life (Blumer 1969:17). Symbolic interactionists assume that face-to-face interaction occurs in social situations and that humans learn their basic symbols, their conception of self and the definitions that they attach to social objects through interaction with others. The interaction of nurses with patients in the units and student nurses when interacting with their teachers on the curriculum content on spiritual nursing care is a case in point. Each person simultaneously carries on conversations with his or her own-self and with significant others which in this study are God (Denzin 1989a:5).

Human experiences take on meaning as they become symbolically significant through shared interaction (Rice & Ezzy 2002:18). Symbolic interactionists state that behaviour is observable at the interaction level and that meaning comes out of the interaction between people. People interact with each other by interpreting or defining each other's actions instead of merely reacting to each other's actions.

Human interaction is mediated by the use of symbols and assigning of meaning and significance to these. To reach a full understanding of a social process, an enquirer needs to grasp the 'meanings' that are experienced by participants in an interaction process within a particular context. Human behaviour and the roles that people play are negotiated in a process of interaction and consequently change over a period of time depending on the situation and context (Blumer 1969:14).

In this study, the temporary product was the interaction and relationship between the nurse and the patient during hospital stay.

3.4.5 Application of symbolic interactionism to this study

SI in this study served as a theoretical framework for research into the social world of the participants. Methodologically, it provided a broad framework of argumentation which guided the researcher in making choices regarding the research process congruent to the fundamental nature of human beings, in this instance nurses and patients. The approach was thus appropriate to eliciting data from in-depth individual and focus groups interviews in accordance with the way in which nurses constitute social reality for providing spiritual nursing care to patients (Meltzer 1978:11).

3.4.5.1 Symbolic interactionism and qualitative research

Symbolic interactionism as a well known perspective for qualitative enquiry was applicable to this qualitative study on the development of substantive theory on the provision of spiritual nursing care (Morse & Field 1995:13). Symbolic interactionists advocate for a qualitative methodology because they see meaning as the fundamental component of society and human interaction (Rice & Ezzy (2002:18). Polit and Beck (2008:250) explain that symbolic interactionists sometimes use semiotics, which refers

to the study of signs and their meanings. A sign is any entity or object that carries information and examples in this study could be a bible, a cross, posture of prayer like closed eyes, physical touch as laying of hands or pictures of religious literature or religious books.

The importance of symbolic interactionism to qualitative inquiry is its distinctive emphasis on the importance of symbols and the interpretative processes that undergird interactions as fundamental to understanding human behaviour. Methods of symbolic interactionism also emphasise the importance of paying attention to how particular interactions give rise to symbolic understandings when one is engaged in using symbols such as eye contact, posture of prayer or pictures on religious material as part of communication (Paton 1990:76).

These features were briefly illustrated in data collection by considering the in-depth interviews with individuals and focus groups. The interviews typically involved two people who were not strangers to each other because the participants were known to the researcher by virtue of their occupation, that of nursing. The researcher had to be able to maintain an open mind and be reflexive of own biases during data collection and analysis (Blumer 1969:12). The philosophy of SI aimed at investigating the symbolic world of nurses through close contact and direct interaction with the researcher. Providing spiritual nursing care is a human phenomenon which required naturalistic inquiry which was achieved through individual and focus group interviews and inductive analysis by the researcher. Consistent with the stated premise of social behaviourism was how the world of the participants was analysed in terms of the participants' actions and interactions, as Blumer (1969:16) maintains. Nurses create meaning during social interaction, as they construct the self or their identity and how they define situations of co-presence with patients or other nurses.

The researcher was able to actively interact with the participants being researched and to see things from their point of view (emic view), and in their natural context.

Griffin (1997:13) concludes that the majority of interactionist's researchers have typically utilised methods such as in-depth and focus groups qualitative interviews, and

unobtrusive methods such as observation to collect and analyse data (Griffin 1997:13-15).

3.5 SYMBOLIC INTERACTIONISM AND GROUNDED THEORY RESEARCH

Grounded theory has its roots in sociology and embraces the notion of symbolic interactionism, which focuses on the social actions and interactions of humans, their shared symbols and thus understanding of each other (Probert 2006:1) According to Polit and Beck (2008:223-224), symbolic interactionism is the theoretical underpinning of grounded theory studies. Stern (1980:20) states that grounded theory studies based on symbolic interactionism is ideal “in investigations of relatively uncharted waters” when salient variables in the health-illness situations have yet to be identified; or when there is a need to gain a fresh perspective in a familiar situation. Grounded theory methods, from the symbolic interactionism perspective, help researchers to translate private experiences such as provision of spiritual nursing care to common language and processes that can be easily understood and applied (Stern 1980:20).

3.6 CONCLUSION

In this chapter the definitions of SI, the historical overview and the notable contributions made by the proponents of this theory were introduced. Pragmatism and social behaviourism were briefly discusses as the philosophical underpinnings of SI. The concept of what subjective meaning of human behaviour is and how it is constructed by language and gestures was discussed. The major constructs of the theory which are mind, self, society, and role taking and human interaction were described. Human interaction in particular in the context of SI was explained in terms of how people relate or conduct themselves in relation to others and their environment. The importance and relevance of SI to qualitative research and possible application to the study was discussed. In addition, the importance of symbolic interactionism for this study is that some of the aspects and its elements discussed will be utilised to guide data collection and data analysis.

Chapter 4 discusses the research design and methodology.

CHAPTER 4

Research design and method

4.1 INTRODUCTION

Prior to applying the empirical phase of a study, the researcher is required to make a series of decisions about the research design that would be appropriate for the study, methods of data collection to can be used and how data should be analysed (Babbie 2007:378; Mouton & Marais 1994:15-16). The research decisions taken in this study included determining the research context, research design and the research method. The research method included discussions on the qualitative paradigm, research population, sampling and sampling technique, and data collection methods and data analysis. Ensuring trustworthiness and ethical considerations were also described in detail.

4.2 RESEARCH SETTING

Research settings are specific places or physical locations where the study is conducted or data collection occurs. In-depth qualitative study is likely to be done in a naturalistic setting or field which is an uncontrolled, real life situation or environment. Conducting a study in a natural setting means that the researcher does not exercise control over or change the environment. Such settings can be at people's homes or places of work (Burns & Grove 2007:29-30; Polit & Beck 2008:57). In grounded theory, research takes place in a setting that allows the researcher to observe the selected social process in action. This means an ability to observe both the environment and the selected participants in the study (Langford 2001:151).

The research setting was an eight hundred (800) bedded academic hospital in the Gauteng Province in South Africa. The institution was a public hospital and not necessarily affiliated to any religious institution. The clinical settings included a variety of units such as surgical, medical, pediatric, orthopedic, ICU, HIV/AIDS clinic and

gynecological units in the hospital where both acute and chronically ill patients were cared for as well as the outpatient department thereof. Patients were of different religious backgrounds and affiliated to different denominations. Some of the patients were reported not to be belonging to any particular faith or religion. The social, cultural and economic characteristics of the patients to whom care was given were not investigated, which might have affected how spiritual care was given or not given.

Focus groups were conducted at the hospital setting while the individual interviews were conducted in the comfort and convenience of the individual participant's homes. Three participants were residing in black townships and one in a predominantly white suburban area. Although the environment was noisy in the townships, the interviews were however conducted in their living rooms which were the most quiet and convenient area for the purpose at the time. In all of the participants' homes, there was adequate space provided, comfortable sitting and taping arrangements. The participants were all of the Protestant Christian faith. It is a faith that accepts the Bible as the only source of revealed truth, the doctrine of justification by faith alone and the universal priesthood of all believers (O'Brien 2003: 122-123).

The research process followed is richly described so that others wanting to replicate the study may be able to do so.

4.3 RESEARCH DESIGN

Research design is defined as the overall plan for conducting research. It is a blueprint that guides the planning and implementation of a study in a way that addresses the objectives and provides answers to the research question/s so that the intended goal can be achieved (Burns & Grove 2007:553; Langford 2001:95).

The research design of choice for this study was the grounded theory. Grounded theory is defined by Polit and Beck (2008:755) as a qualitative research approach to collecting and analysing qualitative data with the aim of developing theories and theoretical propositions grounded in real-world observations.

The primary purpose of the grounded theory approach is to generate comprehensive theoretical explanations of complex phenomena that are grounded in reality, develop further research hypotheses and a theory about the dominant psychological, social and spiritual processes in the context of this study (Burns & Grove 2007:66; Langford 2001:114; Polit & Beck 2008:89; Stern 1980:23). The theory in grounded theory studies is produced 'from the inside' of the data which may be substantive and formal (Glaser & Strauss 1967:34). Substantive theory is defined by Sandelowski (1993:214) as the conceptualisation of the target phenomena that is being studied sometimes to modify existing theories. Strauss and Corbin (1998:12) explain that the theory emerges from the data and is more likely to resemble reality than is theory derived by putting together a series of concepts based on experience or how one thinks things ought to work. Grounded theory research has contributed to the development of many middle range theories that are relevant to nursing (Glaser & Strauss 1967:32-34).

In grounded theory, researchers attempt to hold in abeyance existing knowledge and conceptualisations about the phenomenon under investigation until the substantive theory begins to emerge. Grounded theories offer insight, enhance understanding and provide a meaningful guide to action (Strauss & Corbin 1998: 12-14). The conceptual framework of grounded theory is therefore generated from the data rather than from previous studies (Stern 1980:21).

4.3.1 Origins of grounded theory

Glaser, with a background of quantitative research and Strauss with grounding in qualitative research (Glaser & Strauss 1967:35), both developed systematic and detailed procedures for grounded theory research. A fundamental feature of grounded theory research is that sampling of participants, data collection and data analysis occur simultaneously. When placed on a continuum with other qualitative approaches, grounded theory can be sited closest to the quantitative paradigm (Holloway 2005:147-149). It has become a strong research tradition that offers a rigorous and systematic method of qualitative research analysis of specific social phenomena (Holloway 2005:147; Streubert-Speziale & Carpenter 2003:110-111). According to Strauss and Corbin (1998:31), grounded theory involves "systematic techniques and procedures of analysis that enable the researcher to develop a substantive theory that meets the

criterion for doing “good” science as it maintains a degree of rigor and grounding analysis in the data.

Grounded theory research entails the discovery of theory from methodical data collection and analysis (Bassett 2004:61; Holloway 2005:148; Strauss & Corbin 1998:9; Streubert-Speziale & Carpenter 2003:107). Data collection, analysis, and eventually theory development stand in close relationship with one another. The investigator examines data as they arrive, and begins to code, categorise, conceptualise and begin to write the research report right from the beginning of the study. The researcher may modify data collection according to the advancing theory and ask more penetrating questions as needed (Burns & Grove 2007:66; Langford 2001:114; Polit & Beck 2008:402; Stern 1980:23). Holloway (2005:292) explains that theory is generated through constant comparison of data. Data analysis results in the identification of core concepts and offers explanations for these concepts and processes (Langford 2001:146; Streubert-Speziale & Carpenter 2003:109). Strauss and Corbin (1998:23) provide the following explanation:

“A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory stand in reciprocal relationship. One does not begin with a theory then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge”.

The initial area of study should be broad. Glaser (1992:36) believes that if the focus is too narrow there may be insufficient data to formulate a theory. Strauss and Corbin (1998:88) support the notion of both deductive and inductive reasoning and that the focus narrows as the study progresses.

However, there is a debate about when literature review should be done. An argument against an initial literature review is that preconceived ideas can inhibit the process of discovery. For this reason, Glaser (1998:40) does not recommend an initial review of the literature. Morse (2001:721) on the other hand argues that an initial review combined with bracketing provides novice researchers with needed knowledge that they

can use to refine the research methodology. Strauss and Corbin (1998:48) support this stance and state that this initial review is essential to help grounded theorists not to study an area which has been researched many times before in a similar way. This was the motivation of the researcher when concept analysis (chapter 2) was conducted as the phenomenon has been vastly researched especially in the Western countries. The other reason was that the findings could compare emergent categories on provision of spiritual nursing care and contribute to new knowledge on the phenomenon in an African context. This comparison therefore assisted the researcher to begin a creative process of analysis for theory and model development. In addition, justification for the methodology and rationale for conducting this study required some form of literature review. Ongoing literature review throughout the study enhanced theoretical sensitivity and helped the researcher to determine what is and what is not important to the emerging theory and model (Holloway (2005:150).

The grounded theory design was suited for this study because it guided the researcher to explore and describe spiritual nursing care as conceptualised and practiced by African nurses in a specific South African hospital in a nursing care context.

4.4 QUALITATIVE RESEARCH

Empirical qualitative research, applying the grounded theory research design, was employed to inductively determine the meaning of spiritual nursing care in a specific context and to develop and construct a model for integrating spiritual care into nursing practice.

Babbie and Mouton (2001:270) define qualitative research as an approach in social research according to which people's experiences are explored, described and communicated to the significant other. It is further defined as an objective way to study subjective human phenomena using non-statistical methods of analysis (Langford 2001:138-139; Strauss & Corbin 1998:10-11).

Qualitative research seeks to gain insights about the subjective and holistic nature of human beings (Burns & Grove 2007:61; Langford 2001:139). Qualitative research methods can be used to obtain the intricate details about phenomena such as feelings,

thought processes, and emotions that are difficult to extract or learn about through more conventional methods (Strauss & Corbin 1998:11). The investigation in qualitative research is typically an in-depth and holistic investigation through collection of rich narrative materials using flexible research designs (Polit & Beck 2008:17). This approach results in information that has the potential to elucidate varied dimensions of complicated phenomena, including spiritual nursing care.

Qualitative research involves non-probability sampling. Generalisability of the research findings is not the guiding criterion even though the rigor of the methodologies can be replicated in similar settings. In qualitative studies, researchers are not concerned with the selection of representative samples. Samples are small and non-randomly selected. Small information-rich samples have the benefit of allowing qualitative researchers to conduct in-depth investigations and generate rich data which is required to discover inherent meanings (Burns & Grove 2007:344-345).

Humans are perceived to be conscious, self-directing beings that are continuously constructing, developing and changing their everyday interpretations of their worlds in order to make sense of their lives. Researchers in this tradition emphasise the inherent complexity of humans and the idea that truth is a composite of realities. They acknowledge the ability of human beings to create their own meanings (De Villiers & Van der Wal 2004:239). The findings from in-depth qualitative studies are typically grounded in real life experiences of people with first hand knowledge of a phenomenon (Burns & Grove 2007:252-253).

The qualitative research paradigm utilises naturalistic methods of enquiry to attempt to gain contextualised insight into human phenomena (Strauss & Corbin 1998:11). The focus is on the process by which concepts are given meaning in a given context rather than on the measurement of the variables and their relationships with other variables (De Villiers & Van der Wal 2004:239). Naturalistic methods of enquiry according to Polit and Beck (2008:17) are applied in the field. For example, in this study the naturalistic setting was in wards where acute and chronically ill patients were cared for. The most common data collection methods used were observations, interview and examination of written texts (Bassett 2004:11; Burns & Grove 2007:77; Polit & Beck 2008:236-237).

Qualitative inquiry relies heavily on the inductive reasoning process. It is rendered a suitable paradigm for gaining insight into spiritual nursing care by drawing upon nurses' experiences and conceptualisations about the phenomenon under scrutiny (Delpont & De Vos 2005:47-48). According to Holloway (2005:150), inductive reasoning refers to moving from a narrow focus to a broader focus. It is employed to move from specific observations within the data to building constructs and discovering the relationships between constructs. Grounded theory research uses inductive processes to make theoretical assertions that can be subsequently tested and verified (Bassett 2004:4; Burns & Grove 2007:66-67; Polit & Beck 2008:13).

Applied to this study, qualitative research approach was appropriate to determine how the research participants conceptualised and rendered spiritual nursing care in their everyday care of patients. The use of a small sample allowed for an intense interrogation of the phenomenon under study for the development of a model for integration of spiritual nursing care in clinical nursing practice.

This research paradigm seemed to have the needed potential to enable the researcher through the rich descriptions of the phenomena to understand better how nurses in clinical practice conceptualise and provide spiritual nursing care based on real life experiences in the health care setting because it focused on process rather than the outcome. Issues related to spiritual nursing care are amenable to qualitative methods of research that examine subjective human experiences and assist researchers and clinicians to understand the whole phenomenon. The other advantage was that the participants who participated in the study were knowledgeable informants on the subject of spiritual nursing care. Data was collected through the interviews until data saturation was reached, i.e. when no new information or categories emerged (Polit & Beck 2008:392).

Data collected for a qualitative enquiry is often massive as was in this study, and may present with disadvantages as highlighted by Polit and Beck (2008:392-393) as follows:

- Reduction of data for report writing become complex as some important findings may be lost and the study may suffer loss of integrity

- There are no universal rules for analysing, interpreting and presenting data which is a crucial characteristic in science
- There are huge expenses associated with large amounts of data in terms of time and money and yet the findings are of limited generalisability

These challenges were overcome by using multiple methods of data analysis which included use of the computer assisted programme, constant comparison method, coding process and Tech's (1990:142-145) approach to qualitative data analysis, as cited in Creswell (2003:192-193).

4.5 RESEARCH METHOD

Research method refers to the logical process which is followed during the application of scientific methods and techniques when a particular phenomenon is investigated (Polit & Beck 2008:765). In other words, it is the way in which research is planned, structured, and executed to comply with the criteria for science. Following herein, is the discussion of the research method which was applied as well as methods of ensuring trustworthiness and research ethics.

The study was conducted in three phases as outlined in chapter one. Phase one was the conceptualization and planning of the study which addressed the first objective of the study and is discussed in the three previous chapters. Phase two of the study entailed exploring the registered nurses' conception of spiritual nursing care to address the second and third objectives of the study. Phase three entailed the development of a model to guide the integration of spiritual nursing care to nursing practice.

4.5.1 Phase 2: Description and exploration of the registered nurses' conception of spiritual nursing care.

In this phase, which was the empirical phase, the research process responded to the two objectives of the study. The research method of the study focused on the description of the population, sampling and sampling technique, data collection and data analysis. The understanding of what spiritual nursing care is and how such care was provided by nurses was explored by conducting individual and focus group

interviews. The researcher applied these research procedures to identify the themes, categories and sub-categories leading to theory development.

4.5.1.1 Research population

A research population is the entire set of elements i.e. individuals, objects, events, experiences that have common characteristics to which the researcher has access and meet the criteria for inclusion in a given universe. This can also be called the accessible population. In this study the accessible population was all those people that provided health care to patients in the health facilities. Within the accessible population there is the target population (Burns & Grove 2007:324, 549; Polit & Beck 2008:761). The target population for this current study was professional nurses in the nursing practice settings from whom the sample was selected. This is a specific category within the accessible population identified specifically for contextualisation of the research findings.

4.5.1.2 Sampling technique and sample selection

Sampling technique defines the process for selecting a group of people, events, behaviours or other elements with which to conduct a study where the research population cannot be managed because of its size. There are two sampling techniques namely, probability and non probability sampling techniques. Probability sampling technique is used to select research elements or participants randomly where each element in the population has an equal chance of being selected. This is mainly used for quantitative research, where statistics are used to present the results. Non-probability sampling technique is used to select research participants non-randomly. Examples of the sampling approaches under this technique include purposive, quota, convenience, snowball or network and judgemental sampling approaches. In non-random sampling, elements are selected based on their contribution to data required (Burns & Grove 2007:40; Polit & Beck 2008:759). In grounded theory research, sampling is done to select the participants whom the researcher believes will bring about the greatest theoretical return.

In this study purposive and snowball or network sampling approaches were especially appropriate in order to choose participants who have the relevant knowledge and expertise to inform the study adequately (Stringer 2004: 12).

Purposive sampling was applied to select participants who have knowledge and insight on issues of spiritual nursing care. The selection depended on the researcher's knowledge about the population (Burns & Grove 2007:344-345; Langford 2001:153; Morse 1994:91a; Polit & Beck 2008:355; Stringer 2004:12). The purposive method of sampling assisted the researcher in including only those who met the sampling criteria, and were able to provide the necessary information.

The *snowball sampling* method is defined by Polit and Beck (2008:766) as the selection of participants through referrals from earlier participants which is also called networking. In this sampling method, participants are selected by means of nominations or referrals from participants who were interviewed. This method was used especially to select participants for the focus groups. Snowball sampling method was helpful in identifying participants who had knowledge and experience in providing spiritual nursing care in clinical practice and could talk freely about their spirituality aspects. The selection of focus group participants could also be regarded as *theoretical sampling* because the information provided was used for theory generation (Burns & Grove 2007:557). The researcher gathered relevant data from the focus groups that included information that generated, delimited and saturated the codes in the study needed for theory generation.

Purposive and snowball sampling process was guided by data saturation where inclusion of participants or groups terminated when there was no new information sourced in the interviews or discussions conducted.

Sample

Ellis (2004:100) defines a sample as a subset of the population that is selected for a particular study, members of which become research participants. Holloway (2005:151) confirms that grounded theory studies, like many other qualitative studies tend to have small information rich samples that are not pre-determined.

Greef (2005:294) explains that there are two criteria for a satisfactory number of participants needed for a study. The researcher has to ensure that the sample size is sufficient to reflect representativity so that those who are outside the study may connect with the findings. The other criterion in qualitative studies is saturation of information. This is the point where the researcher during data collection begins to hear the same information reported repeatedly with nothing new emerging from the interviews (Seidman 1998:47-48). However, Morse (1994:58b) cautions qualitative researchers that the claim that they have reached saturation point or “information redundancy” should be done with caution because the samples are small. The researcher should therefore observe and talk to few people of vastly different social backgrounds and situations and conduct in-depth interviews. Polit and Beck (2008:353-354) add that in qualitative studies the use of small, non-random samples is aimed at discovering meaning and uncovering multiple realities through in-depth interrogation of the information at hand. The small numbers in sample size are to allow for adequate time to interrogate the phenomenon.

In this study unstructured interviews were conducted with four individual participants, and twenty four participants who participated in four focus groups selected as discussed under purposive and snowball sampling and in accordance with the set criteria.

The selection criteria were that each of the participants:

- had to be registered with the South African Nursing Council (SANC) under the Nursing Act No. 33 of 2005 (Republic of South Africa 2005:34)
- had to be involved in rendering direct nursing care to patients with either acute or chronic health problems on a daily basis
- have at least two years of professional experience
- have indicated their interest in participating in discussions or interviews related to providing spiritual nursing care to patients
- had to be willing to participate in the study and give a written consent (see Annexure D)
- could be either male or female
- No age restriction

Sampling procedure for in-depth individual interviews

During this grounded theory study on spiritual nursing care the researcher conducted purposive and snowball or network sampling approach. The following process was followed to select participants for the in-depth individual interviews.

- After permission was granted to conduct the study at the hospital (see Annexure C) the researcher contacted the identified potential participants telephonically to find out if they would be interested to participate
- Three of the research participants were initially purposively selected based on their interest in and experience with the provision of spiritual nursing care based on their Christian beliefs, values and attitudes. Following this, one of the participants guided the researcher to the fourth participant
- Four participants, who met the inclusion criteria participated without coercion
- All of the participants were Christians and were informed that they could withdraw from the study if they feel uncomfortable with the process at any stage and there would be no negative repercussions
- Information was provided to those who volunteered to participate about what the study was about, what is expected from them and that a counsellor would be available if needed for any discomfort or spiritual distress
- All the participants signed the informed consent
- Four focus groups composed of at least six members each were constituted (see table 4.2)

Sampling procedure for focus group interviews

In this study, the sample for four focus groups constituted of the twenty four female professional nurses who were identified by the four individual participants was formed. All participants met the inclusion criteria and indicated to have interest in providing spiritual nursing care. They were from a variety of units in the hospital such as medical, surgical, gynaecological, HIV/AIDS clinic, paediatrics, orthopaedics, outpatients department and ICU.

- The participants knew one another, an aspect which made communication amongst themselves easy
- Arrangements to contact the potential participants were made through the nurse managers at the different sections
- The professional nurses in charge made the duty roster available to the researcher to enable her to schedule meetings with the groups because the focus group discussions were to be conducted in the hospital
- The participants were approached by the researcher individually to explain the research process, its purpose and objectives and to obtain an informed consent from all of them

Morse and Field (1995:130) explain that the criteria for selecting interviewees especially for focus groups change according to the concepts which emerge during current data analysis, and which may require further exploration during subsequent data collection. Table 4.1 presents the number of participants who successfully participated in the study and the units they came from.

Table 4.1 Number of participants recruited per unit

Units	Number of participants per unit
HIV/AIDS clinic	2
Surgical	6
Orthopaedic	4
Paediatric	2
Medical	3
Adult ICU	3
Out patients	2
Gynaecology	3
Total = 6 units	24 participants

Table 4.2 presents the number of focus groups that were conducted and the number of participants in each group.

Table 4.2 Number of focus groups and participants in each group

Focus groups	Number of professional nurses
Focus group 1	7
Focus group 2	6
Focus group 3	5
Focus group 4	6
Total 4	24

A total of four focus groups were held with 24 participants. The number per group allowed for intense participation of each member.

Sample size

The guiding principle in determining the *sample size* was data saturation as interviews continued until no new information emerged. Paton (2002:244-245) is of the opinion that the in-depth information from a small sample can be very valuable and that the meaningfulness and insights gained from the inquiry have more to do with the richness of the information given than the size of the sample. In this study, a sample of four participants for unstructured interviews and four focus groups who met the inclusion criteria provide the required information. For the focus groups data saturation was reached by the third focus group interview, but interviews continued with the fourth group because of the various units that formed the groups. For the individual interviews data saturation was reached by the fourth interview. Morse (2001:58) confirms that the number of participants needed to reach saturation depends on a number of factors. An important factor in this study was the clear focus of the study and thus did not take long to reach data saturation. The participants were also good informants as they were able to reflect on their experiences of how they provide spiritual nursing care, communicated effectively, and thus enhanced data saturation with a relatively small sample (Polit & Beck 2008:357).

4.5.1.3 Data collection

Data collection is defined by Langford (2001:94) as a process of gathering data necessary to address a research problem. According to Strauss and Corbin (1998:58), data is inherent in the self reported accounts by participants, observation and other forms of written or pictorial materials. Data collection is aimed at understanding not only human actions and experiences, but also making explicit the underlying intentions and meanings from the data which is in words, gestures, symbols and artefacts. Human actions and behaviour should be understood in terms of observable meanings, intentions, values, beliefs and self-understandings that people hold (Babbie & Mouton 2001:271-272).

In this study several data collection methods, such as in-depth unstructured interviews, focus groups interviews, direct observation and field notes were used. The main data collection instrument used was an interview guide for individual and focus group interviews. A questionnaire was used to collect demographic data.

4.5.1.3.1 The data collection instruments

In this study, a questionnaire, and an interview guide which comprised of part one for the unstructured interview and part two for the semi structured interview. The researcher was also used as a data collection instrument which depended on the information that was required. The questionnaire and interview guide had a set of questions that were posed to the participants. According to Rubin and Rubin (1995:145), an interview is built up of four kinds of questions, which are demographic, open ended, probing and follow up questions. Demographic questions were used in the study as ice breakers. They were presented as written responses in a questionnaire format. Open-ended questions were used to initiate and guide the conversation. Probing questions served to explore the topic on provision of spiritual nursing care under investigation while follow up questions served to provide further detail and clarity.

- **Questionnaire**

A questionnaire (see Annexure E) was used to collect demographic data from the participants who provided their profile in terms of gender, age, marital status, qualifications, and courses done of spirituality, the units where they were working and their religious affiliation

Semi structured interview guide

According to Patton (2002:283), an interview guide is usually unstructured but may have a list of open-ended questions that are to be explored in the course of an interview. An interview guide used in this study was loosely structured to support in-depth data collection from the participants (Holloway 2005:39; Streubert-Speziale & Carpenter 2003:28). A semi structured interview guide which was divided into two parts was used. Part one consisted of two questions asked during the unstructured interview and part two had a list of probing questions based especially on the responses of participants. The same probing questions were asked in all the focus groups (see annexure F).

The two main questions derived from the central research question were:

- What do you understand by spiritual nursing care?
- How do you render spiritual nursing care for your patients in your daily practice?

As in all unstructured individual interviews, probing questions were added while the interview was in progress. The nature of the probing questions was determined by the flow of conversations. Examples of probing question were:

- *Is prayer for you the first usable intervention that you suggest to utilise in caring for your patients spiritually?*
- *If you say you've seen that people get helped by prayer, how were they helped? What did you observe? What did you see that made you say that? Tell me about it*

- *You spoke about you not having enough time. What do you mean? Time for what? What are the activities that take up your time?*
- *“... have you ever nursed a patient where you realised that a patient has a spiritual need”*

“Tell me about it.... what happened ...”

Part two of the semi structured interview guide (refer to Annexure F) was used during the focus group interviews. This had a set of predetermined questions formulated from individual interviews to ensure that the conversations elicit and illuminate sufficient and appropriate data on the specific concepts which the researcher would further explore in depth. In this study the semi structured interview guide for the focus groups was developed from concepts that emerged from the individual in-depth interviews in order to elucidate the basic social and psychological processes that were emerging in the data (Paton 2002:283). The advantage of the use of the semi structured interview guide in the study was that it enabled the researcher to collect maximum data within the time constraints of the busy schedules of the participants. The following are examples of questions asked at the focus group sessions based on concepts that emerged from the individual interviews. However the initial questions asked in the individual interviews were asked as a point of departure.

1. Tell me about what you understand about spiritual nursing care
2. How do you provide spiritual nursing care for your patients in your unit on daily basis?

Probing questions asked were:

1. Tell me more about what you have just said ...
2. What do you understand by holistic patient care?
3. How do your religious values guide your care and relationship with your patients and their family as a nurse?
4. What challenges do you experience when providing spiritual nursing care?

Questions were adapted from Taylor (2002:28)

The researcher as a data collection instrument

The researcher was the primary data collection instrument because she had to think of the questions during the interview or make observations and other strategies to get a clear view of what participants understand about spiritual nursing care and how they provide spiritual nursing care to patients in clinical practice (Parahoo 2006:69).

According to Lincoln and Guba (1985:193-194), the following characteristics are unique to human beings and qualify them as human instruments in data collection especially in qualitative inquiry. They are as follows:

- *Responsiveness*. The researcher as a human instrument can sense and respond to personal and environmental cues
- *Holistic emphasis*. The researcher grasps the phenomenon in its entirety and context in one view
- *Adaptability*. The human being is capable of collecting information about multiple factors happening at the same time
- *Processual immediacy* is possible because only humans are capable of processing data as soon as they become available
- *Opportunities for clarification and summarising*. Human instrument can summarise data on the spot and seek clarification from the participants and deduce meaning by observation
- *Opportunity to explore atypical or idiosyncratic responses*. The research is able to explore atypical responses to test their credibility to reach understanding

Qualitative data collection approaches vary. However those that have been used in this study are a demographic questionnaire, a semi structured schedule and use of the researcher in person.

4.5.1.3.2 Pre-testing the interview guide

According to Polit and Beck (2008:762), a pre-test is a small-scale version or trial run research done to ensure validity and reliability of the instrument in the preparation for a

major study. It is conducted to identify possible weaknesses especially on the questions asked and responses provided by the participants. Seidman (1998:32) suggests a pretesting venture of the interview guide so that the researcher tries out the interview design and questioning with a small number of participants who are not part of the main study. The purpose of the pretesting of the interview guide was to evaluate the comprehension of questions, the duration of the interview and to test the interviewing skills of the researcher as well as the use of the audiotape device.

In this study, a small scale study was conducted with a group of seven professional nurses in a focus group to pre-test the unstructured and the semi structured interview guides, interview skills and the skills on the use of the taping facilities. The respondents who participated in the pre-test were not included in the main study although they fulfilled the criteria that were suggested for inclusion in the study.

The researcher identified various problems related to data collection. The venue used was the staff's tea room and therefore had distractions from nurses coming in and out. The sitting arrangement was such that some of the responses could not be well captured on the audiotape in terms of sound and clarity. This made verbatim transcriptions difficult. The interview lasted 60 minutes which was too long with inadequate coverage of essential information. The posing of questions was also a problem as some probing questions seemed complex for the respondents to answer as they had to be reformulated and simplified. This exercise assisted the researcher in looking for an alternative venue for the interview; estimating the time needed to conduct one session adequately, and helped to identify questions that were too difficult or ambiguous in terms of language, focus and conceptualisation. The errors experienced in this group also enabled the researcher to be able to correct the main data collection process in the actual interviews with better quality of data collection processes.

4.5.1.3.3 *Data collection methods*

There are specific methods of gathering unstructured or semi structured data in qualitative studies. In this study in-depth individual and focus group interviews, field notes and observation were the methods used.

Interviews

Interviews are merely an extended and formalised conversation with a purpose. Conversations are verbal interactions between two or more individuals who ideally have an equal opportunity to express their viewpoints (Greef 2005:292; Holloway 2005:152; Streubert-Speziale & Carpenter 2003:28). Limb (2004:64-65) explains that in grounded theory, the best way of finding out how people think, feel or behave is by simply asking them about it. Stern, Allen and Moxley (1982:210) state that the dynamic psychosocial and social processes that are the focus of grounded theory may be observed from social interactions and by listening to what informants says about them.

Interviews are defined by Henning, Van Rensburg and Smit (2004:53) as a mechanism to source data from participants through structured conversations. If used methodologically and applied according to strict principles of objectivity and neutrality, will yield information that represents reality more or less “as it is” through the response of interviewees. Holloway (2005:153) explains that, interviews are often referred to as “in-depth”, implying that a considerable amount of detailed data is collected. Interviews allow the researcher to tap into the opinions, attitudes, values and belief systems of participants as is the case in this study (Langford 2001:153-154).

In this grounded theory study on spiritual nursing care, the researcher used unstructured and semi structured interview guides to conduct interviews for data collection with individual participants and focus groups (Holloway 2005:151-152). An audio-tape was also used after obtaining permission for its use to capture all information during interviews. The use of an audio-tape assisted the researcher to concentrate better on what was said as some information might have been easily missed out. Data was initially collected through in-depth one-to-one unstructured interviews, as a primary method of data collection, followed by semi-structured focus group interviews.

The researcher kept field notes during and after the interviews. Field notes according to Langford (2001:155) are written accounts of what the researcher sees, hears, experiences and thinks during the data collection process. In this study, field notes were kept to record observations made in the field, and the interpretation of those observations. As suggested by Polit and Beck (2008:754), these observations included the participants' non-verbal behaviours, gestures, facial expressions or postures as they responded to the probing questions as well as other non-verbal responses which were later clarified with them. A reflexive journal was also kept to provide an account and record of own perspectives, thoughts, feelings and knowledge about the topic as the data emerged. The journal and field notes enhanced credibility by creating an audit trail (Krefting 1991:220). Symbolic interactionist's theorists as discussed in chapter 3 contribute that social processes such as communication patterns, use of symbols and creation of meaning in the interaction are fundamental to the methodology. This current study therefore focused on the social interaction between nurses and patients, nurses and the patients' families and nurses and colleagues.

- **Unstructured individual interviews**

In this study, unstructured individual interviews were conducted with a purposively selected sample of four professional nurses. These interviews were relatively broad in focus and gave rise to data from which concepts could be extracted. Limb (2004:65) explains that unstructured interviews are the most appropriate ways to collect data in grounded theory. The unstructured interview guide had two open ended questions to encourage participants to elaborate freely, also because questioning was not predetermined and there was little interviewer influence on the conversations. Streubert-Speziale and Carpenter (2003:28) support this practice by adding that unstructured interviews provide the opportunity for considerable latitude in the answers provided. Mason (2002:62), however, argues that no research interview can be devoid of structure, even if that structure is the use of a single open question to prompt thought or discussion.

Some of the principles applied when conducting individual interviews were also applicable to the focus groups. Sampling and data collection focused on gathering data

that would generate, delimit and saturate the emerging concepts related to spiritual nursing care.

Focus groups interviews

Focus group interview is defined by Carey (1994:26) as "a semi-structured group session, moderated by a group leader, held in an informal setting, with the purpose of collecting information on a designated topic". In this study, the interviewer guided the participants through a set of questions using a semi-structured interview guide. One of the assumptions underlying the use of focus groups was that group dynamics can encourage people to express and clarify their views in ways that are less likely to occur in a one-to-one interview (Burns & Grove 2007:379). The groups by virtue of their construction with participants, who were familiar with one another, offered a protection to individuals who could have felt vulnerable in a one-to-one interview.

The group's sizes varied between four and eight individuals who were assembled to answer questions on spiritual nursing care, because fewer than five participants tend to result in inadequate discussions. Groups this size allowed everyone to participate. Appropriate participants were recruited for each of the focus groups according to their lunch and off duty times (Burns & Grove 2007:379; Greef 2005:305),

Focus groups in this study were found to be helpful because the investigation was dealing with a sensitive topic of religion, faith or spiritual issues especially in the work place. The use of focus groups also had the advantage of being inexpensive, flexible, stimulating, cumulative, elaborative and produced rich data on provision of spiritual nursing care (Greef 2005:299-300; Polit & Beck 2008:395; Streubert & Carpenter 2003:29; Stringer 2004:11).

However in general, it was important to note that interviews are subject to problems of bias, poor or inaccurate articulation of information and in some instances failure of the data collecting equipment. In that regard, the researcher used a reflexive journal to record own feelings, experiences and opinions about the spiritual nursing care as a way of bracketing to avoid subjectivity. Some aspects of the raw data were compared with the field and observational notes to strengthen accuracy of information.

- **Field notes**

Field notes are defined by Polit and Beck (2008:754) as notes taken by researchers to record the observations made in the field, the analysis and interpretation of those observations. The researcher used field notes as a written account in the reflexive journal of what was seen, heard, experienced and thought about during the course of the interview. These notes were both descriptive and reflective and complimented the tape recordings done during interviews and data analysis (De Vos 2005:298).

- **Direct observation**

Observations made during the interview included observing the body language and other non-verbal behaviours like nodding of the head, eye contact and facial expression of the participants. Direct observation also included an objective description of the settings, events, interactions, behaviour of participant during the interview and how they responded to the interview in both verbal and non verbal cues. However, these notes were written after the interview session was completed.

In cases of an audiotape, spare batteries were taken along in cases of power failure or batteries running flat to ensure that discussions are captured in totality until the end of the interviews.

4.5.3.4 Data collection process

In this study the process of conducting interviews followed this pattern:

- **Pre-interview arrangements**

The researcher reviewed the topic in the literature briefly, outlined questions to be asked and decided on the data collection methods. Documents such as consent form, interview guide, demographic questionnaire and journal for taking notes were prepared. The managers of the units where the potential participants worked were informed of the

dates and times as permission to conduct the study was already granted. Entry and access into the research setting was negotiated with the appropriate authorities with permission granted in writing (see annexure C). The researcher arranged and communicated the date, time and venues well in advance for both the individual and focus group interviews, thus preparing the participants psychologically, emotionally and spiritually. In both instances the researcher arrived earlier to prepare the environment to ensure privacy, quietness and comfortable sitting arrangements. According to Moustakas (1994:114), it is the responsibility of the interviewer to create a suitable and conducive environment in which the participants will be able to respond freely, honestly and comprehensively. The role of the researcher is to ensure that the interview process is managed successfully.

- **Introduction of self and the study purpose**

During the introductory stage of the interview sessions, the researcher welcomed the participants and explained the ethical issues as stated in the informed consent form. The general purpose of the research, the specific purpose of the interview and possible benefits such as counselling sessions available if needed were explained. Each participant was then given a consent form to complete (see annexure D). The approximate duration of the sessions was confirmed with the participants.

Interview process

- The researcher conducted one-on-one and face-to-face interviews with the participants
- participants were encouraged to express and deliberate on their ideas freely
- The questions were open ended with associated prompts, probes and follow up questions and remarks designed to elicit narratives that demonstrated the participant's conception of the identified concepts. The researcher used grand tour questions which were asked when introducing the topic, for example:

“Tell me what you understand by spiritual nursing care?”

How do you render spiritual nursing care for your patients in your daily practice?”

- Participants were allowed to finish what they were saying and to proceed accordingly in their own way of thinking and speaking
- They were however guided towards focussing on the issues at hand rather than on unrelated issues
- The researcher applied the techniques of attentive listening, showing interest and respect for what the participants were saying. The interview techniques of probing and prompting (verbal and non verbal) were used. The researcher nodded in between, used phrases such as, “Yes”, “Thank you”, “Can you tell me more about that?” to encourage participants to continue on the narrative (Terre Blanche, Durrheim & Painter 2006:128-129)
- Each interview was audio-taped following permission to do so. The tapes were marked properly for both the individual and the focus group interviews with dates and pseudonyms, for example 15/08/2009 Mabop/3 or Office/22. This represented the date of the interview, the name of the setting and the number of the participant taking part in the interview. Names appearing on the transcripts were pseudonyms and were suggested by the participants for easier communication purpose.
- Both the individual and focus group discussions lasted between 50 – 60 minutes each.
- Field notes were written at the end of each session

The participants were asked if they had any questions or further comments, which assisted in the closure of the interview. Participants were also informed that a spiritual counsellor was available for them if they felt distressed after the interviews.

Unstructured individual interviews

The unstructured interviews were held in the participants’ homes where they felt comfortable and at ease. These were conducted when participants were off-duty on different dates as agreed upon with the participants. Interviews were scheduled for the morning hours as was preferred by the participants. Participants who were willing to participate completed the consent form and a short demographic questionnaire. The

participants were informed of the need for follow up interviews should there be aspects that were not clear or needed further probing for theoretical saturation purposes (Terre Blanche, Durrheim & Painter 2006:129).

Field and Morse (1994:66a) assert that the goal of an interview is to encourage the participants to express themselves freely on the issue under investigation. This, the participants were allowed to do.

Focus group interviews

The venues for the focus groups were easily accessible and supported the establishment of a non-threatening climate. The supervisors' offices were utilised and were prepared before the participants arrived. These provided privacy, comfort and were free from distractions such as noise or other interruptions. Telephone calls were diverted for the duration of the interview. The interviews were conducted on different days and times. The process followed was as follows:

- An office in a quiet place was provided for the purpose with a table and chairs around it for the convenience of the conversation and possible eye contact with one another
- A 'do not disturb' notice was placed on the door to avoid distractions or interruptions
- The sessions were held during lunch times as agreed upon with the unit managers and the participants. Refreshments were served thereafter
- Participants were requested to switch off their cell phones to avoid interruptions
- The seating arrangement was around the table and thus supported interaction among the participants and easy recording of discussions and comments (Greef 2005:294)
- The audio recorder was placed at the centre of the table after the methods of how information will be recorded were explained, and permission to audiotape the interview was obtained from the participants
- Although the participants knew one another, introductions were done as an ice breaking mechanism

- The letter of permission to conduct the study was read to the participants and each participant was requested to sign an informed consent form
- The participants completed the demographic questionnaire
- To commence the interview in each group the researcher asked an open ended question, designed to introduce the topic and to encourage the participants to be free and open. The following questions were asked:

What do you understand by spiritual nursing care?

How do you render spiritual nursing care to your patients in your daily practice?

- Probing questions were directed based on the discussion generated from the opening questions. Some of these were as follows:

How do your religious values guide your care for patients as a nurse?

What do you understand by holistic patient care?

What difficulties or barriers do you experience when providing spiritual nursing care?

How do you handle the identified difficulties or barriers?

- The posing of questions and interview skills yielded better responses than experienced in the pre-test focus group
- All the participants were encouraged to join in the discussions. The interviewer listened attentively, showed interest in the groups and put in an effort to understand the meaning of their basic psychological and social experiences as they provided spiritual nursing care from their point of view. The interview was terminated when all the major areas were covered. Participants were given an opportunity to ask questions. The researcher thanked the participants for sharing the valuable information and for their time. The interviews were terminated when the fourth group could not provide more new information, themes or categories.

The process of recording the interviews

The interviews were tape recorded with the permission of the participants. Using the tape recorder allowed the researcher adequate time to maintain eye contact with the participants. The following process was followed in tape recording:

- The recording machine was pre-tested to ensure that it was working properly. The room had an electric socket that was tested before the interview. The researcher had batteries on standby in anticipation of electric power disturbances
- The tape recorder was positioned between the researcher and the participant/s, or in the centre in the case of focus groups close enough to record the conversation
- The room was quiet with no distractions
- The tapes were marked properly as indicated. According to Lincoln and Guba (1985:271), taped data provides the researcher with an opportunity to review the recorded data as often as is necessary to ensure that conceptualisation of the meaning derived from the interviews has been achieved.

Note-taking during the interview

Before the start of each interview session the researcher informed the participant/s that a few notes would be taken during the interview. Note taking was mostly done after the interviews. Note taking after the interviews was discrete to avoid distracting the participant. Individual participant interviews were conducted over four days while the focus group discussions were also conducted over a period of four days.

A spiritual counsellor was arranged to be available during this period and thereafter for consultation should any of the participants experience spiritual or psychological discomfort. However, none of the participants utilised this service as none of them experienced spiritual discomfort.

4.5.3.5 Data analysis

In this qualitative study, volumes of data were gathered and stored in an organised way for easy retrieval. Data was managed by converting the narrative data into smaller more manageable segments as guided by various qualitative research authors. Verbatim transcription of recorded interview data was done in preparation for data analysis. Each audio-taped individual and focus group interview was recorded and transcribed verbatim by the researcher herself shortly after the interview (Burns & Grove 2007:79; Polit & Beck 2008:508-515; Streubert-Speziale & Carpenter 2003:34). Morse and Field's (1995:131) instructions for transcribing tape recorded interviews were followed. The transcripts were read and verified against data several days later. The interviewer listened to the tapes objectively as recommended by Morse and Field (1995:131) and critiqued her own interviewing style. Inconsistencies were noted on how questions were asked and improvements were made in subsequent interviews. The transcriptions were then typed and imported into a code based theory builder which is the Qualitative Research Solutions Non-numerical Unstructured Data ways of Indexing, Searching and Theorising computer software, known as NUD*IST power version, revision 4.0 to begin with the analysis process. This software assisted the researcher in handling and managing complex non-numerical data (Burns & Grove 2007:79). The transcribed interviews were also submitted to the promoter for validation.

The presentation and interpretation of the findings is presented in chapter 5

As a contribution to nursing practice, phase three of the study will focus on the development of a model to guide integration to nursing practice using symbols and concepts derived from the data findings.

4.6 ETHICAL CONSIDERATIONS

Qualitative research, according to Mahlangu and Uys (2004:19), like all forms of research is subjected to a code of ethics for the protection of human subjects. Although all the participants came from a Christian background, the nature of the study was very sensitive and complex as nurses do not openly provide spiritual nursing care to patients. Moreover, spirituality is regarded as a personal issue. Therefore, conducting research

on such aspects poses a number of ethical challenges. Ethical consideration in this study involved protecting the rights of the participants and the institutions involved, and ensuring the scientific integrity of the study.

4.6.1 Protecting the rights of the participants

Participants who volunteered to be involved in this study were not exposed to situations for which they have not been prepared for. Their right of religious affiliation and freedom was protected by not asking them personal questions about what was not related to the study. Participants in this study were assured that their involvement in the study will not be used against them in any way. The researcher ensured that the researcher-participant relationship will not create room for the participants to be exploited, coerced or manipulated. This was important especially in this instance as the researcher was an authority in the field investigated, and was well known to some of the participants. The rights of the participants were protected in this study by obtaining informed consent, demonstrating respect for confidentiality and anonymity, protecting the right to withdraw from the study, showing respect for human dignity, maintaining privacy and ensuring the principle of beneficence and justice.

- ***Informed consent***

Humans are autonomous beings and have the right to choose a course of action including the freedom to freely decide whether to participate or not to participate in research. Autonomy is interlinked with giving voluntary informed consent. Therefore coercion of prospective participants is considered unethical (Burns & Grove 2007:201, 217).

Although purposive and snowball or network sampling methods were used to select participants, the participants gave voluntary informed consent to participate in the study. The researcher obtained voluntary informed consent (see annexure D) after the nature and implications of participation were explained and the participants were informed of their rights as indicated above. Participants were given full information about the study as to what its requirements, purpose and benefits were. The researcher refrained from applying any coercion techniques.

- ***Right to withdraw from the study***

Participants were informed that they could refuse to participate or withdraw after signing the consent form or at any time during the research process without penalty.

- ***Anonymity and confidentiality***

Anonymity refers to the researcher's ability to keep informants nameless, whereas confidentiality refers to ability to keep data sources protected. Management of private data in research should occur in such a way that the participants' identity is protected and information and responses cannot be linked (Burns & Grove 2007:534). They also have the right to confidentiality, namely to expect that their information will be treated with confidentiality and private information about or by the participants will not be divulged to unauthorised others without the participant's knowledge (Burns & Grove 2007:531; Polit & Beck 2008:747).

In this study the researcher assigned pseudo-names to each participant and ensured that there were no names attached to the interview transcripts. Their identity was not linked to their contributions during the interviews. In addition to this, the audio-tapes and transcripts and demographic forms were stored in a safe place where they were only accessible to the researcher. It was also agreed that the audio-tapes, field notes and interview scripts would be kept under lock and key for a period of three years after the report is released. The audiotapes and field notes were locked away to prevent any unauthorised person from having access to the data. This would allow the researcher to publish at least three articles from the information contained in the audiotapes.

The following measures were taken to ensure anonymity and confidentiality:

- The participants' names were not recorded on the interview guide response sheets.
- The code numbers or pseudonyms were used. For example, Mabop/1, Office/22 codes were used to assist in the analysis of data.

- The identity of the participants was not revealed in the report and would also not be revealed in the publications of the study.
- The data were not shared with any other person apart from those actively involved in the analysis of the data.
- Tapes and transcriptions would be erased three years after the research had been finished, when all the publications had been effected.
- ***Respect for human dignity***

Because human spirituality which underpins spiritual nursing care is a unique and personal issue, it was necessary for the researcher to demonstrate respect for each participant's unique views, belief system and spiritual care practices. The researcher respected the participants' denominational affiliations and refrained from being discriminatory or judgmental. Respect was shown also by how questions were posed and the participants were allowed to express themselves fully without interruption unless where necessary. Difficult questions were rephrased and made simpler for the participants to respond without feeling humiliated. The researcher responded humanely towards their emotionality about the topic. No personal questions were asked.

- ***Maintaining privacy***

Privacy according to Burns and Grove (2007:550) refers to freedom to determine the time, extent and general circumstances under which information will be shared with or withheld from others. Some people regard issues of spirituality as private and not to be discussed openly.

In this study, the researcher ensured that privacy was maintained during the individual interviews by conducting interviews in the participants' homes. Focus groups were also held in an office designated for the interviews. A 'do not disturb' notice was placed at the door to avoid exposing the participants. Their religious views, opinions and beliefs were not divulged to unauthorised persons.

- ***Principle of beneficence***

The ethical principle of beneficence entails doing well and “above all, do no harm” to study participants. Doing no harm refers to doing no psychological, physical, emotional, spiritual or any other harm. Interviewing people on issues of spirituality may bring about discomfort, emotional or spiritual distress, especially in a group interview context during which individuals may be confronted with differing views (Burns & Grove 2007:531). In this study the researcher took care to establish an emotionally safe climate and ensured that all those involved respected the views of others. Considering the risk-benefit ratio, the researcher maintained that the benefits of this study outweighed these risks and it was therefore possible to implement the study. The researcher ensured that participants were not exposed to any spiritual distress because of the nature of the study. A spiritual counselor was made available for support for the participants who required it as a result of their participation. However, no such requests were voiced, while some participants confessed that instead, the process was therapeutic for them.

- ***Principle of justice***

The principle of justice refers to fairness and equity. It entails participant’s right to fair treatment and their right to privacy (Polit & Beck 2008:173).

Fair selection and treatment

The selection of participants to be involved in a study should be based on research requirements and not on the vulnerability or compromised position of certain people. Researchers have an obligation to protect the rights and interests of participants and ensure that they are not exploited for the advancement of knowledge. Those who decline from participating even after agreeing should be treated in a non-prejudicial manner. All promises made to the participants must be honoured. Participants must be afforded courteous and tactful treatment at all times (Polit & Beck 2008:173-174).

In this study participants were purposefully selected on the basis of their knowledge and experience of the study topic. Their participation might have been compromised because most of them were known to the researcher.

4.6.2 Protecting the rights of the research institution involved

The rights of the research institution were protected by obtaining an informed consent and permission from the hospital management (see annexure C). The researcher kept the name of the institution anonymous. Ethical clearance certificate was obtained from the ethics committee of the Department of Health Studies of the University of South Africa (refer to annexure A).

4.6.3 Enhancing the scientific integrity of the study

Scientific integrity refers to honest practices commonly accepted within the scientific community for proposing, conducting or reporting research. Plagiarism was avoided by acknowledging all sources and references utilised in the study. The research findings and presentation was done without falsification and/or fabrication of information obtained from the participants. The thesis report is the original and independent work of the researcher and has not been presented anywhere else for whatever purpose. Those persons who contributed towards the successful completion of the study were duly acknowledged. The measures which the researcher applied to enhance the trustworthiness of the study also served to ensure its scientific integrity.

4.7 MEASURES TO ENSURE TRUSTWORTHINESS

Scientific rigor in qualitative studies is measured by its trustworthiness or the extent to which the findings are true to the data and the research context. The aim of scientific research is to generate truthful (valid and reliable) explanations, models and theories (Babbie & Mouton 2001:138). Trustworthiness refers to the quality value of the final results and conclusions reached in qualitative research (Lincoln & Guba 1985:290).

Lincoln and Guba (1985:291-292) developed a model for assessing qualitative data in terms of its trustworthiness. The four criteria according to which it is evaluated, are truth value or credibility, applicability, consistency and neutrality (Krefting 1991:215; Streubert-Speziale 2003:133).

4.7.1 Truth value

Truth value according to Krefting (1991:215), asks whether the researcher has established confidence that the results are a true reflection of reality. In qualitative research, truth value is usually obtained from the discovery and description of human experiences as they are lived by the research participants, and the context in which the experiences are lived. Qualitative researchers attempt to meet the truth value of a study by enhancing its credibility (Lincoln & Guba 1985:292).

Credibility. Credibility refers to confidence in the truth of the data and interpretation of these. It involves carrying out the investigation in a way that is believable (Lincoln & Guba 1985:291, De Vos 2005:346). Lincoln and Guba (1985:291-293) suggest various strategies to improve and document credibility in a study.

Researcher credibility. Patton (1990:472) posits that researcher credibility has to do with faith that can be put in the researcher. The researcher' training, qualifications and experience are important in establishing confidence in the data. Referring to this grounded theory study on spiritual nursing care, the researcher had a postgraduate background in the principles and methods of research. She also supervised and examined research by postgraduate students, and participated in collaborative research projects as part of her academic duties. Her expertise in the field of spiritual nursing care was enhanced by her academic qualifications and practice experience in nursing and theology. The researcher further improved her knowledge on spiritual nursing care by conducting a literature review through concept analysis for this study.

Prolonged engagement. Prolonged engagement refers to the investment of sufficient time in data collection and analysis activities to have an in-depth understanding of the culture, language, views or opinions of participants (Polit & Beck 2008:542). During data collection the researcher spent an extended period of time with the participants while she conducted unstructured and semi-structured interviews. The participants were allowed to verbalise their feelings without being hurried or interrupted. Questions in some instances were repeated for more clarity. The interviews were conducted until data saturation. During data analysis, tape recordings were listened to over and over again, transcripts were written and re-written, read and re-read to understand the data

obtained. Following analysis, interpretations were taken backwards and forwards to some of the participants for validation. The researcher therefore immersed herself in the data from the time data collection commenced to completion of this report.

Persistent observation. Persistent observation refers to the researcher's focus on the aspects of the situation that are relevant to the phenomenon being studied (Polit & Beck 2008:542). In this study the researcher followed a process of observation-analysis-interpretation-observation-analysis to comply with the regiments of the grounded theory methods.

Reflexive analysis. Reflexive analysis entails self-awareness and a critical self-reflection about one's own biases, preferences and preconceptions during data collection and analysis. During data collection and analysis, a dynamic interaction occurred between the researcher and the data (Burns & Grove 2007:80). Through the process of reflexive analysis, the researcher was able to explore feelings, experiences and knowledge on Christian values and attitudes that may influence the findings. These were recorded in a reflexive journal. The process however, required self-awareness. This allowed the researcher to bracket her feelings and to objectively adapt to the findings of the study.

Peer debriefing. Peer debriefing, according to Polit and Beck (2008:548-549), entails holding sessions with objective peers to review and explore various aspects of the inquiry. The researcher presented the different phases of this investigation into integration of spiritual nursing care to clinical practice to colleagues, research promoters, and conference attendees. These persons gave constructive inputs on how to enhance the scientific quality of the investigation. A scientific paper on concept analysis, which is chapter two of this study, was first presented to post graduate students in a class and then finally presented in an International conference in July 2009 in Australia. This exercise exposed the investigator to the searching questions of other researchers or field experts.

Member checking. Lincoln and Guba (1985:293) consider member checking the most important technique for establishing the credibility of qualitative data. Member checking entails giving the research participants an opportunity to determine whether the

preliminary findings and interpretations are consistent with their views and experiences which they shared with the researcher. Member checking can be carried out both informally in an ongoing way as the data are being collected or more formally after data have been collected and analysed (Krefting 1991:219). In this study the researcher presented the draft of the analytical codes and the preliminary findings to selected participants who were considered to be able to critically judge the researcher's interpretations. Selection of such participants at this stage of higher conceptual analysis in the study was said to be critical. They however, concurred with some of the findings.

Triangulation. Triangulation refers to the use of multiple data collection methods and references to draw conclusions about what constitutes the truth. Various types of triangulation exist, namely data source, method, context, investigator and theory triangulation (Krefting 1991:215-217; Polit & Beck 2008:543-547). In this study the researcher applied the use of a questionnaire, interviews, field notes and direct observation as data collection methods. Investigator triangulation was done by rigorous consultation with the promoters and colleagues, while an intense literature review through concept analysis and use of varied data analysis methods was done as a method of triangulation.

4.7.2 Applicability

Applicability refers to the degree to which the findings can be applied to other contexts, settings or other groups (Krefting 1991:216). It is the responsibility of the potential users of the research findings to determine whether the findings are transferable. According to Lincoln and Guba (1985:293) applicability in qualitative studies can be achieved by enhancing its fittingness or transferability. Various techniques were applied to enhance the transferability of the findings of this study.

Selection of information-rich participants. It is the researcher's responsibility to select the most suitable participants during the process of data generation. In this study the researcher conducted purposive, snowball or networking sampling and theoretical sampling; involving participants who could share a wealth of insights with the researcher. Therefore the involvement of information-rich participants contributed towards transferability (Limb 2004:63).

Achieving data saturation. Saturation of data according to Burns and Grove (2007:554) is a phenomenon that occurs when additional sampling provides no new information, or there is redundancy in information collected. In this study, sampling, data collection and data-analysis occurred until no new data emerged from the interviews.

Providing thick descriptions. It is the researcher's responsibility to provide extensive descriptions of the phenomenon in a report format for consumers to evaluate the applicability of the data to other contexts (Lincoln & Guba 1985:294). Polit and Beck (2008:768) define thick description as a rich, thorough description of the research context, the people who participated in the study, the experiences, transactions and processes observed during the inquiry presented in a written form. Talbot (1995:488) explains that the thick descriptions allow someone other than the researcher to determine whether the findings of the study could apply in another setting. The burden of proof rests with the researcher to provide sufficient information to permit judgments about the applicability of the findings to other similar contexts. In this current study, the researcher provided detailed descriptions of the purpose and objectives, research design and methodology and the outcome of the study for possible application of the framework in other settings. The thick descriptions continued in tapes, transcripts, observations and field notes which were presented in detail in the research report that formed the audit trail for use by other researchers.

4.7.3 Consistency

Consistency considers whether the findings of an enquiry would be repeated, if the inquiry were replicated with similar participants in the same context or in similar contexts (Lincoln & Guba 1985:295). However, in qualitative studies variability is expected. Explainable sources of variability might be due to increasing insight on the part of the researcher, informant fatigue, or changes in the informant's life situation (Krefting1991:216). Consistency could be achieved by enhancing the dependability of a study.

The dependability of qualitative research findings refers to data stability over time and over conditions (Polit & Beck 2008:539). Lincoln and Guba (1985:295) assert that

dependability can only be attained once credibility has been established. In this current study the following strategies were applied to enhance the dependability of a study:

Submitting the study for an audit. The dependability of a qualitative study can be enhanced by ensuring its auditability and submitting it for an inquiry audit. Krefting (1991:221) uses the term 'auditable' to describe the extent to which another researcher can clearly follow the research decisions taken by the investigator based on data recorded. An inquiry audit refers to a scrutiny of the data and the relevant supporting documents such as audiotapes and verbatim transcribed notes, field notes or how data was analysed and interpreted (Polit & Beck 2008:549). An audit can be conducted by an external auditor to follow through all the research decisions undertaken to compare conclusions given same data and context (Krefting 1991:220).

In the current study the researcher established an audit trail by providing a detailed report on the exact method of data gathering, context of the interviews, data analysis and interpretation. Data obtained from the interviews were coded by the researcher and checked by the study promoter. Results were then compared and any differences in themes, categories and subcategories were noted. This information was provided so that those who may be interested to repeat the study may be aware of how unique the situation was, as suggested by Krefting (1991:221).

4.7.4 Neutrality

Neutrality refers to the degree to which the findings are a function solely of the participants and conditions of the research and not of the researcher's biases, motivations and perspectives (Lincoln & Guba 1985:296). Polit and Beck (2008:315) explains that achieving neutrality means that research results are embedded in the obtained data and not on the preconceived ideas, biases, values interests, knowledge and experience of the researcher.

Qualitative researchers are faced with the problem of striking a balance between objectivity and subjectivity. Holloway (2005:152) acknowledges the tension that exists between putting aside preconceived ideas or previous experiences of the researcher and using existing knowledge to develop theory especially in grounded theory. The

researcher's prior information, experience and knowledge have the potential to contaminate the data with elements of subjectivity (Collins 1998:1). However, Holloway (2005:152) and Strauss and Corbin (1998:42-43) indicate that a state of complete objectivity and neutrality in qualitative research is likely to be difficult or even impossible. What was important in this study was that researcher realised that subjectivity was an issue and took appropriate measures to minimise its intrusion into the research process as already indicated.

Confirmability

Confirmability refers to objectivity or neutrality of data which allows for agreement between two or more independent persons about accuracy, relevance or meaning of the data (Polit & Beck 2008:435). Objectivity is the criterion used for neutrality and is achieved through rigour in methodology (De Vos 2005:350). Other aspects to ensure confirmability include establishing an audit trail and the code-recode procedure:

Audit trail. Confirmability can be enhanced by establishing an audit trail to enable others to conduct a dependability audit. The audit trail enables an independent person to come to conclusions about the data (Lincoln & Guba 1985:309; Polit et al 2001:316). The researcher established an audit trail in accordance with the suggestions by Polit et al (2001:316). For the purposes of an audit trail, the researcher did the following:

- Process notes were kept, namely the methodological notes, notes from member checks and the feedback from study promoters
- The research method, including the instrument development information was recorded. The questions which were posed to the participants were also recorded (refer to annexure E and F)
- Intentions about the disposition of materials such as personal notes, audiotapes, and transcripts were indicated. Intentions to write research articles on certain aspects of the findings of the study for publication in accredited journals were indicated
- In addition to this, the data reconstruction products such as drafts of the final report and model were also kept

- A detailed research report was presented for evaluation by scholars

In this study, the research process undertaken was audited from the beginning to the end of the study by the study promoter. A final report was submitted for examination purposes.

The general methods and procedures employed in this study were described in detail. Information gathered from interviews, field notes and direct observation was verified through literature control to determine whether similar experiences were identified in other studies. Consensus with regard to themes, categories and sub-categories was reached between the researcher and the promoter as an independent coder who is skilled in qualitative research procedures.

4.8 CONCLUSION

In this chapter the research design and method was explained. The whole plan of how the research was conducted was discussed in detail especially in terms of the research approach which was the qualitative paradigm and the research design which was the grounded theory design based on the symbolic interactionism philosophy. The research setting was introduced. The research methodology included procedures such as determining the population, sample and sampling technique, data collection, data analysis, ethical considerations and methods of ensuring trustworthiness. The data collection methods utilised was discussed as in-depth individual and focus group interviews. The data collection instruments utilised were a demographic questionnaire, unstructured interview guide of two questions each followed by probing questions, a semi-structured interview guide with a list of questions and the researcher as a data collecting instrument. The analysis of data entailed an inclusive use of the method of the NUD*IST power version 4.0 computer assisted program, constant comparison method; open, axial and selective coding and Tesch's (1990) approach to qualitative data analysis, as cited in Creswell's (2003:190-193). Ethical considerations and methods of ensuring trustworthiness of data were fully described.

Chapter 5 presents data analysis and presentation.

CHAPTER 5

Data analysis and interpretation

5.1 INTRODUCTION

The purpose of this study was to explore and describe nurses' conceptions about spiritual nursing care and their basic psychological and social experiences of rendering spiritual nursing care with an intention to inductively and deductively develop a model on spiritual nursing care. The analysis and interpretation of data focused mainly on the Christian perspective other than other religious traditions. This chapter therefore is part of phase two of the study that presents and discusses the data analysis and findings of the study on provision of spiritual nursing care by nurses in clinical practice.

5.2 STATISTICS OF THE DEMOGRAPHICS

Demographic information collected through a questionnaire was analysed quantitatively through the use of frequencies and percentages. A homogenous group of 28 (100%) female professional nurses (participants) were interviewed in the study of which 4 (14.3%) were involved in the individual and 24 (85.7%) in the focus group interviews. It was interesting to note that a highest number of 18 (64.3%) were in the 41-50 age. Fifteen of them were married and 13 (46.4%) were single. They were all registered nurses according to the Nursing Act No. 33 of 2005 (South Africa 2005:34), only 8(28.6%) had degrees and 20 (71.4%) had varied diplomas and certificates in the field of nursing education and training. However, only 5(17.6%) of them had any training or courses that were related to spirituality and were done in their local churches. The participants were dispersed across the clinical settings as indicate in table 4.1. This was a seemingly stable group, matured and experienced in the profession and in life in general. They all were from the Protestant religious background that ascribes to the Christian faith, although belonging to different denominations.

5.3 QUALITATIVE DATA ANALYSIS

Data analysis is the separation of data into parts for the purpose of answering research questions and objectives. The process involves communicating these answers to other researchers meaningfully (Polit & Beck 2008:68). Data analysis was ongoing during data collection and throughout the study. In keeping with other researchers who have used grounded theory, analysis was undertaken at two levels, 'overview analysis' which is a form of macro analysis and micro analysis using the processes discussed below (Strauss & Corbin 1998:58). Data analysis methods used were the constant comparative method, coding using process, NUD*IST version, revision 4.0 computer assisted software programme and Tesch's (1990) approach of qualitative data analysis, as cited in Creswell (2003:192-193).

- ***Constant comparison method***

Data analysis in this study involved a method referred to as the constant comparison method. The method was used to analyse the contents from the transcripts, field notes and observation notes. The method was useful for discovering the properties and dimensions of categories. The constant comparative data analysis method combined the analytic procedure of comparison with an explicit coding procedure for generated data. This method entailed segmenting and labelling of texts to form descriptions and broad themes that were compared and examined in an ongoing fashion for similarities and differences to identify and refine theoretically relevant categories. In this method therefore, the researcher compared all recorded incidents until themes, categories and subcategories emerged (Hutchinson 2001:228; Polit & Beck 2008:750; Streubert-Speziale & Carpenter 2003:37, 111, and 361).

This analytic approach meant that the grounded theory/model developed was derived from and rooted in the data which had been systematically gathered and analysed through the research process (Strauss & Corbin 1998:12). Using the constant comparative technique (Glaser & Straus 1967:48), codes were clustered into categories, and categories were reduced into themes. Further validation of the emerging themes was done through subsequent focus group interviews which provided additional data. Interviewing continued until all categories were saturated and no new data emerged. Further analysis was done through the coding process.

- **Coding**

Coding is a way of classifying and indexing data which forms the basis for the identification of themes, categories and subcategories. Through coding the researcher began to fit the pieces of the data puzzle together. Each piece had its place in the whole explanatory process (Strauss & Corbin 1998:229). The coding process involved procedures of conceptualising, reducing, elaborating and relating the emerging categories with new information. A categorisation scheme was developed based on a scrutiny of the actual data, which was coded accordingly (Polit & Beck 2008:526-527). There were three levels of coding identified which were open coding, axial and selective coding.

Open coding

Strauss and Corbin (1998:101) define open coding as the analytic process through which data is broken down into segments according to concepts that are identified in the data. The data is examined line by line, paragraph by paragraph to identify the underlying patterns which are marked in the margins (Streubert-Speziale & Carpenter, 2003:116). Holloway (2005:154) adds that this level of coding is initially employed to name and give meaning to data. The whole document was coded in sentences and paragraphs (Strauss & Corbin 1998:102).

In this study the steps and procedures of analysis as suggested by Holloway (2005:154) were applied as follows:

- After transcription, data was read and re-read, broken into segments with similarities and differences identified
- The segments were labelled and given codes
- Verbatim transcripts were compared with each segment for meaning to determine what type of phenomena is reflected in them. Limb (2004:73-74) states that comparing of incident by incident through the constant comparison method helps to clarify the appropriateness of and relevance of codes.
- The important concepts that emerged from close examination of the data were labelled and the labels formed the basis for a categorisation scheme. The words

of the participants deemed appropriate were used to assign labels to the data. Strauss and Corbin (1998:106) advise that the conceptual name or label should be suggested by the context in which the study is conducted.

Axial coding

The next stage of data analysis was axial coding (Strauss & Corbin 1998:229-230). This stage was concerned with category reduction and integration. At this level of coding, many segments were discovered with similar meanings and were linked together and renamed as categories to provide more abstract meaning. Each category was then compared with every other category to ensure that categories that were related were clustered based on a theme that ran through. Early codes that lacked foundation were discarded and more codes were added as data gathering continued. The researcher was challenged to reduce the huge number of emerging categories during data analysis and to connect and fit them under a broad category with a broader scope that was referred to as themes (Stern, Allen & Moxley 1982:142). This step as guided by Streubert-Speziale and Carpenter (2003:118), required constant comparison in the treatment of data. Each category was compared with other categories to ensure that they were mutually exclusive. During this stage, the fitting of the of the data puzzle continued as each puzzle piece had a theme, categories with and some without subcategories. This exercise further reduced the segments and codes (Strauss & Corbin 1998:230).

Selective coding

The last stage of the coding process is known as selective coding which helped the researcher to organise the data in new ways (Holloway 2005:154). Strauss and Corbin (1998:230) define selective coding as a process that links categories and subcategories to a core category referred to as a theme. Through the initial data analysis and coding, themes were reduced through the process of eliminating redundancies.

In this grounded theory study on spiritual nursing care the researcher conducted selective coding by identifying all categories and subcategories that relate to a theme. In this way segments were reduced to a minimum as illustrated in figure 5.1.

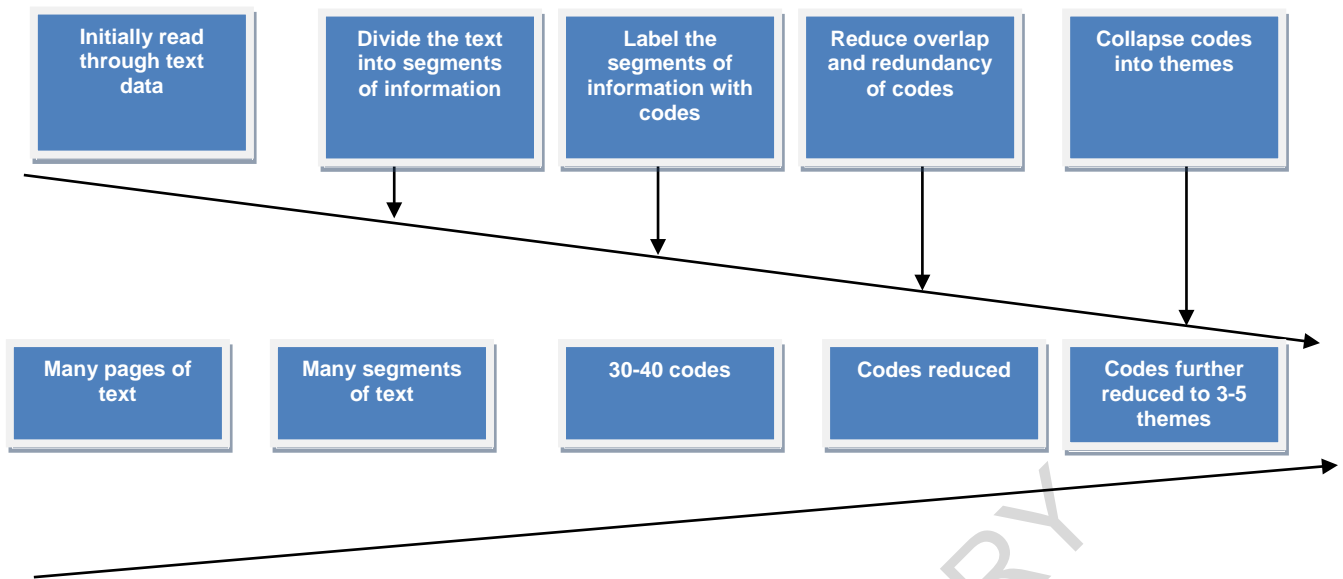


Figure 5.1 A visual model of the coding process in qualitative research

(Adapted from Creswell 2003:251)

Coded data was checked by the researcher and the study promoter independently for agreement and it added the element of consistency (Polit & Beck 2008: 543-544). The process of open coding, axial coding, selective coding, theme, category and subcategory development was rigorously undertaken. Repeated coding was done which yielded the same results with moderate adjustments.

Describing and developing themes from the data consisted of answering the major research questions and forming an in-depth understanding of the central phenomenon through description and thematic development (Creswell 2003:194). The theme/s served as foundational concepts for theory generation (Streubert-Speziale & Carpenter 2003:115).

A theme refers to a variable which is central to and links the particular segment of data. It accounts for most of the variations in a pattern of behavior which helps to integrate other categories that have been discovered in the data (Holloway 2005:155; Hutchinson 2001:222). For example a theme relates to an aspect that:

- recurs frequently in the data
- links various data and guides researchers on how to cluster data

- explains much of the variation in all the data because it is central
- have implications for a substantive theory
- is inherent in categories and subcategories as it becomes more detailed

Computer assisted analysis process

The NUD*IST power version, revision 4.0 computer software programme assisted the researcher with such activities as coding, processing, storing, retrieving, cataloguing and sorting of data collected from both the individual and focus group interviews (Burns & Grove 2007:79; Clarke, 2006:916). The researcher mastered this programme before data collection in order to avoid distraction during data collection and the analysis process (Streubert-Speziale & Carpenter 2003:34). This analysis program was used as a descriptive/interpretive approach for organisation, accurate and comprehensive analysis of the data (Holloway 2005:67). Through this program the researcher created codes, subcategories, categories and themes from the data obtained from the unstructured individual and focus group interviews.

Tesch's (1990) approach to qualitative analysis

The description of the analysis of this qualitative data was also comprehensively presented in the recommended steps by Tesch (1990), as cited by Creswell (2003:192-193). Based on Tesch's guidelines:

- The researcher engaged with the data by reading and rereading the transcribed taped data of each individual and focus group interviewed carefully to acquire a sense of the whole. One document was picked up at a time. This exercise enabled the researcher to immerse herself in the data, making notes and recalling observations and experiences in the field. Field notes were reviewed as additional data to support that contained in the transcripts.
- A question that was always asked was: "What is the underlying meaning?" Emerging ideas and core facts that were noted to identify similar topics were written down in the margin of the document. This was the initial segmentation of data and open coding.

Significant statements that pertain to the basic psychological and social experiences of provision of spiritual nursing care under investigation were extracted by:

- organising data into clusters in order to identify similar topics that existed in them
- making a list of topics as identified in the data for comparison
- a further clustering of topics was supported by the utterances of the participants, words and sentences which were used as units of analysis to support data segments
- the utterances of participants formed “meaning units” which are presented in tables in this chapter
- Utterances of the participants when put together provided subcategories and categories. Common meaning among topics was deduced to form these categories. Categories were further clustered to form themes
- all data belonging to one theme were gathered together and were given appropriate headings for analysis either from the direct quotes from participants or appropriate theoretical concepts as derived from literature

Similar data were grouped together accordingly, coded, categorised and conceptualised. These were compared to develop a full and deeper understanding about the basic psychological and social processes of how the participants viewed and endeavoured to provide spiritual nursing care to patients.

Findings from the data

From the data collected, a total of four (4) themes and eight categories were identified.

These themes and categories were as follows:

1. Meaning of spiritual nursing care

Category 1.1 Human being

Category 1.2 Interrelationship of body, mind and spirit

Category 1.3 Challenges of understanding the meaning of spiritual nursing care

2. *Relationships of the nurse in the health care arena*

Subcategory 2.1 Relationships

3. *Provision of spiritual nursing care*

Subcategory 3.1 Promoting Transcendence

Subcategory 3.2 Communication

Subcategory 3.3 Consequences of provision of spiritual nursing care

4. *Challenges in the provision of spiritual nursing care*

Subcategory 4.1 Feeling spiritually inadequate to provide spiritual nursing care

Table 5.1: A summary of the themes, categories and subcategories

Theme	Category	Subcategory
Theme 1: Meaning of spiritual nursing care	1.1 Human being 1.2 Interrelationship of body mind and spirit 1.3 Challenges of understanding the meaning of spiritual nursing care	1.1.1 Nurse 1.1.2 Patient 1.2.1 Body 1.2.2 Mind 1.2.3 Spirit 1.3.1 Religious care 1.3.2 Intuitive care 1.3.3 Emotional versus spiritual nursing care
Theme 2: Nurse relationships in the health care arena	2.1 Relationships	2.1.1 Nurse-patient 2.1.2 Nurse-family 2.1.3 Nurse-colleagues
Theme 3: How do participants provide spiritual nursing care	3.1. Promoting transcendence 3.2 Communication 3.3 Consequences of provision of spiritual nursing care	3.1.1 Prayer 3.1.2 Bible scripture reading 3.1.3 Singing spiritual songs 3.2.1 Spiritual dialogue 3.2.2 Information 3.2.3 Counselling 3.3.1 Referral 3.3.1 Spiritual well-being 3.3.2 Ability to communicate 3.3.3 Restoration of hope 3.3.4 Meaning and hope
Theme 4: Challenges in the provision of spiritual nursing care	4.1 Feeling spiritually inadequate To provide spiritual nursing care	4.1.1 Lack of education and training 4.1.2 Different religious beliefs 4.1.3 Prefer to be prayed for by a man 4.1.4 Contractual agreement between the nurse and the patient to experience transcendence 4.1.5 Lack of time

Table 5.1 presents a view of all the themes, categories and sub categories generated from the data and constitute the broader scheme and structure that directed the analysis and interpretation of data. The following discussions present the analysis and interpretation of the identified themes based on the SI philosophy and where necessary validation with literature. The literature was incorporated to refute or confirm ideas emerging from the data and to narrow the focus for theory development. The literature is also incorporated to refute or confirm ideas emerging from the data and to narrow the focus and extend the theory. The interviewees were addressed as 'nurses' or 'participants' interchangeably.

The themes, categories and sub-categories ranging from the most general to the most specific were outlined on table 5.1. The researcher identified and examined the themes in view of literature with intent to describe the conceptualisation of nurses about what spiritual nursing care means and how it is provided to patients. The information about these experiences was collected from both individuals and focus group participants. The research questions addressed were:

Tell me, what do you understand by spiritual nursing care?

How do you provide spiritual nursing care to your patients?

Responses from participants to the above questions enabled the analyst to be able to relate what constitutes spiritual nursing care from their perspective and challenges experienced as they provided such care. The ensuing discussions are based on the identified themes, categories and subcategories.

THEME 1: MEANING OF SPIRITUAL NURSING CARE

This theme explored and described the meaning of spiritual nursing care as expressed by the participants accordingly. Participants understand themselves and the patient as human beings in the realm of health care. This was described especially in relation to the application of the concept 'spiritual being' as it applies to the nurse and to the patient. From this theme, the understanding of the interrelationship of body, mind and spirit was explored from the responses presented. The challenges experienced in understanding what spiritual nursing care is were also captured. The presentation begins with a summary of edited meaning units for each category which are examples

of direct quotations from the participants' responses about expressions of understanding what spiritual nursing care means as presented in table 5.2

Category 1.1: Human being

Table 5.2 Human being as a nurse as well as a patient

Category	Subcategory	Meaning unit
1.1 Human being	1.1.1 Nurse as a spiritual being	<i>"Personally I believe that a person has a part of the spiritual being within.... I believe that we have been created by God and there is a part of God in us as spiritual beings... "</i> (Data: 22-33).
	1.1.2 Patient as a spiritual being	<i>"You cannot attend to the spiritual problem of a patient without getting to the spiritual being of a person because for a person to be holistically healthy, the spiritual being should be touched or should be attended to"</i> (Data: 28-33)

Human being

A human being is defined by the *Concise Oxford Dictionary* (1983:485) as a being that is distinguished from animals, machines or objects by superior mental development, power of articulate speech and upright posture. Being refers to existence or nature of a person as a Supreme Being (*The Concise Oxford Dictionary* 1983: 81). It seemed appropriate to briefly share light about the concept, 'human being' as some of the participants referred to their patients as human beings.

Both the nurse and patient were seen as human beings as exemplified in this excerpt:

"... So this is what challenges me on daily basis that I may treat people well as human beings and as people who are created in the image of God, not a an object which will help me get some money come month end" (Data: 136-144).

Firstly, from these responses the understanding of the concept 'human being' emerged as a category. Secondly, participants in this study viewed man as a human being with spirit, mind and physical dimension. One participant suggested that relating with a patient should go beyond the status of being a patient but as a person who is worthy of all respect, attention and consideration of the status of being a human being. They also expressed what a human being is from the perspective of approaching a patient as a normal person and who is at the same level with the nurse:

"... approaching a person as a person and not as a patient, and again allowing the communication or the relationship just to be normal. I am not a nurse or she is not a patient. We are all on the same level where we are able to communicate as human beings" (Data: 255-263).

This expression shows the need to respect patients by how they are addressed as they enter the health care arena and treated as an equal partner in the provision of care. This finding is supported by Rahner's (1975:1620) classic conclusion that behavior of human beings can be understood in the context of who they are as spirit beings. Based on the metaphysics of being and Christian doctrine, being and spirit tend to collide and actually do so in complete identity in God. According to the SI philosophy (Blumer 1969:8), this 'self' of the patient is interpreted on the basis of the "I" who is the real person who is respected by the health care giver, as opposed to the "me" which is a product of society or the health care environment where the patient is seen through the disease or sickness presented.

Further discussions about human being provided a background to introduce the expressions of how the nurse and the patient were seen and interpreted by the participants as spiritual beings.

Sub-category 1.1.1: Nurse as a spiritual being

Nurses are professionally trained and equipped to deal with disease, sickness injury and health promotion. The experience of spirituality both for themselves and their patients becomes normally irrelevant in a medical science environment. In this study it was however realised that nurses are also human beings that have spiritual needs. Heaviness of heart and feelings of being low and dispirited was noted to affect nurses

too. One of the participants explained how sometimes nurses demonstrate depression which is relieved by just talking as is the case in the following extract:

“Even with colleagues after talking to them, you know you can see a person when he comes on duty that this person is not well. After taking them aside and talking to them, just sharing with them a little bit of your experiences ... the mood changes” (Data: 216-221).

Nurses also as human beings struggle with issues of transcendence especially when faced with spiritual concerns of their own and that of patients they have to care for. They have spiritual needs and one can imagine if the provider of care is spiritually burdened what should happen to the patients.

From this finding one realises that even if nurses are expected to provide spiritual nursing care to patients, they also have spiritual needs and experience spiritual distress in the work place as human and spiritual beings.

Hutchinson (2001:215) supports this finding that it is difficult to respond to spiritual needs of others if nurses themselves are experiencing unresolved spiritual concerns or distresses of their own. There is however, an expression reported that explains nurses as human beings by Xiaoyan and Jezewski (2006:103) the authors remark that nurses and patients are spiritual beings with spiritual needs. It is therefore this commonality that should form the basis of the understanding about the need to be aware of patients as spiritual beings with spiritual needs that need to be cared for by nurses.

Subcategory 1.1.2: Patient as a spiritual being

Although patients are indirect participants in the study, they played a vital role in this finding because of the role they played in guiding nurses to make sense of their world as spiritual nursing care providers. Participants demonstrated awareness of patients as human beings and having needs that are beyond the help of medications. That a human being in the form of a patient resembles God in image and likeness is a mind sobering concept. Patients, as interpreted by the participants, should then be treated with high regard and reverence. One participant explained:

“... I believe that we have been created by God and GOD has created us in His image and likeness and God is a spirit and the part of God in us as spiritual beings, and that part cannot be touched by tablets, cannot be touched by ehm! Cannot be touched by injections or whatever we use to heal a person, so the spirit needs the spirit” (Data: 22-33).

Patients come to the health care institutions primarily for medical attention. However, their whole being which includes the spiritual dimension is affected. The nursing profession claims in literature that nurses treat patients, not only as physical beings with disease, but as spiritual beings (Van Leeuwen et al 2006:881). This claim seem according to this finding not to be implemented in clinical practice

Category 1.2: Interrelationship of body, mind and spirit

Table 5.3 Interrelationship of body, mind and spirit

1.2 Interrelationship of body, mind and spirit	1.2.1. Body	“Most of the people have a lot of social problems that at the end cause physical problems” (Data: 294-296)
	1.2.2 Mind	“How do you treat and attend to all the needs of patients are it spiritual, emotional or physical? Then I must attend to them wholeheartedly”(Data: 154-159)
	1.2.3 Spirit	“Man or a person is made out of spirit and is made out of the physic. So there is interrelationship between the spiritual man and the physical being” (Data: 8-11)

Nurses are increasingly expected to nurse the patient as a whole being which includes dimensions of body, mind and spirit. They also seem to understand this composition as iterated in the following excerpt:

: “... man or a person is made out of spirit and is made out of the physic. So there is interrelationship between the spiritual man and the physical being. So as nurses we are to provide holistic care to patients” (Data: 8-12).

The participants referred to holistic care as comprised of the spirit and physical dimension only. The concept of holistic care seems therefore, not to be fully understood. This may be related to their lack of exposure to courses that are related to spirituality as only 5(17.6%) had any such training.

Sub-category 1.2.1: Body

Participants expressed an understanding of the interrelationship between the physical and spiritual part of human beings. They expressed an understanding that physical care cannot be complete without spiritual care. The need for holistic patient care which includes spiritual nursing care is expressed in the following statement:

“Ok, eh! According to my understanding spiritual nursing care to me ehm! refers to when the spiritual life of a person should be attended to because, ya! when one is not well, is not only the body; it is the person as a whole and then the spiritual care forms part of the holistic care of a patient or of a client”(Data: 15-15).

Humans are seen as persons that have more than one dimension in their existence especially recognising the spiritual life. Medical treatment is needed and has its part (major part) to play in the healing of the body. However, in response to the interview questions, participants argued that taking care of the spiritual needs is equally important. Some of the health problems are due to peoples' life styles and behaviours. An example of sexually transmitted diseases that are as a result of behaviour is one such disease. Holistic care for such patients is to provide physical treatment for the body and spiritual intervention that involves God who created human beings and understands how to help them if his help is evoked.

This finding identifies with Milligan's (2004:164) definition of holistic patient care as "... the essence of holistic practice, and the integrating factor that holds together the physical, psychological and social care that nurses and others provide".

The holistic view, in this finding, in relation to spiritual nursing care is seen as an interrelationship between the dimensions of spirit and physique with the exclusion of other dimensions such as mind, psychological, emotional, social and cultural care.

Subcategory 1.2.2: Mind

Participants reported that their patients present at the units with physical health problems, whereas the root of the problem is emanating from other dimensions such as the mind or spirit. One participant made mention of attending to all needs of patients which may be spiritual, emotional or physical:

“How do you treat and attend to all the needs of patients are it spiritual, emotional or physical? Then I must attend to them wholeheartedly” (Data: 154-159).

Participants in this study showed awareness that there is a functional interrelationship between the physical, mental and spiritual dimension of a human being. It could be because of their spiritual ideology or background of faith in God that made them realise the value of caring for the spiritual being of the sick. The aspect of emotional training was part of their professional training as indicated that some of the patients' needs are emotional needs. However there is still no clear indication whether they could differentiate between spiritual, mental or emotional needs.

This finding is supported by Sawatzky and Pesut (2005:23) who indicate that nurses struggle to differentiate between patients' spiritual needs and the need for psychosocial care. Research by Narayanasamy and Owens (2001:450) confirmed this in their research that revealed that, although nurses displayed some knowledge and ability to identify the concrete physical patient's needs, they tended to describe these in psychological or emotional terms.

Sub-category 1.2.3: Spirit

Caring for the spiritual needs of patients was expressed as an attitude of how spiritual care should be provided, with a reasonable understanding of the interconnectedness and interdependence of the body, mind and spirit. Participants defined understanding of 'spirit' from how they experienced caring for the sick. The nurses' role in the context of understanding what spiritual nursing care is, was viewed as building the patients' strength through the spirit:

“... you build a person inside in his spirit and ...” (Data: 91-91).

It is interesting to note that this understanding about spiritual nursing care depended on their view and interpretation of their world from the background of seeing man as a spiritual being who must be build from the inside. This response demonstrated some understanding of the view of provision of spiritual nursing care as caring for the spirit needs of their patients. Although nurses have this idea on holistic patient care they still struggle to understand what it entails. This concurs with the finding of Giske (1995:4) which affirms the notion that a holistic perspective allows nurses to see patients as spiritual beings in need of balanced care that will enable them to grow and develop spiritually and experience meaning and purpose in the midst of their suffering.

The creation of meaning about what spiritual nursing care is, as reported according to the given responses, is however still not clearly indicated as one can deduce that such care is provided on trial and error or how each individual interprets the patients' situations with emphasis on the body and spirit.

Category 1.3: Challenges of understanding spiritual nursing care

Table 5.4 Challenges of understanding spiritual nursing care is

<p>1.3 Challenges of understanding spiritual nursing care</p>	<p>1.3.1 Religious care</p> <p>1.3.2 Intuitive care</p> <p>1.3.3 Emotional care versus spiritual nursing care</p>	<p><i>“I shared salvation with him”</i> (Data: 97-97)</p> <p><i>“With the spiritual care of a patient, it comes from within a nurse”</i> (Data: 247-248).</p> <p><i>“ When some are emotional you can ask, whether they want you to call their pastor or their dominie or their priest”</i> (Data:108-110)</p>
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Participants had a challenge in understanding the meaning of ‘spiritual nursing’. They expressed their belief in the creation of man and the interrelationship between the spirit, mental and the physical being. In this way participants believed that physical care cannot be complete without spiritual care. Although the responses identify commonly the physical and spiritual dimensions that constitute a human being, it is noted with

regard that the need for spiritual nursing care is recognised. However, it was obvious that the participants struggled to understand what spiritual nursing care was. This was evidenced by various responses and answers in relation to religious care, intuitive care and emotional care.

Sub-category 1.3.1: Religious care

It was observed that nurses in this study think of spiritual nursing care as synonymous with religious care. This notion limits care to this sub-category, whereas spiritual nursing care is broader in its sense as it integrates intuitive, interpersonal, altruistic and caring presence of the nurse that is contingent on the nurses awareness of the transcendent dimension of life and reflects the patient's reality (Sawatzky & Pesut 2005:23). This practice is observed in this statement:

"The patient was restless with a look of hopelessness on his face. He was diagnosed with HIV/AIDS and seemed to be guilty of his past behaviour or life style. During history taking He reported to be a non believer and did not belong to any church. I shared salvation with him" (Data: 97-97).

Nurses, based on this finding may be criticised or seen as preaching to patients during on duty time which is a duty perceived to be done by religious agents such as chaplains, pastors or other. It was observed that nurses in this study thought of spiritual nursing care as synonymous with religious care. When participants shared their faith with patients; being available as patients sought meaning and purpose in a situation of sickness and suffering was interpreted as spiritual nursing care as demonstrated in this statement:

"... at least this patient ended up receiving Christ as his personal saviour" (Data: 103-105).

However, this finding from the individual interviews gave evidence that there was confusion of differentiating religious and spiritual nursing care needs of patients. Nurses can meet the religious needs of patients such as baptism in some instances. This is however, not synonymous to spiritual nursing care. This approach was reported as imposing one's beliefs onto the patient who was in a vulnerable position. This question

was further asked during the focus group interviews for more clarity. One participant in the focus groups responded that religious care and related rituals may be initiated by the patients themselves according to perceived needs in times of sickness or fear of death as exemplified in this excerpt:

“A patient who was involved in an accident and suffered quadriplegia was discouraged and depressed. When I talked to him and mentioned that God loves him ... he just asked me about baptism” (Data: 93-93).

Nurses may not be in a position to baptise patients in the health care setting, but may have to refer patients to the appropriate spiritual resource. Nurses are therefore under challenge to differentiate between religious and spiritual nursing care needs which confounds the clear understanding of what spiritual nursing care is.

This finding is comparative to the argument presented by Coyle (2002:591) that there is tension in the literature between the two variables of spiritual and religious care. Nurses who provide spiritual nursing care have a religious commitment to a particular community of faith that has particular spiritual practices, beliefs, attitudes and sentiments. In practice, it is hard to draw the line as nurses provide spiritual nursing care based on their religious involvement and understanding of such care.

Sub-category 1.3.2: Intuitive care

Intuition is defined as the quality or state of having insight or immediate comprehension or of having untaught knowledge (Freshwater & Maslin-Prothero 2005:309). Provision of spiritual nursing care according to the findings in this study, did not seem to be part of the expectation from nurses as professional care providers, but depended on the individual nurse who had the knowledge or passion to do so. It was confirmed by one of the participants that to provide such care is a decision of a nurse who probably must know something about it:

“With the spiritual care of a patient, it comes from within a nurse” (Data: 247-248).

According to this finding, spiritual nursing care was not understood as part of the professional responsibility of the nurse. It was perceived as extra care one could give,

depending on the individual nurse's commitment to God. It confirms the conclusion by Narayanasamy and Owen (2001:450) that the approach to spiritual nursing care is apparently largely unsystematic and delivered haphazardly by the nurses who have the interest to do so.

Sub-category 1.3.3: Emotional versus spiritual nursing care

It seems, according to these findings, that nurses do identify emotional care and spiritual care as the same thing which may make spiritual concerns of patients not to be accurately assessed or appropriately dealt with. One participant stated:

"... When some are very emotional, you can ask whether they want you to call their pastor or their dominie or their priest" (Data: 108-110).

Participants seemed to have difficulty in differentiating spiritual aspects from that of other dimensions such as the emotional aspects. It is however not easy to draw the line as the needs overlap with each one another. Although the participants showed insight about spiritual needs or issues of their patients, there was lack of knowledge and understanding on how to differentiate emotional care from spiritual nursing care.

In support of this finding, Ross (1997:38) argued that although spiritual and emotional struggles maybe intertwined, emotional support alone does not approach the root of the problem which may be spiritually embedded. It will therefore not help a person whose need is spiritual in nature to be referred to psychologists only.

Concluding remarks on theme 1

Nurses in clinical practice seem to be experiencing difficulty to conceptualise what spiritual nursing care is. It is interesting to note that both the nurses and patient are understood as spiritual beings and therefore share common humanity and understanding of need for transcendence. Patients are therefore understood as having spiritual needs, although this seems not to be put in perspective. Rather spiritual needs were confused with religious and emotional needs. It is evidenced that nurses do need exposure to education and training on spiritual nursing care to delineate what it is and

how the needs of body, mind and spirit can be met in balance to achieve the goals of holistic patient care.

THEME 2: NURSE RELATIONSHIPS IN THE HEALTH CARE CONTEXT

In this study, the nurses' relationship in the context of spiritual nursing care referred to their relationship encounter with patients, families and colleagues. It took place in an environment of openness and trust in which there was an exchange of ideas, spiritually inclined social interaction and an interpretation of its meaningfulness to holistic patient care (Miner-Williams 2005:66). Nurses in the study were faced with the challenge of maintaining spiritually related relationships with their patients and others in the health care context. The meaning units related to the theme, categories and subcategories are presented on table 5.3

Table 5.5 the relationships of the nurses

Category	Subcategory	Meaning unit
2.1 Relationships of the nurse	2.1.1 Nurse-patient	<i>"The way you talk to the patient, the way you take care of the patient .When they come and find a person who can listen, a person who understands"</i> (Data: 297-298)
	2.1.2 Nurse-family	<i>"I am grieved these days by the number of deaths in ICU. When this particular patient died in the unit, it was just before the family left after visiting hour and we called them back. It was so hard, well, we prayed with the family ..."</i> (Data: 298)
	2.1.3 Nurse-colleagues	<i>"Even with colleagues after taking ... talking to them, and then just sharing with them a little bit and then the smile (Data 332-335).</i>

Category 2.1: Relationships

The views of the participants about how they related to their patients, families of patients and their colleagues were expressed in various ways.

Subcategory 2.1.1: Nurse-patient relationship

This relationship was expressed in terms of how they interacted with patients and values that were attached to that relationship process. One participant explained that relating with a patient was understood to be spiritual when being conscious of those actions for serving or pleasing God. The patient was seen as a spiritual being to be treated with Godly reverence as implied in the following statement:

“I believe more in ah! doing good than in talking about faith matters with patients. I believe in works rather than words. So I live my life in my faith as I relate with my patients in such a way that I aim to please God in whatever I do or say” (Data: 332-335).

According to this finding, the physical care provided to their patients was done in the consciousness of it being a service to God. Some of them related with the patient by way of how they treated them. Resorting to doing things for patients in a humane way was exemplified as regard for people as human beings that deserves to be treated with compassion and courtesy. For more clarity on this response one participant said:

“I try to walk an extra mile for my patients, and all of them will say that, that I do my best even though they give me the most difficult patients in terms of attitude. I do my best to go an extra mile with my patients through the strength that God gives me” (Data: 339-343).

Some participants suggested that having a positive attitude or thinking positively about patients and sacrificing for them demonstrated compassionate care to those in need of such care. Doing ones' best for a patient was regarded as a positive relationship with patients. Hegarty (2007:47) argues that patients deserve to be treated courteously and with compassion as they are the lifeblood of institutions. Those not taking it out on patients are regarded as being compassionate because the patient is already marginalised by disease, sickness or injury or suffering spiritual pain.

A positive attitude when relating with patients was regarded as a basic necessarily with regard to provision of spiritual nursing care. Participants mentioned that even if you treat difficult patients, you need to have an understanding of their situation. Although most of

the participants had no exposure to training on spirituality, they recognised the value of a nurse-patient relationship embedded in spirituality as an essential aspect of patient care. The values that supported the notion of nurse patient relationship in this study were compassion, empathy, respect, concern and listening as presented on figure 5.1. According to SI, as expounded by Lynch and McConatha (2006:89), the values to be discussed below are subjective interpretation of reality that impacted and helped to influence the relationship of the participants with their patients.

Compassion

Displaying compassionate care was a prevailing expression of service not only to the patient or institution but as an act of serving God as stated:

“We kind of like understand that in the midst of everything that we do, we have to serve our patients and we are serving God” (Data: 317-320).

Characteristic statements supporting compassionate care differed slightly as some participants verbalised that their actions represented how much they valued their patients. The analogy of comparing serve to patients as serving God was a summary of how compassionate care was provided as it represents the love of God for human beings especially the sick and suffering.

This humane, compassionate way of treating patients who are in a sick role was extended to both religious and non religious patients alike.

Participants brought to light that caring for human beings in a health care environment should be orderly. Ordering the physical activities of daily care in a particular order and making sure that hygiene needs are met, is seen as demonstrating respect for the human being.

Compassionate care for the patient was reflected in the expression of the participants in taking time to be with the patient, being available and listening to them and taking time to talk with the patients was seen as an act of accepting them.

Empathy

Both the individual and focus group participants seemed to have witnessed patients being treated as objects, or in a dehumanising way which made them state that:

“You should not treat patients as objects” (Data: 285-285).

Participants demonstrated a commitment to provide spiritual nursing care that valued their patients as human beings worthy of respect and humane care. They demonstrated realisation that no one is immune from sickness as nurses can also assume the sickness role and expressed the desire to be provided spiritual nursing care when in that position. According to participants, patients are often identified with diseases, pain, ailments or suffering as expressed:

“Bed 2 has pain or that patient with a sore throat” (Data: 116-117).

Hospitals are common ground of identifying patients by their diseases and as such be treated as objects. Jeon (2004:250), based on the SI perspective explains that “self” needs should be appreciated as being situated in interaction with others. The “I” is the part of self that is the real person created by God, and sickness or disease reduces its status to that of “me” which depends on how others see the person. In this finding patients are seen as with the disease they presented with to the hospital. The self is never stable and is easily affected by crisis. Therefore patients lose their self identity and assume a self that is relevant to the health context and its language. They become easily labeled and addressed by their disease.

Respect

Some of the questions asked were responded to in terms of spiritual beliefs and faith issues. This was probably due to how the probing questions were asked. Both the participants and patients came from different belief systems. Participants expressed the need to have their own faith respected as they also showed respect to patients during spiritual counseling as reported:

“Again even during counseling, I check the religion of the person so that I can counsel the person without stepping on the toes of the people. Because I really don’t want people to step on my toes because of my faith” (Data: 162-167).

Although the background of the participants was of the Christian faith, this finding does indicate that the patient's beliefs were respected as they were counseled according to their faith or religion or belief.

Concern

Showing concern and love for the patients was described by the participants that it empowered the patients to relate well with them, with God and have hope and strength to cope with the challenging situation of sickness as reported in this response:

"... the other thing that you can do just to meet the spiritual needs of the patient, is showing love or concern to the patient" (Data: 52-54).

It is evident in this finding that the participants made an effort to relate with patients at a human level over and above the professional relationship of providing medications. The assimilation of God's love in the participants' own lives enabled them to regard love as an essential spiritual activity in relating with patients. Nursing as a profession is more concerned about implementation of principles, policies, protocols, treatments and other professional acts, but this finding brings to light that showing love and concern for patients is an essential part of the treatment given to patients.

Listening

Participants in the study realised a need to create the right climate for patients to be free to approach them and share their feelings with them as stated in the response:

"You really need an ear to listen to what the patient is telling you...so just listening to what she is telling you can be spiritual care" (Data: 214-215).

This finding matches research results of Van Leeuwen et al's (2006:883) study that indicate that the basic care activities that seem to form the essence of spiritual nursing care are the nurses' presence, listening and respect approach when relating with patients.

Connecting with the patient by listening, however brief, was perceived by the participants as important.

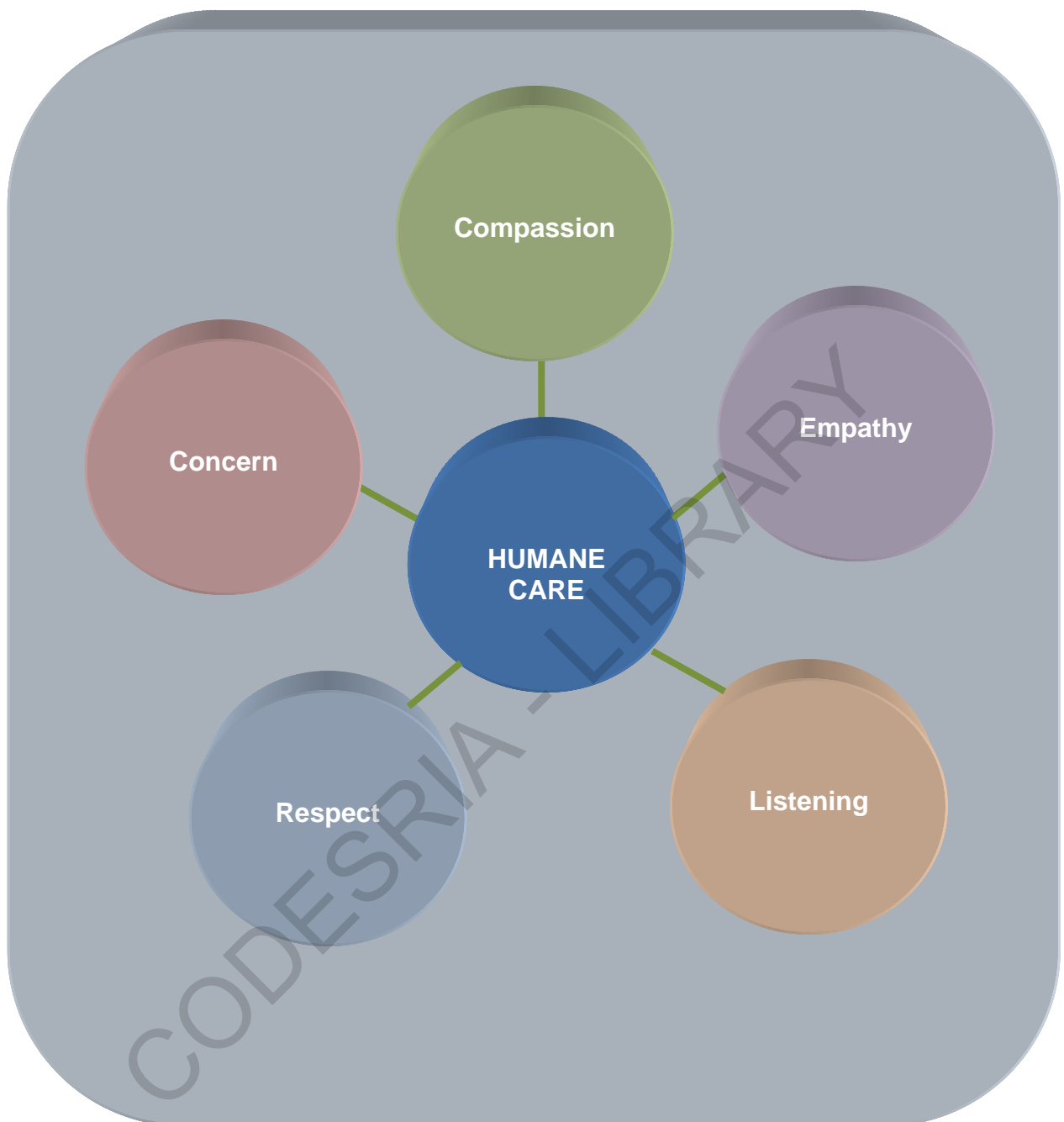


Figure 5.2 Values exhibited in the nurse –patient relationship

There is a golden thread of a core variable that emerges as *humane care* as described by the responses of the participants on how they relate with patients as they provide spiritual nursing care.

Subcategory 2.1.2: Nurse-family relationship

In the study, participants also provided an interpretation of spiritual care in relation to nurse-family relationships. Family members needed support as they were struggling with questions of transcendence when faced with challenges of the sickness or death of their loved ones. Although this study was not focusing on spiritual needs of families but this was a notable finding:

“Well, I had to contact the family before the patient died. About thirty minutes before she died, the wife asked about the husband if he can come and see her. I contacted the husband patient was critically ill but, he agreed. Whilst they were on their way to the hospital, unfortunately she died. So I had to tell that the wife is already late. He was very sad. (Data: 298-309).

In some instances it becomes extremely difficult to confront the truth especially with regard to prognosis. A poor prognosis is very difficult to communicate to the family.

In the findings, truth telling featured as an important spiritual practice which created an enabling environment for the family to can make informed choices and decisions. In hospital settings, the family needs spiritual care. Participants indicated how they communicated with the families of patients in a humane manner that empowered them to create meaning out of their suffering.

The sub-category of nurses' relationship with the family is congruent with spiritual nursing care behaviours described in the literature. Lloyd and O'connor (2007:168) state that there is emphasis on the spiritual dimension of connectedness which is particularly important for family members whose loved ones experiences pain, suffering, sickness or death.

Subcategory 2.1.3: Nurse-colleagues relationship

According to the participants, nurses in the units shared and connected spiritually with one another by engaging in spiritually fulfilling activities such as holding devotions in the units. This is exemplified in the following statement:

"... we used to eh...after we have taken uh... a ward round, we would assemble at the nurses bay, and maybe sing a chorus, share the scripture or a thought for the day, and pray after that" (Data: 164-168).

It was an accidental finding to observe that nurses also had spiritual needs. The participants in the study took an initiative to meaningfully relate with their colleagues during times of spiritual distress. Talking to colleagues in an empathetic way provided them with a release from being stressed and burdened as illustrated in this statement:

"... You know you can see a person when he/she comes on duty that this person is not well. After taking them aside and talking to them, just sharing with them a little bit of your experiences ... the mood changes" (Data: 216-221).

It was a noted fact that the same spiritual actions applied on patients who were distressed brought about positive outcomes on the nurses as well. This finding is similar to that of Musgrave and McFarlane (2003:527) who found that nurses who had high levels of spiritual well-being were aware of their own spiritual needs and were alerted to seek spiritual help and support.

Concluding remarks on theme 2

Participants in the study had to be aware of their own belief system and be tactful not to impose their own belief on patients, their families and colleagues. Although there was consciousness about the stigma on Christianity, but participants seem to have handled their relationships well without fear. The strong points demonstrated in these relationships were the display of values such as compassion, empathy, listening, respect and showing concern in the interactions. These values are common ground across religions, cultures or belief systems that enables nurses to relate in a spiritually therapeutic manner with all patients without being spiritually offensive. Some families

were comfortable with a spiritual approach to care and some were not. Although this was a shock to some of the participants, they however demonstrated respect for such responses.

THEME 3: PROVISION OF SPIRITUAL NURSING CARE

Spiritual nursing care is described by Van Leeuwen et al (2006:881) as simply actions of assisting a patient to recognise a personal unique meaning of life in times of sickness, to strengthen that person's relationship with God and to bring an appreciation of nurse's spiritual actions/interventions in the immediate environment of care. The roles of nurses in the provision of spiritual nursing care was realised in the context of interacting with patients daily. According to participants, these actions or interventions refer to kinds of actions that the nurse undertakes in the health care context to help meet the spiritual needs of patients (Narayanasamy & Owen 2001:629). The actions reflect descriptions that characterise basic psychosocial processes that occur in the nurse patient relationship. Spiritual nursing care interventions reported by the participants indicated as promoting transcendence, communication and consequences of provision of spiritual nursing care.

These actions/interactions of provision of spiritual nursing care are described within an essential structure of the positive role of actors, who according to SI are nurses. In this theme there were three categories with the related subcategories and meaning units as indicated in table 5.4.

Table 5.6 Provision of spiritual nursing care

Categories	Subcategories	Meaning unit
3.1 Promoting transcendence	3.1.1 Prayer 3.1.2 Bible /scripture reading 3.1.3 Spiritual songs	<p><i>"Prayer does help and it reassures the patient that together with the medication that he is getting, prayer is very important" (Data:125-128).</i></p> <p><i>"... or sharing the scriptures with the patient" (Data: 30-30)</i></p> <p><i>"... we used to eh...after we have taken uh... a ward round, we would assemble at the nurses bay, and maybe sing a chorus..."(Data; 120-121)</i></p>
3.2 Communication	3.2.1 Spiritual dialogue 3.2.2 Information 3.2.3 Counselling	<p><i>"So the only thing that I did for the mother, was that I had some minutes to spare with her and I allowed her to vent out her problems"(Data: 136-138)</i></p> <p><i>"I want the doctor to involve me after examining me and tell me what is wrong with me and how he is going to treat me. I must know what is wrong with me"(155-161)</i></p> <p><i>"I have been counselling the person concerning hope in life, that being diagnosed with HIV doesn't mean the end of life. You know attending to the spiritual being of it, it is important because that's where the actual the problem is"(118-122)</i></p>
	3.2.4 Referral	<i>"She will ask you to call the pastor of the church that she belongs to"(Data: 112-113)</i>
3.3 Consequences of provision of spiritual nursing care	3.4.1 Spiritual well-being 3.4.2 Ability to communicate With a smile	<p><i>"When the spiritual being is strong, eh! it affects the physical being positively or negatively" (Data:187-189)</i></p> <p><i>"... They become light and are able to communicate" (Data: 178-180).</i></p> <p><i>"With patients you would see a person who does not have smile on her face and you could see the person is heavily burdened, but after talking to that person everything changes. There is a smile on their face"(Data: 157-157)</i></p>

Category 3.1: Promoting transcendence

Prayer, Bible/scripture reading and of singing spiritual songs were noted in the findings as the common spiritual language and means of transcendence that nurses would ascribe to as a mode of connecting patients with the higher power when needed. Language, as one of the core assumptions of Blumer (1969:10), based on the SI philosophy, gives humans a means by which to negotiate meaning through symbols. Therefore prayer, use of Bible scriptures and singing spiritual songs was identified as the symbols used to create meaning of how nursing care is provided. Meaning in this regard was identified by the patients as nature and tone of voice as the nurse prayed, sung choruses or read the Bible to and for them.

Subcategory 3.1.1: Prayer

Prayer is described by DiJoseph and Cavendish (2005:147) as personal communication with God or higher power of one's belief system. Almost all the participants indicated prayer as a relevant spiritual nursing care activity. Participants preferred to connect patients with God through the gesture of prayer as it is quickly available, time saving and connects the patient with the higher power at the faith level of the nurse or both. Prayer was cited as the most common spiritual intervention employed by nurses to care for their patients. One participant articulated that practice by stating that:

Yah..... prayer is like the first thing that I would go for because, when you're preparing a patient for surgery in a busy setting; you haven't got like the whole of other staff. Prayer is the easiest thing you can have right there to reassure a patient, and to ah... to make them feel that even though they don't go to church or anything; God is looking out for them. So that's ... that's the first thing that ah! I would do and some of my colleagues as well" (Data: 90-101).

Prayer was cited with the highest frequency than all the actions taken or demonstrated by the participants as provision of spiritual nursing care. This category is further deliberated on under section 3.4 on outcomes of provision of spiritual nursing care, because of the impact of prayer on how it brought about positive outcomes on patients' health situations.

Subcategory 3.1.2: Bible/scripture reading

Participants participated in spiritual practices such as reading the Bible scriptures to the patients in order to connect them with God as evidenced in this comment:

“Sometimes you realise that some of the conditions the patient’s experiences are not amenable to medical treatment. I comfort my patients that things are not out of control or help because God is there for them or even share the scriptures with the patient” (Data: 30-30).

It is evident that the participants were Bible readers and easily played this role. The challenge of provision of such care was that not all nurses in the units read the bible or can share the scriptures with patients although Bibles were available in the wards.

This approach offended some of the colleagues who did not believe in the Bible and saw this action as a waste of time or imposition of belief onto another.

Subcategory 3.1.3: Singing spiritual songs

The Concise Oxford Dictionary (1983:986) defines singing as “to utter words in tuneful succession or to provide a vocal melody”. The words and lyrics can be intentionally chosen in a song to bring hope and comfort to the singers or listeners. In this instance the participant s reported singing as a way of providing comfort through the words in the song and the melody thereof. As demonstrated in this statement:

“There was nothing that could be done on that patient. Well the heart rate, blood pressure and the vital signs were very poor, and we even took some blood samples to check the blood gasses and one could see that eh... the blood gas results were not compatible. The doctor decided that we throw in the towel. We had to call in the family. I suggested that we should sing and pray with them because now the patient was critical and terminally ill. So we sung a chorus and I could see the patient and relatives lighten up” (Data: 201-214).

The family and health workers like doctors became spiritually distressed in the reported situation. One participant reported singing a chorus (with spiritual content) as a strategy to connect with God to draw strength and courage in trying circumstances.

The symbols of prayer, reading Bible texts and singing spiritual songs were used to negotiate spiritual meaning of the situations experienced. However, they were applied indiscreetly and not as a patient centred practice. Lloyd and O'Connor (2007:171) argue that the onset of illness, trauma or disease is a traumatic experience that may be experienced as a profound disconnection from self, mind, society, role participation and from a sense of meaning and purpose. Nurses as spiritual care givers may also experience disconnection because of lack of spiritual competency, appropriate spiritual practice skills and support necessary to integrate spiritual care to day to day patient care.

Category 3.2: Communication

SI is defined as a conceptualisation of communication between and amongst individuals or individual and the environment using language, actions, behaviour, expressions and objects to create meaning (Burnier 2005:502). In this study, SI relates to the analysis of the provision of spiritual nursing care as a basic psychosocial process of interaction or communication between the nurses and the patient in the health care environment.

Spiritual nursing care begins at the onset when the participants meet, relate and communicate with the patient in the process of patient care. One participant reported that as reference was made in their conversation about the need for prayer, one patient said:

"...I never expected a nurse to communicate with me like this. I never expected a nurse to speak on spiritual things with us, because we are here for the tablets. We never expected a nurse actually to have spiritually based knowledge. To get help related to spiritual things. We just expect a tablet and injection and then we go" (Data: 267-274).

It is sad to note that even patients in the study context did not expect nurses to care for their spirit needs. It confirms the conclusion that this type of care was provided by few nurse out of their own and not as a generally accepted or expected aspect of

professional patient care. Commonly these needs are referred to the hospital chaplain or the patient's spiritual leaders. This finding is confirmed by Van Leeuwen et al (2006:883) who conclude that nurses should accept the provision of spiritual nursing care within the nursing profession as a coincidence.

Communication related to spiritual care provided by nurses as responded to by the participants focused on aspects such as spiritual dialogue, information and counseling.

Subcategory 3.2.1: Spiritual dialogue

Cantazaro and McMullen (2001:224) describe dialogue as fundamental for processing cognitive and affective learning. However, dialogue in the context of spiritual nursing care is defined by Ming-Shium (2006:1029) as a person-to-person conversation that enhances search for meaning and hope for one's existence, relationship with God or other; and the place of the individual in the whole universe, through the experience of self or others so as to adjust one's life attitudes and behavior.

Dialogue with patients in this study focusing on the personal meaning of their circumstances seemed, according to participants to dominate conversations with patients. Participants reported spiritual dialogue with their patients as actions of talking with, listening, sitting down and holding a conversation with them. The following statement illustrated that a conversation with a patient is important as information shared may be crucial for health care decisions:

"After talking to the patient, after giving that patient a chance of verbalising whatever her fears They can even tell you things that you did not know before" (Data: 12 - 129).

Nurses in the units are very busy and seemingly under pressure to can spare time to converse with patients. Talking with patients on matters not related to their physical treatment, especially spiritual issues, was viewed by other members of the health team as a waste of time. Nonetheless, participants in this study took it upon themselves to have meaningful conversations with their patients. This created an avenue for a free flow of information as reported:

“... where we are able to have a two way communicate it is to make the environment conducive for the person and for the information to flow. I sat down with the patient and we talked. During our conversation I realised that the patient was experiencing spiritual distress...” (Data: 90-92; Data: 263).

Participants reported that although their patients were in a medically oriented environment, conversations held with patients in times of suffering included faith in God as part of the therapy for recovery. Connecting with the patient by listening during a conversation, however brief, was perceived by the participants as provision of spiritual nursing care. It offered the nurse a golden opportunity to make spiritual assessment and meet those reported spiritual needs appropriately as the nurse sees fit. During this conversation the participant was able to empathise with the patient about his problems. It became a window through which the participant asked the patient open-ended questions to stimulate and encourage self-disclosure. Questions related to faith and spiritual beliefs were asked in order to share with the patient's experiences in the faith.

The flow of the conversation between the patients and nurses seemed to be healthy and spiritually empowering. In most instances it was initiated by the patients who expressed a need to engage in a dialogue. Although the nurses in the study showed interest to converse with their patients on spiritual issues, it did not come out as a spiritual activity that they would deliberately initiate as part of spiritual nursing care. This finding is similar to that of Tanyi et al. (2006:534) that those participants (who were patients) that preferred to engage in spiritual dialogue were often reticent to engage in such discussions because some nurses displayed no interest in the topic. This was also because spirituality was regarded as a sensitive topic or a private matter by the nurses.

Ming-Shium (2006:1029) in support of this finding is of the opinion that in many cases nurses do not discuss issues related to spirituality with patients. In a study conducted by Tanyi et al (2006:535), their findings suggest that nurses should engage in spiritual dialogue by asking direct questions that are related to issues such as faith, belief in God, prayer or Bible texts. This kind of engagement was regarded as a simplest way to incorporate the patient's spirituality into their care, although the patient may not be forthcoming with the information.

Subcategory 3.2.2: Information

It is sad to note that in this study participants confirm that the reality in practice is that patients are not given the information they need. One participant empathised about the need for this interaction by stating:

“If I were a patient and want the doctor to involve me, and after examining me telling me what is wrong with me and how he is going to treat me. Person must be informed, and must know exactly what is wrong with himself or herself” (Data: 155-161).

Sickness, injury and disease make patients to be vulnerable and often are left out when discussions are made concerning their care. Participants in this study had picked up the importance to provide patients with relevant information that makes them feel important and of worth:

“... by sharing with the patient he feels that he is important and eh...” (Data: 77-78).

Other sources that participants used to provide patients with God related information was by encouraging them to read books that describe God as a healer:

“Like books that have information about salvation. What is salvation and how one can go through; and some of the books deal with healing and encourages knowing that God is a healer” (Data: 41-42).

This gesture was intended to assist patients to transcend with a higher being who is God and commune with him through prayer or meditation. This is a dimension that transcends the physical, social and material world that needs to be understood and facilitated. Another participant concurred with the notion of using books for reading:

“... what I used to do was to borrow them books that are spiritual in nature so that during his spare time, whilst he is still in the ward he can read and either talk to God through this or come to understand God better in their situation” (Data: 32-36).

The use of spiritual reading material seems to be of help for nurses who have a burden to provide spiritual nursing care but have no time to do so due to work pressures.

Availability of Bibles or spiritual reading material seemed to enhance connection with God in times of need, suffering or pain. In this hospital where the study was conducted, New Testament. Bibles were available in the units. Both nurses and patients were seemingly allowed to can read them for their own spiritual upliftment. Therefore the researcher is of the understanding that nurses, as part of spiritual care for patients can encourage patients to read the Bible texts for spiritual information.

Spiritual reading material can only be of help to patients who can read. Health care environments are strange at first and patients don't know what is happening. Often patients in crisis situations of suffering have questions about purpose and meaning about their suffering or may think that God is punishing them for their sins or has deserted them. Such questions seemed to be hard for nurses in the wards to deal with, hence the participants in this study simply answered by providing reading material.

Subcategory 3.2.3: Counselling

Counselling as a mode of communication was provided by participants in the study on ad-hoc basis particularly for individuals with debilitating conditions such as HIV/Aids or stress. Opportunities for spiritual counselling were identified as non-drug management sessions:

“Spiritual care usually comes at the times of non drug management. There is drug management and non drug management. During the non-drug management, that’s when we do the counseling especially after the information you have collected during the history taking when you have made a diagnosis and in some instances you realize that medical treatment will not be of any help (Data: 67-71).

Patients with HIV infection were the common candidates for this type of spiritual care because of fear of death and hopelessness that accompanied the diagnosis. In this study, spiritual counseling was based on Christian principles because of the participants' belief system. No objection or resistance by patients or colleagues was experienced, instead patients reported being helped, comforted and strengthened to cope with their difficult circumstances. Participants because of their spiritual background based counseling on spiritual context and viewed this as a necessary component of patient care to attain spiritual healing. One would then assume that not all nurses in the

units would regard such counseling as an integral part of their professional responsibility. Counseling would still be done in a way that may address the emotional or social needs of patients and miss out on spiritual counseling.

Interview

Participants used the interview as a counseling method. Interview is defined by Henning, Van Ransburg and Smith (2004:53) as a mechanism or a technology, if used methodologically and applied according to strict principles of objectivity and neutrality, will yield information that represents reality more or less “as it is” through the response of an interviewee. This method assisted the nurses to find out exactly what the patient’s problem was as evidenced in this excerpt:

‘When you continue interviewing a patient, you find that physically there is nothing wrong with the person. You find that there might be a social problem. On further interview, there may be an undefined problem that is bothering the patient. In such instances nothing can be done except wait and see. For Christians we pray about it’ (Data: 49-52).

Participants seem to have difficulty in differentiating spiritual aspects from social aspects. Although the participants showed interest to meet the spiritual needs of their patients, lack of knowledge and competency to differentiate and deal with issues in that regard impacted negatively on patient care. Most patients were referred to social workers for spiritually related concerns interpreted as social problems

Subcategory 3.2.4: Referral

Referral to pastoral or Christian counselling was reported to be done for patients who expressed spiritual concern. Some of the participants related their experiences of having to refer their patients , but this was after nurses attempted to provide spiritual nursing care by talking to the patient and validating with them acceptability of such care. Some institutions have resident spiritual agents as a formal structure available for provision of spiritual care to patients as reported in this response:

“In other hospitals you will find that there are hospital chaplains or a pastor available where you can refer a patient or let the patients be seen by a particular religious person” (Data: 40-43).

Nurse referrals to or involving their spiritual leaders as expressed by the participants either occurred at a patient's request or were initiated by the nurse. Arrangements were made by the nurses according to this finding to have the clergy of the patients' own choice come and offer spiritual care as reported:

“So that's why we will make some arrangements with that particular pastor that is associated with the individual patient or the individual hospital to come and do the necessary rituals” (Data: 45-47).

In such instances one is concerned about patients experiencing spiritual distress in the interim when there is no religious agent to refer to. There is possibility that the pastor might not be available or delayed to come as confirmed in this response:

“My concern is when there is no relevant person to can send the patient to like a pastor in the vicinity, and that we have to postpone the time or date of appointment. Counseling may not be done immediately and the patient's distress worsens” (Data: 185-189).

If such services are not available in the hospital, participants reported that on their own they referred patients to outside spiritual agencies for further counselling. Hutchinson (2001:240) comments in relation to this finding that nurses need to recognise their own spiritual limitations and know when to make a referral or may utilise other team members who are spiritually competent to provide such care.

Some institutions have resident spiritual care givers while others don't. One would assume that even this kind of initiative is often not followed up because of the lack of culture to formally support provision of spiritual nursing care or knowledge about availability of spiritual sources where patients with spiritual distress may be referred to. This finding is supported by the findings in a study conducted by Reid, Field, Payne and Relf (2006:436) that in general there are few alternative formal spiritual resources to access to refer patients to for spiritual care, as a result this part of care is ignored or not

understood. Members of the team who are uncomfortable for some reason about providing spiritual nursing care themselves can use referral to other able providers to make spiritual nursing care part of holistic patient care (Hutchinson 2001:210).

A summary of these findings concurs with the conclusion made earlier on that the cry and efforts of the participants in the provision of spiritual nursing care resemble the characteristics of 'humane care' discussed in theme 2.

Category 3.3: Consequences of provision of spiritual nursing care

Consequences or outcomes are defined by Freshwater and Maslin-Prothero (2005:424) as visible or practical result effect or product. Spiritual nursing care in this study had positive effects on the quality of patient as was best understood and reported by the participants. Meraviglia (1999:25) concur that consequences in the context of provision of spiritual nursing care are useful in determining often neglected aspects of spiritual care, ideas, variables, or relationships that may yield fruitful new directions for clinical practice. Positive outcomes that were brought up in both the individual and focus groups are reported.

Subcategory 3.3.1: Spiritual well-being

Spiritual well-being is one of the outcomes that were indicated as the main desired outcome of effective spiritual nursing care. Spiritual well-being is defined by Musgrave and McFarlane (2003:524) as the affirmation of life in relationship with God, self, community and an environment that nurtures and celebrates wholeness.

Nurses in this study were present when their patients experienced pain, illness, suffering or when dying and to the best of their ability, they created a spiritual environment that facilitated attainment of spiritual well-being. Patients became calm, relaxed, peaceful and strong. Such state was believed to have contributed to the patient's physical healing:

“When the needs of the spiritual being are met, patients become strong to phase painful physical or body affecting conditions such as injury, diseases, sickness or surgery. Spiritual health or well-being enables patients to function and be calm and collected even in difficult times” (Data: 187-189).

Other patients reported to be feeling strong and coping as an n outcome of being spiritually cared for. Participants in this study had an understanding of the importance of focusing on the spiritual well-being of patients as a desired outcome during provision of care.

Subcategory 3.3.2: Ability to communicate

The ability of the participants' patients to self-transcend their difficult circumstances by communicating with the participants was noted as a positive consequence of the spiritual care provided as perceived by the participants:

“They become light and are able to communicate with nurses or respond to questions. Often they are burdened, depressed and feeling alone” (Data: 178-180)

This statement shows how spiritual nursing care enabled the patient to self-transcend the present situation for higher meaning and purpose and enabling the patient to communicate with others. However, it is a noted fact that these actions which could have been prayer, compassionate care, empathetic listening or spiritual dialogue were done on the spot and not in a systematic way as part of the nurses' professional responsibility. Nonetheless the findings in this study compare with the statement that providing spiritual nursing care is important for the attainment of an overall sense of health, well-being and good quality of life (Conco 1995:266). On the contrary, McEwen (2005:163) argue that in the process, the nurse may be regarded to be the spiritual expert while the patients' spiritual capacity and resources may be devalued.

Subcategory 3.3.3: Restoration of hope

The spiritual substance of hope was extracted from the participants' description of their faith that enabled their patients to have hope of life to overcome difficult situations:

"... You give hope. The hope of life, the hope of going on with life even if the spouse or the child is not doing well" (Data: 92-94).

The experience of being hopeful in a hopeless situation was attributed to having faith in God. Hope was also associated with finding meaning in their lives as they regained hope and made sense of their circumstances. Nurses were cited frequently as providers of hope to the hopeless as they encourage their patients to have faith in God who cares about them and is able to help them.

Hope in this study was experienced as a positive outcome for the patients as mentioned in the following excerpt:

"They tend to realise that through prayer, they tend to have hope again" (Data: 120-121).

For some of the patients, it was the nurse who brought the sense of normality, ordinariness and security into an abnormal situation which gave the patients a sense of hope. This sentiment is supported by Coyle (2002:592) who states that providing spiritual nursing care motivates, enables, empowers and provides hope. It is the sense of connectedness to God that has consistently been found to engender hope among people with chronic illnesses.

Cooperate prayer was engaged in by some of the participants as a spiritual ritual practice. It seemed to be a source of strength for the staff before commencing with their routine. This could have been the spiritual influence of the participants not only for their patients but for other nurses too. Spiritual nursing care strategies of transcendence such as singing spiritual songs, reading Bible scripture and prayer were practiced as reported:

"we used to eh...after we have taken ... a ward round, we would assemble at the nurses bay, and maybe sing a chorus, share the scripture and pray after that. (Data: 164-168).

This practice indirectly also was providing spiritual support for the patients nearer the nurses bay. It brought comfort to them to see care givers drawing spiritual strength and

wisdom from God for their perceived benefit. However, it was evident that the preferences of patients had to be considered as not all patients were comfortable with being prayed for by nurses. This finding is also supported by a study that was conducted by Tuck et al. (2001:449) when parish nurses were asked to list spiritual interventions generally performed in their practice. Out of four hundred occurrences of the 89 interventions, the primary intervention cited was 68 responses on prayer (17% of the total reported) which was reasonably frequent compared to other interventions.

Herman and Reynolds (1994:10), who are the proponents of SI, argue that when people are sick or injured they think and attach meaning to objects and symbols such as prayer, as evidenced in this finding. Nurses therefore are cautioned to be careful not to use their power position in such given situations to impose their beliefs on patients. Meeting spiritual needs must be such that patients are able to interpret the care in that regard and assign meaning to its relevance to their optimal health.

Subcategory 3.3.4: Meaning and purpose

According to Lloyd and O'Connor (2007:171), discovering meaning and purpose for life are core aspects of interventions which will assist patients to respond to spiritual care offered by nurses. Meaning and purpose must be found and experienced by each person in different situations and contexts. Quality of the substance of the positive role played by the actors in the context of provision of spiritual nursing care is determined by sub-categories such as meaning and purpose and attainment of hope in times of health crisis.

Not all participants saw search for meaning and purpose by patients and families in the context of prayer as necessary for the prevention of losing hope in times of experiencing sickness and death of their loved ones:

“ ... unlike the first child who passed away, now she is given her the opportunity because she got a chance of being seen by the doctor, being prayed for, and a chance of getting treatment and going back to normal again” (Data: 90-97).

Some of the patients cared for asked questions about their sicknesses. Nurses may not be able to provide answers except through prayer. This state is confirmed by the following observation:

“... through prayer they tend to see life as having meaning” (Data: 122-123).

This finding was a positive outcome described by the recipients of spiritual nursing care provided. Frankl (1962:67) saw search for meaning as a universal trait which is essential to life itself. The claims of Frankl (1962:67) support the finding by expositing that meaning can be experienced and is always there waiting for us to find it. In a situation of people who are suffering, they can choose the kind of attitude they want to meet pain, suffering or death. According to Yura and Walsh (1982:90), ‘the greatest task of human kind is to determine the meaning of life.’

A quote by Le Guin (Collins 2006:256) sums up the finding in this section that ‘it is no good asking what the meaning of life is because life isn’t the answer, life is the question, and prayer is the answer.’

Concluding remarks on theme 3

Spiritual nursing care, according to this study, was provided based on the spiritual background of the nurse, and not necessarily as part of professional preparation of the nurse. It was intuitive care that was provided as an in-between practice depending on the ability of the nurse to identify spiritual needs and do something about it. Prayer was cited as the most frequently used activity of spiritual nursing care by both nurses and those patients are referred to. It is a notable finding to realise that spiritual nursing care is not only about prayer, reading scriptures or use of sacred music only, but other modes of care such as providing patients with information is an example of spiritual nursing care which even non religious nurses can provide. Approach to care focuses on recognising a patient as a spiritual being worthy of respect and dignity.

THEME 4: CHALLENGES IN THE PROVISION OF SPIRITUAL NURSING CARE

Participants in this study shared light on some of the challenges and difficulties they experienced as they provided spiritual nursing care. They seemed to be fighting this

battle alone without the support of management from both the education and clinical practice fields as no mention was made in that regard. Provision of holistic patient care seems to end up in the literature and some of the nurses who are interested in providing such care experience barriers in practice.

Table 5.7 Challenges in the provision of spiritual nursing care

Category	Sub-category	Meaning units
4.1 Feeling spiritually inadequate	4.1 Lack of education and training	"... lack of time, lack of training, concern about activity outside of the physician's area of expertise" (Data: 169-176)
	4.2 Different religious beliefs	"Ehm ... I can't say much because at work everybody seems to hold on to what they believe in" (Data: 196-200)
	4.3 Prefer to be prayed for by a man	"Most patients prefer to be prayed for especially by a man than a woman. It is the influence of their culture" (Data: 32-38)
	4.4 Agreement between the nurse and the patient	. "... In a case when a patient need prayer or reading of scripture, it will be an agreement between me and the patient" (Data: 32-38)
	4.5 Lack of time	"... Lack of time, lack of training, concern about activity outside of physician's area of expertise ... lack of interest or awareness." (Data: 169-176)

Category 4.1: Feeling spiritually inadequate

Most of the participants reported to be feeling inadequately prepared to render spiritual nursing care to patients. Most of the cited care was done as part of their spirituality and service to God, and not necessarily as part of their professional responsibility. This feeling of inadequacy was experienced as lack of education, confrontation with different

beliefs of both patients and nurses, preferences of patients based on culture; need to have a contractual agreement with the patient and lack of time.

Subcategory 4.1.1: Lack of education and training

Participants when asked about whether they knew how to provide spiritual nursing care, indicated lack of guidelines during their basic training years on how to provide such care:

“I think also that it lies within the individual on how to carry out spiritual care. We were not guided or given the spiritual principles during training, I do not think that this is in our training curriculum” (Data: 241-245).

This response is supported extensively in literature. The participants in the study have had both basic and advanced nurse training, but with no exposure to content related to spiritual nursing care. Even though nurses are trained on basic aspects of patient care and communication skills, it does seem that little is said on spiritual aspects of care. One would thus assume according to the above stated finding that spiritual needs of patients are not met in clinical practice as the majority of nurses are not spiritually competent.

Although inclusion of spiritual care into the education of different health professionals is already evident, there is still a need for conceptual consensus that is coherent across all the different health professions, particularly amongst nurses. Nurses still struggle to teach and integrate spiritual nursing care to nursing practice, even though some of the literature have such content (Collins 2006:254; Hurley 2006:10).

Subcategory 4.1.2: Different religious beliefs

People express their belief or faith in the way in which live. According to the participants, some of the patients expressed their spiritual choices or preferences in terms of prayer or should administer spiritual rituals to them.

“You will find that the patient needs to be prayed for, or needs to be eh! [Scratches her head.....pause] need to be spiritually taken care of by the pastor of the religion where she belongs. She will then ask you to call the pastor of her church” (Data: 112-113).

Participants in the study seemed to fear that the patients might perceive providing spiritual nursing care as an act of imposing their faith on them. There seem to be a limitation of this understanding as the nurse should see seeking outside spiritual help for meeting patient’s spiritual needs as provision of spiritual nursing care and as respect of the patients’ religious view and preferences.

Spiritual sensitivity

The Christian faith believers are said to be stigmatised probably because of sharing the gospel with others which is a Biblical mandate (Kumar 2004:24). Sharing the gospel with patients is interpreted as imposing one’s beliefs on others and being insensitive of other people’s beliefs been it patients or colleagues as stated in this response:

“Not all patients are open to spiritually oriented conversation or actions. Nurses who identify spiritual needs or see patients being distressed can probe more about their experience just to listen ... but not to impose on the patient about Christian values, but to be tactful” (Data 277-277).

Although the participants reported that they hold devotions in the morning in some of the wards, it is evident that some of the nurses do not want to partake in such practices. It is their right to be respected in that regard. Participants in the study

Were aware that both nurses, patients’ and their families’ belief system should be respected and their faith not to be imposed on others as demonstrated in this excerpt:

“Not all people believe in God or prayer. Some nurses are uncomfortable to talk about spiritual matters in health care settings for fear of stigmatisation about their faith or accusation that they are imposing their beliefs on vulnerable patients. We should not force people to come for prayers or read the word of God” (Data: 171-172).

The South African constitution (Republic of South Africa 1996) allows people to have freedom of religious affiliation. Participants seem to have understood this right and integrated spiritual nursing care from their point of view and belief with a non-judgmental attitude towards the beliefs of their patients and that of their colleagues.

Subcategory 4.1.3 Prefer to be prayed for by a man

The emergent findings demonstrated the notion that patients have their own perspective or understanding about who should attend to their spiritual needs. Culture in this finding dominated the scenario as spiritual agents were identified with male characters than with females amongst Africans:

“In that case it will be agreement between me being a nurse and the patient or the person that is in need of spiritual nursing care, because others prefer to be prayed for especially by a man character...” (Data: 32-38).

It seemed, especially in the area of prayer, that the patients' choice about who should pray for them had to be considered. The nursing profession as a female dominated profession faces a challenge in this regard because of African culture as already alluded to. Seemingly God who is always depicted as a man is equated to the men as heads of their families. This attitude is reported in the following excerpt by another participant:

“... because with my understanding, it's sometimes a problem when you are to pray for a person after you realise that he has a spiritual need. They tend to believe that they need to be prayed for by a man and you are a lady. They refuse. Others will refuse because they have a way of how to pray or to be prayed for by a man” (Data: 194-201).

Participants however showed respect to this belief or spiritual related attitude. The challenge is how to facilitate prayer for patients with a different way of praying or praying to another deity other than God. However, no mention is made as to how this matter is further handled to meet the spiritual needs of these patients except that they do not force people to pray with them.

Subcategory 4.1.4: Agreement between the nurse and the patient

It was interesting to note that the participants were aware of the need for an agreement with the patient before providing spiritual nursing care because people have preferences when it comes to spiritual matters. Although nurses reported that prayer was the most common, quick and easy spiritual intervention they would use. There still was a need for permission for them to pray for and with the patient:

"... In that case it will be between the agreement of me being a nurse and the patient or the person that is in need of spiritual nursing care, or others will allow you as a nurse to pray for them with an agreement that you have with them" (Data: 32-38).

Participants had knowledge of the value and power of prayer and the word of God in times of crisis, but still an agreement between them and the patients was necessary as reported:

"The wife was really concerned about the health of the husband; and eh... one of my colleagues suggested that we should share the word of God with her including the children. But you know [eyes opened wide] that woman did not agree. She felt that prayer does not work. So it is not everybody who appreciates reading the scriptures to them or to pray with them" (Data: 228-241).

Respect for the patients' choice not to be prayed for or the scriptures read are part of the challenge as it is understood as part of spiritual nursing care. However, it should be realized that there are other strategies of providing spiritual nursing care which do not need an agreement with the patient such as showing concern and respect as examples.

Subcategory 4.1.5: Lack of time

One participant in the individual interviews expressed that limitation of time is one of the barriers or aspect that makes it difficult for them to deal with the patients' spiritual needs:

"... Lack of time, lack of training, concern about activity outside of physician's area of expertise ... lack of interest or awareness" (Data: 169—176).

It does seem that to provide spiritual nursing care is qualitatively different compared to other treatments given in a health care unit. Providing spiritual care is seen as something extra that needs special time to be done and not as part of the nurse's professional expertise in clinical practice.

Govier (2000:35) comments that attending to someone's spiritual need is time consuming and presents a challenge to the nurse who is over stretched by understaffing and the routine demands of busy public hospitals. Van Leeuwen et al. (2006:883) also confirm that nurses encounter varied demands and pressures in their practice.

It seemed a bit complex for the participants to render spiritual nursing care to the patients more than when giving professional care or attending to the needs of other dimensions of an emotional or psychosocial nature.

Concluding remarks on theme 4

One would remark that providing basic spiritual nursing care to patients does not need an agreement or consent, but may be necessary if offering spiritual nursing care which touches areas of belief system, religious worldview or doctrinal practices. Some faith practices allow only men to do certain rituals or activities. Prayer was a common simplest form and example of spiritual nursing care language or symbol suggested by the participants. Often participants themselves showed confidence and ability to do so without difficulty. It was however a challenge as patients subscribes to different belief systems or not to any which was perceived as a barrier to provision of spiritual nursing care. In spite of the constraints identified, the importance of providing spiritual nursing care cannot be underestimated (Ledger 2006:223).

In general, the findings suggest that the participants identified that the outcome of their spiritual intervention had a positive therapeutic effect on their patients.

5.7 CONCLUSION

This chapter included an analysis and interpretation of the findings of the study. A non-mathematical process of analysis and interpretation was employed. Major themes,

categories and subcategories that emerged from the data were tabled and discussed accordingly. Meaning units for each theme that were represented by appropriate quotations from the participants' words were indicated in tables. Creation of meaning was identified as an important component of the findings as the participants were challenged in understanding what spiritual nursing care is. Further discussions expatiated on the relationships of the nurse with the patient, family and colleagues. The related values were also highlighted as these gave evidence of how spiritual nursing care was provided over and above professional clinical expertise to provide quality patient care that addressed the patient as a whole. Different ways of how nurses in the study provided spiritual nursing care was also reported as expressed by the participants. This kind of care was experienced to be having challenges that were indicated by the participants as what made it difficult for them to provide spiritual nursing care.

Data interpretation was based on some of the major aspects of SI philosophy such as the creation of meaning and concepts such as mind, self, society, role taking, and the expression of "I" and "me".

Chapter 6 presents discussions on the development of a model

CHAPTER 6

THESIS: DEVELOPMENT OF A MODEL ON INTEGRATION OF SPIRITUAL NURSING CARE TO CLINICAL PRACTICE

6.1 INTRODUCTION

A grounded theory study, based on the SI philosophy, was conducted to explore and describe how nurses in practice provide spiritual nursing care to patients as part of holistic patient care. The purpose of the study was to develop a nursing model for the integration of spiritual nursing care to patients in clinical practice. The core variable discovered from the data was provision of 'humane care' which resembled the identified elements of spiritual nursing care from the findings. Therefore the qualitative data analysis process led to the emergence of a prevailing category labelled as "Humane Care" approach in providing spiritual nursing care to patients. Analysis of the individual participants and focus group interviews provided data to develop a theoretical structure that guided the researcher in developing a model for the integration of spiritual nursing care in the day to day patient care in the health care settings. According to Glasson, Chenoweth, Hancock, Hall, Hill-Murray and Collier (2005:588), integration of spiritual nursing care in practice is an important focus for holistic care to be realised. In the model that is developed, key concepts that constituted humane care were identified as focus of humane care, humane care nurse relations, humane actions of care and outcomes and barriers to humane care.

6.2 MODEL DEVELOPMENT

Development of the model constitutes the third empirical phase of the study. Freshwater and Maslin-Prothro (2005:365) define a *model* as a way in which a researcher or scientist views and presents his or her material within a certain paradigm. According to Polit and Beck (2008:116-117), a model is often used in connection with symbolic representations of some aspect of reality. It is a visual or symbolic representation of a theory, and it is a conceptual framework that helps to express abstract ideas in a concise and readily understandable manner. In this study, a model on the integration of

spiritual nursing care to clinical practice was developed to provide nurse clinicians with a tool to guide them on what activities to engage in when providing holistic care. The components of the model are established from the findings in such a way as to promote and facilitate humane care interventions in the nurse-patient relationship. Each of the concepts of the model is schematically presented for more clarity on figures.

The model is termed 'Humane Care Model' (HCM) because it posits that over and above the professional expertise of nurses, adding an element of treating patients humanely and with respect to their religious beliefs and as persons, coincide with meeting their spiritual needs. Narratives from the participants expressed a values laden concept of 'Humane Care' as the core category for the study. Humaneness is defined as the quality of compassion or consideration for others, characterised by tenderness, empathy and concern for the suffering or dying (Wordreference.com).

Touhy, Brown and Smith (2005:31) describe humane care as care that encompasses concepts of being compassionate, empathetic, listening, touching and support. Humane caring is viewed as a sense of duty and devotion to God. It is care that brings with it values such as forgiveness, love, respect, compassion, meaning and hope, and transcendence. Thus balancing care for the body, mind and spirit especially during personal crises (Shelley & Fish 1988:45).

6.2.1 Assumption underlying the model

- The main assumption underlying this model from the perspective of the participants is that each patient is a whole person comprised of body, mind and spirit (O' Brien (2002:9). This assumption means that each patient is more than the pressing bodily needs that caused the patient to consult for medical care. It was established from the data that a human being regardless of circumstances is a spiritual being with a spirit that must be built or cared for, and must be treated humanely with respect.
- It is assumed that, in hospital settings physical needs are given more priority than spiritual needs. The notion of holistic patient care demands a balance in meeting the physical and spiritual needs (Smith 2009:2).

The researcher therefore, assumes that the model would provide guide lines and criteria for religious and non religious nurses to provide spiritual nursing care to patients they care for.

6.2.2 Objectives of the model

The objectives of the model are

- to provide a guiding framework that is comprehensible and would increase the nurses comfort level in providing spiritual nursing care in the day to day practice irrespective of their belief system and that of the patients
- to empower nurses with examples of actions or interventions they may engage in to provide for spiritual needs of patients as part of their professional responsibility in the care of patients
- to contribute to the improvement of quality patient care by providing practice guidelines on how and what to integrate as spiritual nursing care to the nursing care plan (Figueroa 2008:38)

6.2.3 Components of the Humane Care Model

6.2.3.1 Focus of humane care

The suggested humane care model brings emphasis on the interrelatedness of the body, mind and spirit. The interrelatedness of one dimension with the other as presented in figure 6.1 illustrates that all the stated dimensions are equally important.

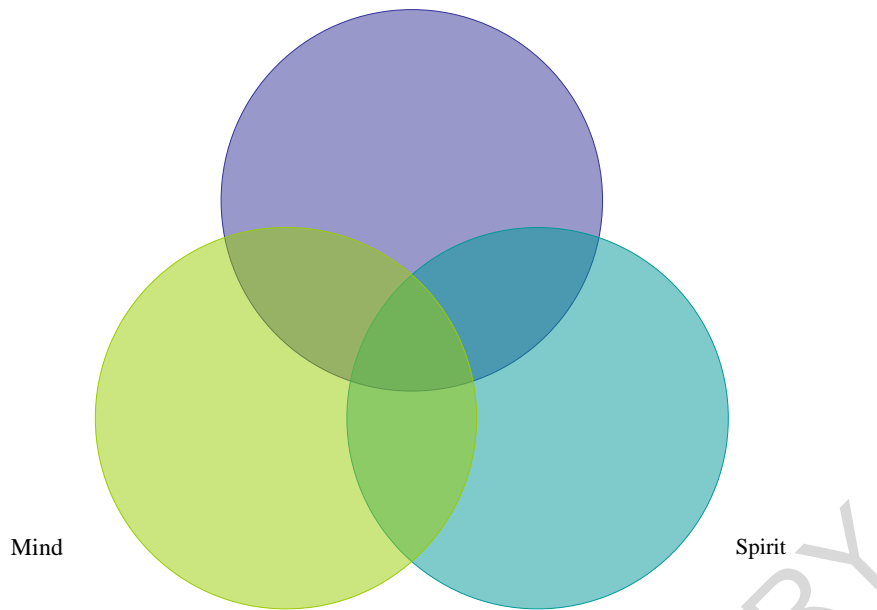


Figure 6.1 Focus of humane care

The body is that dimension which allows the person to be in touch with the nurses, other patients, family, environment and the whole health care team. The body may be treated with medications as identified in the findings of this study. Through the body the patient and the nurse enter into a relationship or interaction which according to the SI philosophy (Shott 1979:1319) is termed social interaction in a given health care society. Significant in this symbolic interactionist view is that individuals are actors in situations as they act on definitions they assign to persons, objects and events that comprise the situation. The health crisis situations that patients find themselves in are always embedded in and shaped by larger contexts of meaning such as the spirituality experienced (Burnier 2005:502). The patient is seen by nurses as suffering from a particular disease or scheduled for surgery often purely from a physiological stance as lamented by the participants in the study. The physiological needs are defined by nurses and the health care team as of more importance than the needs of the mind or spirit which might be needs of fear of the unknown, need for information, emotional pain or need to connect with the outside power greater than the patient or the prevailing circumstances. The humane care model reconciles the fact that patients are spiritual beings and have spiritual needs that need to be addressed too. The interrelationship of

body, mind and spirit can therefore not be ignored because suffering or pain in one dimension affects the response of the other.

Providing humane nursing care is demonstrated by how the physical care is carried out coupled with empathetic listening to and talking to the patient in the midst of hurried ward or unit routines. Building a person in the spirit empowers the patient to have strength to face suffering, surgery or pain. As it is hard to draw the line between the emotional and spiritual needs, providing answers to questions about meaning and purpose of the suffering brings hope to patients. The model concurs with McSherry's (1998:39) argument that within a person's spirit there lies the potential to be conscious of God. The proposed model mandates attention to the problems and concerns of the spirit as well as to those of body and mind in most humane and respectful ways (Govier 2000:32; McEwan 2004:323; O'Brien 2002:10). Although the spirit is described in literature as pervading all other dimensions, the human being according to Carson (1989:9), is and functions as a dynamic balanced whole. The expression based on the model of focusing on caring for the needs of body, mind and spirit is supported in literature that provision of care of spiritual quality "...is not only by giving curative care to the bodies of the sick and injured, but by serving the needs of the spirit and mind as well" (O'Brien 2003:259).

6.2.3.2 *Humane care relationships of the nurse*

A key feature identified by the model is the relationship of the nurse with the patient, family and other colleagues as depicted in the figure 6.2.

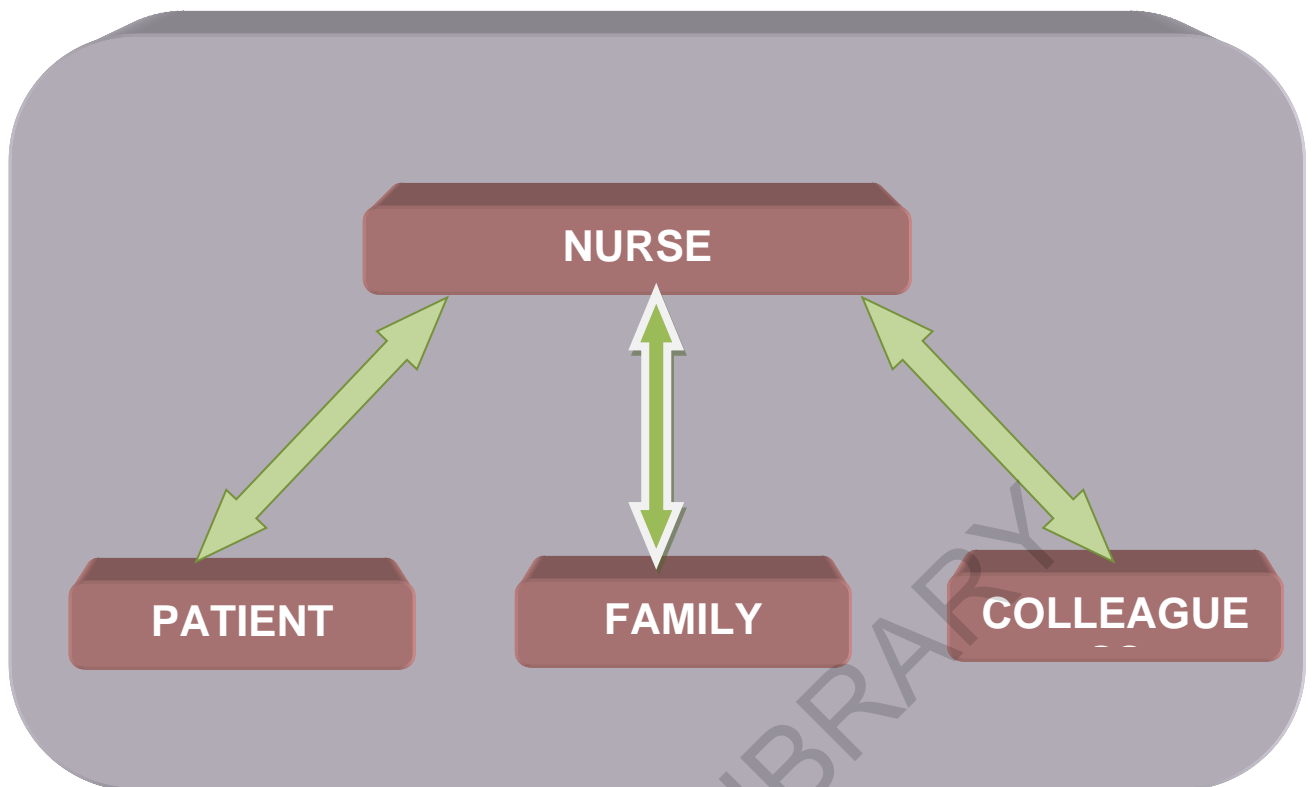


Figure 6.2 Humane care nurse relationships

A humane care type of a nurse-patient relationship process is influenced by various factors such as the spiritual awareness of the nurse and faith in God or interest of the nurse to provide spiritual nursing care to patients. What makes humane care relationship differ from the normal nurse-patient relationship is that patients are recognised as spiritual beings that are not only bodies presented for cure with medication or surgery. Both the nurse and the patient enter into a relationship in which a particular belief system, intuition, faith in God, spiritual strength and emotions are expressed in one way or other (Cornwell & Goodrich 2009:2).

The personal faith in God of the nurse shapes the direction of the relationship between the nurse and patient, family or colleagues. This faith is an internalised theological belief system that directs the relationship with patients and their families in times of health crises and may be overtly displayed through examples of touch, sitting down to talk with the patient or even offering a prayer. Respect for the faith beliefs of patients, their families and colleagues is viewed, according to the model, as a positive role that will enhance good relationships. The arrow that depicts the relationship of the family with the nurse is narrower than the others because spiritual nursing care activities occurred frequently in the units other than at visiting hours or when the family was contacted.

Based on this model, the nurse-patient relationship is demonstrated by allowing a person to express his or her views, fears, anxieties or asking questions and receiving an undivided attention from the nurse as well as meaningful answers that allay their fears. Patients who have no well-defined philosophical or religious belief may wish to explore feelings, values or discuss areas of concern with another person. For some patients the nurse is the appropriate person to relate with (Hubert 1963:30); but those with no well-defined philosophical or religious beliefs may wish to explore feelings, values or discuss areas of concern with another person other than the nurse.

Humane care relations are expressed through the values or symbols as discussed below.

Humane care values/symbols

Central to Mead's (Figueroa 2008:39) approach is the idea that nurses can assist patients to survive in their health care environments characterised by pain, suffering, disease, injury or death by using related symbols. A symbol is any sign agreed upon by convention (Figueroa 2008:39). Humane care nurse relations is expressed in this model by symbols deduced from the findings of the study such as compassion, empathy, listening, respect and showing concern as exhibited in figure 6.3.

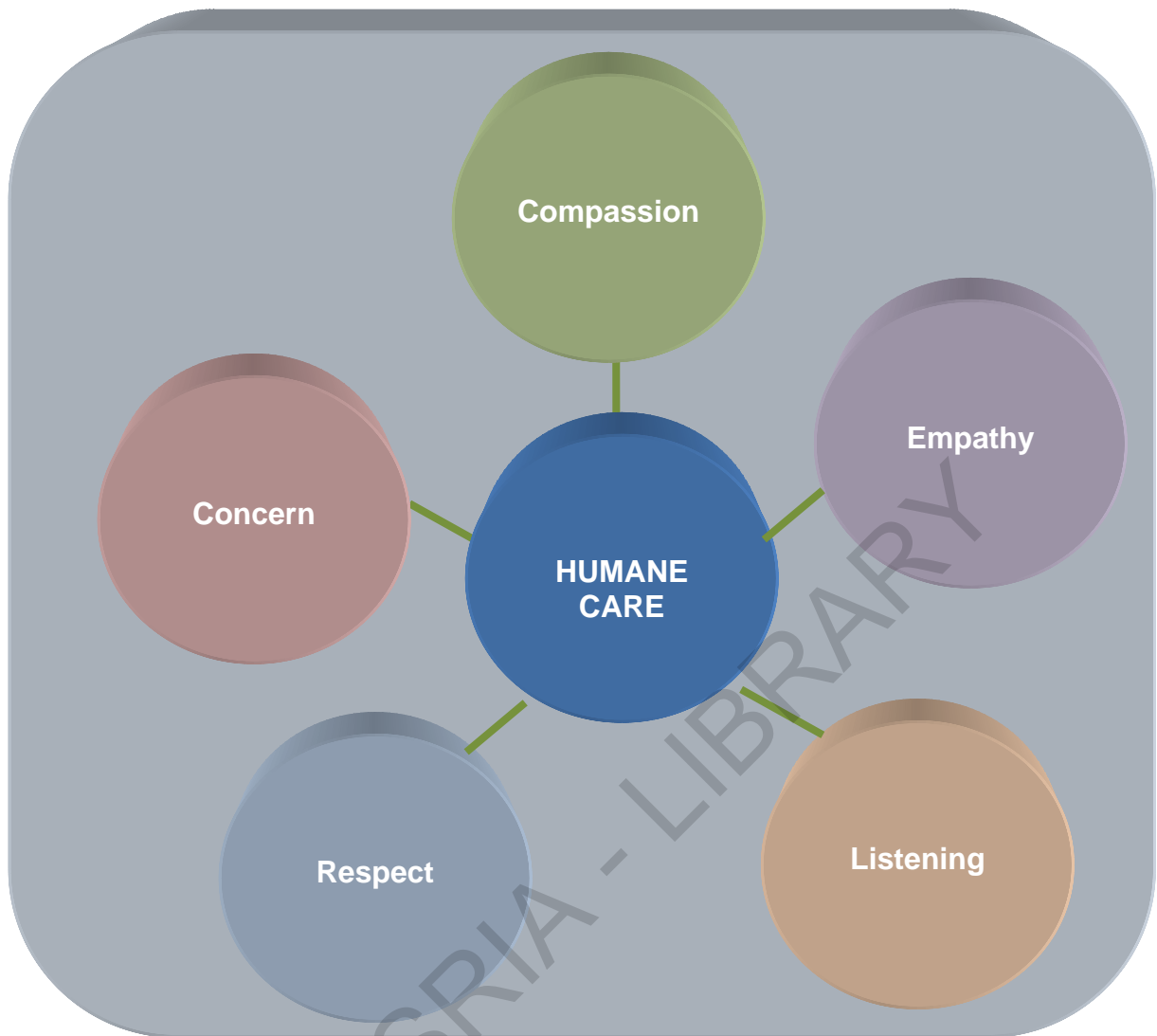


Figure 6.3 Humane care values/symbols in the nurse-patient relationship

The model suggests that nurses in the health care setting need to explore how these values/symbols can be implemented in the nurse-patient relationship without feeling that they are wasting time or imposing values of a particular faith.

Compassion

Compassion is defined as a feeling of deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering or remove the pain by exhibiting concern, caring presence and empathy (*The Concise English Dictionary* 1983:65). Compassionate care demonstrated by the nurse, is often experienced by patients who are already in a vulnerable position. The model proposes that a humane and a compassionate way of treating patients should be extended to both religious and non religious patients alike. Compassionate care should be all inclusive and should meet the physical, psychosocial and spiritual needs of patients by showing kindness, empathetic listening and concern for the patients in painful and uncertain circumstances. This care starts with good basic care demonstrated in practical ways such as making sure that the feeding needs of a patient are addressed, the pain is well-managed and that the patient is assisted to the toilet as needed. Doing the 'little things' and attending to detail in care will always be remembered by those on the receiving side.

Although compassion has always been enshrined in the value statements of the nursing profession, providing compassionate care in a humane way includes recognising common humanity and seeing the person in the patient at all times and at all points of care (Cornwell & Goodrich 2009:2).

Empathy

Empathy is defined as intellectual identification with the feelings, thoughts or attitudes of another: the ability to imagine oneself in the stead of another (*The Concise Oxford English Dictionary* 1983:315). The model synchronises with Shott (1979:1329), who defines empathy as an arousal in oneself of the emotion one observes in another or the emotion one would feel in another's situation. This feeling is supported by a statement made by Hurley (2006:13) that while we are spiritual nursing care givers today, we are the patients of tomorrow. SI proponents interpret this behaviour as an intimate and pervasive form of social control. From the responses noted in this subcategory, the SI perspective views the conduct of empathy demonstrated by nurses as altruistic behaviour. Nurses need to be aware that health care crises may be humiliating and even dehumanising. Patients are to be affirmed that even if they are sick, their roles as

a father, an employee, church elder or child are still significant. Empathy, according to this model, is directed towards strangers who are the patients and are not personal associates of the nurse. However, nurses who provide empathetic care should professionally and spiritually be connected with patients and share with them their spiritual distress of fear of the unknown, loneliness or feelings of despair. This role taking of emotions should however be in accord with the social norms and professional boundaries of the nursing profession as this connection should not overrule the set boundaries (Shott: 1979:1329).

This kind of interaction was communicated in the interviews as participants put themselves in one another's position and viewing the social world of sickness and disease as the other does. The model draws the attention of nurses to be conscious about the possible exchange of sick roles for themselves and their families. Treating patients empathetically should be understood as respect of God's image in every person particularly to those who are sick and suffering and may be eminently faced with death. Nurses should desire to care for patients with humanity and decency, and to give the same kind of care that they would want for themselves or their own family members. The model concurs with Turner & Stets (2005:100) that empathy can be communicated to patients through friendly facial expressions, compassionate care given and words of hope about God and his power to bring a difficult situation under control.

Listening

Nurses are often ideally placed to offer a listening ear to patients. The humane care model guides nurses that, being listened to and cared for, are basic needs of all patients and their families (Smith 2009:4). It would seem that on admission of a patient to hospital, nurses already know what is wrong with the patient, what needs to be done, when and how. This behaviour closes a door to assess or attend to spiritually inclined needs. This is also indicative of an identified salient barrier that nurses have no time to listen to patients empathetically. Some of the aspects disclosed by the patient may not be directly related to his care, but just listening in a caring humane way creates a therapeutic environment for them.

Active listening without being judgemental about their religious standing and showing understanding is regarded as an important vehicle for spiritual nursing care. Patients often wish to unburden their problems, thoughts and feelings related to their suffering and search for meaning to others. It was reported in the findings that patients became aware whether nurses were willing to listen to them or not. Nurses need to be sensitive about patients' spiritual needs as a deliberate action of care and know what to do when such needs are recognised or be able to refer appropriately. The time taken to listen and being sensitive to individual needs is very important when creating an environment in which patients in the health care setting are able to express their spiritual care needs (Tan, Grief, Couns, Braunack-Meyer and Beilby 2005:1054).

Respect

Respect is defined as regard with difference, esteem or honour; avoiding degrading or insulting or injuring or interfering with or interrupting, treat with consideration, spare, refrain from offending; respect of person's feelings or innocence (*The Concise Oxford Dictionary* 1983:279). Respect for the patient as a human and spiritual being was reported by the participants with an observed higher frequency than all the other expressed symbols of care. One needs to understand that nurses spend most of their time with patients. The model guides that respect and high regard for the patient should be seen as a meaningful activity that would positively influence the quality of the lives of patients cared for. Patients themselves are to be encouraged to engage in positive activities of respecting others and themselves. Nurses are to give meaning to these activities through respecting patients as spiritual beings and not only physical being whether they believe in God or not. Respect is recognised as one of the most basic human needs (Cornwell & Goodrich 2009:1).

Disease and illness or injury exposes patients to physical discomfort and intrusion to their privacy by health care providers. Respect for patients is regarded as humane care that is representative of care beyond that which is physical in terms of how they are approached, addressed, sick role interpret and treated. Nurses are to demonstrate respect by being positive even when patients are understandably difficult, and inform them about proposed actions and reasons for these actions. Man according to this model is regarded as a being that is to be respected, whether aware of such respect or not, by the actions or behaviour nurses engage in (Herman & Reynolds 1994:13). In

other words, nurses should inform patients of procedures or decisions taken about their care and obtain consent especially when performing intrusive procedures. This kind of respect is marked as a spiritual nursing care act that caters for the spirit of the person to win their attitude to cooperate with nurses.

The model claims that man is not just one being among others. He is unique and as such needs to be respected as a person (Rahner 1975:1620-1621).

Show concern

Concern is defined as an action of being involved and interested in: to be worried or trouble oneself or be anxious about another person (Dictionary.com).

Showing concern matters to patients. It is the presence or absence of showing concern for patients in times of illness or feelings of hopelessness that leaves a lasting memory about the care they received in a hospital or other health care settings. Patients treated with concern, as established in the data, tend to share more information about their health symptoms and concerns, which then yields more accurate information for diagnosis and planning of care. This value is regarded as a spiritual action as nurses demonstrate commitment by listening, enquiry about patients' feelings and making time to be with them.

Relating with patients in a humane way needs to be experienced by patients who receive the care and must be subjected to assessment as to how this care or relationship was experienced during hospitalisation or at outpatients' department. A variety of assessment methods can be utilised such as interviews, questionnaires, and surveys (Cornwell & Goodrich 2009:3).

The role of teaching nurses both in the classroom and in practice on humane care values is important.

6.2.3.3 *Humane care actions*

Humane care actions, within the context of spiritual nursing care, is a concept that is defined as an act of caring that assists patients to achieve a greater sense of self and harmony with body, mind and spirit (Watson's 1988:30).

The humane care model will help nurses in clinical practice with strategies to care for patients in a way that is considerate of them as both physical and spiritual beings. These strategies as deduced from the data include promoting transcendence which was categorised as a spiritual language or symbols of prayer, reading appropriate Bible passages and singing sacred music. Other strategies included communication which entailed nurses engaging in spiritual dialogue or conversation, providing patients with appropriate information, conducting counselling and referring patients to relevant support services.

Promoting transcendence

The concept self-transcendence is defined by Reed in early studies (1992:349) as the inclination to make meaning through a sense of relatedness to dimensions that transcend the self in such a way that empowers and does not devalue the individual. A transcendent relationship according to the model refers to, as posited by Smith (2009:1), a connection between a patient (inside the body) and something outside or beyond the ability of the patient, for example, God or a higher power not understood by man. This relationship is overtly expressed or demonstrated through modes of prayer, scriptures and spiritual songs as schematically presented in figure 6.4

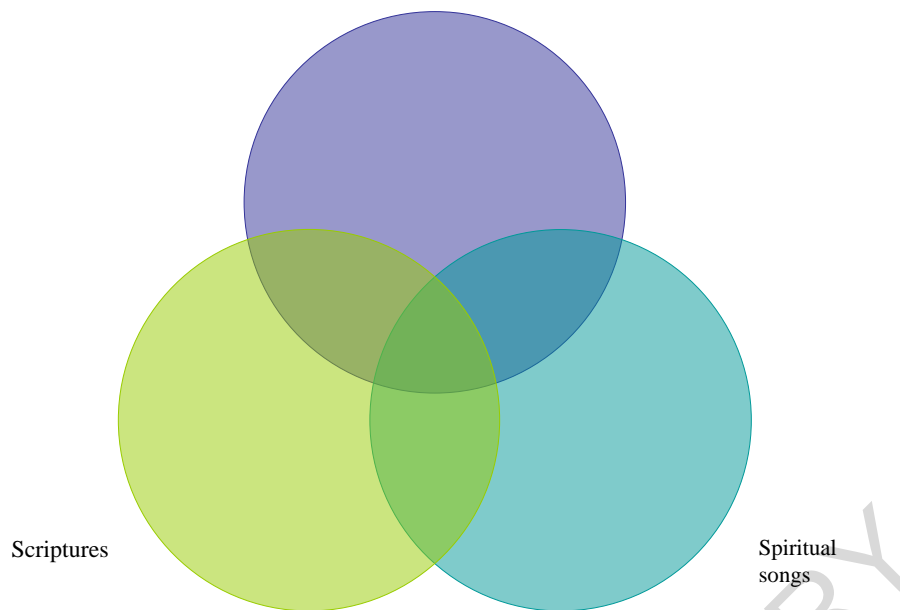


Figure 6.4 Promoting transcendence

Promoting transcendence in the model is described as communication with God on behalf of the patient or with the patient either by the nurse or others through prayer, the scriptures and spiritual songs. In a study by Taylor (2002:56), it was reported that prayer was used by the participants as an intervention to strengthen the patients' resiliency to cope with health problems. Prayer was regarded by the participants in this study as quick and economic in terms of time. According to Smith (2009:2) prayer is recognised as the most frequently used coping mechanism which was noted in the findings of this study. Therefore the humane nursing care model suggests that prayer can be made by nurses for patients in need where permissible or by those preferred by the patients or appropriate referral done in that regard. Prayer connects human beings and God as a coping mechanism in times of health crisis. Prayer can also be offered by others outside the health unit such as family members and church friends who in the finding of this study played a significant role in providing spiritual care that gave hope to the patients even if they came only during the visitors' hour. Prayer, as established from the data, is recognised by the model to have an impact on the recovery of patients. God is valued by those seeking for his help as the higher power that answers prayer by promoting hope, meaning and purpose or healing. As some patients believe that prayer

works for them, nurses should take such opportunities to provide that care. This intervention is simple but important and may have positive implications on the physical healing and spiritual as well as emotional stability of the patient. This approach to care is supported by the SI, as posited by MacKinnon (2005:92) that symbolic interactionists assume that individuals' experiences are mediated by their own interpretation of experiences.

Some of the participants read relevant Bible passages related to health and healing to some of their patients. This should be done with religious sensitivity as other people's religions differ from that of the Bible. The permission of the patient should be sought where needed. The patient's belief, faith tradition and interest should be considered as some are not comfortable to be prayed for by a woman. The model suggests that in hospitals where there are Bibles, patients may be referred to them to read for themselves. Humane care is demonstrated by appreciating the practice of religious leaders to whom patients are referred to by giving them space and time to read the Bible to those patients who have interest. Patients themselves may need to have uninterrupted time for spiritual reading or prayer, or a church group might need to offer a sacred song or blessing. Symbolic interactionists label these activities as gestures that make people to respond to one another on the basis of intentions or meanings of those gestures (Turner & Stets 2005:100).

The model provides guidance for when to pay attention to the patient. An individual patient and the nurse who share the same faith can work together to establish a harmonious connectedness with God. Nurses and patients can work together to identify aspects of connectedness with God that has been affected by sickness or suffering such as need for forgiveness, hopelessness or fear of death. Nurses need to develop spiritual skills, attitudes and knowledge to facilitate such connectedness.

Communication

Communication is an act that demonstrates humane care, as suggested by the findings. It includes strategies such as spiritual dialogue, provision of information, counselling and referral. A schematic presentation of this part of the model is presented in figure 6.5

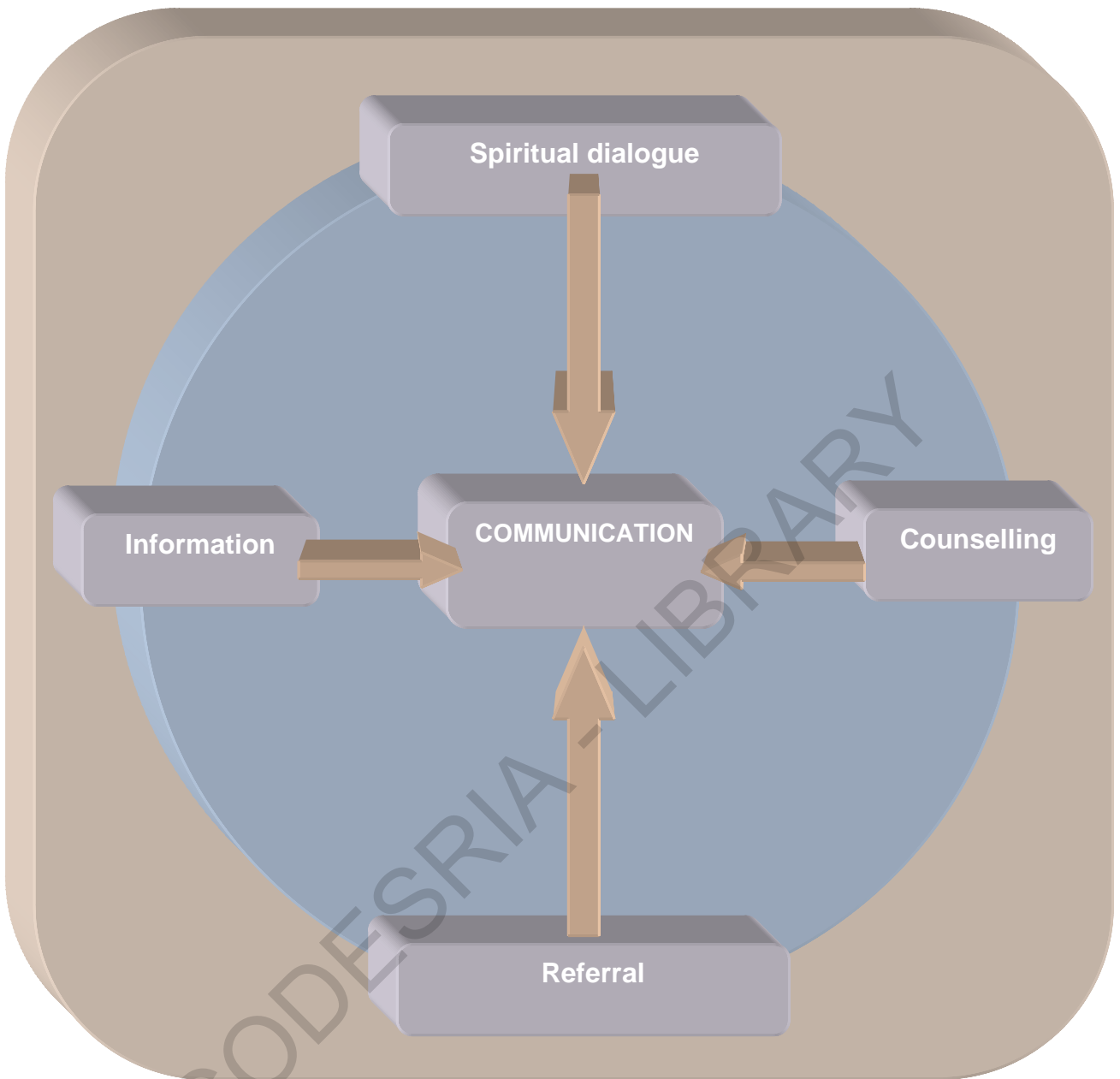


Figure 6.5 *Impact of communication*

Nurses are the first health care providers both patients and families have an encounter with when seeking health care. Even during visiting hours family members upon nurses to discuss the prognosis of their loved one's . It is a matter not only of discussing on treatment or prognosis issues, but also to answer their questions related to search for meaning and purpose or allaying their fears and anxieties in the whole ordeal. This kind of communication is categorised as spiritual dialogue or conversation.

Spiritual dialogue

Spiritual dialogue involves, according to this model, communication that is human to human and person to person rather than just the nurse clinician and the patient. The model concurs with Meltzer's (1978:49) notion that human-to-human interaction is influenced by the norms and values of the society where that interaction takes place. Human beings respond to themselves as other persons respond to them, and in so doing they imaginatively share the conduct of others within that society. Communication is suggested to be, therefore, two way rather than unilateral. Meaningful conversation between the nurse and the patient must be characterised by truth telling as was the case in the findings. Dialogue requires honesty and courage as in some instances nurses are to deal with grieving family members or sad situations of loss. In all circumstances there is a need for both sides of the conversation to be heard. This dialogue might need both the nurse and patient to draw strength from their inner spiritual resources to cope.

Information

Patients and their families need adequate information to make informed decisions about their health care situations. The model brings to focus the importance of this action by the health care providers to make sure that patients' preferences or views about the suggested care are known, respected, and complied with. The simple act of providing patients with information about what is wrong with them, what is going to be done, when and how, is regarded by the model as spiritual nursing care. Patients are to be involved by giving them information about their disease and treatment modalities in all its entity. However, providing such information as part of holistic patient care should be done with respect for the patient as a spiritual being that deserves to be involved as an equal partner in the care plan.

It is in the context of this sub-category that participants expressed that involving the patient in the care plan and informing them about what is going on is the simplest way to understand and incorporate spiritual nursing care to clinical practice.

Spiritual counselling

Nurses need to be aware of different options available to refer patients to when they have a need for spiritual care.

Interview during history taking gives the nurses an opportunity to ask probing questions about the patients' religious background, preferences or interest. Questions posed should not only focus on asking about which denomination they belong to for the purpose of completing admission forms, but on spiritual preferences about prayer, the Bible or use of spiritual books or sacred music. Some patients who are experiencing distress because of disease, depression, loneliness or guilt are afforded the opportunity to be counselled with reference to transcendence.

Referral

Spiritual nursing care often happens as reported by Smith (2009:4) while delivering other care. Referral of a patient to a spiritual agent is regarded, according to the model, as humane care. Nurses should not ignore the spiritual needs of patients due to their spiritual incompetency. Nurses often cannot provide all of the spiritual nursing care needed, therefore, appropriate consultation and referrals to the hospital chaplain, and/or the patient's own clergy or spiritual groups that visits the units for spiritual care to patients, is accepted as humane care that supports meeting the spiritual needs of patients. Spiritual leaders who respond to referrals should be given time and space to, for example, pray or read scripture at the patient's bedside.

6.2.3.4 *Humane care outcomes and barriers*

The model creates awareness about some of the positive outcomes as well as barriers as experienced by nurses when trying to provide spiritual nursing care. Although there are difficulties experienced in trying to provide spiritual nursing care, strategies of rendering humane care without being spiritually offensive had notable positive outcomes. The model supports the conclusion that treating people humanely with respect, showing compassion and concern cuts across religious, denominational, cultural or gender boundaries. These features of the model are presented in figure 6.6.

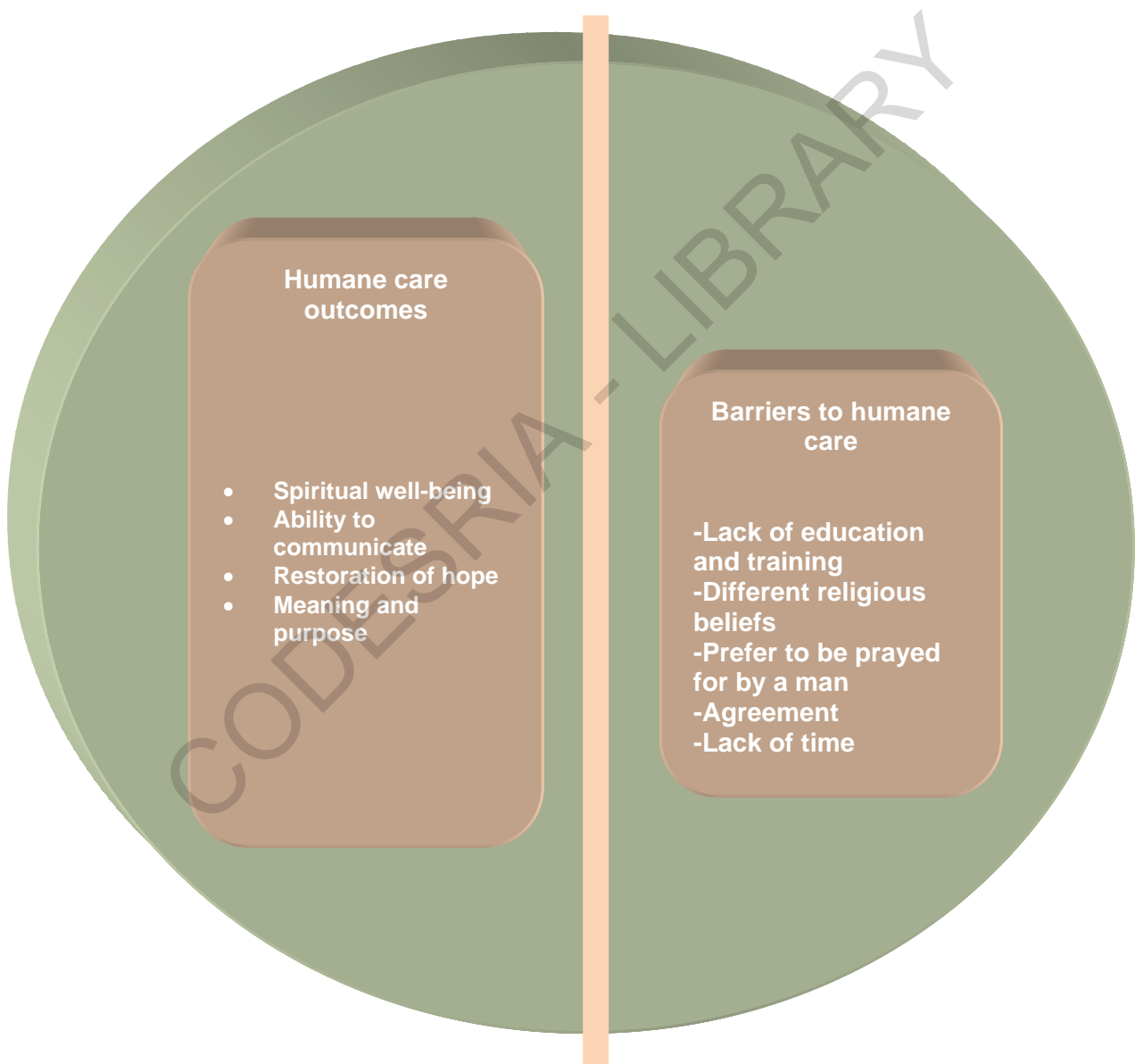


Figure 6.6 *Humane care outcomes and barriers*

Humane care outcomes

Spiritual well-being as an outcome in patient care is a phenomenon of concern to the nursing profession. The model supports Hurley's (2006:13) suggestion that spiritual energies of patients should be facilitated to deal with health crises to promote healing, wholeness and spiritual well-being. Although spiritual nursing care actions are not done in a systematic way as part of the nurses' professional responsibilities, the actions should be aimed at attaining an overall sense of health, well-being and good quality of life (Conco 1995:266). Humane caring approaches enable patients to develop confidence in communicating their felt needs to strangers like nurses and doctors.

The model confirms that patients who were prayed for develop hope in the face of sickness and threat of death. They tend to find meaning and purpose in their illness and being cared for.

Barriers to provision of humane care

A barrier is an obstruction, obstacle, blocking agent or limitation imposed on motion or action (*The Concise Oxford Dictionary* 1983:202). Issues of lack of education and training on spiritual nursing care, different religious beliefs, preferences of patients to be prayed for by a man and the need for an agreement or permission before a prayer can be said or scripture read are identified as barriers to the provision of humane care. Implementation of the strategies already discussed can empower nurses to overcome the barriers. Exposure to curriculum content on spiritual nursing care is ideal to create spiritual awareness and growth in that regard. The role of education and training of nurses on spiritual nursing from the basic training and advanced training is important. The education and training of nurses does not provide measures and means of providing spiritual nursing care apart from its inclusion in the definition of holistic care. This has a detrimental effect to the quality of patient care delivered (Cornwell & Goodrich 2009:4).

Some aspects of care need the permission of patients as a symbol of respect for their belief or spiritual preferences. In a study conducted by Van Leeuwen, Tiesinga, Post and Jochemsen (2006:880), patients stated that it must be the patient who initiates the need for care that is spiritually oriented. The model cautions that it is essential for

professionals to cultivate self-awareness and avoid interference in personal beliefs and biases in ethical, multicultural/religious patient care environments (Anandaraja 2008:3).

Even if nurses assess the situation and realise that there is a need for spiritual intervention, the permission of the individual should be sought for. Nurses need to practice religious sensitivity with regard to cultural factors concerning performance of certain rituals such as prayer or reading the word of God which are conducted by men rather than women in certain cultures.

Lack of time was perceived as a barrier for nurses to effectively provide spiritual nursing care. Clinical nurses require the support of nursing management and nurse educators to integrate and sustain a patient-centred spiritual nursing care model in practice.

6.3 A SUMMARY OF THE HUMANE CARE MODEL

The guidance provided by the model need to be incorporated in both basic and advanced nurses training programmes and piloted in clinical practice. More emphasis is put by Anandarajah (2008:2) that nurses need to receive guidance, education and training on spiritual aspects to be able to diagnose spiritual problems, do spiritual assessments, plan and render effective spiritual nursing care that is *humane*. The guidance provided through the humane care model provides a strong power source towards therapeutic ends. The complete model which also indicates the spiritual needs as identified in chapter 5 is presented in figure 6.7.

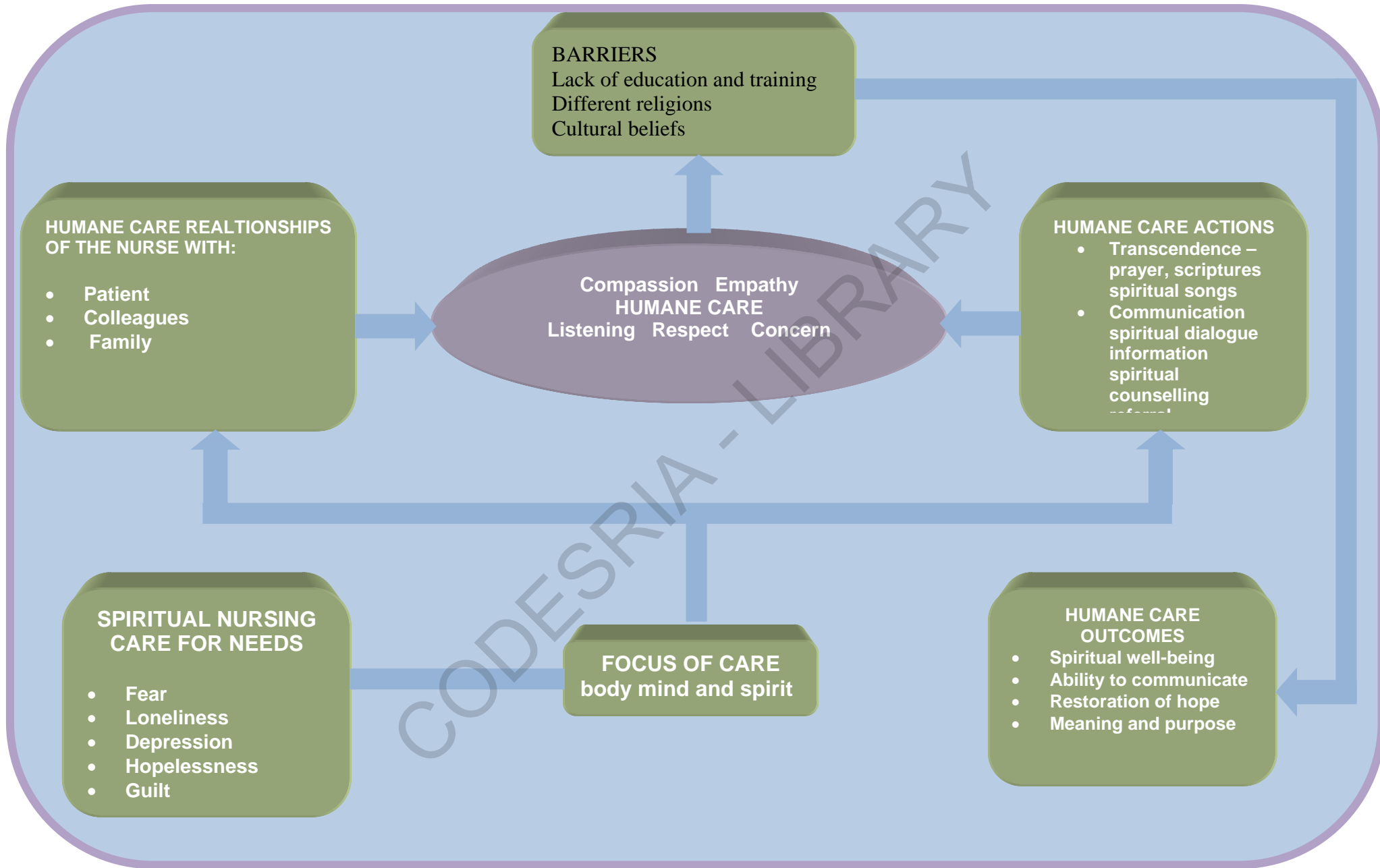


Figure 6.7 Humane care model

Spiritual nursing care within the context of the Humane Care Model (HCM) can make important contributions to bring about care to all the dimensions of care. The first component of the model brings focus of care to human dimensions of body, mind and spirit according to the findings. These are key dimensions of a person often affected simultaneously by illness, sickness, disease or any health crisis according to the findings. Spiritual nursing care is interpreted as humane care that aims to treat a patient as a person who has both the “I” and the “me” concept in balance. The compassionate carer on the side of the nurse conveys the sense, according to the SI philosophy, that “I am here for you” where “I” is more than “myself” (Blumer 1969:6).

As a patient or family member enters the health care arena, there is a nurse-patient relationship that sets the pace of how care will be provided. The model suggests that this relationship should be based on compassionate care principles that demonstrates respect for the person as a spiritual being and included into the entire process of therapy. Empathetic listening and showing concern for the patient’s situation will enhance building a spiritually therapeutic environment. Actions taken by the nurse that demonstrates providing spiritual nursing care includes that of of transcendence such as appropriate prayer, the word of God and/or sacred music to assist patients to transcend the limitations of self. Some of the key spiritual humane actions a nurse can be involved in include positive communication that will allay fears and release negative emotions of fear about surgery, incurable diseases or even death. Providing information about the health situation fills a gap for a patient in strange environments of health care.

Holding spiritual dialogue and counseling patients with respect for preferences and spiritual sensitivity is advisable. Appropriate referral to, for example, chaplains or pastors or spiritual counselors is regarded as a spiritual nursing care strategy. However, the model cautions that nurses experience barriers such as lack of education and training on the phenomena. Some nurses therefore are uncomfortable in talking about religion at work or related approaches. However, nurses who have an interest in providing spiritual nursing care have a way of overcoming these barriers and still provide spiritual nursing care that has positive outcomes on the quality of patient care such as spiritual well-being. All these approaches used by the nurses should be sensitive to the patients’ and other colleagues’ belief system.

6.3.1 Guidelines for the application of the model

Guidelines and activities for implementation were provided and examples for application given. Guidelines are defined as systematically developed statements to assist clinicians to adopt appropriate health care practices or actions for specific clinical circumstances (*The Concise English Dictionary* 1983:145). According to Stanhope & Lancaster (2000:533-535), practice guidelines (or clinical guidelines) are a set of patient care strategies developed to assist in clinical health care practice arena. Many professional organisations have established and published practice guidelines for their clinical specialties. These may vary according to patients' unique circumstances (Stanhope & Lancaster 2000:533-535).

Practice guidelines and activities suggested in this study are not intended to dictate an exhaustive course of action or to replace the existing practice protocols, policies, rules or health care practices of organisations, but are provided as an example of what actions can specifically be taken to meaningfully address spiritual aspects of nursing care in clinical practice. These guidelines were compared with the American clinical guidelines of the Institute of Medicine Committee to Advise the Public Health Service (1990). Attributes cited by this body as good guidelines included validity, reliability, clinical applicability, clinical flexibility, clarity, review of evidence and reproducibility. These characteristics were considered when the guidelines for the study were developed.

The strengths of guidelines

According to Institute of Medicine Committee to Advise the Public Health Service on Clinical Practice Guidelines (1990), guidelines in a healthcare setting have a number of strengths when applied properly. For example, guidelines:

- lead to improvement in both the structure, process and outcomes of care
- synthesise evidence into clear recommendations for practice and thereby help to overcome some practical difficulties faced by practitioners in clinical areas
- attempt to improve the quality of clinical decision making and implementation of those decisions in health services

- have the power to reduce inappropriate variability in decision-making and implementation of care plans
- improve health outcomes
- describe appropriate practice-based scientific evidence and broad consensus;
- reduce inappropriate variation in practice
- provide a focus for continuing nursing education
- promote the efficient use of healthcare resources
- act as a focus for quality control, including audits

With the above statements on the strengths of the guidelines, the researcher believes that in developing these guidelines as suggestions and recommendations to the nurse clinicians, awareness will be created on the importance to integrate spiritual nursing care in practice for religious or non-religious patients.

In this study the purposes of the guidelines and the related activities were to:

- Provide a framework for nurses in clinical practice in the provision of spiritual nursing care
- Improve quality of patient care by providing information to assist nurses with examples of actions or attitudes on how to address issues related to spiritual nursing care.
- Creating a humane healing environment in a hospital setting
- Provide direction to nurse managers in their guidance and supervision of patient care to ensure that spiritual nursing care interventions are incorporated in the nursing process methodology, nursing care plans, patient care protocols and in-service education programs (Institute of Medicine Committee to Advise the Public Health Service on Clinical Practice Guidelines 1990).

The process followed in the development of the guidelines included logical reasoning that guided formulation of guidelines.

6.3.2 Logical reasoning strategies

Logical reasoning is the processing and organising of ideas in order to reach a logical conclusion. According to Polit and Beck (2008:13), logical reasoning combines experiences, intellectual faculties and formal systems of thoughts in solving prevailing problems and is useful in understanding and organising a phenomenon. Logical reasoning consist of two systems of reasoning which are inductive and deductive reasoning. Both inductive and deductive reasoning were used in the formulation of the guidelines.

The inductive reasoning is the process that starts with the details of the experience (observations) and moves to the general picture of the phenomenon to provide a highly probable conclusion (Burns & Grove 2007:16). In this study, inductive reasoning was used when conclusion statement were draw from the findings of phase 2 & 3 and were summarised at the end of each theme presented in chapter 5.

The deductive reasoning process starts from a general premise to a more specific situation (Polit & Beck 2008:13). According to this study, the deductive reasoning was used when the activities related to the guidelines were formulated from the suggested outcomes and were kept simple for easy access and application by the consumers of these findings, particularly those in clinical practice.

The guidelines and activities for implementation provided herein are not exhaustive of how to provide spiritual nursing care but share light and provide examples of what it entails. They are not intended to supplement nursing judgement with respect to particular patients such as those who are Christians, with HIV/AIDS, dying or in special clinical situations such as the ICU. Although the guidelines and suggested activities for implementation are primarily based on the HCM as established in the data, the structure of the presentation utilises the summaries of each theme as the guideline and the categories and subcategories as outcomes for comprehensive and representativeness of the findings. The activities are based on the recommendations suggested in this study to improve nursing practice in the provision of holistic patient care.

Table 6.1 Guidelines for the implementation of the model

Guideline	Outcome	Activity to implement the guideline
<p>1. Establish humane care focus on body, mind and spirit</p>	<ul style="list-style-type: none"> Nurses are enabled to understand and regard the patient not only as a physical being but as a spiritual being too that has body, mind and spirit 	<ul style="list-style-type: none"> Regard a patient as spiritual being that has spiritual affiliations, beliefs, spiritual preferences in the day to day care approach Integrate all patient's needs as these impact on body, mind and spirit at the same time Include aspects of spiritual care on the nursing care plan that reflects assessed spiritual needs and plan to meet and evaluate needs such as fear and loneliness, hopelessness Attend in-service education with regard to holistic patient care with special emphasis on spiritual nursing care View the patient's body as integral to the mind and spirit dimension when caring for patients and always be aware that physical pain and suffering affects the spirit and mind Give medications as prescribed, on time and ensuring privacy to show respect and concern Address patients properly as person to person and not diseases or incapacity Conduct interviews to identify spiritual, emotional or psychosocial issues as differentiated from physical signs at history taking or bedside observation Respond to spiritually related questions and where these cannot be answered refer appropriately Take time to listen to patients when they talk. This shows respect, concern, compassion and empathy Pray for and with the patient where permitted Promote hope, meaning and purpose Allow prayer groups from outside to offer prayers Attend in-service education on spiritual nursing care and the role of prayer in health care Make them aware that bibles are available in the unit Those who can read encourage to read for themselves the scriptures and other spiritual sources, and assist them in selecting relevant texts Invite patients to join in the devotions in the unit Give time and space to hospital chaplains to be with patients
<p>2. Establish healthy spiritually related relations within the health care context</p>	<ul style="list-style-type: none"> Spiritually healthy relationships between the nurse, patient family and colleagues 	<ul style="list-style-type: none"> Practice compassionate presence with an intention to be open, honest and caring Make the patient feel cared for, supported and valued as a spiritual being Always be available for the patient and family Listen empathetically to patient's fears, hopes, dreams or meaning and purpose about the sickness or disease as some might say Why me? Respond on time to call bells or reported needs to show concern Show respect for patient's belief system The patient's family must always be told the truth in line with the patients' wish

Guideline	Outcome	Activity to implement the guideline
		<ul style="list-style-type: none"> • Respect their traditions and spiritual preferences • Reassure them of God's love • Show respect for colleagues' belief system • Sing, pray and share the word together at appropriate times where permissible • Live out the faith through acts of kindness, forgiveness and positive attitude • Share your faith and ways of coping with colleagues where appropriate
<p>3. Determine humane care actions related to provision of spiritual nursing care to contribute to the improvement of patient care</p>	<ul style="list-style-type: none"> • Provision of spiritual nursing care that promotes transcendence, healthy communication and positive outcomes of such care • Determine what positive outcomes are related to the provision of humane care 	<ul style="list-style-type: none"> • Use simple spiritual language and avoid theological terms • Treat the patient as an equal contributor in the dialogue • Offer to pray with or for the patient or family if competent to do so • Allow expression of 'self', 'I' and 'me' • Give patients needed or essential information about their situation or care • Answer questions related to transcendence if able to do so or refer appropriately • Identify counselling opportunities during non-drug management sessions • Establish the patients' faith and respect it • Use the interview strategy to identify spiritual issues that needs the patient to be counselled on such as experiences of spiritual pain, guilt feelings, unforgiveness, depression, hopelessness or fear of the unknown or death • Refer appropriately • Be aware of own spiritual limitations in certain aspects • Be aware of referral spiritual agencies within and outside the organisation • Allow patients to have own choice for certain aspects of spiritual care such as baptism, prayer or reading the Bible • Be aware that appropriate and timeous referring of patients to others who are spiritually competent is emotionally and spiritually important for the patient as it relieves anxiety • Identify patient outcomes such as: <ul style="list-style-type: none"> • Patients communicates freely and expresses own fears, problems and burdens to nurses • Choice of an alternate outlook at the situation by smiling after prayer than to be spiritually distressed or hopeless • Restoration of hope after relevant prayer, the word or singing sacred music • Developing meaning and purpose about the health situation and ability to transcend • Patient's appearance: relaxed, calm and sleeping well

Guideline	Outcome	Activity to implement the guideline
4 Assess the nurses' feelings of being inadequately prepared to provide spiritual nursing care or deal with related barriers	<ul style="list-style-type: none"> • Overcome barriers/difficulties to provide spiritual nursing care 	<ul style="list-style-type: none"> • Advocate for training on spiritual nursing care at basic and advanced level of training • Attend courses that are related to spirituality • Study books that have content on spiritual nursing care • Search and read related academic articles • Attend workshops, seminars and conferences related to spiritual nursing care • Raise the matter on spiritual nursing care in meetings with managers as a holistic patient care issue • Respect peoples' belief systems and don't force them to Christianity • Always respect individual spiritual preferences through the nursing process • Always ask for patients' permission especially to pray or read scriptures to avoid imposition of one's faith on the patient

The guidelines presented here are based on the study's holistic patient care perspective that aimed at viewing patients as integrated body, mind and spirit entity with spirituality at the core of a human being. What was established also from the data was that alterations of well-being in one dimension affect other dimensions. The model would need to be implemented and evaluated for clinical utility, after which some sections might be subjected to further research, additional practice recommendations and changes in presentation.

6.4 Conclusion

This chapter introduced the core variable "Humane Care" that was deduced from the data as a golden thread that was evidenced in the study findings and was used to develop a model for spiritual nursing care. The model constituted five components, identified as focus of humane care, humane care nurse relations, and humane actions of care, outcomes and barriers to humane care, which represented the spiritual nursing care concept for application in practice. Schematic presentation of each facet or component of the model brought more clarity of what the model is about. Practice guidelines and related activities were developed as examples for nurse clinicians.

Conclusions, limitations, recommendations and implications of the findings for nursing practice, education and research are deliberated on in chapter 7.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

This chapter focused on discussions, making conclusions and appropriate feasible recommendations based on the research questions. The primary purpose of this study was to explore and describe how nurses provide spiritual nursing care in clinical practice and to identify gaps or grey areas that need attention both in theory and practice.

7.2 PURPOSE OF THE STUDY

The purpose of this study was to explore professional nurses' understanding of what spiritual nursing care is and their experiences of providing it in clinical practice and inductively develop a model to guide practice. A model identified as 'Humane Care Model' was developed.

Objectives in phase 1

In phase one the objectives were to:

- analyse the concept *spiritual nursing care*
- outline a philosophical foundation for the study

Objectives in phase 2

- explore professional nurses' understanding of what spiritual nursing care is
- explore and describe how nurses **who espouse to Christian values** provide spiritual nursing care to patients in clinical practice

Objectives in phase 3

- develop a model to guide integration of spiritual nursing care to nursing practice

A qualitative non-probability grounded theory research study involving professional nurses was conducted to gain a view on what they understand by spiritual nursing care and how they incorporate it in clinical practice.

The ontological, epistemological and methodological assumptions of the researcher were described in chapter 1 of the study.

7.3 CONCLUSIONS OF THE STUDY

7.3.1 Demographic information

The demographic information was not directly sought as part of data collection or analysis of the study. However, the quantitative data obtained gave the researcher a good view as to the profile of the participants and to realise that most of them were not exposed to any courses on spirituality. Their application of spiritual knowledge was purely from their religious background as all of them were Christians. The 17.6% that had some training on related courses had that experience from their local churches and had to adapt this knowledge to their nursing situation

7.3.2 Qualitative data findings

The research was conducted in **three** phases.

In phase 1 of the study the first two objectives were achieved in which the concept 'spiritual nursing care' was analysed through intensive literature review. The philosophical foundation of the study, which is the Symbolic Interactionism, was discussed and examples of its application to the study given

In phase 2 the second objective in the empirical part of the study in which the qualitative, grounded theory research design and method was used. An unstructured

individual interview was held with four participants using the following open ended questions:

- What do you understand by spiritual nursing care?
- How do you render spiritual nursing care for your patients in your daily practice?

Four focus group interviews were also held with twenty four participants at their work place to elucidate more information about the study phenomena to be able to make rational conclusions. The two first questions were asked and followed up with the following examples of probing questions:

- Tell me more about what you have just said (.....)
- What do you understand by holistic patient care?
- As a nurse what religious values guide your care and relationship with your patients and their families?
- What is your understanding between religious care and spiritual nursing care?
- What challenges (barriers) do you experience when providing spiritual nursing care?
- What positive outcomes can you outline from your experience?

The aim of this approach was to allow the informants to describe their psychosocial experiences from their point of view freely without any influence or imposition by the researcher's bias.

A pre-testing of the interview guide was done in a focus group interview of seven participants as well as in two individual participants who did not participate in the main study. The purpose of the pretesting of the interview guide was to evaluate the comprehension of questions, the duration of the interview and to test the interviewing skills of the researcher as well as the use of the audiotape device. The errors experienced in this group also enabled the researcher to be able to correct the main data collection process in the actual interviews with better quality of data collection processes.

The researcher collected the data personally from individuals and focus groups using unstructured and semi structured interview guides. An audio-tape was also used after obtaining permission for its use to capture all information during interviews. The transcripts from the audio-tapes were then transcribed verbatim before data could be analysed.

The researcher also kept field notes during and after the interviews to record direct observations made in the field, and the interpretation of those observations. A reflexive journal was also kept to provide an account and record of own perspectives, thoughts, feelings and knowledge about the topic as the data emerged.

Data analysis triangulation methods such as the use of the computer software program known as NUD*IST power version 4.0, constant comparative method, Strauss and Corbin (1998:101-103) coding scheme and Tesch's (1990) qualitative analysis guidelines, as cited by Creswell (2003:192-193) were used.

The category system was used to sort and organise data. Subcategories which were subsections of the categories were identified. Four themes finally emerged from the data because of recurring regularity. These were validated through literature control. The direct quotes of the participants were presented as meaning units on tables to validate use of some of the concepts to label the categories. Discussions of each theme began with a table of its own meaning units.

Table 5.1 in chapter 5 of the study contain a summary of the themes, categories and subcategories that emerged from the data.

THEME 1: MEANING OF SPIRITUAL NURSING CARE

The first theme that emerged was a response to the first interview question. Three categories namely Human being, interrelationship of body mind and spirit and challenges of understanding the meaning of spiritual nursing care (table 5.2) emerged. Meanings of what spiritual nursing care is from the perspective of the participants was captured from their significant statements or direct quote. The created meaning revealed how the participants understood what spiritual nursing care was from their own worldview and knowledge background. Spiritual needs were confused with the other

dimensions such as social, psychological and emotional needs. This is problematic because referrals are most of the time inappropriate as patients with spiritual needs are referred to psychologists and **social worker**.

There other matter observed from the findings is that, although the nurses in the study had interest to provide spiritual nursing care, they were however unable to differentiate the patients' spiritual needs from their religious needs. Patients' spiritual needs were equated to a desire to engage in religious rituals such as baptism or leading them to salvation. Although these activities are important, the developed model guides nurses on simple activities such as compassionate care, listening to a patient empathetically or showing unhurried concern as basic spiritual nursing care activities. Nurses are first-line health care givers available to patients twenty four hours a day, and are able to play a crucial role in diagnosing spiritual needs and providing appropriate spiritual nursing care. However, one can conclude based on the data that the understanding and implementation of spiritual nursing care is often dismissed or ignored by the health care system, unless it is seen as care that can be quantified and seen to bring profit to health care institutions.

THEME 2: NURSE RELATIONSHIPS IN THE HEALTH CARE ARENA

Theme 2 relates to the relationships the nurse engages in on daily basis particularly in the context of providing spiritual nursing care. Goffman (1958:17) the proponent of SI describes it as social interaction in social setting like a hospital. Table 5.3 displayed the category and the subcategories and the related meaning units. The interaction of the nurses was observed in chapter 5 under the mentioned sections to be between the nurse and patients (2.1.1) and their families (2.1.2) and colleagues (2.1.3) which emerged as subcategories. What emerged in this category was that:

- Participants in this study had an evident build up nurse-patient relationship that enabled them to be able to pick up cues which one could describe as spiritual in nature in order to make appropriate follow up and essential spiritual dialogue. In most instances the content of the dialogue was about religious care interpreted as spiritual nursing care

- Nurses were noted not to be the only spiritual care givers, but family members played a vital role in being sensitive to meeting patient's spiritual needs as exemplified in the findings.
- Family members presented with spiritual distress that challenged the nurses to address them because of the suffering for their loved ones. Nurses need the training on provision of spiritual nursing care as caring for patients brings the family in the picture especially in cases of parents of children or spouses.
- The concept of talking to the patient and allowing a respectful conversation emerged as an important aspect within a nurse-patient relationship process
- Giving a patient an opportunity to have a say about what is going on concerning his health or care and to make a contribution towards the plan of that care demonstrated a meaningful connection with the nurse who provided the needed care. One would conclude that sitting down to talk or listen to a patient is not a waste of time in the context of spiritual nursing care but may be regarded by other nurses and management as such. It however meets a need that somebody cares and sees the patient as a spiritual-being, a person of more value than just an object or physical being to be given medical treatment.
- Participants in the study were aware of the multi faith environment in which they cared for patients and worked with others. Colleagues of different faiths were shown respect and only involved where they were in agreement. Most of the staff members were sceptical about the Christian faith. This is the problematic area, but the application of the model presents a mode of providing spiritual care in a neutral manner and referral made where people are not competent to provide such care

THEME 3: PROVISION OF SPIRITUAL NURSING CARE

In theme 3, integration of spiritual nursing care was summarised in two categories which were described in chapter 5 as transcendence (3.1) and communication (3.2). Subcategories and meaning units that emerged were displayed in table 5.4.

- There seemed to be an inadequate understanding in nursing practice on how to integrate spiritual nursing care especially as a formal responsibility of the nurse.

Participants provided spiritual related care as a duty and service to God not necessarily as part of their professional holistic care

- Using the Christian approach as the mode of spiritual nursing care was seen by some as imposing their beliefs on patients who were already in a vulnerable position because of sickness, pain and disease.
- Some of the colleagues were supportive of involving prayer, the word of God or other spiritual strategies to the care practice but some were not. This makes provision of patient care which includes spiritual aspects as an individual nurses' choice or out of own interest.
- The responses of participants to the questions about how to provide spiritual nursing care involved a number of values. These values had a positive indication that the participants had insight on what attitudes to display when relating or caring for a patient. These values or symbols (2.1.1.1 in chapter 5) as established from the data assisted the researcher to further develop a model as supported by Kliewer (2004:623) who is of the idea that careful attention to such values can move us forward in the task of providing effective and humane care. These values inform the choice of spiritual practices the nurses engage in and the manner in which these activities are carried out.
- The issue of prayer, reading the word of God to patients and singing sacred music was cited frequently as practices that nurses would resort to when faced with difficult situation of death or medical intervention
- The finding that prayer was the most commonly reported way of connecting with God is similar to other reports in literature. However, the value of prayer in nursing needs empirical data to support it as a valuable strategy to meet patients' spiritual needs. Nurses in the study were comfortable in provide spiritual nursing care especially where it involved prayer
- Communication seemed to be the biggest area of need in the provision of spiritual nursing care. Not providing adequate information about their care or counselling seemed to defeat the purpose of holistic patient care. Referral was commonly used to address social and emotional needs that were confused for spiritual needs. Patients were referred to psychologists or social workers other than spiritual agents
- Spiritual dialogue was evidenced in the data, but one would conclude that this was because of the participants' spiritual background.

- ‘Spiritual caring’ was explained as desired care by patients that go beyond tablets and injections. In this study, it is reported as humane caring for life rather than for dysfunctional heart or diseased lung
- However, although spiritual nursing care was provided as an intuitive act, positive outcomes were noted and reported in the data. This is an indication that if proper attention was given to the preparation of nurses both at basic and advanced level to provide spiritual nursing care, it would have positive outcomes for patients in terms of quality patient care
- The proposed model of Humane Care simplifies some of the attitudes, values and actions/interactions that nurses can engage in irrespective of their belief system or spiritual background. However the challenge still remains in practical terms that the nurse should have own spiritual awareness and sensitivity to that of others.

The major challenge for this study was to develop strategies or guidelines whereby both religious and non-religious nurses would be guided to provide spiritual nursing care for their patients without feeling uncomfortable. The developed model of Humane Care needs to be implemented in practice and evaluated for how it enhances holistic patient care practices. Shelly and Miller (2006: 38) concurs with this notion by iterating that nursing is a profession that claims to provide compassionate care for the whole person, in response to God's grace. The profession per se aims to foster optimum health (shalom) and bring comfort to patients who are ill, suffering from diseases and some faced with dreadful conditions or even death.

THEME 4: CHALLENGES IN THE PROVISION OF SPIRITUAL NURSING CARE

In theme 4, challenges in providing spiritual nursing care were highlighted in relation to category 4.1. Subcategories that emerged and meaning units are presented on table 5.5. The participants perceived barriers or difficulties to provide spiritual nursing care in a number of aspects.

- Lack of education and training of nurses on how to incorporate spiritual nursing care to clinical practice remains the greatest challenge for nurse clinicians, managers and educators. Some text books begin to incorporate content of spiritual care by nurses, but if the educators do not see it as important curriculum

content for training nursing students, it remains of no use or value is a sad state of affairs for such a crucial part of patient care to be perceived as a waste of time. It requires the involvement of senior members of the profession to establish programs in clinical practice to assist nurses in this regard.

- Lack of time could be an issue because of staff shortages and busy routines in hospitals. Some of the suggested strategies need time to be implemented effectively to effect spiritual nursing care. A point that can be raised is in relation to communication where nurses have to talk to patients.
- Participants in the study, in practical terms felt under pressure to provide spiritual nursing care, but busy routines and shortage of staff could not afford them that opportunity. Although they understood providing spiritual nursing care as important nurses experienced time constraint in providing humane care. One could conclude that lack of support and guidance remains a challenge in practice for nurses to provide holistic patient care.
- Cultural factors seem to influence the choice of which gender is supposed to render spiritual nursing care. The nursing profession is a female dominated profession. Most black people's cultures and religious practices dictate that spiritual matters be handled by a man and not a woman. This posed a challenge for nurses especially on aspects such as prayer. Prayer was cited as the most common and quick way of meeting patients' spiritual need in times of stress, but they had to be sensitive to the preferences of patients. Some aspects of spiritual nursing care needed to be carried out with spiritual sensitivity and caution lest more damage is done than good as people belong to different religious backgrounds and belief systems.
- With such pressing reasons for addressing spiritual nursing issues, it still seems to be an individual nurse's burden or interest. The perceived lack of professional provision of spiritual nursing care in clinical practice becomes an apparent reason why most nurses would not be interested in providing such care.
- Some participants expressed that an agreement between the nurse and the patient was needed to provide spiritual nursing care to patients. This would however, depend on the type of action/interaction a nurse is to engage in. Praying for a patient might need an agreement, but showing love and concern does not need an agreement or permission

- Nurses may not be able to make the time to really understand the spirituality of the core values/symbols that are important when relating with patients in the context of busy days in the units (Skall 2006:747).

7.3.3 Conclusions of phase 3

In phase 3 of the study, the third objective to develop a model to guide nurses on how to integrate spiritual nursing care to clinical practice was described.

The model included five components which were: focus of humane care, humane care nurse relations, humane actions of care/interaction and outcomes and barriers to humane care. Figure 6.7 presented all the components of the model as established from the data. Guidelines were provided to guide clinicians on what examples of activities they could engage in to implement the model in practice.

7.3.4 General conclusions

The findings of this study enriched the understanding of the importance of spiritual nursing care as part of holistic patient care. The Humane Care Model, as it relates to spiritual nursing care would help nurses to define what is to be human, and how to think of people as 'whole people' with body, mind and spirit. Patients in the units are struggling with questions of transcendence such as Why me, why am I suffering, Is God punishing me for my sins? Who can pray for me? What will happen when I die? Nurses are ideally positioned to integrate spiritual nursing care to clinical practice because they are directly involved in psychosocial experiences that profoundly have an impact on the patients' health outcomes (Skalla 2006:746). A model called 'Humane Care Model' was developed. Practice guidelines which can be adapted in different hospital units were formulated with activities that guide implementation under each component of the model.

7.4 SCOPE AND LIMITATION OF THE STUDY

Although this contextual research study will yield in-depth insight into various aspects of spiritual nursing care, some people may criticise it for a lack of generalisability of its findings because of the sample size. However, qualitative research in general is not

aimed at yielding generalisable findings, but research processes that can be replicated in similar settings can be utilised. The findings of this study may not necessarily be generalised to other hospitals, but the conceptual model and the practice guidelines developed may serve as a preliminary framework for understanding the phenomenon of spiritual nursing care in diverse health care groups and nursing environments. The researcher provided rich descriptions to enable other researchers to judge the applicability of the research methods or findings to other similar contexts.

A noted limitation that may have affected the credibility of the findings was the use of the purposive and snowball type of sampling methods. Some of the participants were known to the researcher based on their activities in Christian groups while others were identified by colleagues to be in this study. The latter was overcome by ensuring that acquaintances were in the same focus group.

All of the participants who were interviewed came from the Christian world view particularly the Protestant which might have biased the findings to be narrowly interpreted from this view only. The psychosocial processes of the phenomenon as experienced by the participants would likely look different if people of other worldviews could have been sampled. Although the shared values of practice may be experienced across religions, there might be other practices of spiritual nursing care that would be done differently. In addition, some of the suggested activities based on the guidelines might not be appealing in secular settings. The religious practices described may be judged as irrelevant in terms of what constitutes 'spiritual nursing care' for those without this kind of faith or belief. Although the number of participants was small, but the responses generated by the open-ended questions with probing questions generated a lot of data enough to afford the researcher to make conclusions on provision of spiritual nursing care.

Limitations to this study also included the issue of homogeneity of participants as only female nurses were involved. Involving male nurses could have yielded other information or insight that is important about the study phenomena.

7.5 RECOMMENDATIONS

The recommendations for clinical practice were as follows:

- Recommendations based on the findings of this study are that dissemination of relevant information and research findings in nursing literature on spiritual nursing care studies be increased and be available to nurses in practice, more so that skills, attitudes and knowledge on the understanding of what spiritual nursing care is and how can it be integrated in clinical practice may improve.
- The proposed HCM be implemented as a pilot and evaluated in certain units to assess its practicability. Nurses be provided with inservice education on some the main crucial aspects of the model for empowerment of nurses on the integration of spiritual nursing care.
- In cases where nurses themselves, or their loved ones become patients, the nature of their personal experience of spiritual nursing care would have a profound effect on how they would desire that such care be provided. They may be asked to write narratives of how that care was experienced to give feedback to nurses in practice and nurse managers
- Providing nurse's clinicians with a forum for open and honest discussions with their managers about issues of integrating spiritual nursing care to practice can be useful.
- In-service education, workshops and conferences can be held for various groups about provision of spiritual nursing care for nurse managers, educators, students and nurses in the units. Addressing relevant topics such as:
 - Holistic nursing care
 - Respect and dignity in nursing
 - The importance of prayer in nursing
 - Religious or spiritual nursing care – How does it differ from spiritual nursing care?
 - Seeing the person in a patient
 - Humane care for the for the sick
 - Compassion in Health care settings
- It would help to remind busy nurses that patients are spiritual beings and have spiritual needs and spiritual preferences which should be considered during history taking, planning and implementation of care plans

- Attention can be focused on the formative years during the training of student nurses when they come to the clinical practice. The senior nurses to model spiritual nursing care behaviours to them. Mentoring is particularly important to provide guidance to the younger nurses as to what spiritual nursing care is and what activities would evidence provision of such care.
- Management to support such aspects of care by making spiritual nursing care to be evidenced in policies, appraisal systems, documentation, training and evaluation processes. Those in senior positions can model provision of spiritual care through related gestures towards the staff members
None of the suggestions recommended will make much impact, however, if nurses and managers remain unaware of the importance of incorporating spiritual nursing care in clinical practice to improve the quality of patient care.

7.6 CONTRIBUTIONS OF THE STUDY

Although much has been written in the literature on this content, the model will make a substantial contribution in the African context as most of the writings are of the Western world. The HCM, the guidelines and recommendations made provide clinical nurses with a framework or tool that will firstly create awareness about simple, understandable ways to provide spiritual nursing care by both religious and non-religious nurses, secondly, it will enhance spiritual care in nursing as part of the daily practices of nurses to deliberately meet patient's spiritual care needs. The model does not aim to undermine or confuse the present health care practices, or push an agenda of a particular belief system, but to complement and serve as a reminder that there is more to the healing of a patient than just physical care. The model has potential for international use and across cultures.

African Christianity is noted for the important role that singing has as a spiritual nursing care intervention strategy, as reported by the participants in the study using this act to meet the spiritual needs of both patients and their families. Africans loves music and singing in different contexts. This was a finding which was not commonly reported in the literature as an important factor in providing spiritual nursing care in the health care arena. A study conducted by Wallace and Parks (2004:29) examined the meaning and function of sacred music and singing spiritual songs amongst abused women. This was

evidenced as a strategy that relieved their stress and anxieties. This finding in this study is a valuable contribution that the researcher suggested that it be disseminated to the wider reading contexts on issues of provision of spiritual nursing care.

7.7 IMPLICATIONS OF THE STUDY

7.7.1 Implications for professional nursing practice

The nursing profession is conflicted about its obligation to provide holistic nursing care which suggests meeting the spiritual nursing care needs of patients. This phenomena is complicated by issues such as lack of spiritually competent nurses, different religious worldviews, confusion about what spiritual nursing care is all about (Pesut 2006:126). Spiritual nursing care as part of holistic patient care is viewed by many as complex, abstract and problematic. The spiritual aspect of provision of patient care represents a fundamental element of humane care, as well as an unrecognised valuable component of holistic patient care (Witte, Van der Wal & Steyn 2008:91

Implications for nursing practice are indicated as follows:

- Though not scientifically proven, nurses in practice need to be aware that the spiritual dimension of humans integrates and transcends the biological and psychological nature manifested through observable behaviours. It must therefore be dealt with particularly by nurses who spend more time with patients than any other member of the health care team. Nurses understand patients very well and are in a good position to can relate with family and patient's religious leaders for fulfilling spiritual care needs
- Nurses in clinical practice must realise that suffering through sickness, disease or injury or illness in one way or other is associated with spiritual suffering. Patients experiencing sicknesses and disease whose spirit is therefore affected will benefit from having their spiritual needs catered for. Kliever (620:2004) concludes that the process of learning how to integrate spiritual nursing care to clinical practice is a given and not a choice if quality patient care is to be improved.

- Nurses should be empowered to be able to identify spiritual distress experienced by patients where appropriate and provide sensible, humane spiritual intervention as suggested in the practice guidelines.
- Referral to pastoral care givers should be seen as secondary intervention based on the choices that patients make in this regard. In addition, nurse managers need this understanding of provision of holistic care and provide the needed support and training for nurses. Participants in the study had much to share from their experiences in clinical practice which were mostly intuitive responses to caring for the spiritual needs of patients rather than as a learnt art of patient care.
- Nursing care is most effective if it acknowledges the integration of spiritual nursing care in the overall care of patients (Taylor 2002:24). Of central importance in this study is the need for nurses to be guided on the intergation of spiritual nursing care in clinical practice.
- Nurse clinicians must ensure that patients must never believe that their nursing care will be affected because of their belief system that may be different from that of the nurse.

Nurse managers currently provide adequate supervision of nursing care activities in practice, but mentoring nurses for performing spiritual skills remains lacking in the clinical experience of most nurses. Nurse leaders in clinical practice have the responsibility for providing guidance to nurses on how to adequately meet the spiritual needs of patients in all realms which are physical, psychosocial, emotional and spiritual. **Shelly and Miller (2006:39) assert that nursing is a vocation, giving nurses a framework for understanding their mission as clinicians and living out their calling: service to God through caring for others.**

7.7.2 Implications for nursing education

Implications for nursing education are as follows:

- Skills, attitudes and knowlegde on how to provide spiritual nursing care in terms of overall quality of care should be incorporated in both basic and advanced training of nurses. Student nurses in the classroom can be given an oppportunity to imagine themselves as patients and role play themselves as patients to

experience how their spiritual needs are being met, or how they would provide humane care according to the guidance of the model.

- There is a need for education and training for nurses on spiritual conversation methods, personal spiritual awareness and sensitivity, provision of information on spiritual care activities in the curriculum and the spiritual language that goes with it.
- Training of nurses on the provision of spiritual nursing care to be approached through the use of the nursing process methodology in terms of nursing diagnosis of spiritual problems, conducting spiritual assessments, planning for such care, implementation, evaluation and documentation of such care.

7.7.3 Implications for nursing research

Implications for nursing research are as follows:

- Findings in this study indicate that nurses need to promote nursing research for more clarity and understanding on how to provide spiritual nursing care in a way that differentiates the shared values in the findings of this study from traditional professional values which are not necessarily spiritual in nature.
- Future research may need to focus on a multidisciplinary approach involving doctors and allied professionals and not only the nursing staff. Use of the HCMI can provide guidance for research connectedness in humane nurse patient relationships.
- The research presented here should be seen as a step toward contributing to wards an understanding of what spiritual nursing care is and how to provide it to patients in simplified ways within the discipline of nursing.
- In addition to learning about how to provide spiritual nursing care to patients, there would be value in researching the spiritual needs of nurses and how they can be provided for.
- Further research should be conducted on participants who do not belong to the Christian faith for diversity of responses and report of experiences.

A great deal more of research in this phenomenon still needs to take place before health professionals fully understand the ways in which spiritual nursing care has a bearing on the quality of care for patients.

7.8 CONCLUSION

This chapter focused on making conclusions on the three phases and recommendations on the qualitative data analysis findings. The researcher summarised the findings on the provision of spiritual nursing care based on the identified themes, categories and subcategories. The scope and limitation of the study were indicated. Recommendations in general were stated and implications related to clinical practice, nursing education and nursing research were outlined.

It is envisaged that this study, as well as the model and practice guidelines suggested will be implemented and utilised successfully in the clinical practice to provide holistic patient care as reiterated in literature.

BIBLIOGRAPHY

- Ahern, KJ. 1999. Ten tips for reflexive bracketing. *Qualitative Health Research*, 9:407-411.
- Armstrong, K. 2008. *What is transcendence?* From: http://www.selftranscendence.org/self_transcendence/what_is_self_transcendence/ (accessed on 29.06.2008).
- Babbie, E. 2007. *The practice of social research*. 11th edition. Belmont, CA: Thomson Wadsworth.
- Babbie, E & Mouton, J. 2001. *The practice of social research*. South African edition. Cape Town: Oxford University Press.
- Baldacchino, D & Draper, P. 2001: Spiritual coping strategies: a review of nursing literature. *Journal of Advanced Nursing*, 34(6):833-839.
- Bassett, C (ed.). 2004: Qualitative research. In *Qualitative research in health care*. London: Whurr Publishers.
- Bash, A. 2004: Spirituality: the emperor' new clothes? *Journal of Clinical Nursing*, 13(1):11-16.
- Benton, DC. 1996. Grounded theory. In *The research process in nursing*. 3rd edition, edited by DSF Cormack. London: Blackwell Science.
- Benzein, E, Norberg, A & Saveman, B. 1998: Hope; future imagined reality. The meaning of hope as described by a group of healthy Pentecostals. *Journal of Advanced Nursing*, 28:1063-1070.
- Bezuidenhout, MC. 2009. *Leadership in health services management*, edited by K Jooste. Second edition. Lansdowne:Juta.
- Blackwell's Nursing Dictionary*. 2005: London: Blackwell.
- Blumer, H. 1969: *Symbolic interactionism: perspective and method*. Eaglewood Cliffs, NJ: Prentice-Hall.
- Blumer, H. 1971: *Sociological implications of thoughts of GH Mead*, in *School and society*, edited by Cosin, BR. Milton Keynes: Open University Press.
- Blumer, H. 1986. *Symbolic interactionism: perspective and method*. California: University of California.
- Boero, ME, Caviglia, ML, Monteverdi, R, Braida, V, Fabello, M & Zorzella, LM. 2005. Spirituality of health workers: a descriptive study. *International Journal of Nursing Studies*, 42:915-921.

Bradshaw, A. 1994. *Lighting the lamp: the spiritual dimension of nursing care*. Middlesex, UK: Scutari Press.

Bradshaw, A. 1996. The legacy of Nightingale. *Nursing Times*, 92(6):42-43.

Bretheron, R. 2006. Can existential psychotherapy be good news? Reflections on existential psychotherapy from a Christian perspective. *Mental Health, Religion and Culture*, 9(3):265-275.

Brink, H. 1996. *Fundamentals of research methodology for health care professionals*. Cape Town: Juta.

Brome, DR, Owens, MD, Allen, K & Vevaina, T. 2000. An examination of spirituality among African American women in recovery from substance abuse. *Journal of Black Psychology*, 26:470-486.

Brooks, D, LeBlanc, J, Mckenzie, G, Nagy, T, Tallon, H, Wilhelm, T & Flegel-Desautels, C. 2005. Incorporating spirituality into practice. *Canadian Nurse*, 101(6):22-24.

Brown, B, Crawford, P & Hicks, C. 2003. *Evidence-based research: dilemmas and debates in health care*. Berkshire: Open University Press.

Burbank, PM. 1992. An exploratory study: assessing the meaning of life among older adult clients. *Journal of Gerontological Nursing*, 18(9):19-28.

Burkhardt, MA. 1989. Spirituality: an analysis of the concept. *Holistic Nursing Practice*, 3(31):69-77.

Burkhardt, MA. 1994. Becoming and connecting: elements of spirituality for women. *Holistic Nursing Practice*, 8(4):12-21.

Burkhardt, L & Solari-Twadell, A. 2001. Spirituality and religiousness: differentiating the diagnoses through a review of nursing literature. *Nursing Diagnosis*, 12(2):45-54.

Burnard, P. 1988. The spiritual needs of atheists and agnostics. *Professional Nurse*, 4(3):130, 132.

Burnier, D. 2005. Making it meaningful: post-modern public administration and symbolic interactionism. *Administrative Theory and Praxis*, 27(3):498-516.

Burns, N & Grove, SK. 1993. *The practice of nursing research: conduct, critique and utilization*. 2nd edition. Philadelphia: WB Saunders.

Burns, N & Grove, SK. 1997. *The practice of nursing research: conduct, critique and utilization*. 4th edition Philadelphia: WB Saunders.

Burns, N & Grove, SK. 2007. *Understanding nursing research: building an evidence-based practice*. 4th edition. St Louis: Saunders Elsevier.

Byrne, M 2002: Spirituality in palliative care: what language do we need? *International Journal of Palliative Nursing*, 8(2):67-74.

Callister, LC, Bond, AE, Matsumura, G & Mangum, S. 2004. Threading spirituality throughout nursing education. *Holistic Nursing Practice*, 18(3):160-166.

Canda, ER, Nakashima, M & Furman, LD. 2004. Ethical considerations about spirituality in social work: insights from a national qualitative survey. *The Journal of Contemporary Social Services*, 85(1):27-35.

Cantazaro, AM & McMullen, KA. 2001. Increasing nursing students' spiritual sensitivity. *Nurse Educator*, 26:221-226.

Carson, VB. 1989. Spirituality and the nursing process. In *Spiritual dimensions of nursing practice*, edited by VB Carson. Philadelphia: WB Saunders.

Carey, MA. 1994. The group effect in focus groups: planning, implementing, and interpreting focus group research. In *Critical issues in qualitative research methods*, edited by JM Morse. Thousand Oaks, CA: Sage.

Cavendish, R, Luise, BK, Russo, D, Mitzeliotis, C, Bauer, M, Bajo, MA, Calvino, C, Horne, K & Medefindt, J. 2004. Spiritual perspectives of nurses in the United States relevant for education and practice. *Western Journal of Nursing Research*, 26(2):196-210.

Chinn, PL & Kramer, MK. 2008. *Theory and nursing: integrated knowledge development*. 7th edition. St Louis: Mosby Year Book.

Chiu, L 2000: Lived experience of spirituality in Taiwanese women with breast cancer. *Western Journal of Nursing Research*, 22(1):29-53.

Chiu, L, Emblen, J, Van Hofwegen, L, Sawatzky, R & Meyerhoff, H. 2004. An integrative review of the concept of spirituality in the health sciences. *Western Journal of Nursing Research*, 26:405-428.

Clarke, J. 2006. A discussion paper about 'meaning' in the nursing literature on spirituality: An interpretation of meaning as "ultimate concern" using the work of Paul Tillich. *International Journal of Nursing Studies*, 43:915-921.

Collins Essential Thesaurus. 2006. 2nd edition. New York: HarperCollins.

Collins, K. 1998. Negotiating selves: reflections on "unstructured interviewing".
From: <http://www.socre-online.org.uk/3/3/2.html> (accessed on 16th February 2008).

Collins, K.1990. Social work research. In *Introduction to social work in South Africa*, edited by B McKendrick. Pretoria: HAUM.

Collins Essential English Dictionary. 2006. 2nd edition. New York: HarperCollins Publishers. Form <http://www.thefreedictionary.com/spiritual> (accessed on 29.07.2008).

Collins Essential Thesaurus. 2006. 2nd edition. New York: HarperCollins. From: <http://www.thefreedictionary.co./spiritual> (accessed on 29.07.2008).

Collins, M 2006. Unfolding spirituality: working with and beyond definitions. *International Journal of Therapy and Rehabilitation* 13(6):254-257.

Conco, D. 1995: Christian patients' view of spiritual care. *Western Journal of Research*, 17:266-276.

Cornwell, J & Goodrich, J. 2009. Exploring how to enable compassionate care in hospital to improve patient experience. *Nursing Times*, 105 (15):1-8.

Corrigan, P, McCorkle, B, Schell, B & Kidder, K. 2003. Religion and spirituality in the lives of people with serious mental illness. *Community Mental Health Journal*, 39:487-489.

Coyle, J. 2001. Spirituality and health: towards a framework for exploring the relationship between spirituality and health. *Journal of Advanced Nursing*, 37(6):589-597.

Cressey, M & Winbolt-Lewis. 2000. The forgotten heart of care: a model of spiritual care in the National Health Service. *Accident and Emergency Nursing*, 8:170-177.

Creswell, JW. 1994. *Research design: qualitative and quantitative approaches*. London: Sage.

Creswell, JW. 2003. *Research design: qualitative and quantitative and mixed methods approaches*. London: Sage.

Cronk, G. 1973. Symbolic Interactionism: a "left-meadian" interpretation. *Social theory and practice*, 2(3):1-15.

Crooks, DL 2001: The importance of symbolic interaction in grounded theory research on women's health. *Health Care for Women International*, 22:11-27.

Cross, FL 2005: *The Oxford Dictionary of the Christian Church*. From: <http://www.amazon.com/Concise-Dictionary-Christian-Paperback-Reference/dp/0198> (accessed on 13.01.2008).

Culliford, L 2002. Spirituality and clinical care. *British Medical Journal*, 325:1434-1435.

Cutler, L. 2004. *Qualitative research in health care*, edited by C, Bassett. London: Whurr Publishers.

Delport, CSL & De Vos, AS. 2005: Professional research and professional practice, in *Research at grass roots for the Social Sciences and Human Service Professions*. 3rd edition, edited by De Vos. Pretoria: Van Schaik.

Denzin, NK. 1989a. *The research act: a theoretical introduction to sociological methods*. 3rd edition. New Jersey: Prentice-Hall.

Denzin, NK. 1989b. *Interpretive interactionism*. Newbury Park: Sage.

Denzin, NK & Lincoln, YS. 2005. *Handbook on qualitative research*. Thousand Oaks: Sage.

De Villiers, L & Van der Wal, DM. 2004. Researching cultural issues in health care. In *Cultural issues in health and health care*, edited by A Tjale & L de Villiers. Cape Town: Juta.

De Vos, AS. 2005. Qualitative data analysis and interpretation, in *Research at grass roots for the social sciences and human service professions*, edited by AS De Vos. Pretoria: Van Schaik.

De Vos, AS, Schurink, EM & Strydom, H. 1998. The nature of research in the caring professions, In *Research at grass roots: a premier for the caring professions*, edited by AS de Vos. Pretoria: Van Schaik.

Dictionary of Critical Sociology. Symbolic Interactionism. 1989.

From: <http://www.public.iastate.edu/rmazur/dictionar/a.html> (accessed on 05.03.2008).

Dictionary of the Social Sciences. Symbolic Interactionism. 1987.

From: <http://bitbucket.icaap.org/dict.pl> (accessed on 02.03.2008).

Dossey, BM. 1993. *Healing words: the power of prayer and the practice of medicine*. San Francisco: Harper.

Dossey, BM. 1998. Holistic modalities healing moments. *American Journal of Nursing*, 98:44-47.

Dossey, BM & Keegan, L. 2000. Holism and the circle of human potential. In *Holistic health promotion: a guide to practice*. 2nd edition, edited by BM Dossey, L Keegan, LG Kolkmeier & CE Guzzetta. Rockville, MD: Aspen.

Dossey, BM, Keegan, L & Guzzella, CE. 2004. *Holistic nursing: a handbook for practice*. 4th edition. New York: Aspen.

Du Toit, L. 2003. Conceptual analysis. In *Intellectual tools: skills for the human sciences*. 2nd edition, edited by D Rossouw. Pretoria: Van Schaik.

Draper, P & McSherry, W. 2002. A critical view of spirituality and spiritual assessment. *Journal of Advanced Nursing*, 39(1):1-2.

Ellis, L. 2004. Illuminative case studies. In *Qualitative research in health care*, edited by C Bassett. London: Whurr: 90-114.

Emblen, JD. 1992. Religion and spirituality defined according to current use in nursing literature. *Journal of Professional Nursing*, 8(1):41-47.

Emblen, JD & Pesut, B. 2001. Strengthening transcendent meaning: a model for the spiritual nursing care of patients experiencing suffering. *Journal of Holistic Nursing*, 19(1):42-56.

Encarta World English Dictionary [North American Edition]. 2007. Bloomsbury Publishing Plc.

From: <http://encarta.msn.com/thesauru-561588684/spirit.html> (accessed on 01.08.2008).

Fawcett, T & Noble, A. 2004. The challenge of spiritual care in a multi-faith society experienced as a Christian nurse. *Journal of Clinical Nursing*, 13:136-142.

Field, PA & Morse, JM. 1994. *Nursing research: the application of qualitative approaches*. London: Chapman & Hall.

Figuroa, L. 2008. Exploring how nurses may use symbolic interaction family theory as a framework to encourage spiritual expressions and promote coping in African American families susceptible to stress resulting from alcohol and substance abuse. *The ABNF Journal* Winter:37-40.

Fletcher, CE. 2004. Health care provider's perceptions of spirituality while caring for veterans. *Qualitative Health Research*, 14(4):546-561.

Frankl, VE. 1962. *Man's search for meaning: an introduction to Logotherapy*. New York: World Publication.

Frankl, VE. 1969. *The will to meaning: foundations and application of Logotherapy*. New York: World Publication.

Frankl, VE. 1984. *Man's search for meaning*. 3rd edition. New York: Simon & Shuster.

Frankl, VE. 2004. *Man's search for meaning*. Johannesburg: Rider.

Freshwater, D & Maslin-Prothero, SE (eds). 2005: *Blackwell's Nursing Dictionary*. 2nd edition. Great Britain: Blackwell.

Galek, K, Flannelly, KJ, Vane, A & Galek, MS .2005. Assessing a patient's spiritual needs: a comprehensive instrument. *Holistic Nursing Practice*, 19(2): 62-69.

Gill, R. 2007. *Health care and Christian ethics* (Cambridge University Press). New studies in Christian studies.

From: <http://www.cambridge.org/catalogue/catalogue.asp?isbn=970521857239> (accessed on 05.05.2008)

- Giske, T. 1995. Spiritual care in nursing practice. *Christian Nurse International*, 11(4):4-8.
- Glaser, B. 1992. *Basics of grounded theory analysis: emergence versus forcing* 1978. *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.
- Glaser, B.
- Glaser, B. 1998. *Doing grounded theory: issues and discussion*. Mill Valley, CA: Sociology Press.
- Glaser, B & Strauss, A. 1967. *Discovery of grounded theory*. Chicago: Aldine.
- Glasson, J, Chang, E, Chenoweth, L, Hancock, K, Hall, T, Hill-Murray, F & Collier, L. 2005. Evaluation of a model of nursing care for older patients using participatory action research in an acute medical ward. *Journal of clinical nursing*, 15:588-598.
- Goffman, E. 1958. *The presentation of self everyday life*. Edinburg: University of Edinburg, Social Sciences Research Centre.
- Goffman, E. 1974. *Frame analysis*. New York: Harper & Row.
- Goldberg, B. 1998. Connection: an exploration of spirituality in nursing care. *Journal of Advanced Nursing*, 3(1):13-18.
- Gould, D , Berridge, E & Kelly, D. 2007. The National Health Service knowledge and skills framework and its implications for continuing professional development in nursing. *Nurse Education Today*, 27(1):26-34.
- Govier, I. 2000. Spiritual care in nursing: a systematic approach. *Nursing Standard*, 12(14):32-36.
- Graber, DR. 2001. Spirituality and health organizations. *Journal of Health Care Management*, 46(1):39-50.
- Gravertt, S. 2001. *Adult learning: designing and implementing learning events: a dialogue approach*. Pretoria: Van Schaik.
- Greasley, P, Chiu, L & Gartland, M. 2001. The concept of spiritual care in mental health nursing. *Journal of Advanced Nursing*, 33(5):629-637.
- Greef, M. 2005. *Information collection: interviewing*, in *Research at grass roots: for the social sciences and human service professions*, edited by AS De Vos. Pretoria: Van Schaik.
- Greenstreet, WM. 1999. Teaching spirituality in nursing: a literature review. *Nurse Education Today*, 19:649-658.

- Grey, R. 1996. The psychospiritual care matrix: a new paradigm for hospice care giving. *American Journal of Hospice and Palliative Care*, 13(4):19-25.
- Griffin, E. 1997. A first look at communication theory. New York: McGraw-Hill.
- Hall, BA. 1997. Spirituality in terminal illness: an alternative view of the theory. *Journal of Holistic Nursing*, 15:82-96.
- Harkness, G. 2007. *Christian ethics. Return to religion on line*.
From: <http://www.religiononline.org/shoechapter.asp?title=802&C=1076> (accessed 15.05.2008).
- Harrison, J. 1993. Spirituality and nursing practice. *Journal of Clinical Nursing*, 2:211-217.
- Heartlines. 2007. *Living Godly values: heart lines values that connect*. Houghton, SA: Mass Media Project.
- Henning, E, Van Rensburg, W & Smit, B. 2004. *Finding your qualitative research*. Pretoria: Van Schaik.
- Henderson, V. 1977. *The nature of nursing: a definition and its implications for practice, research and education*. New York: Macmillan.
- Hegarty, M. 2007. Care of the spirit that transcends, religious, ideological and philosophical boundaries. *Indian Journal of Palliative Care*, 13(2):4247.
- Hermann, CP. 2001. Spiritual needs of dying patients: a qualitative study. *Oncology Nursing Forum*, 28(1):67-72.
- Herman, NJ & Reynolds, LT. 1994. *Symbolic interaction: an introduction to social psychology*. New York: Altamira Press.
- Hewitt, JP. 2000. *Self and society: A symbolic interactionist social psychology*. 8th edition. Needham Heights, MA: Allyn and Bacon.
- Hodge, DR. 2004. Spirituality and people with mental illness: developing spiritual competency in assessment and intervention. *Families in Society*, 85(1):36-44.
- Holloway, I (ed). 2005. *Qualitative research in health care*. Berkshire, London: Open University Press.
- Hospital Christian Fellowship. 2002. *Spiritual nursing care plan*. Reynfield: Johannesburg.
- Hubert, M. 1963. Spiritual care for every patient. *The Journal of Nursing Education*, 2(9-11):29-31.
- Hutchinson, S. 2001. Grounded theory: the method. In *Nursing research: a qualitative perspective*, edited by PL Munhall. Sudbury, MA: Jones & Barlette: 209-243.

Hurley, JE. 2006. Breaking the spiritual care barrier. *Journal of Clinical Nursing*, 16(3):8-13.

ICN. 1973. *Codes for nurse's ethical concepts applied to nursing*. Geneva: ICN.

Ignatavicius, DD & Bayne, MV. 1999. *Medical-surgical nursing: a nursing process approach*. Philadelphia: WB. Saunders.

Ingersoll, RE. 1994. Spirituality, religion and counselling: dimensions and relationships. *Counselling and Values*, 39(1):98-111.

Institute of medicine committee to advise public health service on clinical practice guidelines. 1990. *Standards, practice guidelines*.
From: <http://www.idsociety.org/content.aspx?id=9088> (Accessed 13.01.2010).

Jeon, Yun-Hee. 2004 The application of grounded theory and symbolic interactionism. *Scandinavian Journal of Caring Science*, 18:249-256.

Joint Commission on Accreditation of Healthcare Organizations. 2002. [On line] Spiritual assessment. In Standards-Frequently asked questions. (Accessed 28.08.2007).

Jonathan, L & Bodian, S. 2007. *Definition of spirituality*.
From: <http://recoveryissexy.com/definition-of-spirituality/> (accessed on 02.08.2008).

Kaplin, WA & Lee, BA. 1995. *The law of higher education: a comprehensive guide to legal implications of administrative decision-making*. 3rd edition. San Francisco: Jossey-Bass.

Karl, R (ed). 1975. *Encyclopaedia of theology – a concise sacramentum mundi*. London: Burns & Oates.

Kendrick, KD & Robinson, S. 2000. Spirituality: its relevance and purpose for clinical nursing in a new millennium. *Journal of Clinical Nursing*, 9:701-705.

King James Version of the Holy Bible. 1994. South Dakota. 21st Century. King James Bible Publishers.

Kliwer, S. 2004. Allowing spirituality into the healing process. *The Journal of Family Practice*, 53(8):616-624.

Koenig, HG, McCullough, ME & Larson, DB. 2001. *Handbook of religion and health*. London: Oxford University Press.

Koenig, H. 2004. Taking a spiritual history. *Journal of American Medical Association* 291(23):2881.

Koslander, T & Arvidsson, B. 2007. Patients' conceptions of how the spiritual dimension is addressed in mental health care: a qualitative study. *Journal of Advanced Nursing*, 57(6):597-604.

- Kozier, M, Erb, G & Wilkinson, JM. 2008. *Fundamentals of nursing: concepts process and practice*. 5th edition. California: Addison-Wesley.
- Krefting, L. 1991. Rigor in qualitative research: the assessment of trustworthiness. *American Journal of Occupational Therapy*, 45(3):214-222.
- Kumar, K. 2004. Spiritual care: what's world view go to do with it? *Journal of Clinical Nursing*, 21(1):24-28.
- Labun, E. 1988. Spiritual care: an element in nursing care planning. *Journal of Advanced Nursing*, 13:314-320.
- Lane, JA. 1993. Returning gospel values to nursing education. *Health Progress*, 6: 30-35.
- Langford, RW. 2001. *Navigating the maze of nursing research: an interactive learning adventure*. London: Mosby.
- Lantz, CM. 2007. Teaching spiritual care in a public institution: legal implications, standards of practice, and ethical obligations. *Journal of Nursing Education*, 46(1):33-37.
- Ledger, SD. 2005. The duty of nurses to meet patients' spiritual and/or religious needs. *British Journal of Nursing*, 14(4):220-225.
- Lewis, JD. 1976. The classic American pragmatists as forerunners to symbolic interactionism. *The Sociological Quarterly*, 17:347-359.
- Limb, M. 2004. Grounded theory, in *Qualitative research in health care*, edited by Bassett, C. London: Whurr Publishers.
- Lincoln, Y. & Guba, E. 1985. *Naturalistic inquiry*. Beverly Hills: Sage.
- Lindeman, CA. 2000: The future of nursing education. *Journal of Nursing Education*, 39(1):5-12.
- Lloyd, C & O'Connor, C. 2007. Integrating spirituality into mental health rehabilitation. *International Journal of Therapy and Rehabilitation*, 14(4):168-172)
- Loh, KY. 2004. Spiritual distress in a terminally ill patient with breast cancer. *International Journal of Palliative Nursing*, 10(3):131-133.
- Lovanio, K & Wallace, M. 2007. Promoting spiritual knowledge and attitudes: a student nurse education project. *Holistic Nursing Practice*, 21(1): 42-47.
- Lynch, M & McConatha, D. 2006. Hyper-symbolic interactionism: prelude to a refurbished theory of symbolic interaction or just old wine? From: <http://en.wikipedia.org/wiki/Sociological> viewpoints (accessed on 26 .09. 2007).

Maier-Lorentz, MM .2004. The importance of prayer for mind/body healing. *Nursing Forum*, 39(3):23-32.

Macrae, J. 1995. Nightingale's spiritual philosophy and its significance for modern nursing. *Image Journal of Nursing Scholars*, 27(1):8-10.

Mahaffey, M. 2008. *Spiritual purpose*.

From: http://www.cedasprings.org/spiritual_purpose.php (accessed on 11.03.2008).

Mahlungulu, SN & Uys, L. 2004. Spirituality in nursing: an analysis of the concept. *Curationis*, (5):15-26.

Martsof, DS & Mickley, JR. 1998. The concept of spirituality in nursing theories: differing world-views and extent of focus. *Journal of Advanced Nursing*, 27:294-303.

Mason, J. 2002. *Qualitative researching*. 2nd edition. London: Sage.

Mayer, J. 1992. Wholly responsible for a part, or partly responsible for a whole? The concept of spiritual care in nursing. *Second Opinion*, 17(3):26-55.

McBrien, B. 2006. A concept analysis of spirituality. *British Journal of Nursing*, 15(1):42-45.

McEwan, W. 2004. Spirituality in Nursing. *Orthopaedic Nursing*, 23(5)321-326.

McEwen, M. 2005. Spiritual nursing care: State of the Art. *Holistic Nursing Practice*, 19(4):161-168.

McGrath, P 1997: Putting spirituality on the agenda: Hospice research findings on the ignored dimension. *Hospice Journal*, 12(4)1-13.

McSherry, W. 1998. Nurse' perception of spirituality and spiritual care. *Nursing Standard*, 14(13):36-40.

McSherry, W. 2004: Education issues surrounding the teaching of spirituality. *Nursing Standard*, 14(42):40-43.

McSherry, W & Cash, K. 2004. The language of spirituality: an emerging taxonomy. *International Journal; of Nursing Studies*, 41:151-161.

McSherry, W, Cash, K & Ross, L. 2004. Meaning of spirituality: implications for nursing practice. *Journal of Clinical Nursing*, 13:934-941.

McSherry, W & Draper, P. 1998. The debates emerging from the literature surrounding the concept of spirituality as applied to nursing. *Journal of Advanced Nursing*, 27(4):683-692.

Mead, GH. 1934. *Mind, self and society*. Chicago: University of Chicago Press.

Mead, GH. 1967. *Mind, self and society: from the standpoint of a social behaviourist*, edited by CW Morris. Chicago: University of Chicago Press.

Meleis. AI. 1991. *Theoretical nursing: development and progress*. 2nd edition. Philadelphia: Lippincott.

Meltzer, BN, Petras, NJ & Reynolds, LT. 1975. *Symbolic interaction: An introduction to social psychology*. Chicago: University of Chicago Press.

Meltzer, BN. 1978. The social psychology of George Herbert Mead, in *Symbolic Interaction: a reader in social psychology*, edited by Manis, J & Meltzer, BN. Boston: Allyn & Bacon.

Meraviglia, M. 1999. Critical analysis of spirituality and its empirical indicators: prayer and meaning in life. *Journal of Holistic Nursing*, 17:18-33.

Merriam-Webster Online Dictionary. 2002.

From: <http://www.merriam-webster.com/online-dictionary> (accessed on 10.06.2007).

Mesnikoff, GF. 2002. Practical responses to spiritual distress by nurse practitioners. *Clinical Excellence Nurse Practitioner*, 6(3):39-43.

Meyer, CL. 2003. How effectively are nurse educators preparing students to provide spiritual care? *Nurse Educator*, 28(4):185-190.

Milligan, S. 2004. Perceptions of spiritual care among nurses undertaking post registration education. *International Journal of Palliative Nursing*, 10(4):162-171.

Miner-Williams, D. 2005. Spirituality in nursing: connectedness in the nurse-patient relationship. *International Journal of Human Caring*, 9(2):66.

Monekosso, GL. 1994. *District health management, planning, implementing and monitoring a minimum health for all package*. Maseru: Barrh.

Morse, JM. 1994a. *Qualitative health research*. London: Sage.

Morse, JM. 1994b. *Critical issues in qualitative research methods*. Thousand Oaks: Sage.

Morse, JM & Field, PA. 1996. *Nursing research: The application of qualitative approaches*. 2nd edition. London: Stanley Thornes.

Morse, JM. 1995. *Nursing research: the application of qualitative approaches*. 2nd edition. London: Chapman & Hall.

Morse, JM. 2001. Situating grounded theory within qualitative inquiry. In *Qualitative health research*, edited by RS Schreiber & PN Stern. New York: Springer.

Mouton, J & Marais, HC. 1994. *Basic concepts in the methodology of the social sciences*. Pretoria: Penrose.

Moustakas, C. 1994. *Phenomenological research methods*. Thousand Oaks, CA: Sage.

Musgrave, CF & McFarlane, EA. 2003. Oncology and non-oncology nurses' spiritual well-being and attitudes toward spiritual care: a literature review. *Oncology Nursing Forum*, 30(3):523-527.

Mullen, PD & Reynolds, R. 1978. The potential of grounded theory for health education research: linking theory and practice. *Health Education Monographs*, 6(3):280-294.

Narayanasamy, A. 1998. A review of spirituality as applied to nursing. *International Journal of Nursing Studies*, 36:117-125.

Narayanasamy, A. 1999. Learning spiritual dimensions of care from a historical perspective. *Nurse Education Today*, 19:386-395.

Narayanasamy, A. 1999a. ASSET: a model for actioning spirituality and spiritual care education and training in nursing. *Nursing Education Today*, 19:274-285.

Narayanasamy, A. 1999b. A review of spirituality as applied to nursing. *International Journal of Nursing Studies*, 36:117-125.

Narayanasamy, A & Owens, J. 2001. A critical Incident study of nurse's responses to the spiritual needs of their Patients. *Journal of Advanced Nursing*, 33(4): 446-455.

Narayanasamy, A, Gates, B & Swinton, J. 2002. Spirituality and learning disabilities: a qualitative study. *British Journal of Nursing*, 11(4):948-957.

Narayanasamy, A. 2004. The puzzle of spirituality for nursing: a guide to practical assessment. *British Journal of Nursing*, 13(19):1140-1145.

New King James Version. 1994: *The Holy Bible*. New York: Thomas Nelson, Inc.

Nightingale, F. 1946. *Notes on nursing: what it is and what it is not*. Norwalk: Appleton & Lunge.

Nolan, P & Crawford, P. 1997. Towards a rhetoric of spirituality in mental health care. *Journal of Advanced Nursing*, 26: 285-289.

Nursing Diagnoses. 2001-2002. *Definitions and classification*. Philadelphia: North American Diagnosis Association.

O'Brien, M. 1982. Religious faith and adjustment to long-term haemodialysis. *Journal of Religion and Health*, 21(1):68-80.

O'Brien, ME. 1999. *Spirituality in nursing: standing on holy ground*. Boston: Jones & Bartlette.

O'Brien, ME 2002: *Spirituality in Nursing: Standing on Holy Ground*. 2nd edition. Boston: Jones and Bartlett Publishers.

O'Brien, ME. 2003. *Spirituality in nursing*. 2nd edition. Boston: Jones & Bartlett.

O'Boyle, K. 2001. [On line] <http://oak.cats.ohiou.edu/~ko371597/symbolic.htm> (accessed 15.03.2008).

O'Connor, CI. 2001. Characteristics of spirituality, assessment, and prayer in holistic nursing. *Nursing Clinics of North America*, 36:33-46.

Oldnall, A. 1996. A critical analysis of nursing: meeting the spiritual needs of patients. *Journal of Advanced Nursing*, 23:138-144.

Online *Etymology Dictionary*. 2006. <http://etymonline.com/index/wiki/Online> Etymology Dictionary (accessed on 26.10. 2007).

Oosthuizen, M. 2007. Factors that may influence South African nurses' decisions to emigrate. *Health SA Gesondheid*, 12(2): 14:26.

Orem, E. 1985. *Nursing: concepts of practice*. 5th edition. St Louis: Mosby.

Ormsby, A & Harrington, A. 2003. The spiritual dimension in military nursing practice. *International Journal of Nursing Practice*, 9:321-327.

Oxford Dictionary of the Christian Church. 1961. London: Oxford University Press.

Pargament, KL, Murray-Swank, N & Ano, GG. 2001. Spiritual struggle: a phenomenon of interest to psychology and religion, in *Psychology and human nature*, edited by WR Miller & H Delaney. Washington, DC: Apa Press.

Parahoo, K. 1997. *Nursing Research: principles, process and issues*. London: Macmillan.

Paton, MQ. 2002. *Qualitative evaluation and research methods*. Newbury Park, CA: Sage.

Peplau, HE. 1952. *Interpersonal relations in nursing*. New York: GP Putnam.

Pesut, B. 2006. Fundamental or foundational obligation? Problemitizing the ethical call to spiritual care in nursing. *Advances in Nursing Science*, 29(2):125-134.

Plummer, K. 1975. *Sexual stigma: an interactionist account*. London: Routledge & Kegan Paul.

Polit, F, Beck, CT & Hungler, BP. 2001. *Essentials of nursing research: methods, appraisal, and utilization*. 5th edition. Philadelphia: Lippincott Williams & Wilkins.

Polit, DF & Beck, CT. 2008. *Nursing research: generating and assessing evidence for nursing practice*. 8th edition. Philadelphia: Lippincott Williams & Wilkins.

Popoola, MM & Clinton, M. 2001. Diabetes and the elderly: a spiritual glimpse. *West African Journal of Nursing*, 15(1):42-46.

Post, SG, Puchalski, CM & Larson, DB. 2000. Physicians and patient spirituality: professional boundaries, competency and ethics. *Annals of Internal Medicine*, 132:578-583.

Pranee, L & Douglas, E. 2005. *Qualitative research methods*. New York: Oxford University Press.

Pretoria News. 2008. 25 April: 1-2.

Probert, N. 2006. Searching for an appropriate research design: A personal journey. *Journal of Research Practice*, 2(1): 1-13.

Rahner, K. 1975. *Encyclopedia of theology*. London: Burns & Oates.

Rankin, EA & DeLashmutt, MB. 2006. Finding spirituality and nursing presence: the student's challenge. *Journal of Holistic Nursing*, 24(4):282-288.

Reed, PG. 1991a. Self-transcendence and mental health in oldest-old adults. *Nursing Research*, 40(1):5-11.

Reed, P. 1991b: Towards a nursing theory of self transcendence. *Advances in Nursing Science*, 13:64-77.

Reed, PG. 1992. An emerging paradigm for the investigation of spirituality in nursing. *Research in Nursing and Health*, 15:349-357.

Reid, D, Field, D, Payne, S & Relf, M. 2006. Adult bereavement in five English hospices: types of support. *International Journal of Palliative Nursing*, 12(9):430-437.

Regulation R2598, 1984. See SANC. 2005.

Regulation R387, 1985. See SANC. 2005.

Regulation R.425, 1985. See SANC. 2005.

Renwick, R & Toka, G. 1998. British and European social attitudes. How British differs, the 15th report, in *East meets west*, edited by R Jowell, J Curtice, A Park & C Brook. Ashgate: Aldershot.

- Rice, PL & Ezzy, D. 2002. *Qualitative research methods: a health focuses*. New York: Oxford University Press.
- Richards, TJ & Richards, L. 1994. Using computers in qualitative research. In *Handbook of qualitative research*, edited by Denzin, NK & Lincoln, YS. Thousand Oaks, CA: Sage.
- Robb, WJW. 2006. Self heals: a concept analysis. *Nursing Forum*, 41(2):60-66.
- Robinson, S & Kendrick, K. 2000. Spirituality: Its relevance and purpose for clinical nursing in a new millennium. *Journal of Clinical Nursing*, 9(5):701-705.
- Rodgers, ME. 1970. *An introduction to the theoretical basis of nursing*. Philadelphia: FA Davis.
- Ross, L. 1994. Spiritual aspects of nursing. *Journal of Advanced Nursing*, 19:439-447.
- Ross, L. 1995. The spiritual dimension: its importance to patient's health, well-being and quality of life and its implication for nursing practice. *International Journal of Nursing Studies*, 32(5):457-468.
- Ross, L. 1997. The nurses' role in assessing and responding to patients' spiritual needs. *International Journal of Palliative Nursing*, 3(1):37-42.
- Rossouw, D (ed.). 2003: *Intellectual tools: skills for the human sciences*. 2nd edition. Pretoria: Van Schaik.
- Rubin, HJ & Rubin, IS. 1995. *Qualitative interviewing: the art of hearing data*. Thousand Oaks: Sage.
- SANC. 2005. *Regulation relating to the scope of practice of persons who are registered or enrolled under the Nursing Act No 33 of 2005*. (Based on the Regulation R2598, 1984, as amended). Pretoria: SANC.
- SANC. 2005. *Rules setting out the acts or omissions in respect of which the Council may take disciplinary steps*. (Based on the Regulation R387, 1985, as amended). Pretoria: SANC.
- SANC .2005. *Regulation relating to the approval and the minimum requirements for the education and training of a nurse (general, psychiatric and community) and midwife leading to registration*. (Based on the regulation R425, 1985, as amended). Pretoria: SANC.
- Sandelowski, M. 1993. Theory unmasked: The uses and guises of theory in qualitative research. *Research in Nursing and Health*, 16:213-218.
- Saracci, R. 1997. *The world health organization needs to reconsider its definition of health*. From: <http://www.bmj.com/cgi/content/full/314/709/1409>. (accessed on 25.05.2007).

Sawatzky, R & Pesut, B. 2005. Attributes of spiritual care in nursing practice. *Journal of Holistic Nursing*, 23(1):19-33.

Seidman, I. 1998. *Interviewing as qualitative research*. 2nd edition. New York: Teachers College Press.

Shelly, J & Fish, S 1988: *Spiritual care: The nurse's role*. Downer's Grove, IL: Intervarsity Press.

Shelly, JA & Miller, Ab. 2006. *Called to care: A Christian Worldview*. Downers Grove : Intervarsity Press.

Shott, S. 1979. Emotion and social life: A symbolic interactionist analysis. *American Journal of Sociology*, 84(6):1317-1334.

Skalla, KA. 2006. Spiritual assessment of patients with cancer: the moral authority, vocational, aesthetic, social and transcendent model. *Oncology Nursing Forum*, 33(4):745-751)

Smith, AR. 2009. Using the synergy model to provide spiritual nursing care in critical care settings. *Critical care nurse*, 26:1-7.

Smith, J & McSherry, W 2004: Spirituality and child development: a concept analysis. *Journal of Advanced Nursing*, 3:307-315.

Society for more creative speech. 1996. *Symbolic interactionism defined by Herbert Blumer*.

From: <http://www.thepoint.net/-usul/text/blumer.html> (accessed on 05.03.2008).

South Africa. 2005a. Nursing Act, No 33, 2005. Pretoria: Government Printer.

South Africa. 2005b. Nursing Act, No 50, 1978, as amended. Pretoria: Government Printer.

South Africa 1996: South African Constitution. Pretoria: Government printers.

South Africa. 1985. *Regulation relating to rules setting out the acts and omissions in respect of which SANC may take disciplinary steps*. R387, in terms of the Nursing Act, 1978 (Act No 50, 1978, as amended). Pretoria: Government Printer.

South Africa. 1984a. *Regulation relating to the scope of practice of professional nurses*. R2598, in terms of the Nursing Act, 1978 (Act No. 50, 1978, as amended). Pretoria: Government Printer.

South Africa. 1984b. *Regulation relating to the scope of practice of professional nurses*. R2598, in terms of the Nursing Act, 2005 (Act No. 33 of 2005). Pretoria: Government Printer.

Stallwood, J & Stoll, R. 1975. Spiritual dimension of nursing practice. In *Clinical nursing*, edited by IL Beland & JY Passos JY. 3rdedition. New York: Macmillan.

Stanworth, R. 2002. Attention: A potential vehicle for spiritual care. *Journal of Palliative Care*, 18 (3):192-195.

Stern, PN. 1980. Grounded theory methodology: its uses and processes. *Image*, 12(7):20-23.

Stern, PN, Allen, LM & Moxley, PA. 1982. The nurse as a grounded theorist: history, processes and uses. *Review Journal of Philosophy and Social Sciences*, 7(6):142, 200-215.

Stoll, R. 1979. Guidelines for spiritual assessment. *American Journal of Nursing*, 79:1574-1577.

Stoll, R. 1989. Spirituality and chronic illness. In *Spiritual dimensions of nursing practice*, edited by V Carson. Philadelphia: WB Saunders.

Stoter, D. 1995. *Spiritual aspects of health care*. London: Mosby.

Stranahan, S. 2001. Spiritual perception, attitudes about spiritual care and spiritual care practices among nurse practitioners. *Western Journal of Nursing Research*, 23(1):90-104.

Strauss, A. 1987. *Qualitative analysis for social scientists*. New York: Cambridge University Press.

Strauss, A & Corbin, J. 1998. *Basics of qualitative research: techniques and procedures for developing grounded theory*. 2ndedition. Thousand Oaks: Sage.

Streubert-Speziale, HJ & Carpenter, DR. 2003. *Qualitative research in nursing: advancing the humanistic perspective*. 3rdedition. Lippincott: Williams & Wilkins.

Stringer, E. 2004. Focus groups, In *Qualitative research in health care*, edited by Bassett, C. London: Whurr Publishers.

Sun, Fan-Ko, Long, A, Boore, J & Tsao, Lee-Ing. 2005. Patients and nurses' perceptions of ward environmental factors and support systems in the care of suicide patients. *Journal Compilation*, 83-92.

Sykes, JB (ed). 1983. *The Concise Oxford Dictionary*. 7thedition. Glasgow: Oxford University Press.

Talbot, LA. 1995. *Principles and practice of nursing research*. St Louis: Mosby.

Tan, HM, Grief, M, Couns, PC, Braunack-Meyer & Beilby, J. 2005. The impact of the hospice environment on patient spiritual expression. *Oncology Nursing Forum*, 32(5):1049-1055.

Tanyi, RA. 2002. Towards clarification of the meaning of spirituality. *Journal of Advanced Nursing*, 39 (5):500-509.

Tanyi, RA, Recine, ACG, Werner, JS & Sperstad, RA. 2006. Perceptions of incorporating spirituality into their care: a phenomenologist study of female patients of haemodialysis. *Nephrology Nursing Journal*, 33 (5):532-538.

Taylor, EJ, Amenta, M & Highfield, M. 1995: Spiritual care practices of oncology nurses. *Oncology Nursing Forum*, 22:31-39.

Taylor, EJ. 2002. *Spiritual care: nursing theory, research and practice*. Upper Saddle River, NJ: Prentice Hall.

Taylor, EJ & Mamier, I. 2005. Spiritual care nursing: what cancer patients and caregivers want. *Journal of Advanced Nursing*, 49(3):260-267.

Terre Blanche, M, Durrheim, K & Painter, D. 2006. *Research in practice: applied methods for the social sciences*. 2nd edition. Cape Town: University of Cape Town Press.

The American Heritage Dictionary of the English Language. 2003. 4th edition. New York: Houghton Mifflin.

The Concise Oxford Dictionary. 1983. Oxford: Clarendon Press.

The Norwegian Thesaurus. 1995. Norway: Icon group.

The Oxford Pocket Thesaurus of Current English. 2008. London: Oxford University Press.

Timasheff, NS & Theodorson, GA. 1976. *Sociological theory: its nature and growth*. New York: Random House.

Tjale, A & De Villiers, L (eds). 2004. *Cultural issues in health and health care*. Cape Town: Juta.

Thorne, S. 2000. Data analysis in qualitative research. *Evidence-based Nursing*, 3(3):68-70.

Touhy, TA, Brown, C & Smith CJ. 2005. Spiritual caring: end of life in a nursing home. *Journal of Gerontological Nursing*:27-35.

Tournier, P. 1954. *A doctor's case book in the light of the Bible*. London: SCM Books.

Treloar, LL. 2001. Spiritual care: safe, appropriate, ethical. *Journal of Christian Nursing*, 18(2):16-20.

Tuck, I, Mc Cain, NL & Elswick, RK. 2001. Spirituality and psychosocial factors in people living with HIV. *Journal of Advanced Nursing*, 33(2):776-783.

Turner, JH & Stets, JE. 2005. *The sociology of emotions*. London: Cambridge University Press.

Unabridged Dictionary. 2006. Random House, Inc.

From: <http://dictionary.reference.com/browse/spirituality> (accessed on 31.07.2008)

Uustal, DB. 1992. *Values and ethics in nursing: from theory to practice*. 4^t edition. East Greenwich, RI: Educational Resources in Nursing and Holistic Health.

Vachon, M, Fillion, L & Achille, M .2008. A conceptual analysis at the end of life. *Journal of Palliative Medicine*, 12(1):53-59.

Van der Wal, DM. 1992 Caring in nursing education. Unpublished dissertation. Pretoria: Department of Health Studies, UNISA.

Van Dover, L & Bacon, JM. 2001: Spiritual care in nursing practice: a close-up view. *Nursing Forum*, 36(3):18-30.

Van Leeuwen, R & Cusveller, B. 2004. Nursing competencies for spiritual care. *Journal of Advanced Nursing*, 48(3): 234-246.

Van Leeuwen, R, Tiesinga, LJ, Post, D & Jochemsen, H. 2006. Spiritual care: implications for nurses' professional responsibility. *Journal compilation*, 875-884.

Van Loon, AM. 2005. The challenge of spiritual care in a multi-faith society expressed as a Christian nurse. *Journal of Clinical Nursing*, 13:266-268.

Villagomez, LR. 2005. Spiritual distress in adult cancer patients: toward conceptual clarity. *Holistic Nursing Practice*, 19(6):285-294.

Walker, LO & Avant, KC. 2005. *Strategies for theory construction in nursing*. 4th edition. Upper Saddle River, NJ: Pearson/Prentice Hall.

Walter, T. 1997. The ideology and organization of spiritual care: three approaches. *Palliative Medicine*, 11:21-30.

Walton. J. 1996. Spiritual relationships: a concept analysis. *Journal of Holistic Nursing*, 14(3):237-250.

Watson, J. 1985. *Nursing: human science and human cure: a theory of nursing*. Norwalk, Connecticut: Appleton-Century Crofts.

Watson, J. 1988. *Nursing: human science and human care, theory of nursing*. New York: National League for Nursing.

- Watson, J. 1999. *Post-modern nursing and beyond*.
From: http://findarticles.com/articles/mi_qa3929/is (accessed on 12.10.2007).
- Weaver, K, Morse, J & Mitcham, C. 2008. Ethical sensitivity in professional practice: concept analysis. *Journal of Advanced Nursing*, 62(5):607-618.
- Sociology Dictionary*. 1995.
(<http://www.public.iastate.edu/rmazur/dictionar/a.html>) (accessed on 02.03.2008).
- Webster Dictionary*. 1913.
From: <http://.hydroponicserach.com/spelling/simpleserach.php> (accessed on 31.07.2008).
- White, JM & Klein, DM. 2003. Symbolic interaction. In *Family theory*, edited by DN Adams & D Klein. 2nd edition. California: Thousand Oaks, Sage.
- Winslow, GR & Winslow, BW. 2003. Examining the ethics of praying with patients. *Holistic Nursing Practice*, 17(4):170-177.
- Wilson, J. 1963. *Thinking with concepts*. New York, NY: Cambridge University Press.
- Wikipedia, the free encyclopaedia. 2009. Love. From: <http://en.wikipedia.org/wiki/Love> (accessed on 16 June 2009).
- Witte, AS, Van der Wal, DM & Steyn, HC. 2008. Mystical experience in the context of health care. American Holistic Nurse Association.
From: <http://jhn.sagepub.com> (accessed on 05.03.2009).
- WordNet 3.0. 2003-2008. Farlex clipart collection. New Jersey: Princeton University, Farlex Inc.
From <http://www.thefreedictionary.com/spiritual> (accessed on 31.07.2008)
- WordReference.com English- Italian Dictionary. 2009. From: <http://www.wordreference.com/enit/a> (accessed on 19 November 2007).
- World Health Organization. 1948. *Construction in basic documents*. Geneva: WHO.
- Wright, S. 1998: The searchers. *Nursing Times*, 94(34):32-33.
- Wright, KB. 2003. Professional, ethical, and legal implications for spiritual care in nursing.
From: <http://www.chaus.org> (accessed on 20 February 2008).
- Wright, R & Ward, K. 2008. *Discussion on what self-transcendence is*. On line interviews.
From: <http://www.selftranscendence.org/self-transcendence/what-is-self-transcendence/> (accessed on 13.09.2008).
- Xiaoyan, B & Jezewski, MA. 2006. Developing a mid-range theory of patient advocacy through concept analysis. *Journal of Advanced Nursing*, 57(1):101-110.

Yang, W, Lai, W & Chao, cc. 2008. A nursing experience of holistic care on total suffering of a patient with terminal illness [Chinese]. *Journal of Nursing (China)*, 55(6):101-106.

Young, A, Van Niekerk, CF & Mogotlane, SM (eds). 2004. *Juta's Manual of Nursing. Volume 1*. Landsdowne: Juta.

Your Dictionary. 2002.From: <http://yourdictionary.com/> (accessed on 9 November 2007).

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List of abbreviations

AIDS	:	Acquired Immunodeficiency Virus
GT	:	Grounded Theory
HIV/A	:	Human Immunodeficiency Virus
HMCM	:	Humane care Model
ICN	:	International Council of Nurses
JCAHO	:	Joint Commission of Accreditation of Health Care Organizations
NANDA	:	North American Nursing Diagnosis Association
RSA	:	Republic of South Africa
SANC	:	South African Nursing Council
SI	:	Symbolic Interactionism
USA	:	United States of America
WHO	:	World Health Organization

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List of annexures

- Annexure A: Ethical clearance certificate
- Annexure B: Letter requesting permission to conduct the study at Hospital X
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