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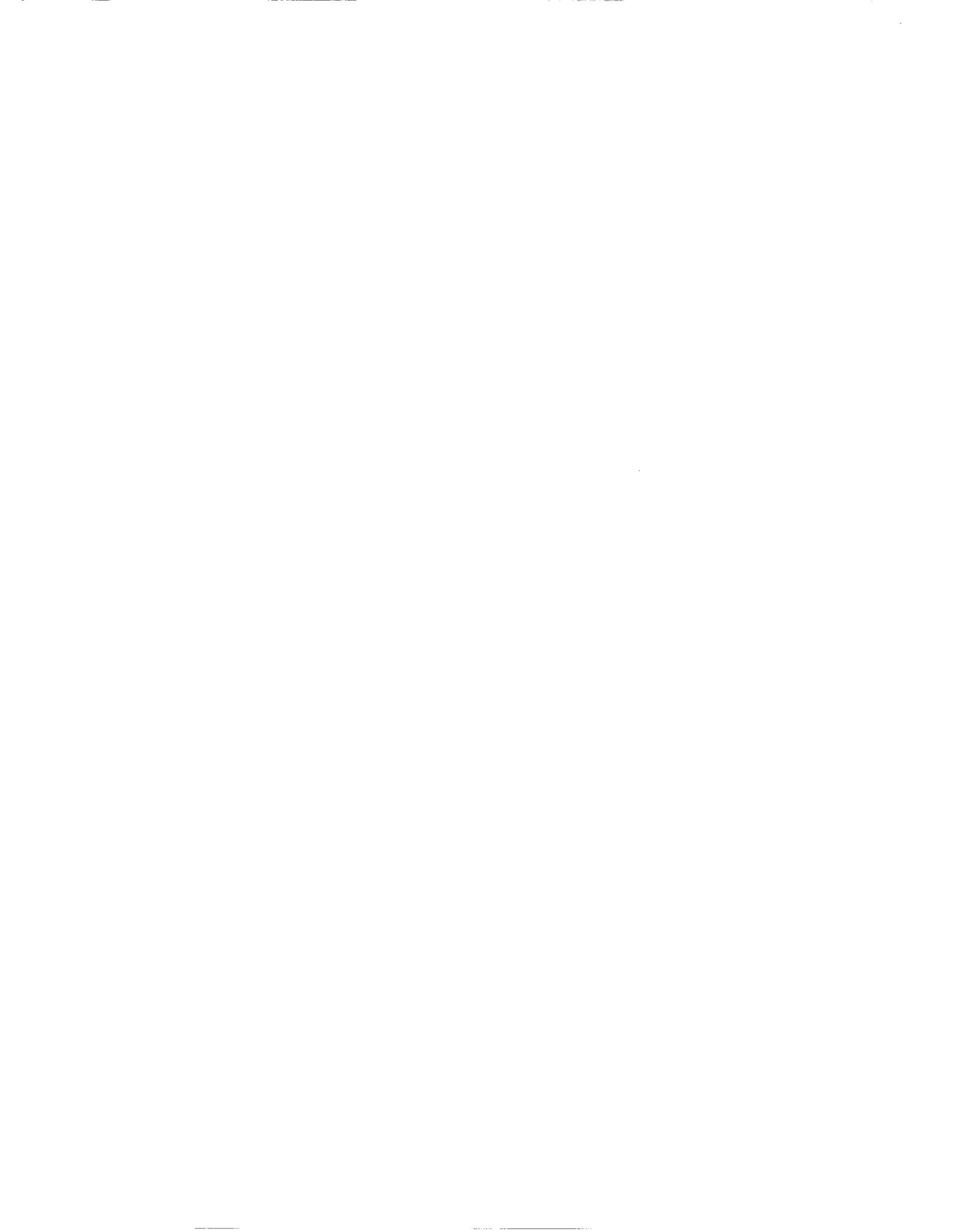
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“THE NURSE’S SPIRIT:
THE LIVED EXPERIENCE OF SPIRITUALITY FOR
NURSES WHO WORK IN PALLIATIVE CARE SETTINGS”

by
Jayne Rajaratnam

A Thesis
Submitted to the Faculty of Graduate Studies and Research
Through the Department of Nursing
In Partial Fulfillment of the Requirements for the
Master’s of Science Degree in Nursing
The University of Windsor

Windsor, Ontario, Canada

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ABSTRACT

Purpose: To examine the lived experience of spirituality in Hospice Palliative Care Nurses (HPCN)

Significance: Contribute to the overall definition of spirituality from nurses' perspectives.

Methods: Existential Phenomenology using the approach developed by Thomas & Pollio (2002); six participants engaged in a one hour interview and reported their perceptions about spirituality.

Results: Three common themes were identified by the participants when defining spirituality; 1) strength 2) spirituality as being different from organized religion and 3) spirituality gives meaning and purpose in life.

Six global themes were also identified: 1) professional self, 2) reflective self, 3) the nurse's relationship with god, 4) the patient/family journey and the nurse's role, 5) time in the profession of hospice palliative care, 6) being present.

Conclusions: Results of this study can inform nursing curricula and positively influence nursing practice by increasing our understanding of the perception of spirituality in hospice/palliative care nurses.

DEDICATION

There are several people who have supported me on my academic journey that I would like to thank. To begin, I would like to thank my mothers and siblings (extended and immediate family) for your love, support and belief in me, knowing that this was an achievable goal when I felt defeated. I would like to thank my husband Justin for your brilliance, your patience and your kindness, as you have rekindled my passion for nursing once more. I thank you for your endurance and longevity, and aspire that I too will be able to do the same for you one day. Thank you for loving me. I would like to thank my children Kieran and Emma Jayne for just being you! You have both brought me closer to knowing my self and have brought me so much joy and laughter. You have truly been my inspirations to learn and grow. I would especially like to thank my father Noel McVicker, for showing me the other side of spirituality. Dad it is because of you that I can now say that I have come to understand spirituality full circle. I began this journey only knowing how to care for others who were dying, I then learned how to become a researcher, studying the phenomenon of spirituality and now, because of you, I now know what it is like to care for a parent who is traveling his own spiritual journey with terminal illness.

I thank God for each and every one of you, because you have made this the lived experience of a lifetime!

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“THE NURSE’S SPIRIT:
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NURSES WHO WORK IN PALLIATIVE CARE SETTINGS”

CHAPTER I

INTRODUCTION

Phenomenon of Interest

It has been said that belief in a spiritual domain is one aspect that differentiates humans from other living creatures (Benner-Carson, 1989). The concept of spirituality has been examined for centuries. Spiritual beliefs and values have been documented among tribal communities and are believed to have existed within communities of primitive man (Narayanasamy, 1999). Primitive explanations and propositions that helped Homo-sapiens explain phenomena and life events gave power and influence to those who understood, maintained and performed the rights and rituals that became associated with the knowledge and beliefs of a spiritual domain. Acknowledging that spirituality has become integrated into our way of living, coping and understanding of the world in which we live, as a Western society, we have come to realize through human recording that wisdom, strength and a spectrum of future possibilities are often aligned with spirituality and a spiritual life.

Definitions

Definition of Spirituality

According to the Oxford dictionary (2006), the term spirituality is derived from the word spiritual. Spiritual is defined as “relating to the human spirit as opposed to material things.....relating to religion or religious belief” (Oxford English dictionary,

p.731). The word spirit evolves from the Latin term *spirare*, which means “to breathe” (Merriam-Webster, 2005, p.475). Spirit is described as “the part of a person that consists of their character and feelings rather than their body, often believed to survive after their body is dead, a supernatural being, courage, energy and determination” (Oxford English dictionary, p.731). Merriam-Webster describes spirit as a “life giving force, the animating principle: soul” (p. 475). Spirituality is also described as “the breath of life” or as the quality or state of being spiritual (Brillhart, 2005, p.31; Taylor, 2002).

Definition of Religion

Many individuals assume that religion and spirituality are synonymous. While this is not true, both spirituality and religion can impact and influence one another (Taylor, 2002). Despite the fact that spirituality can be reflected through religious practice, both religion and spirituality are independent of one another. Religion “is a narrower concept than spirituality” (Taylor, p. 10) and can be defined as,

a set of beliefs concerning the cause, nature and purpose of the universe, especially when considered as the creation of a superhuman agency, usually involving devotional and ritual observances and often containing a moral code governing the conduct of human affairs (Dictionary.com).

In the Oxford dictionary (2006), the origin of the word religion derives from Latin meaning “obligation or reverence” (p. 635), and it is defined as “the belief in and worship of a God or gods, a particular system of faith and worship” (p.635). Merriam-Webster (2005) defines religion as “the service and worship of God or the supernatural, devotion to a religious faith, a personal set or institutionalized system of religious beliefs, attitudes and practices” (p.421). It is evident that the concept of religion is stricter than that of

spirituality and that there is a belief system to which individuals must adhere in order to belong and identify with specific religions. These belief systems can be expressed through “myths, dogma, doctrines and stories but must be acknowledged when one participates in religious practices and observances” (Taylor, 2002, p.10). Religion can help facilitate spirituality by encouraging ways of “thinking, feeling and behaving in order to seek meaningfulness” (Taylor, p.10). Family variables such as role patterns, values, ethical/cultural identifications, historical beliefs, geography, and one’s life experiences all directly impact individuals’ choices to practice religion (Taylor; Regional Palliative Pain and Symptom Management Consultants/Educators, 2006).

The profession of nursing is expected to respect and honor individuals’ spirituality (College of Nurses [CNO], 2005) therefore, nurses are taught to see their clients holistically including mind, body, and spirit (Clark-Callister, Matsumura, Bond, & Magnum, 2004; Hoffert et al., 2007). While caring for their clients holistically, nurses may find that humour, courage, reverence, and serenity are commonly used indicators to express spirituality (Narayanasamy, 1999). The question is however, does this relate to all cultures? Does a nurse need to understand the aspect of spirituality in others to be a competent professional? The affirmation of this attribute comes with the definition of cultural competence. Culturally competent care is “the application of knowledge, skill, attitudes and personal attributes required by nurses to provide appropriate care and services in relation to cultural characteristics of their clients” (p.1) The Canadian Nurses Association (CNA, 2004), supports spirituality as one aspect of culturally competent care. This is further supported by its inclusion in the National Competencies for Canadian Registered Nurses (CNO, 2008), indicating that there is a mandatory expectation that

cultural competence is a requirement for professional nursing practice. The expectation is that the nurse will promote and facilitate the care of others. In this relationship, spirituality is perceived as extra-personal or in the other person (Chow, 2005). Wright (2002) believes that when spiritual needs are attended to, team support, connectedness, relationships, meaning and purpose in the workplace are facilitated. In the externalized active process of care-giving, nurses focus on their care-giving of others, often forgetting their own needs, including their spiritual ones (Kociszewski, 2003). Others believe that spirituality may also improve a nurse's coping skills, relationships with family, friends and colleagues, and most of all restore mental, physical and spiritual health (Hoffert, Henshaw & Mvudu, 2007; Taylor, 2002; Thompson, 2002; Wright, 2002). In this age of evidence-informed practice and the proliferation of best practice guidelines, varying perceptions of spirituality can create confusion and a lack of personal and/or professional relevance to practice. Is it better for nurses to have an active spiritual component to their personal cultural identity? Do we have evidence to show how or if nurses integrate spirituality for intrapersonal care of the self?

Nursing can have many areas of responsibility and role identity (Thomas, 2009). Care-giving can be provided across the lifespan from preconception to post mortem periods. One of the most challenging responsibilities is that of caring for the terminally ill and dying person of any age. How do nurses perceive spirituality in this situation whether on a mixed hospital unit, in the home, or in a hospice setting?

Hospice/Palliative Care Nurses

Hospice/palliative care nurses are a specialized group of healthcare providers who offer comfort and support to a diversity of individuals. In their role, palliative care nurses

may assist clients and their family members with health attainment, comfort during illness and palliative care. The nurse will allow them to come to terms with death and dying, promote the spiritual connection through culturally and personally meaningful ways, and foster patient and family intimacy by coming together and being close spiritually, physically and emotionally (CNO, 2009; Regional Palliative Pain and Symptom Management Consultants/Educators, 2006; Taylor, 2002). To facilitate this, they too may need to explore, understand, and feel comfortable with their own spiritual beliefs (Friedmann, Mouch, & Racey, 2002; Kociszewski, 2003; Sellers & Haag, 1998; Taylor). If they do not participate in their own spiritual self reflection, they could possibly hinder the spiritual growth of their clients, therefore contributing to impaired coping, deteriorating health and poor quality of life (Taylor). This is not easy work and is subject to the pressures of the workplace such as too few experts in hospice/palliative care (Miller, 2008).

At present, there is a global shortage of nurses, in general, causing stress and burnout within the nursing profession (Owens et al., 2001; Thomas, 2009). This shortage is becoming more evident as the baby boomer population begins to age and experience declining health. There will be an unprecedented need for hospice/palliative care nurses to care for people who are living longer in greater numbers with chronic illnesses due to advancements in medicine that prolong life but do not cure. According to the National Hospice and Palliative Care Organization, "between the years 1992 and 2002, there was a 259% increase of patients" who required hospice/palliative care services (Abendroth & Flannery, 2006, p.348). There is a belief "that for those who are dying, they often need more care...palliative care implies a holistic approach which considers not only the

physical but psychological, social and spiritual concerns” of the individual (Twycross, 2002, p.67). Due to the nature of their work, hospice/palliative care nurses deal frequently with spiritual concerns (Clark et al., 2007) that are usually expressed by either the client or a family member.

Currently, little is known or published about the lived experience of spirituality in nurses who work in palliative care settings. Most of the available literature examining spirituality in nursing focuses on researchers' assumptions about the importance it has in client-centered care and how nurses should be implementing spirituality into their daily practice (Cavendish et al., 2006). The professional writing that was found in the literature search for this study revealed that spiritual beliefs positively enhance individuals' overall health and well-being, but it did not address whether or not Canadian hospice/palliative care nurses themselves are influenced or impacted by spirituality. In this study, I asked hospice/palliative care nurses to share their innermost thoughts and feelings about spirituality. My motivation for exploring this phenomenon was the hope that the findings of this study may provide other health care professionals, educators and managers with a glimpse into how spirituality is viewed by hospice/palliative care nurses.

Purpose of the Study

After completing a critical review of the literature concerning the state of spirituality within the hospice/palliative care movement, it is not currently known whether Canadian hospice/palliative care nurses view themselves as spiritual beings, or if they even consider the impact of spirituality on their nursing practice. The perception of spirituality in hospice/palliative care nurses has not been adequately researched (Musgrave & Mc Farlane, 2003); therefore, the purpose of this study was to examine the

meaning of spirituality among hospice/palliative care nurses within two end-of-life settings.

Research Question

The research question for this proposed study was: What is the meaning of spirituality for nurses who work in palliative care settings? The existential phenomenological approach developed by Thomas and Pollio (2002) and colleagues (Pollio et al., 1997) from the University of Tennessee, was the method of inquiry used to guide the investigation of this phenomenon. As applied phenomenology, this approach is well suited to generally describing topic areas/phenomena of interest to the profession of nursing (Thomas & Pollio).

Philosophic Perspectives in Existential Phenomenology

The term phenomenology first began to appear in philosophical texts in the eighteenth century with the work of “Immanuel Kant, George Wilhelm, Friedrich Hegel, and Ernst Mach” (Moran, 2000, p. 1). However, Edmund Husserl (1859) is credited with creating phenomenology as a movement and introducing phenomenology as a “new way of doing philosophy” (Moran, p.1). According to Sokolowski (2000) the term phenomenology derives from the Greek words “phainomenon and logos...It signifies the activity of giving an account of various phenomena and the ways in which things can appear” (p. 13). The concept of phenomena refers to “pictures..., remembered events...imagined events... words and people” (Sokolowski, p.13).

As time has passed, phenomenology has grown and expanded into its own branch of qualitative inquiry. As cited in Thomas and Pollio (2002), Caelli, reports that at a recent conference researchers have identified up to “18 different forms of

phenomenology” (p.11). Max van Manen, a renowned phenomenologist, has mapped phenomenological inquiry as having “the following topical domains: orientations, sources of meaning, methodology, methods, writing, and practice” (2002).

The methodology that provides the ‘best fit’ with the research question for this study is existential phenomenology as described by Maurice Merleau-Ponty (1962) because existential phenomenology seeks to understand or give meaning to the everyday world of people and their human experience. According to Secret (2007) phenomenology allows individuals to “understand a phenomenon in the everyday world, investigating people’s experiences and the meanings these experiences have to them” (p. 6). As quoted by Merleau-Ponty, “phenomenology is the study of essences; and according to it, all problems amount to finding definitions of essences” (pvii). It is the philosophy of phenomenology that puts essences back into human existence. Ploeg (1999) felt “the goal of phenomenology is not to develop models or theories, but to actually describe an individual’s lived experience of the phenomena under study” (p.25).

Existential Phenomenology

“Keirkegaard, a Danish philosopher, is the founder of existentialism” (Plaas, 2007, p. 6). His work focuses on the adversities of humans in everyday life and their perspectives of life and living. As cited by Plaas, Kierkegaard’s research looks at individuals’ “perceptions of existence and how their lives are humanly lived” (p.6). Thomas and Pollio (2002) refer to this as how “we come to live authentic lives” (p.9). Combining existentialism with phenomenology gives rise to the method of inquiry known as existential phenomenology.

In summary, by examining phenomena in its purest form, phenomenology allows qualitative researchers to gain “insight into the deeper meaning of humans’ experiences” (Thomas & Pollio, 2002, p.7). Existential phenomenology is a method of inquiry that is frequently used to study phenomena associated with the nursing profession. The “lived experiences of addictions, pain, urinary incontinence, cancer, anorexia, caring, empathy, courage, and air hunger” (Thomas & Pollio, p.6) are just a few areas in nursing that have been studied using the phenomenological approach. This same approach has been used to discover and understand other nursing topics such as: the wonder of meaning: a phenomenological understanding of spiritual distress (Smucker, 1993), the meaning of type two diabetes for women with previous gestational diabetes (Patrick, 2006), and the lived experience of hope for mothers of premature infants in the neonatal intensive care unit (Plass, 2007).

The lens of Merleau-Ponty, a French phenomenologist, has been used by Pollio and colleagues (1997) to establish their applied nursing phenomenology. Choosing this lens allows nursing researchers “to see familiar phenomena in a new light” (Thomas & Pollio, p.19). When understanding and describing the phenomenological approach of Merleau-Ponty, there are three major concepts that contribute to his philosophy. They are 1) functional intentionality, 2) thrownness, and 3) freedom. Function and intentionality are usually combined into functional intentionality within the phenomenological domain (Thomas & Pollio). These three major concepts contain four major grounds of human existence which are time, body, others and world (Thomas & Pollio, p.4)

Phenomenological Concepts

Functional Intentionality

For the purpose of this study, the two aspects of function and intentionality are merged and become functional intentionality, following the philosophical work of Thomas and Pollio, and Merleau-Ponty. The concept of *functional intentionality* is an important component of phenomenology. As cited in Thomas and Pollio (2002), Carr states that “functional intentionality is found in the walk, the look, the reach, the mutual corroboration of the senses in the perception of an object, the general orientation of the body which, like pure consciousness, is always, in relation to its world” (p.15). Functional intentionality implies that human experiences have “meaningful directions towards a definite goal” (Carr as cited in Thomas & Pollio, p.15). Intentionality alone refers to the teaching that “every act of consciousness we perform and every experience we have we are conscious of ...as every experience is correlated with an object” (Sokolowski, 2000, p.8). According to Thomas and Pollio they describe intentionality as “the fundamental configuration of human existence...connection and relationship describe the most general properties of our being-in-the-world and of our being-with-others” (p.14). In phenomenological intentionality, it “describes a basic configuration of person and world that is most obvious in human perception” (Thomas & Pollio, p.15). As interpreted by Thomas and Pollio, they describe Merleau-Ponty’s view on functional intentionality as “a more embodied form” (p.15) of intentionality, therefore including the activity of human behaviour as part of his definition. As cited in Thomas and Pollio, Carr best describes the embodied nature of functional intentionality as:

The body is never a fully constituted object...there is even biological functions that link the body to its environment in a way which is not purely mechanical. In sexual behaviour the body is the perfect example of functional intentionality. It is not an objective physical process, but the meaningful direction toward a definite goal...an awareness with sexual activity can never be just intellectual awareness (p.15).

According to Thomas and Pollio, when Merleau-Ponty describes individuals' behaviour it is always expressed in "first person significance" (p.15). As cited in Moran (2000), Merleau-Ponty describes behaviour (in his book *Structure of Behaviour*) as "an embodied dialectic...a kinetic melody gifted with meaning" (p.414). The idea is that behaviour is another way in which we share and experience the world. There is a "behavioral way of telling us what is significant to some specific organism in some specific situation...what we do reveals both who we are and what is important to us" (Thomas & Pollio, p.15).

Thrownness and Freedom

Projected thrownness and *freedom* are the remaining two important concepts that contribute to the understanding of phenomenology. It is believed that in human life "humans are *thrown* into situations beyond their wishes" (Thomas & Pollio, 2002, p.16). It is these current circumstances that allow individuals to *project* themselves forward into perhaps new or better situations, therefore contributing to individuals' awareness of themselves (Thomas & Pollio).

In phenomenology, the concept of *freedom* is contextualized in life situations. The idea that "freedom is limitless and situationless" (Thomas & Pollio, 2002, p.17) is

not always possible for individuals as it depends on one's current life situation or his/her being-in-the-world. Freedom of choice can have varying meanings. According to Frankl (as cited in Thomas & Pollio) it is important to recognize that freedom can also be expressed through one's attitudes and behaviours in life. Freedom has been a topic of classical study over many centuries (Matthews, 2002). In this contemporary study, freedom is applied to the context as described by Merleau-Ponty to reflect continuity and integrity with his method of phenomenology.

In addition to the three major concepts described briefly above, the examination of four grounds namely "time, body, others and world" (Thomas & Pollio, 2002, p.4), are critical to the systematic exploration and eventual understanding of a selected life event, in this case, end-of-life palliative care by nurses.

Four Major Grounds of Human Existence

As mentioned above, there are four major *grounds* when examining human existence. They are known as "time, body, others and world" (Thomas & Pollio, 2002, p.4). These grounds are explored to help define human existence especially when they are examined through the "first-person perspective" (Thomas & Pollio, p.4). There are "different perspectives that may be taken- that of an observer and/or that of the person in question" (Thomas & Pollio, p.19). When describing the major *grounds* of human existence, as stated by Thomas (2005), it is the grounds of time, body, others and world which "stand out as figural or focal to a person" (p.69) and provide a way of describing and explaining the human experience.

In this study I examined the subjective experience of hospice/palliative care nurses and their perspectives of how spirituality affects them as individuals and as such,

the aspects of the first-person perspective are essential to gaining understanding of their lived experiences with, in this study, the essence of spirituality. The purpose of the phenomenological interview is not only to listen attentively to the descriptions of the participants' lived experiences but to also facilitate "learning in which the participant or interviewer may come to understand something new about the phenomena" (Thomas & Pollio, 2002, p.25).

Researcher Perspective

Prior to the conduct of this research study, I was actively involved in the hospice/palliative care sector. In my twelve years of nursing I have been fascinated with death and dying from a personal as well as a professional perspective, as I know it is something we will all have to confront at some point during our existence. I have come to understand the importance of embracing life and being grateful for all it has to offer. In my early twenties I began to evaluate my life as I experienced many transitions or *life traumas*. These traumas brought me closer to understanding myself and my purpose for being. I began to ask myself, "Why am I here and what is it that I have come to do?" "How can I use my nursing to help others?" I soon began to realize that these questions probed into my own life-purpose, especially the spiritual dimension. As a result of my personal reflection, I began to seek knowledge and understanding about the concept of spirituality. As I became more knowledgeable, I grew more comfortable with my own spirituality and then began to incorporate its practices and guiding principles into my nursing. It was during this time in my career that I found myself caring mostly for palliative care patients in both the community and hospital settings. Contrary to many of my colleagues, I preferred caring for palliative care patients and welcomed the

experience, as I knew there would be more wisdom and knowledge to be gained as I had learned the beginning lesson of inquiry, namely openness to the possibilities of life-events shared by others. As a novice researcher, I became aware of the power of listening objectively and actively as described by Thomas and Pollio. These early insights proved to be essential to the qualitative research method that I learned about in preparation for this study. As a result, I have come to realize that most of my spiritual teachings originated from palliative care clients and their families, as they have been the teachers and I have been the student.

Through the years of accumulated stories and reflections, and in my valuing of spirituality, I have learned the importance and significance it can have in one's life, positively affecting one's state of mind and overall wellbeing. Since I have become more spiritual myself through my ongoing inquiry and knowledge integration into my practice, I have found myself to be more grounded, patient, forgiving, and less judgmental. Through my palliative care clients I have learned to be more grateful but most importantly, to be more open and accepting of others. I have come to learn that individuals express and practice spirituality differently, but that all expressions are equally important and relevant to individual's wellbeing.

I have come to appreciate the humanity behind the professional expectation of providing culturally competent/safe care as spirituality has been one of the elements of culture-care that I now attend to in all my relationships. As I have found a rich source of fulfillment and meaning as I give care from the perspective of conscious spiritual attentiveness, I wonder if other hospice/palliative care nurses feel the same way? Knowing that they deal with death, dying and spiritual concerns frequently, I am curious

to know how does this impact them as individuals? Do they gain strength, courage, wisdom or resiliency from palliative care clients? In times of crisis, do they use spiritual modalities to help them cope with difficult decisions in their life or even to recharge their own spirit? I believe there are answers to these questions, answers that lie dormant within hospice/palliative care nurses themselves.

It is an assumption of the researcher that there is a gap in understanding the phenomena of spirituality and how it affects Canadian hospice/ palliative care nurses because I could not find evidence that the question has ever been asked from an existential phenomenological perspective. Understanding how Canadian hospice/palliative care nurses perceive spirituality could provide the health care profession with increased understanding and insight about how spirituality is viewed and provide a scholarly foundation upon which to suggest practice applications or to develop evidence-informed guidelines or blueprints. Perhaps other categories of nurses, such as nursing students, nursing faculty, medical/surgical nurses and emergency nurses have differing viewpoints about spirituality and how it affects them personally or perhaps there is a core of phenomenological knowledge that could help inform and enlighten others for personal as well as professional self understanding.

Knowing that there is insufficient spiritual education in nursing curricula (Hegarty et al., 2005; Hoffert, Henshaw & Mvudu, 2007; Lantz, 2007; Swinton, 2006), perhaps this research could contribute to a foundation for understanding the nurse's spiritual dimensions and give it the validation and credence it deserves.

Delimitations

Little is known about Canadian hospice/palliative care nurses' understanding of, appreciation of, and reflection on the phenomenon of spirituality. This study will elicit descriptions of spirituality as it occurs in everyday situations for hospice/palliative care nurses. The delimitations of this study focused on the perceptions of hospice/palliative care nurses in their professional or personal life either in the community or in a hospital setting.

Hospice/palliative care nurses deal frequently with spiritual concerns and distress (Regional Palliative Pain and Symptom Management Consultants/Educators, 2006; Taylor, 2002). It was for this reason that they were chosen as the key informants for this study. Due to the nature of their work hospice/palliative care nurses might be more familiar and comfortable sharing their innermost thoughts and feelings about spirituality. The greater percentage of existing research has been conducted on patients' perceptions of spirituality, how they have benefited from spirituality and the lack of spiritual care nurses provide when nursing sick patients (DiJoseph & Cavendish, 2005; Taylor & Outlaw, 2002).

The researcher purposefully chose the process of Thomas and Pollio (2002) and colleagues' (1997) as the method of inquiry to study spirituality in hospice palliative care nurses as it is heavily based in existential phenomenology and uses the lens of Merleau-Ponty. Seeing that little research has been done to understand the perceptions of Canadian hospice/palliative care nurses' views on spirituality, this qualitative methodology allows the nursing researcher to begin unfolding the lived experience of these nurses and to discover the meaning behind their stories. Once we begin to

comprehend the impact and effect that spirituality has on hospice/palliative care nurses, we can begin to dig deeper into understanding how other nurses may be affected by spirituality or how faculty and nursing programs might be restructured to include and explore the spiritual dimension of self and others. It is important to understand the nurses' perceptions as this helps guide future research and postulates new questions for inquiry. Using the lens of Merleau-Ponty, Thomas and Pollio and colleagues acknowledge participants as holistic, embodied and perceiving, three fundamental key concepts which individuals possess. This method is congruent with the research question and the current state of knowledge about hospice/palliative care nurses' perceptions on spirituality (Thomas & Pollio) and meets the necessities for scholarly inquiry into the phenomenon of spirituality.

This study did not focus heavily on religion. As mentioned earlier in the introduction, the researcher established the difference between religion and spirituality, as they are not synonymous. Unless religion and religious beliefs are discussed in participants' interviews, this study will remain open to the participants' viewpoints and beliefs, whatever they may be. This decision will not prejudge any beliefs, values, thought or traditions of any of the participants and so may provide a more open perspective and worldview.

Another delimitation of this study was that all of the participants volunteered in this study, therefore all sharing the same viewpoint, pro-spirituality. If the researcher had obtained her sample through random sampling, then perhaps some participants in the study would be less or a non believer in spirituality, therefore potentially changing the outcome of this study.

In the organization of this study, the researcher has adopted the structure of Plaas' (2007) dissertation, an unpublished dissertation in which the methods of inquiry of Thomas and Pollio (2002) were applied to conduct her study undertaken when Kristina Maria Plass was a doctoral student of Dr. Sandra Thomas, in May 2007 at The University of Tennessee, Knoxville.

Significance

Currently there is a gap between knowledge and understanding with regards to the phenomenon of spirituality and its relationship to nursing practice. It is anticipated that this study will further contribute to the overall definition of spirituality from a nurses' perspective rather than that of patients. In this study I explored and described this phenomenon through the words of the Canadian hospice/palliative care nurses as participants describing the meaning they attach to spirituality in their nursing work. Asking hospice/palliative care nurses to describe their lived experiences of spirituality, recording and transcribing processes prior to thematic analysis steps and knowledge distribution activities of the findings all helped to reduce the gap, and contribute to nursing's larger body of knowledge.

CHAPTER II

REVIEW OF LITERATURE

In this chapter, published literature related to the concept of spirituality as it is used and described in relation to the end of life by those nurses giving care during these events was explored. Specifically, the first section of this systematic literature review will analyze and synthesize the current research literature about nurses and their connection to spirituality. The question used to guide this literature review was, “how is spirituality described and/or perceived by nurses and especially nurses who work in hospice/palliative care settings?”

Search Strategy

The following databases were searched for relevant literature regarding research on spirituality at the end of life and/or relevant to the profession of nursing: CINAHL (Cumulative Index to Nursing and Allied Health Literature), Ovid, Proquest, and Cochrane. The literature review was limited to research between 1970-2008 and included both qualitative and quantitative studies that addressed the concept of spirituality. In this review, selected key words and search terms were used including: spirituality, spirit, nursing, hospice, existentialism and palliative care. Each article was reviewed and critically appraised for validity and applicability using the process described by DiCenso, Guyatt & Ciliska (2005). When critically appraising qualitative research, these researchers asked three questions: 1) what are the results, 2) are the results valid and 3) how can I apply these results to patient care. When evaluating the validity of the research, DiCenso, Guyatt & Ciliska state that you must ask “was the research question clear, was the design appropriate for the study, was the sampling appropriate for the

research question, and was data collected and managed systematically and was data analyzed appropriately” (p.122).

Twelve quantitative studies were found that met the above criteria, as well as twenty qualitative studies and one with mixed methods. First the literature that encompasses how spirituality has been described in the nursing literature is explored, followed by an appraisal of the literature pertaining to spirituality and hospice/palliative care nurses. This background knowledge assisted the researcher in performing interviews as it provided guidance and insight into similarities and differences about what currently exists in the literature.

The Review

Spirituality and the Hospice/Palliative Care Nurse

There is little research that describes and discusses the effects and direct impact that spirituality has on hospice/palliative care nurses. There is literature however that describes the deep roots of spirituality in nursing and the progression of concepts to date.

Historical Context of Spirituality in Nursing

Spirituality is not a new concept, but one that has existed since the beginning of time. As reported by Benor (1999), “spiritual healing is probably the oldest recognized therapy, used in every known culture” (p. 369) and has been expressed in many different forms such as “shamanism, laying of hands, distant healing, energy work, faith healing and mental healing” (p.369). According to Narayanasamy (1999), spirituality in nursing has a documented history dating back to primitive man. Engebrestom and Wardell (2007) state that, “human touch or laying-on of hands for the purpose of healing has been used historically and cross-culturally for centuries” (p.243). Until recently, Europe and

the United States acknowledged these therapies as modalities for “spiritual healing” (Engebrestom & Wardell, p.243).

In ancient Egypt, India, Greece, China, Palestine and Babylonia, nurses were portrayed as intuitive, holistic and responding to the health needs of communities. Nursing was performed by the women of the household and spiritual care was included in their total nursing intervention (Narayanasamy, 1999).

It was felt that the role of nurses really became defined with the birth of Jesus, and his teachings, “as Jesus was a great healer” (Benor, 1999, p.370). He had a compassion, kindness and spiritual nourishment for the ill and believed that by attending to the ill and the needy, individuals were serving God, known as the higher power (Narayanasamy, 1999). It was believed that Jesus and his apostles used, “touch, saliva, mud and cloth vehicles, as well as words, prayer, exorcism, faith and compassion for healing” (Benor, p. 379). According to Dolan, a nurse historian (as cited by Johnson, Tilghman, Davis-Dick, & Hamilton-Faison, 2006), “the way Jesus tended to the infirm set standards for those who served to follow” (p.60). As the Christian church developed from Jesus’ influence, priests were chosen to share their healing gifts with the people in their communities. Some priests were believed to heal individuals with their touch, while others claimed to observe miracles. Despite their varying gifts, “prayer for healing powers” and the responsibility of serving God were considered to be a priest’s biggest achievements (Benor, p.370).

After the fall of the Roman Empire, nurses continued to serve God and care for the sick. They were now Crusaders on the battlefield (Narayanasamy, 1999). It is here amid battles where military nursing began as it “was of extreme importance that nursing

care of the soldiers be close to the battle field where nursing care could be rendered” (Johnson, Tilghman, Davis-Dick, & Hamilton-Faison, 2006, p.61). Due to war and confronting their own mortality, the focus of nursing care remained holistic and their role was primarily defined in spiritual terms (Narayanasamy). Due to the terminal state of the soldiers, it is here where the first hospices were erected, as this would provide a place of rest, shelter and healing for the sick and dying (Johnson, Tilghman, Davis-Dick, & Hamilton-Faison).

This time also gave rise to women's diverse roles as healers, midwives, counselors and visionaries in pagan communities (Schwartz, 1990). During this time there was the misconception that these practitioners exercised the work of Satan; however in the Pagan religions there is no belief in Satan (Smith-Stoner & Cedarwind-Young, 2007). Despite the criticism, these women continued to practice their ancient earth-based spiritualities (Schwartz). Between the fifteenth and eighteenth centuries as many as two million people were executed for witchcraft, usually burned at the stake; eighty percent of these people were women (Butler, 1996). Fraser (1990) found the following:

midwives were often burned because they knew how to lessen the pain of labor while the church viewed labor as punishment for the sins of Eve and women's sexuality was viewed as evil because it threatens male holiness and spirituality (p.14).

The era of the Renaissance remained a bleak time for nurses because there was now a struggle between Catholic and Protestant countries. It was during this time that formal education for nurses began with the help of St. Vincent de Paul and his charities as “nursing had taken on a more definite role” (Johnson, Tilghman, Davis-Dick, &

Hamilton-Faison, 2006). Prayer was the modality of choice for visiting nurses who began to work with the sick in the community.

In the nineteenth century, illness was on the rise due to “industrial accidents, poor health and crowded conditions” (Johnson, Tilghman, Davis-Dick, & Hamilton-Faison, 2006, p.61). It was especially these crowded conditions and un-hygienic styles of living that contributed to the spread of disease. It was during this time that Florence Nightingale’s quest for improved nursing education became an important component of scholarly, competent nursing practice. Both Narayanasamy (1999) and Luck (1998) described her as a visionary who pushed nursing to incorporate spirituality, to service those in need; she was a driving force who transformed nursing as a holistic dimension, integrating mind, body and soul. It was discovered that Florence Nightingale wrote several letters addressed to “family servants, townspeople, craftsmen, teachers and coachmen” about “issues of major public concern” (Freeman & Glass, 2001, p. 174). In these letters she establishes her beliefs in God, her own physical and emotional suffering during the Crimean war and her pain related to the suffering of the soldiers. It was discovered in a letter that one of her favorite books was entitled “The Love of the Spirit”; she offered to send this book to her friend back home in England, providing her with the same wisdom Florence had gained (Freeman & Glass, p. 174). Knowing that Florence Nightingale was inspired and impacted by spirituality, it is easy to see how she might have influenced its existence in nursing. She relied on her intuition, inner truth and balance to guide her nursing and always had compassion and love for humanity (Narayanasamy; Luck). To this day many see her as “a pioneer of modern nursing” (Miracle, 2008, p.21)

The twentieth century signified change and development for the nursing profession as scientific inquiry, nursing research and nursing education was valued and considered important (Johnson, Tilghman, Davis-Dick, & Hamilton-Faison, 2006). As early as the 1940's, nursing theorists began to grapple with the concept of spirituality and its impact on nursing. The profession of nursing is understood through its interpretation of grand and mid-range nursing theories. These theories are the foundational building blocks for nursing practice and provide nurses with guidance and insight on how to care for their patients holistically. Frequently the spiritual dimension of holistic health is absent or hidden within nursing theories, thereby making it very difficult for nurses and healthcare professionals to interpret and understand the importance of spirituality (Oldnall, 1995). In either grand or mid range theories, spirituality is rarely defined as an independent core concept; it is usually described and buried or classified with other concepts, such as caring (Leininger, 1970, Bevis, 1973; Watson, 1979-2002), holistic practice (Levine, 1969; Rogers, 1970; Parse, 1970), and has been outlined as a nursing responsibility (Abdelah, 1960). Some theorists have included the spiritual dimension within the paradigms of person (Roy, 1970; Neuman, 1970; King, 1969) and health (Travelbee, 1966). When reviewing nursing theories, theorists provide very generalized ideas and blanket statements about the importance of the spiritual dimension in individuals, nursing and healthcare, however there is never an explanation provided as to how they derived their conclusions.

Faye Glenn Abdelah, Myra Estrin Levine, Sister Calista Roy, Betty Neuman, Imogene King, Joyce Travelbee, Martha Rogers, Rosemarie Parse, Madeline Leininger, Jean Watson and Olivia Bevis are the few nursing theorists who make reference to

spirituality in their theories (Appendix A). Of all of the theorists listed, Jean Watson's theory of human caring speaks the most clearly or philosophically or integratively, to spiritual well-being for both the nurse and the patient (Marriner-Tomey & Raile Alligood, 2002).

Theoretical Reflections of Nurse Theorists

Abdelah's nursing theory (1960) is based on the Typology of Twenty-One Nursing Problems. Her school of thought originates from Maslow's hierarchy of needs and Erickson's stages of development (Marriner-Tomey & Raile-Alligood, 2002). She believes that these problems are "principles of nursing practice and constituted the unique body of knowledge that is nursing" (Marriner-Tomey & Raile-Alligood, p.118). If nurses were diligent in addressing all twenty-one problems when caring for their patients, then they were providing holistic care. From her list, she assumes that nurses "facilitate progress toward achievement and personal spiritual goals" (Marriner-Tomey & Raile-Alligood, p.114). Reflecting on this theory in the twenty-first century scope of nursing practice, this statement is very vague in nature and therefore caused uncertainty among nurses on how it is they are to achieve this goal. None-the-less, it remains an early example of how nursing included the spiritual domain.

The Conservation Model created by Levine (1969) suggests that the concepts of wholeness, adaptation and conservation, otherwise defined as "keeping together" (Marriner-Tomey & Raile-Alligood, 2002, p. 215) are necessary when maintaining a holistic approach to care. According to Barnum (1998), "a holistic theory is one whose subject matter is conceptualized as an indivisible whole, an entity that is fractured and distorted if considered as a collection of parts" (p.91). When a theory is holistic in nature

it “may incorporate a spiritual component of man; they may see the human being as an entity that is far more than physiological” (Barnum, p.56). When describing spirituality, Levine identified it as an external, conceptual factor of one’s environment. She felt that this conceptual level is “characterized by cultural patterns and spiritual existence” (Marriner-Tomey & Raile-Alligood, p.215), however she fails to define spiritual existence and the spiritual dimension of individuals.

Sister Calista Roy’s Adaptation Model (1970) focuses on the concepts of adaptation, stimuli, coping mechanisms and responses. While individuals adapt to new stressors and strains, there are four different modes in which an individual responds. These modes have been identified as possible coping mechanisms. They are: 1) the physiological-physical mode, 2) the self-concept-group identity mode, 3) the role function mode and 4) the independence mode. Roy identified one’s “spiritual and psychic integrity” (Marriner-Tomey & Raile-Alligood, 2002, p.273) within the self-concept-group identity mode. Roy believed that this mode focuses on the spiritual and psychological components of an individual’s being. She felt that it is important for one to know oneself so he/she may “exist with a sense of unity, meaning and purposefulness in the universe” (Marriner-Tomey & Raile-Alligood, p.273). When describing the paradigm of personal self, Roy felt that there is a “moral-ethical-spiritual” component to self (Marriner-Tomey & Raile-Alligood, p. 273), but neglects to describe what this dimension of self looks like.

Betty Neuman’s System Model (1970) explores the individual as a system that responds to specific stressors through flexible, normal lines of defense and lines of resistance. The strength of the system determines the health and well-being of the

individual. In her theory, she makes little reference to spirituality specifically, but within the major assumptions of her theory she believes that there are interrelationships between client variables, and they are physiological, psychological, sociocultural, developmental, and spiritual in nature. It is these variables that determine the extent and reaction to stress an individual might experience. She postulates that all humans have lines of defense that protect them from harm. If these lines of defense are strained or broken, individuals then become vulnerable to illness (Marriner -Tomey & Raile-Alligood, 2002). Since first developing her theory, Betty Neuman describes “the spiritual variable as an innate component” of a human being, therefore “consideration of the spiritual variable is necessary for a holistic perspective and for caring concern for the client” (Marriner-Tomey & Raile-Alligood, p.314).

Within Imogene King's Theory of Goal Attainment (1964), there is little mention of spirituality. Despite the fact that this theory focuses on the nurse-client relationship and how it leads to the achievement of goals, King is very clear in stating “individuals are spiritual beings” (Marriner-Tomey & Raile-Alligood, 2002, p.342) when describing the paradigm of person. Like many of the other theorists, King also lacks any further description or explanation of her statement.

In the Theory of Human-to-Human Relationship Model, Joyce Travelbee (1966) explores the therapeutic relationship among nurses and patients describing specific concepts such as illness, suffering, hope, interaction, communication, empathy, sympathy and human -to- human relationship (Marriner-Tomey & Raile-Alligood, 2002). Her theory is well known to the hospice nursing community and very much a touchstone philosophy of death and dying. She begins to make reference to spirituality during her

explanation of suffering. She describes suffering as “displeasure which ranges from simple mental, physical or spiritual discomfort to extreme anguish” (Marriner -Tomey & Raile-Alligood, p.420). She also describes health as being both subjective and objective in nature. Physical, spiritual and emotional status is identified through one’s subjective experience of health however she does feel that there is a role for “spiritual directors” to evaluate and perform assessments for objective health (Marriner-Tomey & Raile-Alligood, p.421). It is her belief that all individuals will eventually be confronted by illness therefore leading them to spiritual, mental or physical suffering. She describes illness and suffering as “spiritual encounters” (Marriner-Tomey & Raile-Alligood, p.422). She also believes that nurses’ spiritual values and beliefs directly impact individuals and their families (Marriner-Tomey & Raile-Alligood). Despite her references to spirituality, she still does not define spirituality in her nursing theory.

The Theory of Unitary Beings (1970), established by Martha Rogers, is an abstract system of ideas. Her theory was based of Rogerian science which included ideas, values and beliefs about subjects such as “anthropology, religion, mathematics, psychology, history, biology, philosophy, sociology, physics and astronomy” (Marriner-Tomey & Raile-Alligood, 2002, p.227). Roger’s theory was heavily influenced by quantum physics, “Einstein’s theory of relativity and Burr and Northrop’s electrodynamic theory relating to energy fields” (Marriner-Tomey & Raile-Alligood, p.227). Rogers believed that individuals and the environment are constructed from energy fields that are constantly communicating with each other and are mutual, continuous processes and open systems. In her theory she states “human beings are not disembodied entities nor are they mechanical aggregates.... they are pandimensional (without spatial or temporal

attributes) energy fields identified by pattern and manifesting characteristics of the whole" (Marriner-Tomey & Raile-Alligood, p.229). By experiencing individuals and the environment as emerging energy fields, there is a belief that "nurses will focus on human expressions of reflection, experience and perception to form a profile of the patient" (Marriner-Tomey & Raile-Alligood, p.233). It is anticipated that this theory will allow nurses to let go of traditional thoughts and that reduction categories such as "physical, spiritual, mental, emotional, cultural and social assessment frameworks" (Marriner-Tomey & Raile-Alligood, p.233) will be transcended. In this theory the individual's spiritual domain is referred to as reducible and divisible in nature; however, there is no explanation as to how it is all encompassing to the individual as a whole. This theory has been used in practice when discovering and exploring the modalities of therapeutic touch, guided imagery, meditation and self reflection, all used in the connection of one's spiritual domain.

Rosemarie Parse's Theory of Human Becoming (1970) is especially influenced by Martha Rogers' ideas and her theory on Unitarian Beings. Like Rogers, Parse too believed in "energy fields, pandimensionality, patterns and openness...people are human beings who relate at multiple realms with the universe and who are irreducible, ever changing, and recognized by patterns" (Marriner-Tomey & Raile-Alligood, 2002, p.528). The theory of Human Becoming was created with existential phenomenology (Merleau-Ponty, Heidegger, and Sartre) as the driving force, whereby the "lived experiences of human beings and their freedom and participation in life" is the essence of being (Marriner-Tomey & Raile-Alligood, p.528). Similar to Rogers, Parse does not define or describe the concept of spirituality in her theory; however she does state that humans are

“coexisting while co-constructing rhythmical patterns with the universe and that humans transcend multidimensionally (Marriner-Tomey & Raile-Alligood, p.534). In Parse’s theory, she identifies and describes three common themes for human becoming, they are: 1) meaning, 2) rhythmicity and 3) transcendence. The concept of transcendence is common in spiritual literature; however in her definition she does not limit the concept the spiritual dimension. She defines the source of transcendence as “the possibilities arise with the human-universe process as options from which to choose personal ways of becoming” (Marriner-Tomey & Raile-Alligood, p 534-535). Could the options she refers to be spiritual in nature? Parse is vague in her description of transcendence and therefore leaves readers uncertain in their interpretations. More clarification would be helpful.

Through the method of qualitative research, Madeline Leininger was one of the first theorists to study different cultures as an undergraduate, graduate student and as a faculty member. Through her studies and findings she created the Theory of Culture Care: Diversity and Universality Theory (1970). She defined the concept of caring as being able to “assist, support or enable experiences or behaviours toward or for others or groups with evident or anticipated needs either to ameliorate or improve a human condition, life-way or to face death” (Marriner-Tomey & Raile-Alligood, 2002, p.508). Leininger uses the same definition when defining her concept of culture care; however, she adds, “subjectivity and objectivity, learned and transmitted values, beliefs and patterned life-ways” (Marriner-Tomey & Raile-Alligood, p. 508) help facilitate this form of caring. In her theory Leininger does not define or make reference specifically to spirituality, however she does identify “religious beliefs, social kinship, political, and

economic, educational, technological and cultural values as influencing and affecting human behaviour” (Marriner-Tomey & Raile-Alligood, p. 508).

Similar to Leininger, Em Olivia Bevis created her Curriculum Building Framework (1973) with the concept of caring in mind. It is her belief that nursing practice and education involves three stages: 1) input 2) throughput and 3) output (Bevis, 1989). These stages mimic that of the nursing process, whereby input reflects nursing assessment, throughput targets diagnosis and planning, and output represents implementation and evaluation (Bevis). In this theory nursing is a process that focuses on the person as an open system. Bevis begins by describing the input phase where problems, needs, goals and desires are identified in either intrapersonal (self, individual) or interpersonal (others, groups, communities) relationships. In order to achieve client centered goals as an outcome, nurses help clients facilitate life processes better known as maturation and adaptation (Bevis). Maturation and adaptation can take place through the use of client system sub processes or through nursing resources, strategies or tools. The client's sub processes are identified as: 1) learning, 2) critical thinking, 3) stress/strain, 4) communication, 5) human growth and maturation, 6) change/leadership, 7) self-responsibility, 8) caring and 9) life-ways and lifestyle elements whereas the nursing resources are identified as: 1) caring, 2) communication, 3) teaching, 4) problem-solving, 5) leadership, 6) research and 7) empowerment for self responsibility and advocacy (McMahon, 2009). Within a curriculum framework Bevis has described the four stages of caring, 1) attachment, 2) assiduity, 3) intimacy, 4) confirmation, as a “transactional relationship with meaning founded on an existential awareness of self and others, transcending the limits of illness and optimizes actualization of human potential” (Blatner

as cited in Mc Mahon, p.14). In these stages of caring there is no reference, description or definition of spirituality, however there is much emphasis on self reflection, revelation of self and self actualization, all concepts that exist within spirituality literature. At present it is uncertain whether Bevis acknowledged or intended to acknowledge the domain of spirituality. More clarification is needed for readers to understand where the concept of spirituality fits.

Jean Watson's work (1979-2002) was very much influenced by the work of Nightingale, Rogers and Leininger. In her theory, Jean Watson best describes the spiritual dimension of individuals through her Theory of Caring. Within her theory she defines ten carative factors. These factors are: 1) the formation of a humanistic altruistic system of values, 2) installation of faith and hope, 3) cultivation of sensitivity to others, 4) development of a helping-trusting relationship, 5) promotion and the acceptance of the expression of positive and negative feelings 6) assistance with gratification of human needs 7) promotion of interpersonal-teaching learning 8) systemic use of the scientific problem-solving method for decision making 9) allowance for existential phenomenological forces and 10) provision for a supportive, protective and corrective mental, physical, sociocultural and spiritual environment. It is obvious that Watson's theory is very abstract and philosophical in nature compared to the other theories; however the last carative factor is opposite to that of Levine's conceptualization of environment. Rather than seeing spirituality as being connected to the external environment, Watson believes spirituality has more relevance within one's own internal environment. She views external variables as "safety, comfort, privacy, clean and aesthetic surroundings" (Marriner-Tomey & Raile-Alligood, 2002, p.150), as these are

links from Nightingale's philosophy. Watson does believe that humankind shares a relationship with the universe allowing individuals to connect with divine power and that this type of thinking allows individuals to "acknowledge spiritual dimensions of existence" (Marriner-Tomey & Raile-Alligood, p.151). Watson also believes that there is a path for honoring the unity of body, mind and spirit and that her theory is a reflection of the interpersonal-transpersonal-spiritual aspects of life (Marriner-Tomey & Raile-Alligood). She describes the spirit as one's inner sense of self and that as individuals come to understand their spiritual sense this may allow them to find meaning and harmony in difficult times.

Caring and Spirituality

After reviewing the work of many nursing theorists, it is easy to see how they combine the concept of caring with that of spirituality. Mayeroff (1971), an expert in the field of caring, defined caring as "helping another grow, is a process, a way of relating to someone that involves development in the same way that friendship can only emerge in time through mutual trust and deepening and qualitative transformation of the relationship" (p.1). In order to care for others Mayeroff stated that "devotion" (p.8) must be present, and when it is, that an individual needs to "be there" (p.8). In order to care for individuals effectively, Mayeroff believed that there were specific ingredients that must be present in order to facilitate the caring process. These ingredients included: knowing, alternating rhythms, courage, trust, patience, honesty, humility, and hope (Mayeroff).

Some of these same ingredients are associated with the concept of spirituality but rather than the focus being on others, or on the interpersonal relationship, spirituality tends to be focused on discovering oneself, more of an intrapersonal relationship. Some

feel that as individuals we have to connect with our spiritual domain first before we can care for others. For example, Chung, Wong and Chan (2007) state “through serenity, nurses come to realize how to relate the self with a dimension beyond and in turn can connect with the client spiritually” (p.167). Through spirituality and self reflection, individuals come to understand themselves and their meaning and purpose in life (Nussbaum, 2003). In Macrae’s work, (as cited by Perkins, 2003), she states:

for Nightingale spirituality is a much broader, more unitive concept...spirituality involves the sense of a presence higher than human, the divine intelligence that creates, sustains and organizes the universe and an awareness of our inner connection with this higher reality. Through this inner connection comes creative energy and insight, sense of purpose and direction....spirituality is intrinsic to human nature and is our deepest and most potent resource for healing (p.32).

Lewis (2003) feels that “spirituality calls us to move beyond ourselves through caring with others...the interconnectedness of relationships and spirituality is how persons gain meaning in daily life, and spiritual relations reflect how we grow as persons in the human web of life” (p. 38). Whether caring facilitates spirituality or spirituality facilitates caring, there needs to be a balance between these two concepts. As Watson further develops her theory she demonstrates the balance between spirituality and caring by sharing that “the spirit, inner self or soul of a person exists in and for itself... people still need each other in a caring and loving way” (Marriner-Tomey & Raile-Alligood, 2002, p.153).

During the twenty-first century there has been a resurgence in spirituality research with a focus on examining the effects of prayer and healing touch on clients. There is

little research that focuses on the nurse's role and opinion with regards to these modalities, however researchers do feel strongly that nurses should be participating in the exploration of spirituality and be open to new ideas and ways of thinking (Hoffert Henshaw & Mvududu, 2007; Swinton, 2006).

Contemporary Spiritual Modalities

The God Spot

A biological reaction in the brain is now the newest way of describing spirituality. Spirituality, a concept once only studied by theologians and philosophers, is now a topic of interest for biologists and scientists (Lynch, 2006). In 1997 a group of neuroscientists from the University of California, San Diego discovered that there is a region of the brain that is connected to prayer and spiritual matters, otherwise known as the God Spot (Trull, nd). This group began to study the electrical brain activity of individuals with epilepsy versus those without, as epileptics were discovered to be more prone to religious experiences and spiritual orientated visions (Trull). During their study, this group of neurologists found that epileptics had a specific neural center in the temporal lobe that would react when they thought about God or had spiritual ideas. This same center of the brain is where most of the electrical activity takes place when individuals are having seizures (Trull). When the epileptics were asked how they felt after the scan, they described this feeling of "not being alone" as if God or someone else was there present with them (BBC, 2003). Due to these findings, there is now a hypothesis within the scientific world that perhaps "we as species are genetically programmed to believe in God" (Trull). Canadian researchers, Beaugard and Paquette put this hypothesis to work by inviting fifteen Carmelite nuns to high-tech brain scans (WebMD, 2006). As their

electrical brain activity was being measured, they were asked to recall their most intense mystical experience- defined as a sense of union with God (WebMD). Upon completion of this study, it was found that no particular God Spot was identified on the nuns' brain activity scans, rather the opposite was discovered. As the nuns were experiencing their most intense mystical experience, several brain areas were active on the scan therefore questioning the original hypothesis. Like the epileptics in the original study, the nuns too experienced feelings of peace, God's presence and unconditional love (WebMD).

The God Particle

The newest theory to be tested and explored is that of the God Particle. Scientists and physicists alike have come from around the world to work on this project in Geneva where "two beams of particles will race in opposite directions around the tunnel, which forms an underground ring seventeen miles in circumference. At four different locations the beams will converge, sending the particles crashing into each other at nearly the speed of light" (Achenbach, 2008, p. 1). It is anticipated that from this collision particles such as the Higgs particle will be seen for the very first time and that matter will be transformed by the collision into energy (Achenbach). It is believed that this work will explain how the universe evolved and contribute to theories such as quantum physics. If this work is successful, there is the potential of linking the physics and science of the world to reveal and search for evidence of a spiritual essence in humanity. This theory allows researchers to move beyond thinking and philosophical arguments to the visualization of evidence. Currently, scientists are still in the process of putting these large colliders in place, ensuring that this high tech equipment is functioning and ready for use.

Prayer

Unlike the God Particle there are some contemporary spiritual modalities that are less scientific, but just as powerful, such as the modality of prayer. In recent years, the spiritual modality of prayer has been at the forefront of complementary therapy research (Robinson-Smith, 2002; Taylor, 2002). Meraviglia (1999) discovered that “prayer is an activity of the human spirit reflecting connectedness with God - a defining attribute of spirituality” (p.26). In this same study, prayer was found to give individuals strength, support, reduce stress and anxiety and serve as a coping strategy. Robinson-Smith studied prayer and its relationship to quality of life and yielded strikingly similar results to that of Meraviglia’s study. Robinson-Smith discovered that other themes were associated with prayer such as comfort and being without burden. DiJoseph and Cavendish (2005) have developed their own theory, The Four Point Guide for Spiritual Care- “giving from a synthesis of nursing theory on prayer” (p.147). This guide focuses on nurses’ responsibilities when providing spiritual care to clients. The four steps are: performing a spiritual assessment, respecting prayer practices, observing the positive benefits of prayer and ensuring the proper use of prayer in practice. By supporting prayer practices DiJoseph and Cavendish believe that nurses can improve clients’ spiritual care.

The limitations revealed by this nursing research study were expressed by DiJoseph and Cavendish (2005) as they felt nurses had a remarkable uneasiness with prayer. They discovered that nurses were uncomfortable with prayer as they lacked education about prayer and spirituality in their academic nursing programs; “one reason for nurses’ lack of preparedness to provide spiritual interventions is that their basic education only minimally discusses spirituality” (McEwen, 2004, p. 20).

Similar to DiJoseph and Cavendish's (2005) Four Point Guide for Spiritual Care, Puchalski and Romer (2000) created their own model for obtaining patients' spiritual histories. Their model is identified by the acronym FICA, highlighting four fundamental dimensions that contribute to a patient's spiritual history. It is defined as: F - faith and belief, I- importance, C- community and A- address in care or action. Puchalski and Romer identified the dimension of I- importance as whether a patient has "specific spiritual practices or rituals" (Puchalski & Romer, p.131). Rituals such as prayer, might contribute to his/her overall health and well-being, and therefore is important for clinicians to be aware of. This may help clinicians, "strive to know how a person's spiritual beliefs influence that person in the way the person cares for him/herself" (Puchalski & Romer, p.132). In conclusion, it is "the domain of importance that determines the influence of spiritual beliefs on the person's life" (Puchalski & Romer, p.132).

Taylor and Outlaw (2002) studied the use of prayer among thirty individuals who were diagnosed with breast, lymphoma, colon, prostate and lung cancers. When they were asked to describe the purpose of prayer they stated they felt "connected and closer to God, staying right with God, getting salvation, making requests, sharing secrets, finding comfort, relieving stress, dealing with emotions and thoughts, helping one to grow and become a better person" (Taylor & Outlaw, p.52). Participants were asked how prayer made them feel. They responded with "comforted, consoled, calm, purposeful, relieved, rested and confident" (Taylor & Outlaw, p.56). DiJoseph and Cavendish (2005) noted similar positive benefits of prayer with the addition of "peace, wellbeing, healing and recovery" (p.152).

When reviewing this study there was a brief mention as to participants' religious denominations. It was not until the end of the study, the limitations section, where it becomes apparent to readers that there was a "predominant" portion of the sample who believed in the Christian faith (Taylor & Outlaw, 2002, p.57). The results of this study could be misleading, especially if the Christian participants prayed frequently due to their faith-based beliefs and values. The researchers should be commended for their insight into recognizing that they are uncertain if "Asian, Latino Americans or non-Judeo-Christians" pray when dealing with cancer (Taylor & Outlaw, p.57). Readers should be leery when generalizing the results of this study as there needs to be more representation of individuals from the groups mentioned above. Unless these other individuals are included in this study, it is unethical to make generalizations about prayer use by general population, diagnosed with cancer.

Prayer is also described as a coping strategy by individuals recovering from strokes (Robinson-Smith, 2002). During her qualitative interviews with eight stroke patients Robinson-Smith discovered a total of eight major and minor themes describing prayer and its effect on stroke victims. These major and minor themes include: "(1) being connected to God, (2) ways of praying now, (3) reaching back to early family life, (4) finding strength through prayer, (5) considering self, others and nature, (6) becoming more focused on every day, (7) linking present and past and (8) being unburdened and comforted" (Robinson-Smith, p.359).

Several significant weaknesses were discovered in this descriptive qualitative study. This study is difficult to follow as the method section is poorly outlined. It was discovered that this research is an extension of an original study which is briefly

discussed in the design section of the article. The researcher states that participants were required to answer a self-care/ self-efficacy instrument prior to participating in this current study, however there is no description of the instrument or documentation provided to show readers what it looked like. As a reader one assumes that it is the same group of participants who contribute in both the original and the current study but it is unclear. The researcher also did not discuss the validity or reliability of her tool, therefore leaving readers wondering not only how she measured self-care and self efficacy but whether the original study is legitimate. In the discussion section, Robinson-Smith (2002) makes a very broad statement that “nurses may build self-care/self-efficacy by encouraging patients to describe spiritual rituals used for coping” (p.363). Again this is an assumption of the researcher and perhaps should be a focus for future studies.

It is clear that the modality of prayer has some significantly positive effects on individuals, and according to DiJoseph & Cavendish (2005), “prayer is the most frequently used spiritual practice, addressing the relationship between prayer and spiritual care needs” (p.147). When Marsh (as cited in Holt-Ashley & Lindquist, 2000) studied the meditational effects of prayer on nurses’ spiritual wellbeing, it was found that higher spiritual well-being decreased burnout among the nurses studied. Whether they prayed for themselves (Cavendish, Kraynyak- Luise, Konecny, & Lanza, 2004), with their patients (DiJoseph & Cavendish; Taylor & Outlaw, 2002), or for others (Taylor & Outlaw) there was still a need for nurses to understand and be knowledgeable about the modality of prayer. For those who believed, spirituality and prayer were relevant to health promotion as they assisted individuals in coping with mental, emotional and physical ailments and provided strength, courage and empowerment (DiJoseph

&Cavendish; Meraviglia, 1999). Studies have occurred using control groups of clients with illness, examining those who were prayed for and those who were not. The client groups who were prayed for had faster healing rates, decreased hospitalization, minimal antibiotic therapy, minimal ventilator assistance, lived longer and had better quality of life (DiJoseph & Cavendish; Meraviglia; Robinson-Smith, 2002). Statistics on spirituality and prayer can be compared as evidence of change and through scholarly analysis it becomes evident that prayer affects individuals positively and might be a valuable modality for nurses to incorporate into their daily practice.

Healing Touch

Healing Touch is a medication-free, alternative therapy that can be practiced by anyone who has the appropriate training; it is not just limited to health care professionals. It is commonly used for palliative care clients or those who are simply interested in improving their spiritual health and well-being. In a quantitative study, Wardell (2001) examined the spiritual modality of healing touch by asking the following questions. Is there a difference in spirituality between nurses and non nurses within the Healing Touch Program? What are the most common spiritual experiences with healing touch? Is there a difference in spirituality in the participants between levels of the program? After collecting questionnaires from 447 nurses, Wardell found that there was no difference in spirituality between the nurses and non nurses within the Healing Touch Program (2007) first hypothesized and evidenced by Janet Mentger (1980). According to Mentgen and Bulbrook, Healing Touch is defined as “an energy therapy in which practitioners consciously use their hands in a heart-centered and intentional way to facilitate physical, emotional, mental and spiritual health and healing” (Mentgen & Bulbrook, p.12). The

intention of Healing Touch is to “restore harmony, balance in the energy system placing the client in a position to self heal. Healing Touch compliments conventional health care and is used in collaboration with other approaches to health and healing” (Mentgen & Bulbrook, p.12).

In Wardell's (2001) study the participants all considered themselves healthy and felt that spirituality was an important aspect of one's health. The three most common experiences found relating to healing touch were an overwhelming experience of love, profound inner peace and God's energy and presence. When examining the level of spirituality in the participants between the stages of the program, it was discovered that there was a significant difference in those nurses who were at a higher level of the program. “There is a higher sense of spirituality in the higher levels of the program. It may be that involvement in an energy-based therapy is one way to develop spiritual awareness” (Wardell, p.71).

Wardell (2001) felt that this study would generate more research by examining the outcomes of healing touch, but most of all, would serve as a hallmark study from which to derive new theories. The first limitation in his study was that there was no standard mechanism for recording results or evaluating the outcomes of healing touch. The second limitation was that some of the participants became leery of the study and chose not to participate since healing touch is not a tangible or concrete therapy.

Shamanism

Another link to the power of spiritual belief is that of shamanism. In the discovery of shamanism, there are very few studies that explore the effectiveness of shamanistic healing and the effects it provides to others. Current available literature describes the

practices of shamanism world-wide, from the tribe of the Muscogee Creek American Indians (Walker & Thompson, 2009), to the mountains of northern Peru (Glass-Coffin, 2006) and the Angami people of Nagaland northern India (Joshi, 2004); it seems to be a practice that interests many. Native- American shamans facilitate “orally transmitted healing and spiritual practices. They have a reverence for earth, feelings of connectedness and abundance and respect for all forms of life and mineral resources, belief in spiritual guides and affinity within a higher consciousness” (Cox, 2003, p.31). The American Indians believe that “spirituality is an integral, inseparable aspect of life...spirituality embodies and is ultimately responsible for all aspects of health as seen through the supreme natural balance of mind, body and spirit...American Indians see spirituality as being in harmony with themselves and with other non-humans alike” (Walker & Thompson, p. 131).

Glass-Coffin, a professor of anthropology at Utah State University, shares her findings about the *curranderos* (shamanic healers) that practice in Peru. These healers feel that there is a “co-essence rather than transcendence which is at the heart of the shamanistic journey that both healers and patients embark upon in order to transform suffering” (Glass-Coffin, 2006, p.893). Through her studies Glass-Coffin has discovered that there is an attitudinal shift the shamanic healers ask their patients to participate in, should they wish to maximize their healing. Throughout the course of healing the patients are asked to: “1) accept and surrender to all that life brings rather than transcend the everyday world, 2) accept all aspects of life as sacred, regardless of the imperfections, and lastly 3) embrace the power of transformation that they embody within themselves” (Glass-Coffin, p.894-895). By forgiving others, sacrificing one’s own well-being for the

good of another, being empathetic and compassionate, disciplined and letting go of our need to be in control, the *curranderos* of Peru feel that this is the ultimate form of being, which facilitates individuals' experiencing of their authentic and altruistic self (Glass-Coffin).

In Nagalan, northern India, there are two types of healers: 1) those who are herbalists and masseurs and 2) those that "depend on tutelary spirits, the shaman" (Joshi, 2004, p. 269). It is the beliefs of the Angami people that "shamans are usually assisted by two or more spirits, although some shamans are unsure as to the exact number of spirits, due to their elusive nature...sometimes they are not always available for divination" (Joshi, p.273). Depending on the seriousness and diagnosis of an individual, if a full set of spirits is needed, they will make themselves available. Like the Peruvian shamans, the Angami shamans feel it is important to experience the suffering and symptoms of the individuals they are healing (Joshi). To activate divination between the spirits and the shaman there are three ways in which this can be done, they are: "1) through grains of rice which have been touched by the patient, 2) through the stem of a plant called *ciesenha* and 3) through money in odd numbers" (Joshi, p. 273). Dropping the rice, the plant stems and the money on the ground, the shaman then reads the patterns in which these objects unfold. The shaman will identify either good or bad omens and will help the patient accordingly. One woman in the village uses dream analysis in her shamanistic work and feels that "the spirits tell her in her dreams about the cases that will come to her and the cures required" (Joshi, p. 274).

In summary it is evident that the concept of spirituality has existed and influenced the role of the caregivers, including the discipline of nursing. With the dawning of

different time periods across history, spirituality has involved diverse modalities and client centered beliefs. From a historical perspective, it appears that there has always been a gap in the knowledge about, plus an understanding of the meaning and perception of nurses' experiences with spirituality. The researcher will now focus a further examination of the literature focusing on the concept of spirituality as it relates to hospice/palliative care nurses.

Spirituality and Hospice/Palliative Care Nurses

According to Ferris and his colleagues (2002) hospice/palliative care is defined by six fundamental traits. These traits are:

- (1) Aims to relieve suffering and improve the quality of living and dying;
- (2) Helps the person and family prepare for and manage self-determined life closure and the dying process and to cope with loss and grief during illness and bereavement;
- (3) Promotes opportunities for meaningful experiences, personal and spiritual growth and self actualization;
- (4) Acts appropriately for any person and /or family living with or at risk for a life threatening illness due to a diagnosis;
- (5) Complements and enhances disease-modifying therapy (Western Medicine); and
- (6) Most effectively delivered by an interdisciplinary team of healthcare providers who are knowledgeable and skilled in all aspects of the caring process

(as cited in the Fundamentals of Hospice Palliative Care, Regional Palliative Pain and Symptom Management Consultants/Educators, Southwest Region, Ontario, 2006, p.4).

These six traits not only define hospice/palliative care but they also define the role of the hospice/palliative nurse.

Current State of Hospice/ Palliative Care Nurses

Hospice/palliative care nurses experience the daily stress of death and dying (Kulbe, 2001; Payne, 2000; Power, 1988). In turn they have reported that there is increased complexity within their nursing discipline because they must support heightened emotional needs of clients and family. They state that they feel unprepared to deal with others' emotions, have difficulty controlling clients' symptoms, work long hours and must discuss terminal care options with clients and families (Power). Sabo (2008) has discovered that healthcare professionals working with palliative care clients are more susceptible to experiencing "adverse consequences of caring" (p.23). As a result of these consequences, compassion fatigue, burnout and vicarious trauma are three concepts frequently reported by palliative care staff, impacting their physical, emotional, psychological and spiritual wellbeing.

From a sample of 216 hospice/palliative care nurses, Abendroth and Flannery (2006) found in their quantitative study that seventy eight percent of the nurses were classified as moderate to high risk for compassion fatigue with twenty six percent presenting in the high risk category. They found that hospice/palliative care nurses were especially vulnerable to compassion fatigue but that it was exacerbated when the nurses lacked their own self-care. *Compassion fatigue was triggered by the stress and burnout of dealing with difficult family dynamics, a sense of loss when their patients died and multiple patients dying during short periods of time.*

Hunnibell, Reed, Quinn-Griffin and Fitzpatrick (2008) felt that emotional exhaustion might be a key element in burnout among hospice/ palliative care nurses. Because women are more prone to experiencing emotional exhaustion (Maslach, 2003),

and a large proportion of hospice/palliative care nurses are female, it was hypothesized that this puts female nurses at more risk for burnout because of the socialization of females in society.

Viewed through the rigor of increased awareness in research methodology, results of this quantitative study show limitations with regards to the sample and generalizability, plus confusion about the instruments used in this study. Hunnibell, Reed, Quinn-Griffin, and Fitzpatrick (2008) do point out that their study has “methodological limitations” (p.177) as their study relied on a convenient sample of nurses who may or may not have been working in the field of hospice and palliative care. The unclear results limit the generalizability of study findings to all working hospice and palliative care nurses. This study is also limited in its generalizability as only 28% of the sample returned their surveys to the researchers. A total of 563 surveys were included in the data analysis due to the inclusion criteria out of a total of 1993 surveys. Both validity and reliability were established for the two instruments used in this study, however there might have been some confusion with regards to how participants responded to the surveys, “for they may have misinterpreted one of the tools as one that usually measures burnout” (Hunnibell, Reed, Quinn-Griffin, & Fitzpatrick, p.178).

Hawkins, Howard and Oyebode (2007) studied the stress and coping behaviours of clearly identified hospice staff and discovered that nursing workload, inadequate preparation for dealing with the family's and patients' emotions and dealing with death and dying were found to be significantly high sources of stress for hospice staff. The researchers discovered that if individuals were “securely attached” (Hawkins, Howard, & Oyebode, p.564), meaning they saw other colleagues as being supportive, potentially

available and saw themselves as worthy individuals, this would significantly decrease their risk for psychiatric morbidity, directly impacting their mental health and wellbeing. From a sample of 215 nursing participants who met the clear inclusionary criteria, only 22 nurses reported being securely attached. The team of Hawkins, Howard and Oyeboode were instrumental in describing the concept of nurses being "securely attached". As a reader their description was explicit and easy to understand.

New Areas of Research for Hospice/Palliative Care Nurses

The spiritual care practices and the concept of resiliency of hospice/palliative care nurses have been recently examined as elements of spirituality defined by this nursing cohort. Taylor, Amenta, & Highfield (1995) discovered that hospice/palliative care nurses pray with their patients, utilize chaplains and practice active listening when talking to their patients about spiritual needs. Belcher and Griffiths (2005) discovered similar findings. However, besides the use of prayer, the nurses participating in this study practiced journaling and meditation, engaged themselves in nature, and used readings of a spiritual nature and scriptures to express themselves spiritually. Attending church, participating in church/faith-based rituals and in religious community ministry and believing in a higher power known as "God" were also deemed significant in order for nursing participants to meet their spiritual needs. Examining resiliency in hospice/palliative care nursing is a new concept that researchers are beginning to understand. Contrary to other findings, Ablett and Jones (2007) recently discovered that "palliative care staff report lower levels of burnout than staff working in other specialties" (p.733) and feel that becoming aware of their own spirituality and discovering their own sense of humour contributes to their resiliency. Of interest to the

researcher of this current study, the aspect of resiliency will be explored as a critical element of spirituality.

Another new area of research impacting hospice/palliative care nurses is the study of job satisfaction among the hospice interdisciplinary team (Clark et al., 2007). Despite the fact that this study examines hospice/palliative care nurses in the interdisciplinary team, this study still leaves readers guessing as to how nurses' job satisfaction is directly impacted by spirituality. Researchers failed to distinguish satisfaction among the disciplines within the hospice/palliative care sector. Perhaps this would be a consideration for future research?

Burkhart and Hogan (2008) have created a framework of spiritual care in nursing practice that will assist hospice/palliative care nurses to ensure they are meeting the spiritual needs of their clients. However there is still no consideration for the individual spiritual needs of the nurses using the framework. For future reference, perhaps the researchers will consider the spiritual needs of the nurses using their tool to expand their framework and include this spiritual dimension.

Spiritual Education among Hospice/Palliative Care Nurses

The Study of Thanatology

Thanatology is best described as the "study of death" (Malacrida, 1998, p.5). In this study, themes such as loss, grief, denial, fear, and shame are the topics of interest (Malacrida). Researchers take time to study family members and friends who are grieving, to understand their perception and lived experience of good death versus bad death, how individuals mourn and the strategies they use to cope with death and dying.

Researchers also compare the different reactions and experiences of family and friends when a child or pet dies versus that of an adult human being.

Wolfe and Jordan (2000) are clinicians who specialize in thanatology research, and feel that there is great importance in asking “as clinicians, what does thanatological research teach us? Do we integrate research into our practice? How does this research help us to improve as clinicians?” (p.569-570). As experts in the field, they both feel that healthcare workers are not prepared or educated thoroughly to be able to make “choice points” (Wolfe & Jordan, p.570), which could positively or negatively impact those who are grieving. The choice points that Wolfe and Jordan are referring to are questions such as: “1) who is the important player in the family and how do I become involved with the family and their experience 2) is intervention necessary with this family or do you as the clinician just offer support and offer it when it is requested, 3) should clinicians offer physical touch to those who are mourning during the grieving process 4) should children be allowed to view bodies of their family members and friends 5) what interventions should be offered to groups beyond the families (i.e., school personnel, nurses, and other staff), 6) what types of resources will sustain caregivers in their job as support persons for people at times of high stress and crisis” (p. 574-576). There are many questions and uncertainties that, according to Wolfe and Jordan, still need further exploration. As important as this research is for understanding family coping and survival, Wolfe and Jordan feel that clinicians are at a disadvantage to facilitate conversations about end of life and bereavement, as they themselves are unfamiliar and perhaps uncomfortable with the process of death and dying. Educational workshops, journaling and conferences are

just a few ways in which clinicians can become more knowledgeable about the study of thanatology.

Little research has been conducted examining the spiritual care education of hospice/palliative nurses. Highfield, Johnston-Taylor, and O'Rowe-Amenta (2000) are the few researchers to study hospice/palliative care nurses with regards to their understanding of spirituality from the education they received during their academic nursing program. They discovered that from a sample of 181 oncology (hospital palliative care) nurses and 645 community hospice nurses, "thirteen percent more hospice than oncology nurses reported receiving spiritual content in their basic nursing education, and only 7 % of the hospice nurses reported no training in spiritual care, compared to 24 % of oncology nurses" (Highfield, Johnston-Taylor, & O'Rowe-Amenta, p.57). As an overall group, 52% of the nurses reported inadequate preparation for spiritual care giving (Highfield, Johnston-Taylor, & O'Rowe-Amenta). Hospice nurses reported feeling better prepared than the oncology group. Highfield, Johnston-Taylor, and O'Rowe-Amenta also discovered that the hospice nurses were more philosophically based in their spiritual beliefs. In summary, the hospice nurses were found to be more knowledgeable about spiritual values and beliefs, potentially linked to frequent registration in programs that had more identifiable spiritual content.

One cautionary aspect of this study of Highfield, Johnston-Taylor, and O'Rowe-Amenta, (2000) was that they base some of their conclusions and discussion on personal assumptions. The first assumption targets the idea that because the hospice nurses had more years of work experience, this might have contributed to their increased spiritual awareness. The researchers' second assumption suggests that the hospice nurses in this

study are more spiritual in nature because they have a strong personal philosophy about spirituality. There is nothing in their quantitative study that supports that either assumption is true. Perhaps further studies of inquiry need to take place to examine whether these hypotheses can be proven. Support of these statements and assumptions would facilitate possible studies for future research.

Hospice/palliative care nurses are a specialized group of nurses who comfort and support terminally ill clients. In their role they assist clients and their family members facilitating opportunities for them to come to terms with intimate death and dying and often anticipatory grief. Nurses offer patients hope of a possible existence beyond this world thus promoting the spiritual connection by allowing patients and family to come together and be close. They provide strength, extend love, care, and help to reestablish and facilitate loving relationships between clients and family members. The role of the hospice/palliative care nurse is fundamental in listening and encouraging people to search for their own sense of spirituality. If hospice/palliative care nurses do not have a fundamental understanding of spirituality or are not comfortable with their own spirituality, they may be unable to support and nurture others' quest for spirituality (Musgrave & Mc Farlane, 2003; Volker & Limerick, 2007). This could have a detrimental effect on both clients and family members. By gaining insight into the perceptions of spirituality held by hospice/palliative nurses, other nurses may be prompted in turn to evaluate their own belief systems, and may possibly be encouraged to begin an investigation into their own spirituality. This activity of intra-reflection is an ongoing expectation of all registered nurses described in Standards of Practice (CNO,

2005), but when specific to hospice/palliative care practice, reflection may have particular benefits for resilience.

Spirituality and the Hospice/Palliative Care Nurse

The element of spiritual self-care for individual nurses is just beginning to unfold. Carroll (2001) is one of the few researchers who has explored the nature of spirituality and spiritual care. In Carroll's phenomenological study among 15 hospice nurses, she identifies themes such as: "spirituality and the soul" (p.87), "spirituality an interconnectedness with ourselves, God, others and Universe" (p.88), "demonstrating empathy and developing a trusting relationship" (p.91), "seeking help" (p.92), "recognizing when to let the patient be" (p.93), and "fostering the search for meaning" (p.94). Despite these groundbreaking results, the phenomenologically based research question driving this study is absent in the article therefore allowing readers to imagine and assume different types of questions which the researcher might have asked. From the descriptions provided by the researcher, it is still uncertain if spirituality impacts the participants' overall wellbeing or their individual practice. Regardless, this study is still a foundational building block for understanding hospice nurses' perspectives on spirituality, but it leaves readers wondering if palliative care nurses view spirituality differently. More current studies need to be conducted to gain a thorough understanding of hospice/palliative care nurses' perspectives on spirituality so generalizability can be made for this population.

There is little research that examines the quality of life of hospice/palliative care nurses; however, systematic reviews have been done on developing and sustaining healthy work environments. Pearson et al., (2006) concluded that personal and

professional reflection can impact nurses' practice, that collaboration between nurses results in positive outcomes for nurses and that a "positive attitude directly impacts staff stability, turnover rates and the functioning of the nursing unit or organization" (p.25). By facilitating understanding one's spiritual meaning and purpose from a qualitative perspective, research might provide in-depth understanding about the spiritual nature of nurses and promote positive attitudes among hospice/palliative care nurses, therefore facilitating collegial collaboration and self reflection.

To conclude, it is evident that while earlier attempts have been made to understand spirituality from the hospice/palliative care nurses' perspective, additional research needs to be completed to examine whether hospice/palliative care nurses are adequately prepared for spiritual care-giving and if this preparation may be significant in their practice.

Spirituality in the Nursing Literature

In the current literature, there is an overwhelming amount of research focusing on the patient's perception of spirituality. The literature describes how spirituality is understood by clients, the positive outcomes they experience when their spiritual needs are met, and nurses' lack of education and knowledge about the clients' spiritual dimension. Nurses can now begin to draw upon these definitions and concept developments to understand the perceptions of nurses' spiritual beliefs, therefore contributing to the larger body of nursing knowledge.

Concept Development and Definitions of Spirituality

Spirituality is a concept that has a wide semantic range (Narayanasamy, 1999; Pesut, 2006). It strengthens the human bond and it motivates individuals to find inner

peace, happiness and wisdom (Delgado, 2007; Regional Palliative Pain and Symptom Management Consultants/Educators, Southwest Region, Ontario, 2006). Spirituality is a powerful force that positively impacts individuals, communities and the world (Nagai-Jacobson & Burkhardt, 1989; Wright, 2007). According to McEwen (2005), Pesut, Regional Palliative Pain and Symptom Management Consultants/Educators of Southwestern Ontario, and Taylor (2002), spirituality is universal. Spirituality for some represents compassion, love, caring, and joy (Castledine, 2003); for others, it represents inner truth, balance, intuition, and direction (Luck, 1998). Spirituality has been shown to affect individuals positively by providing them with hope, balance, guidance and strength (Cavendish et al., 2004; Jackson, 2004).

As noted throughout the ongoing exploration of the term, spirituality is a broad and abstract concept that is affected by individuals' worldviews and life experiences. Spirituality can have a variety of meanings and purposes (McSherry, 1998, Meraviglia, 1999 ; Sellers & Haag, 1998; Watson, 2003), descriptive metaphors as a life journey (Kelly 2004, Kociszewski, 2003; LeRoy, 2002; Watson), a feeling of inner peace, love or wisdom (Kociszewski; Watson) and can be defined through interconnectedness of one's self with Nature, God/Supreme Being or the Universe (Belcher, 2006; Kociszewski; Meraviglia; Pesut, 2006; Watson). Spirituality is forgiving (LeRoy), accepting, nurturing and has no rules, preconceived notions or perceptions. Some authors feel spirituality can be described as "being present" (Kociszewski, p.141). By being present there is a notion that individuals are more perceptive, sensitive, reflective and in touch with themselves and the Universe (Belcher; Long, 1997; Malinski, 2002). It is believed

that spirituality is whatever the individual believes it to be (Malinski; Meyerhoff, Van Hofwegen, Harwood, Drury & Emblen, 2002).

Recently there has been a resurgence in spiritual research and a shift in the population being studied (Burkhart, Solari-Twadell, & Haas, 2008; Nussbaum, 2003; Nemcek, 2007; Wright, 2002). Nursing researchers are now recognizing and validating the importance of individuals' spiritual dimensions and how nurses might have a direct impact on their clients' health conditions depending on their own personal beliefs. At present, spirituality in nursing continues to be understood through patients' perceptions and is most commonly described as: being a journey, a characteristic of human need, holistic, connected, universal, and having individuality (Maslow, 1943; Narayanasamy, 1999; Pesut, 2006).

Spirituality as the Journey

Spirituality has been described as a journey of personal growth and self reflection that is gained from lived experiences (Pesut, 2006; Touhy & Zerwekh, 2006).

Meraviglia (1999) states, "life experiences bring us closer to our own awareness of spirituality" (p.23). Kelly (2004) postulates that there are stages that individuals move through in order to become spiritual. This spiritual journey is described as "the journey towards self actualization; and that individuals must explore, understand and develop meaning and purpose in their life before they proceed to the next four stages of connectedness, transcendence, faith and hope" (p.166). Once these stages are complete, individuals may see themselves as self- actualized.

Kelly (2004) hypothesizes that individuals' discovery of self actualization, meaning and purpose in life is crucial to their spiritual journey (McSherry, 1998;

Meraviglia 1999; Sellers & Haag, 1998; Watson, 2003). Some researchers feel that individuals discover meaning and purpose in life as they journey (McSherry; Sellers & Haag; Watson), others feel that purpose is an outcome of discovering spirituality once the journey is completed (Meraviglia). By questioning one's meaning and purpose, spirituality acts as strength for acceptance thereby confirming one's place in the world (Cavendish et al., 2004). This questioning allows individuals to validate themselves and provides reasons for their existence. Suffering, trauma, loss, death, diagnosis of a fatal illness and life challenging events have all been described as a part of an individual's journey towards a more spiritual life (Kociszewski 2003; Le Roy, 2002; Watson). Kociszewski calls this "spiritual awakening out of tragedy" (p.402). Illness and tragedy allow individuals to reflect on their life, explore their spiritual self and discover their meaning and purpose.

The spiritual journey is not always an independent one. Kociszewski (2003) makes reference to a "nurse-client spiritual journey" in which nurses have the ability to "open the doors for the spiritual journey" (p. 139). In this relationship nurses "placed the clients and their families at the center of care" (Kociszewski, p.139) allowing for individuals to be present in each other's space, to be respectful, to treat each other with dignity and to see each other as spirits with similar needs. Through this companioned journey, individuals have an opportunity to embrace spirituality knowing that they have each other for support. Besides discovering the concept of the nurse-client spiritual journey, Kociszewski is one of the few researchers to address the theme of "spiritual nurse" (p.136). In her research she discovered that nurses reported "there is something

more to life”, that “spirituality is a way of being” and “the most important step in caring for others, is caring for yourself” (Kociszewski, p.137).

Despite her discovery into the nurse-client journey and the spiritual nurse, her study had several limitations. The most significant limitation was the sample from which she derived her results. This qualitative study consisted of a sample of three registered nurse participants who were in turn “colleagues” of the researcher (Kociszewski, 2003, p.135). It is obvious that more participants would be required to achieve saturation, conclude these findings, and generalize them for the population. Another limitation was the lack of continuity in her sample. The three participants all had different positions and worked in different clinical areas. Her participants consisted of a nurse educator, a critical care nurse and a nurse who specialized in pain in palliative care nursing. The participants' diverse clinical experiences prevent the researcher from discovering any comparisons or similarities within her study and achieving saturation. Despite the researcher's question, “describe the experience of providing spiritual care to a patient or family” (Kociszewski, p.135), there is still a lack of understanding on the meaning and feeling behind the theme “spiritual nurse” (Kociszewski, p.136). In the research there is no mention of how spirituality individually affects the participants; rather, modalities such as prayer are described as helping participants attain spirituality.

Maslow's Self Actualization

The theoretical construct of Maslow's hierarchical needs supports the concept of spirituality, as it describes spirituality as a characteristic of self-actualization. Built on early research and inquiry, Abraham Maslow, a leader of the humanistic school of psychology, established his conceptualization of a hierarchy of human needs in the

1950's and 1960's, (Maslow, 1943). He saw humans' daily needs in the form of a pyramid, consisting of five levels (Maslow). The very bottom level of the pyramid represents basic physiological needs such as oxygen, water, temperature, rest and activity. The second layer represents safety needs such as stability, protection and order. Belonging needs define the third level, representing the need for friends, fellowship within a community and loving relationships. The fourth level represents esteem needs; this is where an individual develops self esteem, respects others, and develops confidence and mastery. The very top of the pyramid is called self-actualization. Maslow refers to this level as individuals being full, creative, healthy and "satisfied in their needs" (Maslow, p.383).

When individuals are self-actualized, Maslow believes that individuals dig deep within themselves to discover their potential and who they really are as individuals. He feels that at this stage individuals are interested in completing themselves; "what a man can be he must be" (Maslow, 1943, p.382). This is done by being present in the world and your environment. Maslow describes each stage as a journey that individuals must complete and feel confident about before he/she moves on to the next level. These stages are consecutive in nature and will not allow individuals to skip levels; there are certain attributes they must learn from each level first before they can proceed to the following level. Self-actualization is all about self discovery and personal journey. However, there is a "desire for self-fulfillment, the desire to become more and more what one is, to become everything one is capable of becoming" (Maslow, p.382).

Maslow theorized that as individuals self-actualize they experience peak experiences. Maslow's theory of self actualization contributes to specific characteristics

found in individuals such as: (1) authenticity (2) acceptance (3) openness (4) satisfaction (5) a sense of exploration (6) transcendence and (7) joyfulness (Maslow, 1943). It is during this last characteristic that Maslow theorized that individuals begin to develop an appreciation of things, life, people and themselves. It is here where Maslow feels individuals live their life in the moment, live their life to the fullest and experience transcendence and spirituality. The work of Maslow was further enhanced by Kalish (Kozier et al., 2010).

Spirituality as Holistic

As the quest to understand spirituality continues, there is much emphasis on the integration and the interconnectedness of the individual's mind, body and spirit. Kociszewski (2004) states, "spirituality is a component of everything emotional, whole, body and spirit... all gathered into one" (p.404). This holistic approach promotes balance within individuals, and between others and self, nature, and God (Kelly, 2004, Meraviglia, 1999, Sellers & Haag, 1998). By creating balance, Cavendish and colleagues (2004) feel that this balance: a) encourages harmony and promotes healthy perspectives and attitudes, b) signifies the importance of spirituality, and c) facilitates relationships between health and spirituality. As cited by Kelly, Florence Nightingale makes reference to spirituality, in her Notes on Nursing (1860) stating that "the needs of the spirit are as critical to health as those individual organs that make up the body" (p.162). According to Nightingale, "...of all the parts of the body, the face is perhaps the one which tells the least to the common observer" (Kelly, p.116).

There is much discussion associated with nurses and their roles in providing holistic care. In the literature, there is a feeling that all healthcare disciplines have a

responsibility to provide holistic care. In their research, Pesut (2006), Sellers & Haag (1998), and Watson (2003) all conclude that nurses understand holistic care, have an ethical responsibility to provide holistic care, and comprehend the detrimental effects that take place if holistic care is not provided. By understanding the interrelationships of mind, body and spirit, nurses can begin to prioritize their care for others and begin to see themselves as holistic beings, which in turn might contribute to their own self concept.

Spirituality as Connectedness

Holistic individuals see themselves as interconnected with the world (Narayanasamy, 1999). Kociszewski (2003) discovered that there are four different relationships that an individual can engage in when they consider themselves to be spiritual. These relationships exist with 1) one's inner self, 2) outer self, 3) Nature and 4) God. Connecting with one's inner self allows individuals to: i) explore who they really are ii) examine their authenticity, and, iii) help them to develop a world view with regard to their own values and beliefs about spirituality (Kociszewski, 2004; Reig, Mason & Preston, 2006). There is a common belief in the literature that nurses must develop and nurture themselves spiritually before providing spiritual care to others (Oates, 2004). When nurses become fully present in knowing and understanding themselves, it allows them to develop their intuitiveness, their altruism, and develop integrative expressions with regards to spirituality (Blecher, 2006; Kelly, 2004). Once individuals understand their own spirituality they can then begin to explore the concept of transcendence and develop spiritual relationships with others (Belcher). Meraviglia (1999) refers to these relationships as the horizontal and vertical dimension. The horizontal dimension consists of relationships with self, others, Nature or supreme values and beliefs and the vertical

dimension focuses on a relationship with God (Meraviglia). This relationship is expressed through the use of prayer and meditation. In the literature, spirituality is frequently associated with having a connectedness to something larger such as God or Universe. Watson (2003) often makes reference to the Universe in her research by stating

honoring the reality that we are part of each other's journey; we are all on our own journey toward healing as part of the infinity of the human condition; when we work to heal ourselves, we contribute to healing the whole (p. 201).

Spirituality as Universal

For many individuals there is a belief that harmony and love exist throughout the world and that it can transcend time, person, and place (Mc Ewen, 2005; Mc Sherry, 1998). Some individuals believe that they are created and sustained by God and others describe God as a support, salvation, and a spiritual guide. By participating in spiritual awakening, individuals recognize that God helps facilitate connectedness, intuitiveness and holistic views by allowing individuals to practice spirituality (Myss, 1996). Myss believes that divine light can be spread out into the world by individuals, "the movement toward working as one world is an extension of the release of divine light into the world" (p.271). By acknowledging the existence of the Universe, nurses can begin to see how they are interconnected with others within the world.

Spirituality as Individual

The research describes spirituality as being a personal, unique, and dynamic process that can be represented as a universal dimension of the person (Mc Sherry, 1998; Meraviglia, 1999; Pesut, 2006). Reig, Mason and Preston (2006) state nurses must

understand their “own values, beliefs and world views about spirituality before assisting others with their spiritual growth” (p. 251). Reig and colleagues report that if nurses do not examine their own spirituality, nurses may not comprehend others' feelings or ideas towards spirituality and may potentially hinder their clients' healing.

Patients Report Positive Effects

There are several positive effects that individuals experience once they achieve or practice a state of spirituality. Some of these positive outcomes are described as hope, strength, and meaning (Jackson, 2004), as well as balance, guidance, and enriched lives (Cavendish et al., 2004). Spirituality is found to have a significant positive effect on health and well-being by providing individuals with comfort, increased self-esteem, love, peace, trust, joy, forgiveness, and increased sense of wellbeing (Meyerhoff, Van Hofwegen, Harwood, Drury & Emblen, 2002; Oates, 2004; Swinton, 2006; Thompson, 2002).

A qualitative approach was applied to a study of 12 survivors of hematological malignancies (Mc Grath, 2004). Mc Grath discovered very different attitudes among these individuals with regards to life and living. This group of survivors had an increased desire to live life to the fullest, increased self awareness, were less judgmental, more compassionate, experienced positive changes in work values and priority, had increased respect for others, a strong sense of family and friends, but most of all, experienced an improved quality of life. These attitudes and outlooks were attributed to a sense or state of spirituality that was consistently reported by all participants..

In light of these results, McGrath (2004) acknowledges that the findings from this study were all positive in nature. It was discovered that only individuals with positive

experiences were studied. The sample of this study was provided by a support worker who worked closely with these individuals through an educational group called "Thankfully I'm Still Here" (Mc Grath, p.281). It was discovered later in the research that "the participants in the research had positive treatment outcomes and had been well supported during their treatment" (Mc Grath, p.287). This study while interesting, would benefit by including participants who had experienced negative treatment outcomes as this would validate the generalizability of the results. Correction of the report and description of the sample group could provide authenticity and a more accurate reflection of the effects of the outcomes. Could it be that positive outcomes among survivors can actually be the result of well supported treatments? Might this study have inadvertently discovered the power of positive expectations? The link to spirituality may have been in the descriptions of compassion, acceptance, strong interpersonal support and quality of life.

Brillhart (2005) studied the effects of spirituality on 230 individuals who had suffered spinal cord injuries. In her quantitative research she discovered that spirituality and life satisfaction are positively correlated. This means that as participants reported high levels of spirituality, they also expressed high levels of life satisfaction. Brillhart feels that by knowing and understanding this phenomenon, rehabilitation nurses have a responsibility to help spinal cord victims "redefine their lives" by finding "purpose and meaning in life, support their strengths and help actualize their life goals" (p.33).

Brillhart (2005) describes the Satisfaction with Life Scale and the Quality of Life Index, both instruments used to measure life satisfaction. In the limitation section of her study she does address the need for targeting a larger population to "represent persons

with a larger variety of views towards spirituality” (Brillhart, p.33). She also feels she should have included people’s religious affiliations, as it was discovered that “people’s personal faith in God had a positive correlation with life satisfaction” (Brillhart, p.33). Brillhart states that “life satisfaction is correlated with levels of spirituality” (p.33); however, in the discussion section of the study there is no explanation as to why this might be. The researcher does mention that subjects from this study “wrote personal notes when completing questionnaires that indicated their high level of life satisfaction” (Brillhart, p.33). Perhaps these notes could have been included in the discussion section of her study or been explored through hermetic analysis, as they may have given the readers insight as to the relationship between spirituality and life satisfaction.

Spirituality has also been found to transform a person’s attitude and physiological response to stress, changing it into deep relaxation (Lane, 2005). This relaxation is found to boost individuals’ immune system, decrease heart rate, decrease blood pressure, regulate respiratory rate, increase endorphin release, and decrease pain (Samuels & Lane, 1998). Research into the arts has been used to examine the positive effects of creative writing, dance, movement therapy, art therapy and complimentary therapy and the effects these therapies have on individuals. For those who practice these therapies, research has shown that individuals consider themselves to be more connected to the spiritual realm. These creative pursuits and therapies have been associated and documented to have positive effects on individuals’ health and to promote relaxation (Hanna, 2006; Harris, 2003; O’Mathúna & Quiring- Emblem, 2001). Little research has connected the beneficial aspects of these activities to the health and relaxation of nurses or their sense of spiritual health (Musgrave, 2003).

The World Health Organization and Spirituality

The World Health Organization (WHO) recognizes spirituality as an important attribute, contributing to one's quality of life. As of the late 1990's the WHO has incorporated spirituality, religion and personal beliefs, as its last indicator for measuring individuals' quality of life. The specific instrument is known as the WHOQOL-100 and it is used to document an individual's quality of life and general health. It focuses on six domains of "self" (WHO, 1997): "physical health, psychological health, level of independence, social relationships, environment and spirituality, religion and personal beliefs" (WHO, p. 4). This instrument belongs to the WHO's mental health program and is used in clinical practice to: "1) improve doctor-patient relationships, 2) assess effective relative merits of different treatments, 3) appraise health service evaluations, 4) examine research and 5) inform policy making" (WHO, p.3). This document is fundamental to establishing and generating information about human spirituality and revealing the impact it has on the quality of life and well-being of people around the world.

A quantitative study by Li, Young, Zhou and Zhou (2004) found that by using the WHOQOL-100 with their sample of 460 patients, there were positively correlated outcomes of active spirituality with physical health, psychological health and social health of the patients studied. The patients' spirituality and personal beliefs were then compared to those of their caregivers, mostly family members. It was found that the patients were significantly more affected by their spiritual beliefs whereas caregivers were found to be more directly affected by their physical and psychological domains as these were more representative of their loss of energy, fatigue, sleep, positive and

negative feelings of self. It was thought by the researchers that it was the lived experiences of the patients suffering with chronic disease that made them more aware of their spiritual beliefs; therefore, contributing to their positive correlation with the spiritual domain. Patients who were diagnosed with breast cancer, stroke and hypertension experienced higher scores of spirituality. No work was done in the study to explore this spirituality factor for the professional care providers, particularly omitting nurses.

After reviewing the literature it is obvious that the individual's spiritual dimension is a critical component, contributing to one's physical, emotional, and mental well-being.

Nursing Definitions of Spirituality

In the last three decades there has been an attempt to understand and define the concept of spirituality within the discipline of nursing. As cited in Taylor (2002), one of the first nursing-specific definitions of spirituality was described by Valliot as:

the quality of those forces which activate us, or are the essential principle influencing us. Spiritual, although it might, does not necessarily mean religious; it also includes the psychological. The spiritual is opposed to the biological and mechanical, whose laws it may modify (p.5).

Reed (1992), explores the relationship between the clinical aspect of nursing and that of spirituality, refers to spirituality as:

the propensity to make meaning through sense of relatedness to dimensions that transcend the self in such a way that empowers and does not devalue the individual. The relatedness may be experienced intrapersonally (as a connectedness within oneself), interpersonally (in the context of others and the

natural environment) and transpersonally (referring to a sense of relatedness to the unseen, God, or power greater than the self and ordinary resources) (p. 350).

Narayanasamy (1999), another renowned researcher whose work focuses heavily on spirituality, spiritual care, education and training of nurses, defines spirituality for nurses as being:

rooted in an awareness which is part of the biological make up of the human species. Spirituality is therefore present in all individuals and it may manifest as inner peace and strength derived from perceived relationship with a Transcendent God/ an Ultimate Reality, or whatever an individual values as supreme. The spiritual dimension evokes feelings which demonstrate the existence of love, faith, hope, trust, awe and inspirations; therein providing meaning and a reason for existence. It comes into focus particularly when an individual faces emotional stress, physical illness or death (p.274-275).

These are some of the most frequently referred to definitions when examining the literature on nursing spirituality. Despite the variation of these definitions, there is a common theme among them. This theme involves 'self awareness'. According to Taylor (2002) "spirituality is a concept that applies to all persons" (p.4) and

... by recognizing self as a spiritual being who experiences, reflects on and explores the meaning of one's own spirituality, the nurse develops abilities as a practitioner of holistic nursing care. The nurse's understanding of self as a spiritual being can facilitate the experience of spirituality for others (Nagai-Jacobson & Burkhardt, 1989, p.20).

Goldberg (as cited in Taylor, 2002) contributes to the definition of spirituality in nursing through an extensive literature review to search for similarities, differences and new/old concepts when exploring spirituality during nursing care. It was discovered that primary phenomena such as “meaning, presencing, empathy, compassion, giving hope, love, religion, transcendence, touch and healing” (Taylor, p.9) were some of the common concepts discovered. Goldberg felt that nurses “have a more narrow perception of spiritual care... and that connection represented all of these phenomena” (Taylor, p.9). In conclusion the author implied that spiritual care is necessary when providing “quality nursing care...and that spiritual care is inseparable from other dimensions of nursing care because spirit motivates the body” (Taylor, p.9).

Barriers and Facilitators to Providing Spiritual Care

Spirituality research is now identifying the barriers and the facilitators to nurses when providing spiritual care (Molzahn & Sheilds, 2008). Nurses' lack of knowledge and education about the development and maturation of the spiritual domain are identified as the largest barriers to spiritual care (Hoffert, Henshaw & Mvududu, 2007; Mc Sherry & Watson, 2002; Pesut, 2006). This finding is similar to that of hospice/palliative care nurses; they too lack “formal integration of the spiritual dimension into nursing education programs” (Carroll, 2001, p.96). Researchers feel there is a gap in nurses' practice with regards to assessing and facilitating spiritual growth for their clients. They feel this gap exists due to nurses' own lack of understanding about spirituality and the role they play in providing spiritual support. Nurses are taught to view their clients holistically (Greenstreet, 1999; Hoffert, Henshaw & Mvududu); however nurses often forget to acknowledge their client's spiritual dimension (Hegarty et al., 2005; Hoffert,

Henshaw & Mvududu) or pass along responsibility for its maintenance to formally identified religious providers or faith leaders. Due to nurses' uncertainty and feelings of incompetence when assessing spiritual distress, nurses often refer their clients to Pastoral Care in order to have their spiritual needs met (Lemmer, 2005). Lemmer reported that Pastoral Care referrals are usually the sole resource used in addressing spiritual needs because of lack of knowledge and understanding of the nurse as a possible facilitator. O'Connor and Kaplan (as cited in Clark et al., 2007) reported from their study, "spiritual care is too critical to be left exclusively to clergy...hospice care nearly always includes the spiritual dimension" (p.1322).

Nurses' Spiritual Education

Stranahan (2001) found, after studying 269 Nurse Practitioners (NP), that more than 57% of advanced practice nurses felt unprepared to provide spiritual interventions. She quantified that 16% of the NP's indicated that spiritual content was integrated through their undergrad nursing curriculum and 13% was integrated in the graduate nursing program. Similar to Stranahan, McSherry (1998) reported that out of 1,029 nurses, 71% of nurses in her study did not feel they received adequate nursing training to deal with patients' spiritual needs. There were four barriers articulated in Mc Sherry's research. These include: lack of insight and knowledge (being of the utmost importance); lack of time and resources; lack of privacy when engaging in spiritual conversation; and lastly, difficulty understanding the concepts of spirituality. Stranahan's work is supportive of McSherry that the concepts of spirituality and religion need to be operationally and conceptually defined, however in contrast to Mc Sherry's study

Stranahan reaffirmed “the greater the degree of spirituality, the more frequently the nurse provides spiritual care” (p.101).

Like Stranahan's (2001) study, Mc Sherry's (1998) research was also lacking description of some of its fundamental concepts. The question driving this research was what are nurses' perceptions of the concepts of spirituality and spiritual care? Rather than using either qualitative or quantitative methodologies, this study used mixed methods, descriptive research and rating scales to obtain conclusions about the research question. From the established research question, there was then another five-part questionnaire exploring different concepts and ideas about spirituality. As the reader I found this very confusing to follow as there was no specific explanation or appendices outlining the actual questionnaire. If the researcher would have chosen one methodology to conduct her study, there could be less confusion and a better flow of ideas. For example the core purpose of this study was to describe nurses' perceptions with regards to spiritual care. Other than the fact that nurses feel they do not have enough education to provide spiritual care, the concept of spiritual care is not defined or described by the subjects. Another limitation to this study is the sample that Mc Sherry uses to conduct her research. She describes her subjects as ward based nurses from all grades, which in turn refers to different types of nurses with varying degrees of education and experience. Mc Sherry also refers to her subjects as “qualified nurses” (p.38); however she does not provide inclusion criteria to define the term qualified.

Stranahan's (2001) study supports the work of Hall and Lanig, (1993), and Ross (1994b), which already established a positive correlation between “nurses' perceptions of his/her own spirituality and the tendency to provide spiritual care” (p.101). Despite

Stranahan's reaffirmation, there is still a limited confidence in her results as validity and reliability are not readily established in the study. Outcomes such as "praying privately with a patient, referring to clergy and talking with patients about spiritual topics" (Stranahan, p.101) were established as part of the NP's practice; however, there is still no description as to how these outcomes impact the NPs personally and professionally.

When examining 53 nursing students' perceptions, Pesut (2002) discovered that there was a difference in student nurses' spirituality and spiritual care-giving when their program was established at a private Christian University. Pesut discovered in her qualitative study that students had a very strong sense of personal spirituality and high level of well-being due to learning about others' beliefs. This experience allowed students to learn about their own Christian spiritual paths through self-reflection. As part of this particular university's curriculum, education about spiritual growth and development takes a priority position in their learning. This allows the students to become more connected and in-tune with their Christian spiritual beliefs and values.

It is evident that a major limitation to this study is that it was centered with the context of Christian faith and beliefs. For future research it would be interesting to inquire about spirituality and spiritual care-giving when students were more educated about spirituality and spiritual care-giving as students would hypothetically have a better sense of themselves and their own spiritual dimension, no matter the religious affiliation.

There is an agreement among researchers that there is a significant gap in the spiritual care component within nursing education (Hoffert, Henshaw & Mvududu, 2007; Stranahan, 2001). Highfield, Johnston-Taylor, and O'Rowe-Amenta, (2000) and Hoffert and colleagues suggest that nursing faculty should examine and explore their own

comfort level and competency with regards to understanding and teaching spirituality and Carroll (2001) and Mc Ewen (2004) agree that nursing faculty need to examine their own spiritual beliefs and interventions, review spiritual articles, practice spiritual assessment, and most importantly, complete spiritual self-assessments frequently. Little research has been conducted in this field of study and could perhaps benefit from future exploration by other researchers.

Therapeutic Relationships

At present there are very few factors that have been identified as facilitators that positively influence spiritual growth. Currently, the use of therapeutic relationships is the most frequently documented facilitator demonstrated in the literature. By developing and building kind, compassionate, and caring relationships with others, Pesut (2002) believes that this promotes spiritual care of not only the client but that of the nurse as well. Pesut believes that spiritual growth may be achieved through one's perceived relationship with his/her higher power. Lemmer (2005) agrees with the concept of therapeutic relationships and feels that simple tasks such as having consistent patient assignments can help facilitate this relationship. It has also been thought that therapeutic relationships facilitate trust, learning and spiritual growth for both the client and nurse (Taylor, 2002). Lemmer has also discovered that personal journaling, nursing support groups, plus supporting and participating in patients' prayer allows for self reflection and provides nurses with spiritual insight. Wright (2002) has discovered that by providing staff with meditation programs, this too facilitates therapeutic relationships and team work among colleagues and co-workers. By attending to the staff's spiritual needs, employers are facilitating meaning and purpose for staff in the workplace (Wright).

Nurses' Understanding/Perception of Spirituality

The act of identifying nurses' facilitators and barriers to providing spiritual care begins the examination of the nurses' role and perceptions about spirituality. As discovered in the patient outcome study described by Tuck, Alleyne, and Thinganjana (2006), it is their suggestion that spirituality should be included in nursing practice as "increased awareness of spirituality and promoting spiritual growth and well-being have powerful implications for stress reduction" (p.252). This proposed study addressed a gap in the existing literature pertaining to the meaning of spirituality for hospice/palliative care nurses and how their spirituality influences their relationships with their patients. Besides the relationship between nurse and patient, this study also contributed to the understanding individual nurses have about their own spiritual beliefs and how it has influenced and changed them as professionals and as ordinary people.

By understanding hospice/palliative care nurses' perceptions and beliefs about spirituality it is hoped that this research will contribute to existing knowledge and our understanding of the meaning of spirituality for Canadian palliative care nurses.

CHAPTER III

METHODOLOGY

This chapter provides a synopsis of the methodology used in this study. Included are the basic philosophical underpinnings of existentialism and the research principles of phenomenology with specific information regarding the phenomenological approach to research and practice developed by Thomas & Pollio (2002). The steps used in conducting this study are included in this chapter with descriptions of the participants, the setting, procedures for participant selection, ethical considerations, a description of the phenomenological interview, data collection procedures, the interpretive process used for data analysis, the bracketing interview and measures taken to ensure the rigor of the analysis.

Phenomenology: Philosophy and Research Approach

Phenomenology has been described in the literature as, “the study of human experience and of the way things present themselves to us in and through such experience” (Sokolowski, 2000, p. 2). As such, a researcher who uses a phenomenological approach is concerned with the subjective experience of a phenomenon from the perspective of the research participant (Patrick, 2006). The goal of phenomenology, according to Ploeg (1999) is to describe, as accurately as possible, a person’s lived experience of the phenomena being studied. Distinct to a phenomenological approach is the concern of the researcher for the totality of the experience with all its nuances (Sokolowski, 2000). The phenomenological approach requires a researcher to be attuned to his/her own preconceived beliefs about the phenomenon as well as the surroundings of each participant in the study (Thomas &

Pollio, 2002). Polit and Beck (2004) describe phenomenology as an alternate way of “thinking about what life experiences of people are like and what they mean” (p.47)

Phenomenology has as many as six different orientations according to Max van Manen (2002). These six orientations include transcendental phenomenology, linguistic phenomenology, ethical phenomenology, phenomenology of practice, hermeneutical phenomenology, and existential phenomenology (van Manen). As a method of inquiry, phenomenology uses a strong philosophical base to provide a lens for the researcher to develop an understanding of a phenomenon through rich descriptions of feelings, values and meanings from the perspective of the participants. In this study, existential phenomenology as described by Thomas and Pollio (2002) provided both the lens for describing the lived experience of spirituality for hospice/palliative care nurses and a method of hearing their stories and making meaning of their narratives. Existential phenomenology is both a philosophical and methodological approach to research and brings together the philosophy of existentialism with the methods of phenomenology (Thomas & Pollio). This method of inquiry and philosophical approach helps guide researchers in their understanding of the existence of human beings in particular experiences. As stated by Secret (2007), the researcher’s objective “is to reveal the nature of human experience from the perspective of the one who lives it” (p.9).

In essence, existential phenomenology is about the lived experience and subjective experiences of the world in which a person lives. Existential phenomenology emphasizes: “(1) respect for all individuals participating in the study, (2) in-depth interviews to discover individuals’ perceptions and feelings, and (3) rigorous interpretations of texts that result from such interviews” (Thomas & Pollio, 2002, p.4).

This method not only allows participants to share their ideas and feelings about their experiences but also attaches “meaning about what is happening to those who are experiencing it.... the concern is the meaning of the human experience” (Thomas & Pollio, p.6). Mayerhoff (1971) philosophized on “living the meaning of life” (p.62). He believed that we create meaning for our own life by “helping and finding appropriate others... this meaning is not external to my life, there is a rightness and necessity about it that is acknowledged in my being: the meaning is acknowledged to be my own.....no one else can give meaning to my life but me” (Mayerhoff, p.62).

As suggested by Thomas and Pollio (2002), the researcher used the lens of Merleau-Ponty to gather meaning and understanding about participants' life experiences. This lens allows readers and researchers to view phenomena in new and different ways. The method involves an investigator, a participant and a question of inquiry. The investigator asks the question of the participant and then listens attentively to the participant's answer. “The phenomenological question is not designed to elicit a theoretical explanation or statement” (Thomas & Pollio, p.24); however, it allows participants to talk openly and freely about their life experiences, thus providing the researcher with insight into the “individual's first-person meaning” (Thomas & Pollio, p.19). As described by Thomas and Pollio, existential phenomenology “sheds light on meaning of what is happening to those who experience it” (p.6) and as a methodology “...has great value for studying those aspects of our patients' experiences that are not measurable by blood pressure cuffs, rating scales and questionnaires...”(p.5). With its eidetic or Husserlian perspective, this method of inquiry was well suited to answer the question: What is the lived experience of spirituality in nurses who work in palliative care settings?

Eidetic Phenomenology

Eidetic or descriptive (Husserlian) phenomenology “rests on the thesis that there are essential structures to human experience” (Cohen & Omery, 1994, p.147). Cohen and Omery state that it is these structures that enter consciousness “then take on meaning of that experience for the participant” (p.148). How individuals describe the meaning of their life experiences and know this to be true is the goal of eidetic phenomenology (Cohen & Omery).

The Lens of Merleau-Ponty

The lens chosen to guide this research is based on the philosophy of Merleau-Ponty, as it is deeply rooted in existential phenomenology (Merleau-Ponty, 1962). Due to the nature of Merleau-Ponty's holistic, embodied and culture driven applied phenomenology, “it is an excellent fit for nursing” (Thomas & Pollio, 2002, p.12). Merleau-Ponty's philosophy focuses on the three themes: primacy of perception, lived experience and embodiment.

Matthews (2002) interprets Merleau-Ponty's ideas on perception as something that is “experienced before it is theorized” (p.8). Thomas and Pollio (2002) describe Merleau-Ponty's view of perception as “ongoing transactions between person and world” (p.14). These transactions are defined as “direct experiences, objects, events and phenomena” occurring between the world and an individual (Thomas & Pollio, p.14). Merleau-Ponty (1962) perceived the human body as a living organism by which we body-forth our possibilities in the world, meaning that the body is the vehicle by which individuals experience their life. The primacy of perception instills that the body cannot be solely viewed as an object; the body is a vehicle by which individuals access the world

and what it has to offer. His understanding of perception is that “our own body is the world...” (Merleau-Ponty, p.235) and those individuals “... live, act and move about” (Matthews, p. 8) in the world providing them unity and meaning. During his work on perception, Merleau-Ponty concluded that the perception of individuals is very much influenced by race and gender, therefore the world is a very social and subjective experience (Matthews; Merleau-Ponty; Wilde, 1999). In order to understand others and their culture, he felt that individuals’ norms and practices must be understood. He states:

I will experience a certain cultural environment along with behaviour corresponding to it.... I conceived analogically the kind of man who lived in it. But the first need is to know how I experience my own cultural world, my own civilization (Merleau-Ponty, p. 406).

According to Thomas (2005), Merleau-Ponty wrote that all meaning and knowledge occurs through perception and it is learned through individuals’ specific environment. Most importantly Merleau-Ponty felt that body, time, relationships with others and the world in which we live all contribute to helping us understand individuals’ perceptions (Merleau-Ponty, 1962).

When Merleau-Ponty discussed his philosophy of the lived experience he felt that *all individuals have different life experiences when engaging in particular life events*. He describes individuals in the world as “the absolute source, who move out towards their antecedents, physical and social environments to sustain them... this is how one brings being into themselves” (Merleau-Ponty, 1962, ix). In his writings, he described how individuals attach values and meanings to specific experiences and how these values and meanings begin to shape individuals into what they become. As interpreted by Thomas

and Pollio (2002), Merleau-Ponty believed that it was important for individuals to understand and recognize these meanings and values, so as to allow them to participate in their own self discovery and self reflection. As cited by Mathews (2002), Merleau-Ponty also used the term "being-in-the-world" to describe one's lived experience (p.55).

Mathews goes on to describe the term being-in-the-world as "an activity and engagement rather than pure contemplation, and consequently the world is not a mere collection of externally related objects, but is a realm of meaning, in some sense of that world" (p.55).

As interpreted by Thomas and Pollio, Merleau-Ponty felt that there were two components that contributed to one's lived experiences. These are intentionality and relationships with others. Thomas and Pollio believe that Merleau-Ponty describes relationships as "...connection- not alienation and distance- describe the most general properties of our being-in-the-world and of our being with others" (p.14).

As cited by Thomas and Pollio (2002), when Merleau-Ponty discussed intentionality he described it as how humans relate to the world. He described intentionality as interconnectedness between humans and the life world and this is where humans come to understand specific life events, objects and phenomena (Merleau-Ponty, 1962). As interpreted by Thomas (2005), Merleau-Ponty believed "all experiences take place in relation to something other than itself" (p.70).

Relationships with others are also identified as contributing to one's lived experience. Thomas and Pollio (2002) believed that Merleau-Ponty perceived life as a network of relations that directly impacts one's behaviour, which in turn, impacts "first-person significance" (p. 15). It is important for others to be connected in dialogue and communication because this is where understanding of others is generated (Merleau-

Ponty, 1962; Thomas, 2005). As reported by Thomas, relationships have the ability to create profound positive or negative effect on individuals, and it is from this experience one can come to understand the importance and necessity of that person during that period of their life. Thomas refers to this as creating a “dialogic connection” (p.72). In order to have a profound and meaningful lived experience, Merleau-Ponty believed that individuals must recognize the importance of intentionality and the relationships they have created with others because it is these two dimensions that help shape individuals into who they are today (Merleau-Ponty).

Embodiment

Phenomenological studies frequently refer to the concept of embodiment when attempting to understand and study health, illness and its impact on individuals. According to Merleau-Ponty (1962) embodiment is viewed as how we as humans experience the world through our bodies. Perception, emotion, language, movement in space, time and sexuality are all important factors that influence and impact individuals' life experiences (Merleau-Ponty). Through Merleau-Ponty's work, Wilde (1999) interprets individuals as being affected by “social, cultural, political and historic forces” (p.27) and sees the body as a “...unique source of knowledge...” in which individuals interpret their own existence in the world (p.27). According to Wilde's (2003) newest work and interpretations of Merleau-Ponty, the methodological approach of phenomenology contributes to “embodied knowledge plus practical personal knowledge” (p.71). As cited by Thomas, Braken and Leudar (2004), they report that Merleau-Ponty sees embodiment as a contribution to individuals' self concept by creating an “...awareness of their past, their present and possible future actions” (p.19)

According to Merleau-Ponty's phenomenological view, Wilde (1999) interprets "...body, time and space..." as essential core components that help define embodiment (p.27). The relationships among these three dimensions are not independent of one another; they are synergistic in nature and help create individuals' embodiment (Merleau-Ponty, 1962). Thomas Bracken and Leudar (2004) perceive Merleau-Ponty's philosophy of time, body, and space as being intertwined and constantly interacting with one another. Merleau-Ponty felt that an individual's body also determined one's spatiality and temporality in the world (Merleau-Ponty). In his book on Phenomenology of Perception (1962) Merleau-Ponty addresses bodily space by stating "the experience of our own body teaches us to embed space in existence" (p.171). He also believed that existence is known through the body and embodied existence takes place within the contextual world that each person is born into and lives (Merleau-Ponty). As cited by Thomas (2005), Merleau-Ponty coined this key term the lived body. If we are truly cognizant of our surroundings, Thomas, Bracken and Leudar, interpreted Merleau-Ponty as describing our bodies as giving us permission to experience and enjoy different "...cultures for a particular time and commit to particular projects..."(p. 17). The body allows individuals to experience the world through "visual, tactile and motor" stimuli by which or through which all individuals interpret the world (Merleau-Ponty, p.172).

As interpreted by Thomas, Bracken and Leudar (2004), they believed that Merleau-Ponty recognized that one's body can define different dimensions of time and space. These dimensions are known as the past, the present and the future. Time and space are considered to be very subjective experiences; however, it was Merleau-Ponty's belief that the best dimension to live in was the present as individuals could choose to

either live in the past or the future (Merleau-Ponty, 1962). He described holding onto the past and future as “precarious” (Merleau-Ponty, p.404). According to Thomas (2005), Merleau-Ponty described individuals who live in the present as “undecidable and open” (p. 71). Living in the present allows individuals to make sense of things at the time. As stated by Merleau-Ponty “the experience of the present is that of being assured of his existence once and for all, whom nothing could ever prevent from having been” (p.51). Thomas, Bracken and Leudar interpret Merleau-Ponty’s understanding of lack of living in the present as missed opportunities for the future. Depending on one’s specific life events, Thomas believed that Merleau-Ponty described individuals as “bursting forth” in time and space. (p. 72). For example, if an individual has experienced traumatic events during his/her life, such as a terminal illness, it is believed that they can choose to propel themselves forward into a present state of consciousness whereby individuals choose to be happy and live their life to the fullest. Like children, adults will begin to experience themselves as active participants in their life and recognize all the world has to offer. By being in the world, Thomas, Bracken and Leudar believe that Merleau-Ponty views individuals as creating and interpreting “human contexts in which objects and events stand out and make sense” (p.16).

According to Thomas and Pollio (2002), there are four major existential grounds in which individuals come to understand their life. They are “...others, body, time and world” (Thomas & Pollio, p.4). Human life and experiences emerge from these grounds and Thomas (2005) reports that Merleau-Ponty believes that these grounds directly impact individuals’ embodiment. It has been documented that when individuals experience pain, trauma or illness, individuals have reported feelings of disembodiment

or “feeling not connected with one’s body” (Wilde, 2003, p.170). Studies have shown that experiences inflicting trauma, pain and illness on individuals can affect their physical, mental, social and spiritual well-being (Wilde). These negative experiences have the ability to change the total person, therefore negatively impacting individuals’ holistic health and changing their ways of being in the world. According to Thomas, Bracken and Leudar, (2004), being in the world is the human context in which events and objects stand out for individuals, therefore providing them meaning for that particular experience. It is Wilde’s belief that Merleau-Ponty describes the importance of individuals feeling connected to and embodied within themselves as it is “not only a philosophical approach but a human state of being” (p.171). The state of optimal embodiment or connectedness, and hence health and well-being, therefore reflect the essences of oneself as holistic body, in defined space with the world at present time, related to others. Living without the context of one of the four existential grounds can create imbalance and disharmony such that the holistic self is threatened or at risk of spiritual distress and trauma. Nurses are expected to promote and respect individuals’ existential grounds and the lived meaning they associate with them.

Merleau-Ponty’s lens of viewing the world is open, accepting and embodied in nature. Using this form of phenomenology allows the researcher to fully understand and describe hospice/palliative care nurses’ ideas and perceptions about spirituality and their lived experience of being in the world.

Procedure

Participant Selection

The participants for this study were invited to participate through the method of purposeful targeted sampling and subsequent participants were recruited through snowball sampling. The volunteer sample was recruited through the use of workplace emails and large posters (Appendix B) and business cards posted in one Windsor community hospital, and one Windsor volunteer agency that focuses on end of life issues. The posters provided information about the study for those who were interested in participating in the research and small business cards were available, providing the researcher's contact information.

The sample size was six participants and it was achieved through the method of saturation. Polit and Beck (2004), state "data saturation involves sampling to the point at which no new information is obtained and redundancy is achieved" (p.312). When themes and ideas become redundant "the general rule of thumb is that the researcher interviews two more participants..... at this point the phenomena is thought to be well described, and there is little or no need to seek additional exemplars of participants" (Thomas & Pollio, p.42). By the fourth interview the researcher discovered that repetitious ideas and perceptions were being shared among the participants, therefore as suggested by Thomas and Pollio, the researcher facilitated two more interviews. These two extra interviews ensured that the researcher had an accurate description of hospice/palliative care nurses' perceptions of spirituality; therefore the total sample size for this study was six.

Participants met a set of inclusion criteria. The criteria were as follows.

Participants were: 1) registered with the College of Nurses of Ontario; 2) were Registered Nurses (RN); 3) 18 years or older; 4) understood and read English; 5) had at least six months of experience caring for palliative/terminally ill clients; 6) able to give informed consent to the interviewer.

Protection of Human Subjects

This study obtained research ethics board approval from the University of Windsor (Appendix C), one Community Hospital (Appendix D) and a letter of permission was granted from one Volunteer Agency (Appendix E) that focuses on end of life issues. This study was completely voluntary and participants were offered the chance to withdraw from the study or decline to respond to interview questions at any time.

Participants were required to sign a consent form agreeing to participate in this research study (Appendix F), sign a letter of information (Appendix G) outlining the details of the research project, consent to an audio taped interview process (Appendix H) and lastly complete a demographics data information sheet (Appendix I). Participants provided informed consent prior to their initiating the study and participants were reminded of their right to withdraw consent at any time.

Consent forms were stored in a separate secure filing system away from the transcribed interviews. The participants' rights to privacy were preserved through confidentiality on the part of the researcher. Prior to the interview, participants were asked to choose a name they would like to use for the duration of the interview. This pseudo name maintained the participant's confidentiality by reducing the ability to be identified from transcripts. Identities of the actual participants were solely known by the

researcher for the purpose of providing them the results of the study. After completing a successful defense of the research, all original tapes, notes and transcripts were destroyed by a reputable secured disposal process.

Setting

The participant's interview took place either in her home, a quiet room in her workplace or at the interviewer's home. These places were all selected by the participants. These environments promoted feelings of safety and confidentiality among the participants as they shared their thoughts and feelings about spirituality. All of these settings were free of background noise and interruptions.

Recruitment

Prior to recruiting participants for the study, the researcher participated in a bracketing interview, conducted by an expert in phenomenological interviewing. Before the first interview occurred, the researcher's bracketing interview was transcribed, read and analysis work begun.

Prior to posting the posters in the chosen organizations, the researcher called all nursing facilities with established palliative care programs within the study's catchment area and identified the total pool of participants who could have participated in this study. The researcher was interested in gathering information about the hospice/palliative care nurses' place of work (community versus hospital setting), amount of hospice/palliative care Registered Nurses (RN) working within the organization, gender, and education/special certifications obtained by this group of nurses. After these demographics were collected, posters (Appendix B) were posted and study participants were identified. Eligible participants were contacted by the researcher, either by phone or

email, introducing them to the study. In this initial communication, the researcher explained the study purpose in detail to the participants and answered any questions they had about the study. A mutually convenient time and meeting place was arranged between both the participants and the researcher in order to facilitate the interview process.

During this study, participants were given a ten dollar gift card to a local coffee shop as thanks for their contributions. If the participants requested information about what some of the other participants said during their interviews, the researcher shared with them preliminary results at the end of their interview (Patrick, 2006). As the interviews took place, saturation was reflected by the frequencies of similarity and repetitious meanings, examples, themes, emotions and metaphors.

Data Collection

The researcher met with each participant in a mutually agreed upon location and answered any questions about the study prior to starting the interview. While the tape recorders were tested by the researcher, the participants signed the consent to participate in research (Appendix F), the consent for audio taping (Appendix H), completed a demographics data information sheet (Appendix I) and were given an information letter which the researcher and the interviewee signed (Appendix G). Participants' interviews were audio taped with two tape recorders to facilitate back-up and prevent lost data and were then transcribed verbatim. Thomas and Pollio (2002) suggest the researcher use two tape recorders to audio tape the participants' experiences, to "bring plenty of batteries and extra tapes should there be some type of equipment failure" (p.27). Prior to

transcribing any interviews, the researcher had the transcriber sign a confidentiality pledge (Appendix J).

The interviews began with the researcher sitting face to face with the participant validating the selected code pseudonym, checking for any last needs such as unanswered questions and affirming the participant's readiness to begin. The researcher began the tape recorder with the participant's pseudonym, date, and a description of the study's purpose, then asked the participant: What is your definition of spirituality? What are your experiences with spirituality in your daily work as a nurse who works in a setting with people who are terminally ill? As the participant began to answer the questions, throughout the interview the researcher used an interview guide and asked the participant probing questions such as: could you tell me more about that, what does that look like to you, or what does this mean to you (Appendix K), as this helped facilitate more detailed description and clarification of the words chosen by the participant.

The researcher gave the participants her business card, should they require or request more than one interview. Additional interviews have been found to allow participants time to reflect and recall more details of meanings that they forgot to share with the researcher during their first interview (Patrick, 2006). In this study all of the participants requested only one interview.

The researcher had a filing cabinet in place, used to organize hard copies of documentation that was required to be complete for this study. The researcher followed Groenewald's (2004) suggestions as to what documentation should be filed in the filing cabinet:

- 1) informed consent forms (Appendix F & H) and demographic data information sheets (Appendix I)
- 2) notes the researcher made during the interview
- 3) additional information provided by the participant during the interview
- 4) notes made during the data analysis process
- 5) confirmation of correctness and/or commentary by the participant about the transcript and analyses of the interviews
- 6) additional communication between the participant and the researcher (p.16-17).

Data Analysis

The process for data analysis and interpretation occurred using the *Steps in Conducting an Existential-Phenomenological Study* from Pollio and Thompson, (as cited in Thomas & Pollio, 2002, p. 45) (Appendix L). All the data used in this study came from audio-taped interviews, transcribed verbatim. Key words and phrases were used verbatim to target and describe the lived experience of these participants.

In a brief overview, data analysis began with transcribing interviews verbatim, as participants were identified in the transcripts using their pseudo name. The researcher examined the text from all interviews by reading, reflecting and intuiting the participants' lived experiences. The researcher scrutinized all individual transcripts for themes, categories and topics using the audio taped interviews as supportive methods. Recurrent themes and beliefs were gathered among all of the transcripts and were then formulated into findings and discussion.

Data analysis initially began with the researcher reading the “complete transcript and then connecting specific parts that stood out” (Thomas & Pollio, 2002, p.35). These significant parts of the text were related to the whole text, as “all passages are understood in terms of their relationship to the larger whole” (Thomas & Pollio, p.35). This allowed for the development of “meaning units” (Thomas & Pollio, p.35), which in turn created the themes of this study. Themes were identified as words/phrases and patterns of description that was repetitiously used throughout the interviews by more than one participant.

NVivo 7, the qualitative data analysis software package, was used to identify, organize and highlight themes from the participants' transcripts. Nodes were created identifying the four major grounds of human existence as outlined by Merleau-Ponty: body, world, time and others. As dialogue was identified as belonging to a specific node, the researcher cut and pasted these findings onto large pieces of paper to map out what the participants were sharing in their interviews. It was important for the researcher to understand the words that were communicated in the interview, the context in which they were used and the relationship these words had to the participants' narrative as a whole. Analyzing and mapping out the finding, allowed the researcher to identify other subcategories of themes. Transcripts were analyzed by the researcher through the method of highlighting text and passages by hand.

The faculty advisor and the researcher analyzed the bracketing interview using NVivo 7 and the other members of the research committee interpreted one other interview. The researcher randomly selected interview number two; this interview was presented, read aloud, discussed, analyzed for themes and verified for meaning and metaphors within the

research committee. This verification helped maintain the rigor of this method, but most importantly provided a learning opportunity for the researcher to practice data analysis. The research committee consisted of the researcher, the faculty advisor, the second reader and the outside reader. The group's interpretation of the selected transcript was then used to identify meaning units and create themes. There was no disagreement of opinions within the group with regards to analysis. However if there had been disagreement, the group would have,

returned to the words of the participant. The ultimate authority is the text itself. The group member, who proposes a certain theme, or name of a theme, must return to the typed transcript of the interview and find words of the participant that exemplify that theme. Generally, we do about an hour and a half of intensive work toward the end of the project, when someone is at the blackboard, and tentative themes are proposed, rejected, etcetera, until there is a collective affirmation that we have arrived at an accurate and pleasing thematic structure. The principal researcher still goes back to reflect on the text and review the transcripts after that, and takes the proposed thematic structure back to some of the participants to obtain their corroboration. We know we have gotten it right when participants give a vigorous affirmation. Van Manen talks about this as the phenomenological nod (Sandra. P. Thomas personal communication, May 31, 2009).

Whether the transcripts were being reviewed independently by the researcher or by the research committee, thematic descriptions and commonalities from other interviews were clustered and identified in order to gather the essence of what participants were sharing. Global themes were sought out across the interviews, "rendering the words

taken directly from participants' interviews" (Thomas & Pollio, 2002, p.37). Once themes were identified in the research they were analyzed and understood in terms of relationships and how they contributed to the larger picture of spirituality.

The identified global themes lead to the development of a thematic structure. The thematic structure was viewed and interpreted through the lens of Merleau-Ponty. This study's thematic structure is presented in the form of a diagram, outlining and demonstrating relationships among the identified global themes. Both the researcher and the research committee agreed upon the thematic structure. When the written results were finalized, they were shared with the research team and mailed out to the study's participants. The researcher compared the participants' results against the existing literature to establish whether new themes were discovered or existing themes fortified.

Strategies to Assure Rigor

Reliability

According to Thomas and Pollio (2002) reliability is "...often defined as the consistency of research findings" (p.39). Reliability within qualitative research is very ambiguous however, Thomas and Pollio state that reliability in phenomenological research can either be seen as "...an understanding of the researcher's viewpoint...or....the reader adopts the same viewpoint as articulated by the researcher and can also see what the researcher saw..." (p.40). In this study, reliability was identified in two ways, through congruent individual interviews and through the method of saturation. When the researcher asked each individual participant to expand or clarify her lived experience in spirituality, explanations remained consistent and congruent throughout the duration of their interview. All participants' statements and beliefs remained accurate

within their interview therefore supporting reliability of the study. Reliability was also achieved through the method of saturation. As themes were repeated consistently across all six participants' interviews, this also contributed to the study's reliability. In conclusion, reliability was achieved through participants' individual interviews and through the identification of global themes across the interviews of all six participants.

Validity

According to Thomas and Pollio (2002) validity is defined as "whether one has investigated what one wished to investigate" (p.40). Throughout the interviews the researcher probed the participants for deeper meaning and understanding about their experiences and asked the participants for clarification of words, ideas and beliefs. By asking for clarification, the researcher ensured that she accurately represented her participants' experiences, therefore matching the researcher's findings and interpretations to those of the participants. When analyzing the data, the researcher was sure to use the exact words and statements of the participants. This method was rigorous in nature because it allowed the researcher to use participants' exact words to describe the phenomena of spirituality. Participants' feedback was essential in confirming that their stories and interviews were accurately described by the researcher. When the data was collected, the researcher quoted the participants verbatim, ensuring that the same words and phrases were used to describe their experiences. After the research was analyzed the researcher compared it to research that was already known to see if any similarities exist. If the researcher identifies new findings, these can be seen as "...plausible and illuminating" (Thomas & Pollio, p.41).

This approach was well suited to answer the research question as it allowed for the collection of rich descriptive data provided by the participants. From the collected data, the researcher was able to unfold the meaning and the lived experience of spirituality for hospice/palliative care nurses and began to fill the gap of knowledge surrounding this research question.

Bracketing Interview

Participating in a bracketing interview allowed me to recognize and acknowledge my own assumptions, beliefs, values and attitudes about spirituality in hospice/palliative care nursing. This interview facilitated the acknowledgement of my own personal bias and recognized the presence and role of me as the researcher, as the interpersonal experience. This interview allowed me to become knowledgeable about my own ideas and beliefs about spirituality, therefore ensuring that I was not "imposing demands or presuppositions on those individuals participating in the study" (Thomas & Pollio, 2002, p.33). According to Thomas and Pollio,

phenomenology demands that we initially bracket all that we think we know. We must enter humbly into the life world of the patient. We must listen in respectful silence.....our understanding of the other person's experience is radically altered through dialogue, and insights regarding the deeper *meaning* of an experience (p.7).

The research committee facilitated bracketing, "by conscientiously questioning the assumptions each member brought to the interpretation of the phenomenon under consideration" (Thomas & Pollio, 2002, p.34). In order to maintain some procedural stability, I presented the same introductory script for each interview. This process

allowed for the natural emergence of the thematic structure as participants were encouraged to represent their experience and the meaning associated with that experience as a whole (Thomas & Pollio).

I did not set out to either confirm or disprove particular expectations or hypotheses, but the bracketing interview allowed me to identify my own assumptions of hospice/palliative care nurses and their perceptions of spirituality. My assumptions for this study evolved through my own lived experiences while caring for hospice/palliative care patients in both community and hospital settings. From a long period of interaction with other professionals, patients, families, society and the world, I have synthesized my own core of beliefs that have been derived from my own professional experiences. The following beliefs and expectations were recognized and bracketed during data collection analysis:

- hospice/palliative care nurses view spirituality as an important dimension of their clients
- spirituality is whatever hospice/palliative care nurses believe it to be
- hospice/palliative care nurses want more education with regards to spirituality
- hospice/palliative care nurses experience improved mental, physical, and emotional well-being if they became more aware of their spiritual dimension

My experiences as an acute care educator also contributed to the development of several personal core beliefs:

- that hospice/palliative care nurses are comfortable providing spiritual care

- hospice/palliative care nurses see themselves as spiritual beings.

Completing the bracketing interview provided me with an understanding as to what it was like for others to participate in this study, therefore promoting a more “open and nonjudgmental attitude when conducting the interviews” (Thomas & Pollio, 2002, p.33). It was my joy to listen and learn from my participants as they had so much knowledge and wisdom about the spiritual domain of others and themselves. During this study I was able to experience the stories and the emotions of my participants as they described the death of their patients and the strong connections they had made with these individuals prior to their death. During this study, I too was able to remember and reconnect with the tragic loss of my own grandmother, someone who brought me great comfort and security. By resurfacing difficult events and my own personal traumas, for me, this study has allowed me to find closure, peace and healing within my own life.

Chapter IV

RESULTS

The purpose of this study was to examine the meaning of spirituality among Registered Nurses working in settings that focused on end of life issues. The participants who volunteered to be interviewed were hospice/palliative care nurses in a Community Hospital (CH) and hospice palliative care nurses working in a Volunteer Agency (VA). This study's results provide a wide range of insights into the domain of spiritual care and how it impacts hospice/palliative care nurses.

In this chapter, I first describe the potential pool of applicants that could have participated in the study, the worldview of hospice/palliative care as described by the Registered Nurses (RNs) who participated, and a demographic description of the participants. I then define spirituality using the words of the participants and provide a thematic structure and identify the six most common themes, as reported by the participants, using Merleau Ponty's philosophical approach of existential phenomenology as the lens to guide data analysis.

Population of Hospice/Palliative Care Nurses in the Study Pool

The population of hospice/palliative care nurses, in the study catchment area, was determined through a process of information gathering for the purpose of identifying the potential pool of participants. Key stakeholders in five organizations with established hospice/palliative care programs were asked a series of questions to determine fit with the study objectives. Answers to these questions are listed below in the following chart:

Table 1

Population of Hospice Palliative Care Nurses in the Study Catchment Area

Organizations	# of Hospice/Palliative Care Nurses (RN & RPN)	# of RN's	Male (M) vs. Female (F) RN's	Levels of Education (RN)	Specific Courses (RN)
#1	56	18	M=1 F=17	BScN=6 Diploma=12	*CAPCE= 5 **Fundamentals = 8
#2	21	16	M=3 F=13	BScN =1 Diploma= 15	*CAPCE=5 **Fundamentals=16 ***CHPCN (C)=2
#3	42	31	M=3 F=28	BScN=8 Diploma=23	*CAPCE=8 **Fundamentals=29 ***CHPCNC=2
#4	27	10	M=0 F=10	BScN=4 Diploma=6	*CAPCE= 2 **Fundamentals=10
#5	68	38	M=2 F=36	BScN=6 Diploma=32	*CAPCE=4 **Fundamentals=38 **** Palliative Specialist=3
Total	214	113	M=9 F=104	BScN=25 Diploma=88	*CAPSE=24 **Fundamentals=101 ***CHPCNC=2 ****Palliative Specialist=3

*CAPCE=Comprehensive Advanced Palliative Care Education

**Fundamentals= Fundamentals of Palliative Care Level 1

***CHPCNC=Certified Hospice Palliative Care Nurse in Canada

****Palliative Oncology Nurse Specialist (courses created within the organization)

The above chart demonstrates that from the five organizations with established palliative care programs, a total of 113 RNs could have been interviewed for this study with 9 of these RNs being male and 104 being female. From the 113 RNs who could have participated in this study, 25 had completed their BScN and nearly all the nurses had completed a course based on national principles and norms of hospice palliative care

called, Fundamentals of Palliative Care Level 1. This course is funded by the Ministry of Health and Long-Term Care (MOHLTC) and is recognized throughout Southwestern Ontario.

From this pool, a total of six nurses were chosen to be part of the study through a process of recruitment that included a variety of strategies such as work emails, large posters and the use of the researcher's business cards attached to posters. The sample size of six participants was achieved through the method of saturation and individuals were interviewed until the same themes were heard over again. According to Thomas and Pollio (2002) there is generalizability of a research study when consistencies are noted between the interviews of the participants, "when recurrent patterns are hard to overlook...and if no new patterns or themes emerge, the phenomenon is thought to be well-described, and there is no need to seek additional participants" (p.44).

Demographic Description of Participants

In this study, a total of six Caucasian women were interviewed ranging from ages 31-62 years. A more detailed description of participant characteristics are presented in Table 2. Three nurses were employed at a Volunteer Agency (VA) that focused on end of life care and three nurses were employed at a Community Hospital (CH). All six nurses chose pseudo names to maintain their anonymity and therefore identified themselves as Janie, Sally, Izzy, Kate, Karen, and Patricia. More specifically, two of the nurses who participated from the (VA) group held the title of Nurse Educator while the third (VA) nurse identified herself as a Palliative Care Coordinator. All three (CH) nurses identified themselves as Staff Nurses. All participants were married and identified themselves as having a practicing religion. Two out of six nurses were BScN prepared

and the remaining four nurses were diploma prepared. Four nurses had obtained Level 1 of the Fundamentals of Palliative Care Course, 5 nurses had obtained CAPCE (Comprehensive Advanced Palliative Care Education), 4 nurses had obtained CHPCN (C) (Certified Hospice Palliative Care Nurse in Canada), 1 obtained a LEAP course (Learning Essential Approaches to Palliative and End of Life Care) and 2 obtained a Pain and Symptom management course identified by their employer as specialized education. The total number of years of employment as an RN ranged from 10 to 41 years, with the specialty of hospice/palliative care ranging from 1 to 17 years of experience.

Table 2

Demographic Characteristics of Participants

Interviewee	Age (Year)	Marital Status	Practicing Religion	Education	Specialized Education	# of years nursing with current employer	Total # of years nursing
1 Izzy	58	Married	Anglican	Diploma	*CAPCE **Fundamentals ***CHPCN (C)	6	38
2 Janie	46	Married	Catholic	BScN	*CAPCE ***CNPCN (C)	6	18
3 Sally	62	Married	Catholic	Diploma	*CAPCE **Fundamentals ***CHPCN (C)	1	41
4 Kate	37	Married	Christian	BScN	*CAPCE ***CHPCN (C)	8	15
5 Karen	31	Married	Christian	Diploma	**Fundamentals ****LEAP *****Pain & Symptom Management	3.5	10
6 Patricia	57	Married	Catholic	Diploma	*CAPCE **Fundamentals *****Pain & Symptom Management	17	37

*CAPCE=Comprehensive Advanced Palliative Care Education

**Fundamentals= Fundamentals of Palliative Care Level 1

***CHPCN=Certified Hospice Palliative Care Nurse in Canada

**** LEAP= Learning Essential Approaches to Palliative and End of Life Care

***** Pain & Symptom Management= Course recognized by the Community Hospital as specialized education

Descriptions of Participants Work Environments

The researcher observed that there were significant differences between the Volunteer Agency setting and that of the Community Hospital setting. Due to their differences, the researcher has decided to include a description.

The Volunteer Agency Setting

When describing the Volunteer Agency (VA) it was very different from that of the Community Hospital (CH) setting. These participants visited patients in their homes, providing them care in the comfort of their own home environment and most of their visits took place during the day time between nine and five o'clock. These participants reported feeling less stressed because they created their own scheduled visits and had good working relationships with their patients. Participants reported having strong and trusting relationship with their patients and family members because they have come to know each other over time. For the VA participants, their visits usually begin when the patients are first diagnosed with terminal illness and lasts until their death. They reported having very close relationships with some of their patients and the family members, where they felt as if they were adopted into their family. Due to these close relationships, the VA participants reported doing a lot of planning with the patient/family for end of life and felt they had control and autonomy and respect by their other colleagues to facilitate changes within their patients' plans of care should it be necessary. There was an agreement that all VA participants' felt close to their colleagues and that there was equality among all the members of their hospice/palliative care interdisciplinary team. It was their belief that there was no hierarchical power driving their organization and everyone contributed to patients' plans equally. As colleagues, the participants reported feeling knowledgeable about the lives of the individuals they worked with as they saw themselves as being responsible for supporting and caring for them too.

The Community Hospital Setting

When describing the participants from the Community Hospital setting, they had very opposing viewpoints. These participants reported feeling very tired, emotionally exhausted and felt they had very little control over their patients' current health situations and providing them holistic care. These participants worked in more of an institutionalized setting where they would have to prioritize care for four to five dying patients. They reported that many times they felt guilty as they really never got to know some of the patients they cared for before they died. Due to their patient population and work assignment, some CH participants reported never having taken care of certain patients until the day they died. CH participants also shared that some patients arrive to their facility and die very quickly because they are in the end stage of their terminal illness, therefore never having had an opportunity to really get to know them. This was a difficult point for the CH participants to share, but it was a reality of their work environment. It is because of patients dying quickly, dying frequently and not having opportunities to get to know their patients and family members that they suspect contributes to their feelings of exhaustion, uneasiness with family, and their potential for becoming angry and bitter nurses. They reported working eight hour shifts and sometimes sixteen hour shifts if they were short a nurse. It was difficult to cover shifts and often difficult adjusting from day to night shifts in quick succession. There were also reports of inconsistent assignments and inappropriate workloads. CH participants saw their organization as hierarchical in nature having managers making "poor decisions" on their behalf and not being well informed as to the staff nurses' job responsibilities and the work that they do. There were also reports of clique groups within their population of

staff and how they felt divided at times due to differing personalities and priorities. It was this group who also reported their observations with nurse anger, sharing that there were many of their colleagues that were “angry nurses” when providing care for their patients, with whom they did not enjoy working with.

When comparing both groups of participants it was obvious that the Volunteer Agency participants felt very positive about their workplace setting whereas the Community Hospital participants, although they loved their work, their perception of their work setting was more negative and presented more challenges than they would have liked to experience.

Personal Definitions of Spirituality

All interviews began with the researcher asking each nurse to define spirituality. Throughout all six interviews each nurse began her description of spirituality with a generalized, abstract definition. This abstract definition began the search for a more in depth and comprehensive understanding of spirituality in relation to the nurses and the work they do. The most common themes used by the nurses to describe spirituality were: strength; spirituality is different from organized religion; and spirituality gives meaning and purpose to life.

Strength

According to Janie, “spirituality is just your, just your strength...where you draw strength from a structured religion or it just might be from life experience or your family”. Janie believed that strength was drawn from someone or something else, outside of self. Whereas Patricia explained the concept of strength coming from within, that you yourself could “find your own source of strength” and that strength is necessary to deal

with everyday problems and living. This particular nurse indicated that she needed to have this strength to be able to support her immediate family who were undergoing extreme stress and strain with a recent cancer diagnosis. Patricia continued to express her need to remain strong for her adult child and her family as she shared that spirituality “might be a source of strength for our going through difficult times and now especially with palliative care end of life situations”.

Spirituality is Different from Organized Religion

Despite the fact that all of the nurses identified themselves as belonging to a practicing religion, all nurses agreed that there was more to spirituality than what they practiced in their current organized religion. Janie stated, “I think a lot of people automatically when you hear spirituality you automatically go to religion and that, that’s not spirituality”. According to Patricia, spirituality lived outside of organized religion “probably more often than not”. Similarly, Izzy voiced her opinion by stating “well I think kind of spirituality isn’t necessarily you know what religion you are, what church you attend....I think it’s an overall belief and um that really comes into play very much at the end of life”. Despite the fact that religion and spirituality were viewed as two separate phenomena, Kate expressed that there was a relationship between religion and spirituality, “religion is definitely part of spirituality but it’s not religious”, but did not describe what this relationship looked like. In summary, although all of the participants defined spirituality as being different from that of religion, they did not go into detail to describe how they differed. This was the end of their discussion on religion; no other explanation was given to describe their viewpoint.

Meaning and Purpose in Life

In their interviews, several of the participants voiced that spirituality provided them with meaning and purpose in their life. For example Kate expressed spirituality as “the part of someone that searches for meaning and purpose within their human existence...it’s the awareness that you have of that and the part that is looking to define that purpose, that meaning”. Sally described spirituality as “the experience of life, it’s who you are; it’s what makes you the person you are”. Throughout her interview she continued to emphasize the importance of self reflection. It is her belief that self reflection assists individuals in establishing their meaning and purpose. Like the others, Patricia was very self reflective in her interview by stating “I believe spirituality cuts to the core of who people are and it delves into the important questions about what does it all mean”. At the end of her explanation she proceeded to ask the question “what does it all mean?” She expressed this as simple yet explicit question summing her thoughts as to what spirituality was all about.

In summary the three most common themes that emerged from the interviews when defining spirituality were: 1) strength, 2) spirituality is different from organized religion, and 3) meaning and purpose in life. Nearing the end of her interview, Patricia shared that she felt the concept of spirituality should not even be defined “for one thing we’re not smart enough or probably not got it right but it’s not up to us to define it...It is what it is and it is what it is to each of us”. As she stated so succinctly, she believed that we should accept others’ viewpoints and beliefs because each of us will experience spirituality differently depending on our life experiences and circumstances. This sentiment was expressed by several of the other participants and therefore reaffirms the

idea that nurses need to be open and accepting of others' ideas about spirituality, whether their perceptions are similar to that of the nurse or not.

It was the researcher's observation that those nurses who were more seasoned were more confident and expressive about their understanding and beliefs about spirituality. For example Karen who was the youngest of the participants shared "I am probably more uncomfortable with my own spirituality right now than I have ever been but I think that's because I've been introduced to some new things... I don't quite understand it all yet". At this point in time Karen was sharing that she had just started going back to church with her husband and that she was currently learning different spiritual ideas and beliefs through him. During her interview, she voiced how uncertain she was about the concept of spirituality and believed that practice was another component to spirituality, "...the more you practice something the better you get..." In comparison to her other colleagues, she was in a very new "exploratory" phase of spirituality whereas the other participants were very certain and confident in their responses.

The World of Hospice Palliative Care

All six participants had similar ideas and perceptions about spirituality and its link to their nursing role. By using their specialized knowledge, skills and expertise, all of the participants agreed that they had the ability to make end of life issues easier for patients and their family members. All of the participants except for Karen knew that they were drawn to palliative care prior to actually working in the field. During the interviews, the other five participants, Kate, Izzy, Sally, Janie, and Patricia, all shared that they had experienced either death of a loved one or had dealt with their own personal life trauma.

They all agreed that these experiences gave them time and opportunity to reflect on and value their own existence. Through self reflection and tragedy, these five participants believed they came to do palliative care nursing and to understand their own spiritual domain. During her interview, Karen shared that she had never experienced a death of someone close or her own personal trauma; therefore it is her belief that the field of palliative care has chosen her. The department she originally agreed to work in had a medical/surgical background: her current area of employment then transformed into a palliative care unit. In the beginning, Karen shared that she was very uncomfortable and angry that she had to transition to palliative care nursing. However, over time and with practice she has now come to enjoy palliative care work and caring for those individuals at the end of their life.

During the interviews, the researcher noticed that all six participants agreed that team support is necessary within palliative care. This support exists within the interdisciplinary health team and between the patient, family and health care providers. Remarkably, all six participants strongly agreed that the palliative care team within their organizations have a responsibility to connect with patients and their family members in order to determine their unmet needs. Both groups of nurses had weekly team meetings to help support their patients and family. According to Patricia, the purpose of these meetings was to ensure that "everyone was on the same page". Despite these organizational similarities, there were vast differences in relation to supporting the palliative care staff that worked in these settings. All three VA participants shared that their particular organization took the team meeting one step further and incorporated a weekly team check-in meeting to help support each other as colleagues. This concept of

check-in meetings occurred with all disciplines at the table, and allowed the team to become aware and sensitive to their colleagues' present situations. By becoming knowledgeable about their colleagues, one VA participant shared "this allowed us to become cognizant about supporting each other and checking in with each other and making sure that we're OK to do the job". Those participants who were from the CH setting did not experience these check-in meetings in their workplace.

As rewarding as this work was to the participants there were also universal frustrations that existed within the world of palliative care. All six participants agreed that palliative care work is difficult and is not task outcome orientated but requires great patience and attentive listening skills. All of the participants expressed that their work was more psychological in nature and focused more on counseling patients and families who were experiencing end of life. Kate shared that it was her experience that managers and higher level administration did not fully understand the world of palliative care as it is very much an abstract and emotionally charged type of nursing. In her interview, she stated "well I spend lots of time doing, giving emotional support and I can write that down in two words, but it might take me 45 minutes and I've got nothing concrete to demonstrate to my manager...this is frustrating". It is a form of nursing that is not necessarily tangible, but requires nurses to be more open, calm and non-judgmental in character. Because this work can be very emotionally draining and distressful, all nurses expressed the importance of creating boundaries in their every day work, separating professional work from that of personal life. Due to the nature of this work two CH nurses shared their common frustration of lack of time, feeling that they simply did not have enough time in their shift to meet the needs of their patients. As stated by one CH

participant, "in the hospital you have your shift , there's certain things you have to get done and you know at 3pm it is time to go, you just don't have time to spend with them, this is frustrating because the patient is what's suppose to count". Later on in the same interview, the same participant described that if she could change anything about her work it would be to "have more time to spend with our patients and families".

In summary there were few differences between the CH and VA nurses when comparing their views on palliative care. All participants agreed that the biggest achievement for palliative care nurses is to know that they have made a difference in the lives of others and to the field of palliative care. It was from these worldviews within hospice/palliative care that six figural themes were identified.

Thematic Structure

In the pictorial representations of Figure 1:1 and 1:2, major contextual grounds, identified as body, time and others are represented by large overlapping circles, contributing to the worldview of palliative care. The overlapping areas of circles represent the figural themes. These figural themes, emerged from the narratives that stood out most predominantly against the existential grounds of body, others and time. These figural themes were identified as 1) professional self, 2) reflective self, 3) relationship between nurse and God, 4) relationship between nurse and patient journey, 5) the impact of time on the hospice palliative care nurse role and 6) present time.

Figure 1

Thematic Structure

The Experience of Hospice/Palliative Care Nurses who Work in Palliative Care Settings

Community Hospital

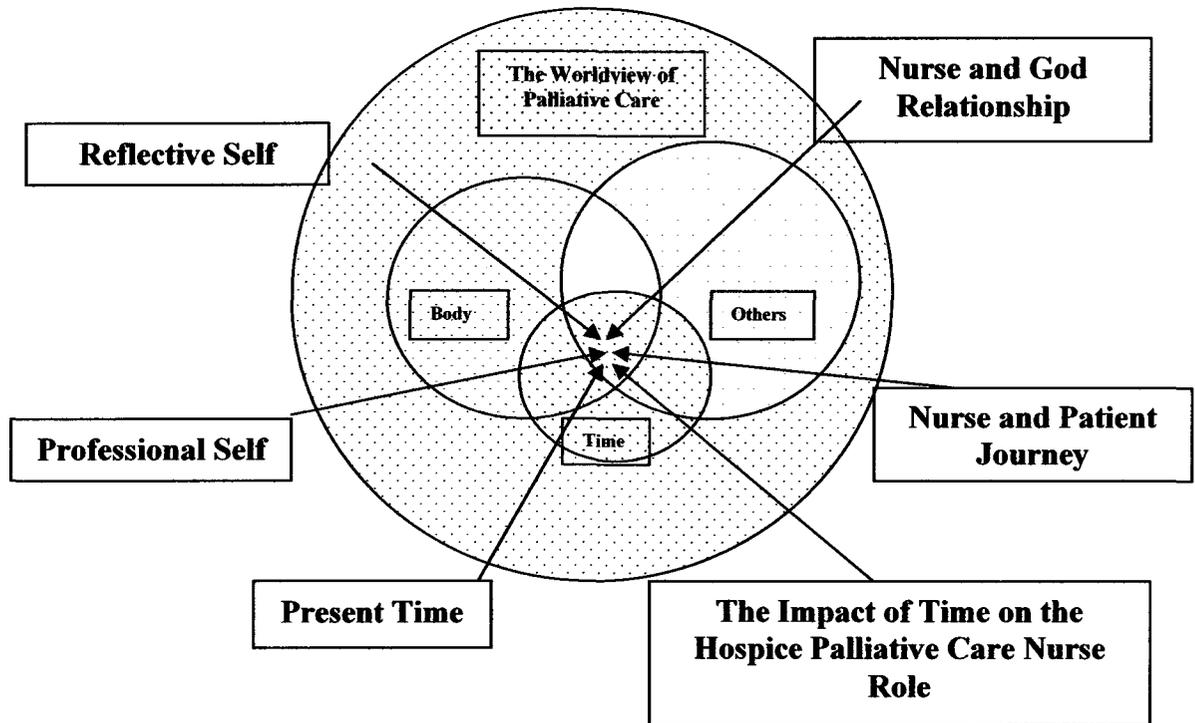
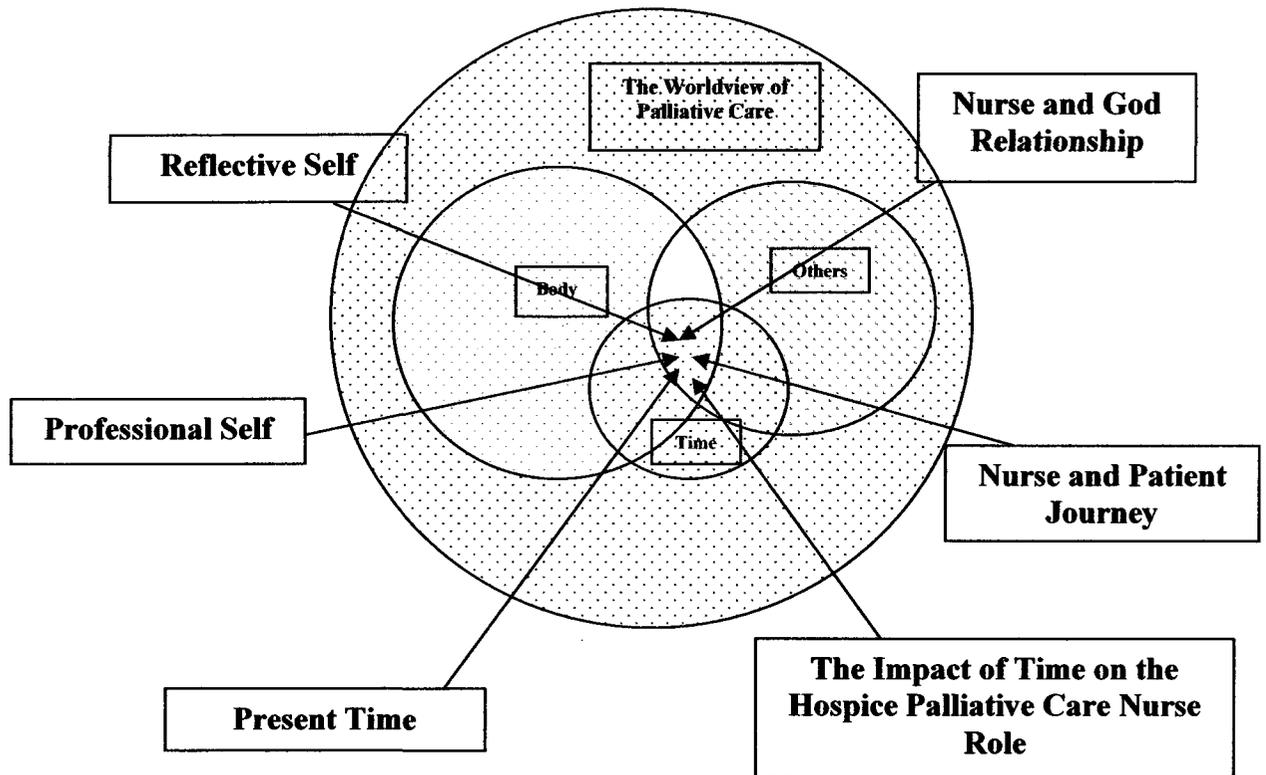


Figure 2

Thematic Structure

The Experience of Hospice/Palliative Care Nurses who Work in Palliative Care Settings

Volunteer Agency that focuses on End of Life Issues



Similarities and Differences between Figure 1 and Figure 2 Thematic Structures

When analyzing the participants' interviews, all of the same themes emerged across both settings, however the perception of others and body were reversed.

Figure 1

Within their world view of hospice/palliative care, the CH participants reported in their interviews that the ground of other people was more important than the ground of body or time. Within this group of nurses, the focus was the betterment of others and how the CH nurses, as professionals, interacted with and facilitated the wellbeing of patients and their family members. This group expressed the importance of having a relationship with God, but especially with the patient. Through these relationships, the CH participants agreed that they had a responsibility to help facilitate their patients' journey through life and terminal illness. Unanimously, the CH nurses agreed that the journey of life must be completed by their patients. This group concluded that their role was more supportive in nature, supporting and walking with their patients as they experienced end of life, rather than doing for. It is for this reason that others are represented with the largest circle, then body, then time with the smallest circle.

Figure 2

Figure 2 demonstrates that the VA participants reported the ground of body; both professional and reflective self was of significant importance when describing their perceptions and experiences of spirituality, in comparison to the ground of others and time. The VA group shared in their interviews the importance of understanding themselves from a reflective dimension as well as that of a professional one. It was their belief that by defining their own purpose and meaning in life, they could then help

facilitate their patients' meaning and purpose. Connection with others was very important in their work, but having boundaries between professional work and personal life was an essential component to their health and wellbeing. By taking care of themselves the VA group concluded that their patients would benefit from their actions. Therefore in this diagram the ground of body is given the largest circle, others is second largest and time is the smallest.

The Thematic Circles of Times

The concept of time was equally important to both sets of participants and the thoughts and ideas expressed about this ground were equally represented among all six interviews. The ground of time was given the least amount of importance, but very much impacted and overlapped both the ground of body and others. Time was defined by these six participants as impacting their role of being effective hospice/palliative care nurses. For the VA participants, time was seen as an opportunity to facilitate effective therapeutic relationships with their patients and family members, whereas for the CH participants, time was a barrier to providing holistic health care. All participants described the theme of being present through the ground of time, whereby enjoying their immediate present moment in life as it will never be experienced again.

In summary, the ground of time demonstrated important findings in this study, but the grounds of body and others were prioritized by both VA and CH participants, as having more importance and relevance to their hospice/palliative care work.

Global Themes

Body

According to the interpretation by Matthews (2002), Merleau-Ponty's theory of body was "our bodies are for us the means by which we are in the world...to be self is to be a living creature that is in the world through the vehicle of one's body" (p.69). In all six interviews the participants identified two very distinct aspects of self: the professional self and the reflective self. All of the nurses who participated believed that both professional self and reflective self existed within palliative care nurses, especially when exploring the phenomena of spirituality.

Theme 1: Professional Self

When examining the theme of professional self, all of the participants expressed qualities that they felt all hospice/palliative care nurses should have when facilitating their work from a spiritual dimension. These qualities were divided up into two categories. The first category examines nurses' qualities when creating therapeutic relationships with their patients/family members and the second category focuses on strategies nurses must engage in to help themselves with their work.

Hospice/Palliative Care Nurses and Therapeutic Relationships

When developing therapeutic relationships with the patient/family, the participants expressed the need to be attentive listeners, be empathetic and have a patient demeanor. Both Izzy and Sally shared in their interview that by "just listening" to their patients and "being calm, this opens the door for conversation". By listening and being open to patients/families, Sally goes on to emphasize the importance of this skill as it helps facilitate "telling stories" and creating trusting relationships. There was an

agreement among these two participants that the skill of active listening creates trust and collaboration between nurse, patient, and family and is a fundamental component of therapeutic relationships.

Almost all of the nurses agreed that empathy towards their patients/families was another important component to therapeutic relationships. Karen makes a profound statement about empathy in the role of a health care provider by stating, "if you can't understand what they (patients) are going through, how can you effectively be there for them?" In her statement, Karen was very passionate and matter of fact when discussing empathy and the role of the hospice/palliative care nurses for her, being knowledgeable about her patients' experiences and feelings were of the utmost importance when creating a trusting therapeutic relationship. Like Karen, Izzy discussed the challenges and difficulties of her patients who have been recently diagnosed with terminal illness and shared why she felt it was important for hospice/palliative care nurses to understand and respect their patients' feelings. In her interview Izzy states "how would we feel if we were you know diagnosed and have family or grandchildren and you know suddenly our trajectory and our journey has changed you know completely. Yeah we'd be angry too. We really try to put ourselves in their place."

By empathizing with others, both Izzy and Karen shared that they could better understand their patients and their current life situations and perhaps are better nurses for it. Patricia had an opposing view point when talking about her patients, "you really can't imagine what they're going through, and they have a different way of looking at things. You just try to be what you need to, what you can be for them". She emphasized the fact that unless you have actually been in the same situation as your patient, it is her belief

that you cannot fully understand the circumstances and the present situation of another individual.

Patience was the last quality that was identified as contributing to a therapeutic relationship between patient/family and nurse. Sally was very passionate about the quality of patience and felt that nurses must have patience first in order to be attentive listeners and empathetic care providers. In her interview she emphasized the importance of hospice/palliative care nurses being patient when answering questions from the patient/family members. Due to the circumstances of her patients, she described them as “needing repetition because they’re on overload”. It was her experience that this particular group of patients was overwhelmed with facts, life altering decisions and emotional exhaustion therefore leaving them victim to the business of the nursing world and the professionals that work in this environment. Throughout her interview, she continued to state, “more nurses needed to have patience and understanding” as currently it has been her experience that they do not.

In summary, the qualities of attentive listening, empathy and patience were all identified as being fundamental for therapeutic relationships between the hospice/palliative care nurse, patients and their family members.

Strategies Hospice/Palliative Care Nurses Engage in when Bettering Themselves

Most of the participants agreed that when you are aware of your spiritual dimension, there are three strategies that nurses can engage in, in order to better themselves personally and professionally. These strategies include: 1) humor, 2) learning about others, and 3) self care.

Throughout the interviews, the researcher noticed that all six nurses used laughter and jokes to describe their work in hospice/palliative care. It was apparent that the participants used humor as a tool to connect with their patients and colleagues when dealing with end of life issues and stressful times. It was the researcher's observation that within the world view of hospice/palliative care nurses, there was a realness and acceptance of dying. According to Sally "we used black humor...I mean I have been over a dead person and when I worked in Michigan we'd sometimes we'd be laughing but it wasn't laughing at the situation I think it was just in general". During her interview Sally continued to describe humor as, "you need to have that and I think that can help you in some ways because you need to have laughter in your life. You can't be doom and gloom as palliative care nurse... you know you have to have some ray of sunshine in all of this".

To Karen, "humor is a big thing...we do really goofy things...sometimes we dance around in their (patient's) rooms and stuff and they appreciate it... you know it lifts their spirits". Similar to Sally and Kate, Karen agreed that humor is essential to have within your palliative care team, but also concluded that humor is important to express when caring for terminally ill patients. Karen continued to share in her interview that humility is also important to have within her work and through humility one can also find humor. During her interview, she described to the researcher how she and her colleagues know how she deals with stress during work, "I go have little cries". These "little cries" allow her to deal with her stress, but this has also become her trademark among her colleagues. She later goes on to describe that she and her colleagues have laughed about her crying in certain circumstances and she believes that her crying has been used as a

comical release, a coping strategy, among her colleagues. In no way is she ashamed of this, but is rather proud that she has the ability to laugh at herself and help facilitate coping among her colleagues. In summation to her discussion about humor she stated, "well laughter is the best medicine and I believe it".

The concept of learning about others was the second strategy that the participants identified in their interviews as being of great importance. By being open and learning about others, participants agreed that this allowed them to grow spiritually and professionally. As emphasized by Izzy, she believed it was important for hospice/palliative care nurses to know their patients,

listening to them and just talking to them and asking them what's important to them and there's things, rituals at the end of life for some, that are really important to them... we have to learn about that. We need to try and learn more from them (patients) and if, if their religious beliefs if there's anything at the end of life that is very important to them we want to help facilitate that.

Similar to Izzy, Karen expressed the same viewpoint as she felt it was important for her to continue going to church as she "wants to learn more about the Bible and Jesus and his teachings". Because of her husband's belief in Jesus and the Bible, this has brought her closer to understanding her own spirituality and has provided her confidence in identifying herself as having a Christian background. In her interview she states, "if I know more, then I may be more helpful to my Christian patients or even patients of other religions...if I have a better glance at my own spirituality and am more comfortable with myself...then it will definitely impact my patient care." By learning more about her husband's Christian beliefs it is her understanding that she might be more instrumental to

others. In her interview she did not identify herself as having Christian beliefs, as she expressed that she was still learning and uncertain of her own spiritual dimension.

Both Kate and Janie agreed that hospice/palliative care nurses need to open themselves up to learning about others' ideas about spirituality. By being open and non judgmental it was Kate's belief that hospice/palliative care nurses are more cognizant of others beliefs, therefore being mindful not to "push your own beliefs on others". The concept of learning about others was succinctly summarized by Janie when she stated, "I think that's what life is all about. It is just always learning about others".

When examining the ability to care for self, Sally, Izzy and Kate all agreed that this was of the utmost importance to the preservation of hospice/palliative care nurses' personal and professional self. Out of these three participants Sally was the most passionate as she expressed, "we have to take care of ourselves...I think the best thing we learn to do is give ourselves permission to do our work but, don't take it home for one thing, that's important". In her interview Sally proceeded to make a profound statement by stating "if you don't take care of yourself in a reasonable way, it's pretty hard to take care of others". Like Sally, Izzy agreed that balance and boundaries between work life and home were essential for her personal and professional well-being. Izzy expressed that spirituality helped her maintain and achieve "balance between work and my family" and similarly Sally shared, "I have learned to create a boundary, I think it's very healthy for my life and for my patients and I think that also is a part of my spirituality to learn how to do that". In her interview Sally shared that creating boundaries was a learned strategy that occurred after experiencing emotional exhaustion and burnout in her previous job. To add to the concept of self care, Patricia and Kate shared a similar view

when they described anger among their nursing colleagues as a regular occurrence. It was their understanding that perhaps their colleagues were tired and needed a break from their current job and needed a break from work. In her interview Patricia also alluded to the idea that it was her experience that her colleagues had poor coping skills and simply did not “know how to handle their feelings”.

In summary, Sally stated it best by sharing, “give your best at your work and consider it your job and keep your personal life away and when you need help for your own self look out at how you can do it...give them (patients) yourself totally and professionally cause this is what palliative care and nursing is about”.

Theme 2: Reflective Self

Besides the professional self, the participants also described themselves as being reflective in nature. Their reflective self was expressed through different concepts, but the most common of these were, being a good/spiritual person, being mortal, and their perception of terminal illness.

Both CH and VA participants reflected, in their interviews, their ability to be and the importance of being a good spiritual person. By being an evolved spiritual palliative care nurse, Kate believed that hospice/palliative care nurses should be asking themselves the question, “what happened today, what did I do today? Did I interact with anyone in a meaningful way or did I just spend the whole time running around and doing stuff that’s really not important in the grand scheme of things?” By asking herself this question, Kate believes she is challenging herself to be the best hospice/palliative care nurse she can be. These questions assist her in her reflection by ensuring that she has not lost sight

of her meaning and purpose. These statements allow her to be cognizant of her own actions and to be constantly reevaluating herself in her professional and personal life.

In order to be a spiritual individual, Sally shared “you can reflect on how you’ve lived your life and reflect on who you are and be able to accept yourself for who you are”. In addition to Sally’s statement, Patricia added “just realizing that you’re part of something greater than just the physical make-up...it’s really who you are, your essence”. In her interview Patricia (CH) continued to define spiritual individuals as having “the power of goodness and kindness...it is very real...we all take it for granted”.

For some participants, coming to grips with their own mortality contributed immensely to their spiritual person. Throughout her interview, Izzy frequently reflected on her own mortality. She described how she recently took a workshop that opened her eyes to her own existence, as she explained that the facilitator asked her and her colleagues, “what would you do, personally if you were given ...let’s say a month to live?” Izzy then proceeded to share with the researcher, “I have to admit I went back and kind of relooked at my will and I wrote my own obituary ‘cause I want it to be nice”. Throughout her interview Izzy continued to reflect on the importance of how she wished to be remembered once she died and how this was so very important to her and her patients. Coincidentally, Sally attended the same workshop and shared her thoughts and feelings about this experience. Like Izzy, Sally too reflected about her own existence but it was shared in a different way. Sally was very open and honest by stating “it’s just the one’s that we’re working with now are just going ahead of us...it’s not to mean that we are exempt from this, she (the facilitator) just really made us think about our own mortality”. In Sally’s dialogue there was bluntness to her conversation, as she believes

everyone is going to die, but rather we all have a time to go. For Sally her reflection with her own mortality was when she would die rather than how she would be remembered.

Throughout the interviews, several of the participants reflected on their own ideas about diagnosis and terminal illness. Five out of six participants had all experienced their own personal life trauma with either their own life threatening diagnosis or a terminal diagnosis of a close friend or family member. As shared by Janie, she had experienced her own personal diagnosis of cancer. From her diagnosis she spoke about her realization of equality, knowing that she was no different in her ability to be diagnosed with cancer than that of her patients, "I'm no different than anybody else...cancer diagnosis, you know for a brief second, you ask why me but then I quickly turned it around to say why not? I guess if you know how quickly, how your life can change and how you might be on the receiving end one day....and how you want to be treated so that makes me make sure that I give all that I can and be the strongest advocate because I would want that and I did want that for myself"

In contrast, Sally saw terminal illness as a gift, "not that being sick may not be a gift in some way because spirituality and relationships can be rekindled ... it's a gift if you can put your life together and feel like you've resolved issues". She continued to describe her experience of working with those who were terminally ill and she focused on the "wellness of life as a gift and enjoying that to the fullest and your experiences and your time here on earth....I'm the kind of person that lives for today through the work I do".

In summary, as identified by the participants, being a good spiritual person, reflecting on your own mortality and your perceptions of terminal illness were all important concepts that contributed to their self reflection.

Others

As interpreted by Matthews (2002), Merleau-Ponty believed that individuals are influenced by their experiences and environment, whereby it is from these experiences and the world around us in which individuals develop their own perceptions, values and beliefs. In addition to experiences and environment, people are also considered to influence individuals' ideas and interpretations, "we communicate with other subjects through language and ...share cultural intuitions with them...therefore our individual experience is thus lived out against the background of a certain social reality" (Matthews, p.9).

When exploring the ground of others the themes of the nurse's relationship with God and the nurse's role when assisting the patient/family on their life journey, emerged from the interviews.

Theme 3: The Nurse's Relationship with God

All six participants reported having a close and intimate relationship with a higher being, which they named God. In her conversation Patricia described God as "goodness and light" while Karen described God as a "source of strength and guidance". Janie echoed this same belief as she too agreed that God represented strength, "God helped me to get to where I am right now with my cancer diagnosis". She also saw God as a form of comfort and reassurance, "just knowing that he's there" she also found that when she needed "rejuvenation" she could call on God to help her achieve this. As described by

Kate, God provided her with meaning and purpose, "it gives me, a reason to be I suppose...my goals and my aspirations are related to what I think either the hopes and the aspirations that higher power, that God has for me, so all of that tied up in one thing, what God has in mind for me". Kate described her connection to God as that of a "spiritual relationship rather than of an intellectual knowing". From this relationship Kate described herself as having purpose and mentorship as to the type of person she would like to personify, "all of my values and stuff comes from the God in me, the Jesus in me... some of these things I can do well because of God in me... and so I trust that all comes across, that some of the differences I make is because of my relationship with God and not just because I think I'm a good palliative care nurse". Throughout her interview, Kate describes God as being part of her, "we all have a God shaped hole in our lives and the only way that it can be filled is with God....we're never really satisfied until we make that relationship with God". It is Kate's belief that God exists within herself, is demonstrated through her actions with others, and has helped her to be the caring person she is today.

Not only did the participants express being connected to God, but also shared that they conversed with God. Prayer was the most common tool used when talking to God and Karen believed she could talk to God at any time as "he is my inner voice". In great detail Izzy described the conversation with God that she has before every nursing visit and that she and her colleague would "stop the car in the driveway for a second or so and kind of collected ourselves and say dear God please just help us to say the right things...help guide us in what we say and what we do as we're about to go in to meet a new patient and family". Similar to Izzy, Janie described her praying to God, but from

have their own caregiver journey that they must travel. Therefore it is Kate's experience there are two journeys that exist, that of the patient and that of the spouse.

The patient's journey was also described by Kate as being an opportunity for growth for hospice/palliative care nurses. She continued to describe how she learns from her patients as she "accompanies them on their journey". As she learns and grows from her patient, she sees herself as a palliative care nurse who "walks with" her patients "as they work out their purpose, their meaning and their life threatening illness". In this quotation, Kate interprets the patient journey as a trajectory of life. Later on in the same interview, Kate also refers to the concept of dying as being part of that same journey, "dying is a journey right?" She was passionate in sharing with the researcher that "it's something we haven't done before...none of us has ever died before so I mean we don't know quite what that looks like". She later went on to share her thoughts that "even if you have had someone close to you die, this is still a different journey 'cause it's a different person dying and you have a different relationship with that person".

In summary, Kate purposely chose this statement as it was her experience that hospice/palliative care nurses were very routine in their conversations about death and dying with patients and their family members. As a hospice/palliative care nurse, she believed it was important for other hospice/palliative care nurses to understand and honor their patients' differences. By doing so, hospice/palliative care nurses would therefore respect the journeys of both their patients and their caregivers.

Time

Thomas and Pollio (2002) define time as a human experience. Viewed, through the lens of Merleau-Ponty "time is our direct experience, is not a system of objective

positions through which we pass but a mobile setting that moves toward and away from us” (p.160). Thomas and Pollio describe the difference between past, present and future by stating “the present is the point on which past, future and present turn; it is that moment in which we glimpse time past and time future as these emerge in time present” (p.160).

When listening to the participants' discussion about time, the researcher discovered that there were two common themes. These themes included, time in the profession of hospice/palliative care nursing and present time.

Theme 5: The Impact of Time on the Hospice/Palliative Care Nurse Role

The importance of time in the world of hospice/palliative care was a common theme that was expressed by both CH and VA participants. Sally shared that it was important to have conversations about death and dying with her patients and their family members: “as a palliative nurse, you have to have confidence in the knowledge you have and then be able to know when the right time is to approach the patient and family with this conversation”. As discussed in Sally's quote, timing of conversations with patients and families were of the utmost importance as she viewed hospice/palliative care nurses as key stakeholders in helping facilitate these conversations and assessing the patient/family's willingness to share.

Lack of time was a significant barrier identified by Kate when providing quality care to her patients,

we don't have enough time as patient staff ratios are not what they really should be in order to treat the person as a whole...In the hospital, you have your shift, there's certain things you have to get done during your shift and you know at 3:00

it's time to go. I mean you can choose to stay over which you know some of us do from time to time but along their journey you just don't have the time to spend with them.

At times there were feelings of frustration and anger, as some participants expressed their inability to care for patients as time was a barrier for them. Prioritizing patient care was an important strategy for some participants when balancing their workload. Patricia believed that if she could spend more time with the patient and his/her family on admission day, this would free up her time later on during the patient's stay on the unit, "I think it's a really good use of time to spend the time on admission and have them familiar with everything you have to offer and finding out what they have to offer". By spending the time during a patient's admission, it was Patricia's belief that this was an investment, therefore facilitating answers to the patient's and family's questions and establishing a plan between the patient and the health care team. In the eyes of Patricia, time during admission day was seen as proactive and a time saver.

Theme 6: Present Time

When exploring the concept of time all nurses agreed that being aware of present time is of great importance. By living in the present, the participants explained that this allowed individuals to be reflective and in-tune with their current situations. As described by Janie, she believed that she experienced what her patients experienced, as she was also, "a human being who was part of what's going on during that time". By making this generalized statement, she believed that health care providers can experience similar circumstances to their patients when they are present and attentive. By living in the moment it was her belief that her patients and their family members respected her

more because they saw her as equal to them and they “felt safer because I’m not always the professional one”. By being herself and being present, Janie shared that her patients were more likely to trust her and feel comforted by her as they felt validated as individuals. This validation contributes to a more therapeutic relationship between nurse and patient.

Throughout many of the interviews the participants spoke about the concept of being present and sitting/spending time with their patients. There was a unanimous agreement among both CH and VA participants that the physical action of sitting down beside a patient allowed nurses to be present in their relationships with their patients, “it’s connection of trying to get to the part of what they want, getting them to give you the information they need and again I’m going to go back to that trusting relationship of trying to have them understand that we are there to help them” (Sally). Sally later goes on to describe “you know, sometimes it’s just being able to sit at the bedside and say, you know what she really wanted to talk to you today because there’s still some things that she needs to say”. By sitting at the patient’s bedside Sally facilitated a presence for her patient but coincidentally helped herself too. “I think we need to just take a deep breath and sit down and say after all what is all this about”. By taking the time to sit, stop and reflect, Sally evaluates her current situation and therefore gains clarity as to how to proceed.

Some of the participants described the concept of present time as being in someone’s physical space while others felt that present time was achieved through attentive listening skills. Regardless of how the participants interpreted present time, there was still a key word that was frequently used when describing this theme. They

used the word “moment” to describe the concept of present time. The word moment was used when referring to their existence, “living in the moment” or during their work, “that’s how I do it in the moment”. These statements are congruent to those of Merleau-Ponty when he described his phenomena of being in the world. It was his philosophy that present time allowed individuals to experience and be involved in the world in which they existed (Matthew, 2002).

In summary, when describing the grounds of body, others and time within the worldview of palliative care the most common themes that emerged from the data were: 1) professional self, 2) reflective self, 3) nurses relationship with God, 4) the patient/family journey, 5) time in the profession of hospice/palliative care, and 6) present time. In the following chapter, further discussion will take place describing these figural themes and how they relate to the current body of knowledge.

Chapter V

The purpose of this study was to describe the lived experience of spirituality among hospice/palliative care nurses who cared for terminally ill patients in a city in Southwestern Ontario. Six nurses, who had been working in the field of palliative care from one to seventeen years, were interviewed. Study transcripts were analyzed by the researcher following the method developed by Pollio, Henley and Thompson (as cited in Thomas & Pollio, 2002) in their guide to conducting an existential phenomenological study (Appendix L). The results of this study were described in the previous chapter in the words of the study participants. In this chapter, I will explore the findings in the context of the published literature and describe the implications for future researchers, focusing on nursing education, professional practice and public policy.

Discussion

The definition of spirituality was defined by the participants in this study as:

1) providing strength 2) being different from that of organized religion and 3) providing individuals with meaning and purpose in life. When discussing their life experience with spirituality, six global themes were identified:

- 1) Professional Self
- 2) Reflective Self
- 3) The Nurse's relationship with God
- 4) The Patient/Family Journey and the Nurse's Role
- 5) Time in the Profession of Hospice Palliative Care
- 6) Being Present

Some themes were found to be congruent with published research findings, while others were found to be new and not yet described. Due to the lack of research that has been conducted studying hospice/palliative care nurses, much of the current published research focuses on patient outcomes and their perspectives of spirituality. Very few studies have focused on hospice/palliative care nurses' perspectives of spirituality.

The Definition of Spirituality

The language of spirituality is diverse, therefore its interpretations make spirituality inherently difficult to comprehend and define. It is an abstract concept and can be multifaceted depending on one's beliefs and values. In this study hospice/palliative care nurses differed in their definitions, however the participants unanimously agreed that the themes of 1) strength, 2) organized religion is different from spirituality and 3) meaning and purpose in life, best supported its definition.

Strength

In keeping with the philosophy of Merleau Ponty, the participants' words and language are very important in the analysis and interpretation of interviews (Thomas & Pollio, 2002). When interviewing the participants, the word strength was identified as describing their ability to move forward with difficult or uncomfortable situations, either with patients or their own family members. Strength was defined from two opposing viewpoints. For some participants, strength was achieved through outside sources, such as religion and family members. Other participants described strength as being generated from within one's own self. Internal strength was identified by the participants as inner strength, otherwise known as one's will and determination to deal with everyday problems. Reflective work was associated with inner strength and participants believed

that individuals needed to look within themselves in order to channel this strength. Only a few of the participants in this study felt that strength was achieved through both self reflection and outside sources.

When examining the literature on spirituality there is little evidence to support the concept of strength contributing to the definition of spirituality. Only two studies were found to support the researchers' findings.

Spiritual Strength from Outside Sources

In Albaugh's (2003) research he had similar conclusions when he studied patients confronting a life threatening illness. His phenomenological study focused on the perspective of the patient and discovered that "strength from their spiritual beliefs" (Albaugh, p.596) was one of his five emergent themes. This strength was achieved through outside sources such as "prayer, scripture readings, songs and a belief in God" (Albaugh, p.596). It was through this faith in God that these participants gained the will and determination to sustain themselves through their diagnosis and treatment. There was no mention of participants having inner strength, or generating strength from within oneself.

Similar to Albaugh's work, Wittink, Joo, Lewis, & Barg, (2009) at when patients shared about their experiences of spiritual care, they agreed that their strength came from various groups of people, family, friends, social workers but also religious leaders. Even though these patients knew that nurses had a role to provide spiritual care, they felt that they could not fulfill this role due to their workloads; therefore they were not identified as an outside source.

Inner Spiritual Strength

In contrast to Albaugh's work, Langer (2004) developed a spirituality resiliency protocol from a gerontological perspective. This protocol looked at senior individuals, asking them to "identify spiritual resources within their life from which they gained strength" (Langer, p.615). From these resources social workers then studied the ability to cope with difficult situations in the senior participants and how they have changed as individuals throughout their lifetime. In her conceptual framework, Langer describes their "experiences as a source of strength...inner strength is a dynamic process that extends throughout their lifetimes and evolves from learning to live with loss and adversity...people grow from strength" (p.615). It is Langer's perception that strength can be, and is most often generated from within.

In summary, strength has been identified as a core component of spirituality. It has been identified as being obtained through outside sources and through internal self reflection. More research studies need to be conducted to truly understand the concept of strength from the perspective of the hospice/palliative care nurse, when and how they gather strength during their practice and why it is necessary for them to do so.

Spirituality is Different from Organized Religion

In this study, spirituality was identified by all of the participants as being different from that of organized religion. All participants agreed that spirituality exists within all of us but is separate from that of religion. Seeing that all of the participants in this study identified themselves as belonging to a religious denomination, a few participants believed that their religion had contributed to and encouraged them to be more spiritual whereas other participants believed that it was their deep seated belief in spirituality that

had contributed to their success in being a more compliant and faithful Christian or Catholic.

Despite the fact that all of the participants from this study agreed with this belief, more research is needed in order to generalize this statement in relation to the population of hospice/palliative care nurses and to understand specifically how their ideas of religion and spirituality differ. Several other researchers have discovered this same belief in their own research; however their focus remains that of the patient perspective (Pulchaski, & Ferrell, 2010, Taylor, 2002). As stated by Relf (1997) "although spirituality is believed to be associated with religion, the concept of spirituality is more than just religion" (p.2). Through future investigational studies, researchers can then ask participants to explain the differences between spirituality and religion, with a focus on the hospice/palliative care nurse perspective.

Meaning and Purpose in Life

Meaning and purpose was the last theme identified by the participants as contributing to the definition of spirituality. The participants described meaning and purpose and spirituality as having a reciprocal relationship. Participants agreed that individuals meaning and purpose in life could be achieved through adversity and difficult life experiences therefore contributing to their spiritual dimension. In opposition to this belief, some participants agreed that by being more present in their spiritual dimension, individuals could then reevaluate their life, therefore contributing to their self reflection, and meaning and purpose in life. Either way participants in this study felt that individuals' meaning, purpose and spirituality were closely connected and could positively influence each other.

Researchers such as Albaugh, (2003), Martsof and Mickey (1998), Relf (1997), and Ross (1997) similarly found meaning and purpose were identified by their participants as being a foundational concept supporting the definition of spirituality. In these studies, there was a lack of understanding and uncertainty as to how spirituality and meaning were connected. Frankl's theory (as cited in Thomas and Pollio, 2002) is based on the perception that if individuals have a firm belief in God, then they have a stronger sense of meaning and purpose. It is Frankl's conviction that "the spiritual person has a personal mission that is given to him by a personal being, which is the source of meaning for the individual" (Thomas & Pollio, p. 87). More in depth research needs to be conducted examining hospice/palliative care nurses perceptions of spirituality, to see if Frankl's theory is supported.

According to Puchalski and Farrell (2010), the inability to find meaning and purpose leads to depression and anxiety...and is also apparent during end of life, as people face their dying" (p.74). It is therefore imperative that hospice/palliative care nurses understand their own meaning and purpose in life in order to facilitate their own mental and emotional health, but to also help others discover their meaning and purpose.

In summary, out of the three identified themes that contributed to the definition of spirituality, meaning and purpose were valued the most by the participants. It was the participants' beliefs that meaning and purpose gave individuals a reason to live, to understand their strengths and weaknesses and to grow and learn more about their spiritual dimension. When looking at the literature as a whole, there are several differing viewpoints when defining spirituality, mostly from a patient perspective. More research needs to be done when examining hospice/palliative care nurses' perception of

spirituality. Only after hospice/palliative care nurses are asked to define spirituality in their own words, will educators, researchers and other nursing populations begin to understand and question their own spiritual beliefs. According to this study's participants, spirituality was whatever a person believed it to be and therefore they needed to be accepting of others' ideas. Malinski (2002) supports this belief from her study as she states from her findings, "it is still important to remember that the only one who can define spirituality is the one experiencing it" (p.284).

Body

Throughout the interviews all of the participants described themselves as having two selves. These selves were identified as the Professional Self and the Reflective Self. They were identified as being different from one another, but often these two selves came together when caring for their patients. Depending on the situation in which they found themselves, these participants shared in their interviews that one self would sometimes be more present with their patient than the other. Participants spoke of trying to balance both selves during their day but they appeared to be more comfortable and confident with their Professional Self.

Theme 1: Professional Self

The most commonly referred to self was that of the participant's Professional Self. This self was described as the professional nurse who had admirable qualities that made hospice/palliative care nurses outstanding in their field of practice. Some qualities that were reported during participants interviews include being respectful, honoring others' beliefs and remaining positive. The most frequently mentioned qualities included listening, being empathetic and being patient, which all contribute to nurses' therapeutic

relationships with their patients. Concepts such as humour, learning about others, and self care were identified as strategies that nurses could engage in when bettering their professional self.

Hospice Palliative Care Nurses and Therapeutic Relationships

In this study, the participants agreed that the concepts of 1) listening, 2) being empathetic and 3) having a patient demeanor all contributed to their success in being a professional hospice/palliative care nurse. Participants believed that these three qualities contributed to their success when connecting to their patients and families in difficult and uncomfortable end of life situations. Similar to this study, Johnston and Smith (2006) discovered that “nurses saw effective listening as a core element of the expert nurse role” (p.705) when caring for others. Through their analysis they found that nurses defined the expert nurse role as “getting to know their patients” (Johnston & Smith, p.705), through the method of listening. Like Johnston and Smith’s analysis, this study echoed the same findings.

Listening to Others

To the participants, listening was defined as a tool to assist hospice/palliative care nurses to better assess, understand and identify the emotions of their patients and their family members. These same participants unanimously agreed that in order to listen effectively, they needed to physically sit down close to their patients, taking time to focus on their patients’ needs. It was the hospice/palliative care nurses’ perception, that listening is done poorly in their profession as they are too busy caring and problem solving for their patients. They expressed that they do not take time to stop during their shift; therefore it is their belief that they do not fully understand their patients’

experiences. By sitting at their patient's bed side, the participants reported that this allowed them the opportunity to get to know their patients and family members and to create trusting relationships. It was their belief that spending time and listening to their patients in general saved them time during their shift, as all of their patients' needs were met and their questions answered.

The Empathetic Hospice/Palliative Care Nurse

By practicing empathy, the participants reported closer connections and empathetic relationships with their patients and their family members. According to some of the participants, patients and family members were more likely to share their inner most thoughts and feelings about their end of life experiences because they had developed trust with their hospice palliative care nurse. Both empathy and trust have been identified by the College of Nurses (CNO) as components of the nurse-client relationship. According to the CNO (2006), "there are five components to the nurse-client relationship: trust, respect, professional intimacy, empathy and power. Regardless of the context, length of interaction and whether a nurse is the primary or secondary care provider" (p.3), these components are also essential.

Mary Raudonis, a PhD student from the University of Austin (1991), conducted a nursing study looking at empathy from the perspective of the hospice palliative care patient. In her research, she established that there are four phases to an empathetic relationship between nurses and palliative patients. These phases include: initiating, building, sustaining and separation phases. In her work Raudonis states that none of these phases exist unless "there is a relationship present" (p.86) between both nurse and patient. She goes on to identify empathetic nurses as "competent professional caring

people...sharing their personhood and humanity” (Raudonis, p.86) with their patients. Sharing their personhood demonstrates a certain level of transparency and equality between both nurse and patient, therefore contributing to a trusting and therapeutic rapport.

Being Patient

There has been little research exploring the concept of patience in nursing and patient therapeutic relationships. In this study, patience within the hospice palliative care nurse was expressed as a key concept, contributing to the successfulness of the participants' ability to create relationships with their patients. It was the belief of the participants that patience facilitated attentive listening but also assisted with the coping of stressful situations for both patients and the participants. By having patience, one participant in particular believed that this contributed to her longevity in dealing with stressful and abusive banter from her patients. When she was in a peaceful and patient state, this allowed her to forgive patients and their family members from being verbally abusive towards her, but also allowed her to empathize with her patients' current situations. To several of the participants, patience was viewed as a very important quality for the success and demeanor of the hospice/palliative care nurse.

Strategies Hospice/Palliative Care Nurses Engage in when Bettering Themselves

In this study the participants identified 1) humor, 2) learning about others, and 3) self care as being spiritual in nature. It was the participants' beliefs that these three concepts contributed to their own sense of betterment and professional self.

The Humorous Hospice/Palliative Care Nurse

The concept of humour has been studied, primarily focused on patient and caregiver perspectives. For example, researchers such as Jarvis, Worth and Porter (2006) studied caregivers who were caring for individuals over the age of seventy-five. In their findings they determined that this particular group of caregivers was at very high risk for anger related to their current situation and tension with other family members. Humour was identified as a coping strategy to assist these caregivers with their current situations. From a sample of 172 caregivers, 136 of them identified the importance of “seeing the funny side of the situation” (Jarvis, Worth & Porter, p.1453) in times of managing difficult caring.

Kanninen (1998) performed a literature review examining the use of humour within palliative care and discovered that it was frequently used by terminally ill patients. For some patients, humour was used as a method of coping with adversity and challenging life events (Frank-Stromborg, 1986; Martin & Lefcourt, 1983). For others, humour was identified as an enabling factor, assisting palliative care patients to alter their stressful perceptions of life to those that are more manageable (Herth, 1990). Humour has also been identified in promoting relaxation and pain relief, as it has proven to have a physiological response to the body (Cousins, 1976, 1979, 1989; Seigel, 1986).

Kinsman-Dean and Major, (2008) studied humour from two different perspectives: 1) within the professional health care team and 2) in patient care. Within the health care team perspective, humour “contributed to a sense of community, helped energize the team and was a means of mutual support. Humour was a means of bringing people closer together, building trust, cementing relationships, strengthening them and

equipping them to withstand stressful situations” (Kinsman-Dean & Major, p.1090). In addition to their findings, Dean and Major also noted that dark humour was frequently used by their sample of critical care nurses. This form of humour is “common in areas where health-care providers are continually exposed to critical incidents and proximity to loss and grief” (Kinsman-Dean & Major, p.1090). The health care team’s engagement in humour positively affected their patient populations “by forging connections with them, establishing rapport and putting them at ease with their current medical status” (Kinsman-Dean & Major, p.1093). Esplanade (2006) claims that from a nursing perspective, if nurses were to use humour more frequently in their practice, they could develop new perspectives on stressful situations and perhaps prevent the occurrence of compassion fatigue.

Similar to Kinsman-Dean and Major’s (2008) findings, this study too identified dark humour within the nurses’ interviews. Several times throughout the interviews, participants, especially those that were from the community hospital setting, were very comfortable talking about death and dying as regular occurrences on their unit. They were respectful of their patients and their dying process, but one participant in particular spoke about how she drowns her stress and frustrations in her hot tub after work. This was her humorous way of dealing with stressful situations after her shift. Another participant jokingly referred to her constant release of tears and crying, as she felt this was her way of coping with frustration and dying. The last participant made light of how she talks to her newly deceased patients as she is preparing their body; she talks to the patient’s spirit. After sharing this finding with the researcher, in a joking manner she

then asked the researcher not to commit her as many individuals would find this ludicrous.

Humour was reported from both the VA participants and those of the CH setting. As part of their daily dealings with stressful situations and enhancing comradeship, humour was often used and experienced within the two groups of hospice/palliative care nurses. Dark humour, within one's self, was frequently mentioned within the CH group whereas the VA group was more focused on coming together and laughing as an inter-professional team. There is uncertainty as to why humour within both groups differed. Factors such as environment, staff roles (staff nurse vs. nurse educator), collegiality and inter-professional relationships could all influence the results of these findings. More research is needed to explain these findings and to fully understand the quality of humour and its role in nursing.

Learning about Others

The participants in this study agreed that learning about others was a method of personal and professional growth. By gaining education through their patients, the participants from this study reported feeling more comfortable and confident caring for others. By learning about their cultures, ethnicities, beliefs, and values, participants reported a greater sense of accomplishment in providing their patients with the best care possible. Learning about their patients, allowed these participants an opportunity to help fulfill their patients' end of life wishes, as now they knew exactly what their patients wanted in their final days of life. It was reported by the participants that this education would assist them in providing future care to individuals of the same ethnicities and backgrounds. Learning from their patients was viewed as an investment, as many times

the participants reported feeling more like students, as they learned from the teachers, their patients and family members.

Taking Care of Self

Self care was the last concept reported by the participants with regards to bettering their professional selves. Both the VA and CH participants unanimously agreed that boundaries between them and their patients were essential in maintaining their own mental health and well-being. It was reported by all of the participants that this is a learned skill that is developed over time, where some colleagues are very good at creating the boundary and others are not. It was the participants' belief that boundaries assist in the prevention of burnout and the attainment of job satisfaction. In their interviews, the participants stressed the importance of leaving their work related problems at work. The participants believed that these problems, should they choose to bring them home, could negatively impact their own personal family members and in turn affect the health and wellbeing of their family.

There has been much work conducted, looking at boundaries within the nurse-patient therapeutic relationship. For example, the College of Nurses of Ontario (CNO) (2006) created a Standard of Practice entitled Therapeutic Nurse-Client Relationship. In this standard, CNO states that a boundary "is the point at which the relationship changes from professional and therapeutic to unprofessional and personal" (p.4). Maintaining and sustaining practice settings that facilitate boundaries can assist frontline staff by "relieving stress, supporting them when requesting a change of assignment due to stress and supporting them in developing therapeutic relationships" (CNO, p.13).

Other self care strategies to help support hospice/palliative care nurses in the creation and maintenance of boundaries include having an existence outside of work and having personal relationships with others that meet their own personal needs. It is thought that if personal relationships cease to exist for the hospice/palliative care nurse, then it is sometimes replaced through the professional relationship between nurse and patient (Peternelj-Taylor & Young, 2003). It is at this point where the boundary between nurse and patient relationship has been crossed.

In addition to the creation of boundaries, two participants discussed the anger and frustration projected from their colleagues when under extreme stress. The anger which the participants spoke of was not directed at the patients, but more so towards their colleagues and was experienced by the palliative care team. Both participants continued to share how they did not enjoy working with these colleagues as their negative attitudes affected their work, polluted their work environment, and negatively affected the patients for whom they cared.

Nursing anger is usually associated in the published literature with emotional exhaustion and burnout. Thomas (2009) described anger and burnout as being linked together, "however it is uncertain if anger leads to burnout or is a by-product of it" (p.26). Hillhouse and Alder (1997) conducted a study and found that those nurses who scored high levels of burnout reported having the greatest amount of conflict with both their supervisors and colleagues. There have been studies done examining the relationship between anger and depression (Bromberger & Matthews, 1996). There is a belief that when individuals hold onto their anger and don't express how they feel, this allows for interpersonal conflict and rumination on unmet issues. Bromberger and Matthews

studied 460 women who were more introspective and passive for three years. During this study these women did not share with others how they felt, but rather ruminated about their unjust situations. As a result of their current situation, these women were found to be more prone to depression. It is thought that this rumination is more likely to be experienced by women after negative events, whereas men are more physical in nature, therefore distracting them from their current situation (Nolen-Hoeksema, 1987).

In summary, none of the participants in this study reported themselves as being angry, nor did they report their angry colleagues as ruminating about unjust situations. It is important for hospice/palliative care nurses to be cognizant of this newest finding, as most of the nursing work force is comprised of women who might not fully disclose their emotions. By being aware and open about their emotions, hospice/palliative care nurses can then start to become more reflective in their own self assessment, identifying their own feelings and therefore work towards sharing these feelings with their colleagues. Sharing their emotions with other team members begins to create trusting working relationships and collaboration with the team.

Theme 2: Reflective Self

As described earlier, the concept of body was identified by the participants as representing both a Professional and a Reflective Self. By being reflective, participants expressed that this helped them to evaluate and dig for a richer and more meaningful description of their lives. As participants reflected on their current life situations, there were three concepts that were identified as contributing to their spirituality: 1) being a good/spiritual person, 2) being mortal, and 3) their perception of terminal illness.

Being a Good Spiritual Person

All six participants agreed that being a good spiritual person was of great importance in their work and in their everyday life and living. When the participants reflected on their beliefs and values about spirituality, they often associated it with the concept of goodness and positivity. By being a good and positive person, participants thought that this impacted their current state of mind and would also affect others. By being a good and positive person, it was the participants' beliefs that this contributed to their happiness, their love of helping others and their ability to be open and honest with patients, family members and their own family and friends. In conclusion, by living a life of goodness and spirituality, it was thought that this allowed these participants to experience a happier life, facilitate better coping of stressful and uncomfortable situations and assist them with prioritizing stressful life events.

The Mortal Hospice/Palliative Care Nurse

When examining the concept of mortality, it was the researcher's observation that the participants, who were more seasoned, were more likely to share feelings about their own mortality. They discussed with the researcher their uneasiness when caring for terminally ill patients who were of similar age. Participants' reflection on mortality took place during all stages of their patients' terminal illness, starting with their diagnosis and ending with their death. Knowing that they were well; it was difficult for the participants to witness other individuals of the same age suffering, watching their patients fade as they progressed through the death and dying process. Several of the participants reflected on how these patients could be them in the next few years and how some of the participants have already begun writing their obituaries and planning their funerals. This writing and

planning is an indication of their reality with death and dying, as they know that one day this too could be them lying in the very same bed. Participants reported a sense of equality between their patients and themselves, as dying is part of the circle of life. They agreed that society creates an altered sense of comfort and hope, as the societal belief emphasizes that the natural progression towards death and dying should be associated with old age. In this study, the participants agreed that this is a myth, as it has been their experience that they have been caring for younger and sicker patients. It is their belief that due to the increase in technology and early diagnosis, individuals are therefore undergoing treatment at a younger age.

For the participants who struggled with this mortality dilemma, they still reported how thankful and appreciative they were for their own health and happiness. During their interviews the participants emphasized the importance of enjoying life, family and friends. They continued to express their thankfulness for being able to help others in their work but to also reflect on the importance of not taking their life and others for granted. They described life as a process by which opportunities and participation is sought by individuals. They believe that individuals choose their own destinies, as only they are responsible for the outcome of their own existence.

Terminal Illness and Hospice/Palliative Care Nurses' Perceptions

In their interviews, participants reflected on their patients' experiences with terminal illness and agreed that this impacted their views and beliefs on spirituality. In addition to their patients' experiences, the participants also agreed that their own personal experiences with life threatening illness or that of their families also contributed to their perceptions. According to the participants, terminal illness was viewed as an opportunity

for participating in self reflection and self assessment. Terminal illness gave the participants permission to evaluate their lives and their meaning and purpose. Knowing that time is usually limited with terminal illness allowed participants to accept and engage in life sooner, therefore enjoying life in the present moment.

For some of the participants, terminal illness was viewed as a gift, as it allowed participants and their patients to rekindle relationships and come to peace with difficult and uncomfortable life situations. Terminal illness allowed patients to change their negative ways, facilitated thankfulness and appreciation for their life, but most importantly allowed individuals to be apologetic and forgiving for things that took place in the past.

In summary, the researcher could not find literature to support the themes of being a good/spiritual person, reflecting on one's mortality or differences in others' perceptions about terminal illness. More research is needed to fully understand and support these concepts, especially from that of the hospice/palliative care nurses' perspective. What is known in the research is that the concept of self reflection is used often in repairing the lives of those who have been recovering from abuse. Through self reflection, according to Baumann (2007), self reflection allows individuals to be "nonjudgmental, facilitating a letting go of anger towards others, including the abuser and self...and seeks balance and wholeness for the victim" (p.346). Self reflection has been identified as a fundamental component of healing as it helps facilitate acceptance of difficult and traumatic life experiences and discovers self transcendence (Baumann).

Others

Theme 3: The Nurse's Relationship with God

All participants agreed during their interviews that having a belief and a relationship with a higher being, or purpose greater than the self was something of great importance. All six participants unanimously used the word God to describe this higher power. Knowing that all six participants identified themselves as belonging to an organized religion, it is uncertain whether this impacted their choice of referencing God or whether their organized religion had no impact at all. What was evident in this study is that all of the participants felt it was important for them to have a relationship with or be connected to God. This connection took place in several different ways. The most common way took place in the form of a conversation. This conversation took place in quiet, private settings, such as participants' cars or in a quiet room during break time. Most times the conversations with God took place with just the participant and God; for others, it took place among colleagues. Some participants spoke out loud to God while others prayed quietly, and one nurse believed that God was an inner voice that spoke to her, giving her guidance and direction during stressful and challenging days at work.

All participants agreed that God existed outside of their nursing work life, but stressed how important this relationship was to them especially during difficult times at work. Besides guidance and support, God also provided the participants with resiliency, peace, and calmness in their day. In this study, God was expressed as friend, but also as a mentor. One of the participants described her very strong opinion that God was within her and was demonstrated through her actions with others. It was because of this internalized God that she is the person she is today. The concept of an internalized God

was frequently mentioned by the participants as many of them described their belief that God was always with them and could be called upon whenever he/she was needed. They believed that God was nestled deep within them, but was always present and available.

Very little research has ever examined relationships with God from the perspective of the hospice/palliative care nurse; most of the existing research has focused on patients' perspectives. Koeing, Bearon, Hover and Travis (1991) were some of the first researchers to examine the potential relationship that existed between nurses and God. They discovered that 100% of the nurses in their study believed in a higher power, however these results were classified as religious characteristics as all of the nurses in this study belonged to a variety of different religious denominations. In the discussion of this study, Koeing, Bearon, Hover and Travis defined the participants' spiritual needs and beliefs according to their religious denomination, ignoring the possibility that participants could have varying beliefs about spirituality and God, despite the religion to which they belonged. Ross (1997), pointed out the belief that with respect to rituals and customs, some people can experience this relationship with God through their religion, however "it should not be assumed that the practice of religion by an individual indicates the existence of this relationship" (p.38).

It has not been until recently that new studies such as that of Weis, Schank and Matheus (2006) studied empowerment from the perspective of parish nurses and discovered that "the presence of a higher power was identified by many parish nurses as a source of empowerment" (p.20). Through qualitative interviews, participants in this study reported feeling relieved that God was there to help them and give them guidance when they did not know how to respond to their patients. Similar to this study's findings,

Weis et al., discovered that their sample of parish nurses reported feeling comforted by the knowledge that God was always present and available to help them in their time of need.

Walker (2008) studied a total of 48 nurses, in various nursing specialties such as medical/surgical, ICU and postoperative nursing, and discovered that they too connected with God, which brought them “personal comfort and strength in their faith with God to be a conduit for others” (p.275). Through a method called Heart Touch Technique, nurses were given education and role play sessions on how to manage thoughts and feelings tied to stress and alternate responses to frustration and anger. After a month of practicing this technique, these same nurses began to use this strategy in their everyday practice and reported that connecting with God became easier to do and they reported feeling closer to God.

In order to fully understand the relationship between hospice/palliative care nurses and a higher being, more research is needed. This study demonstrates that a relationship between God and hospice/palliative care nurses does exist; however there is still uncertainty on to the details of the relationship and how it directly impacts these nurses personally and professionally. The next step for researchers would be to uncover the relationship from a qualitative perspective, examining the deeper meaning of the hospice/palliative care nurse and God relationship. Uncovering this relationship might allow other nurses to be more open and honest with their own beliefs about God and perhaps encourage them to be more self-reflective.

Theme 4: The Patient/Family Journey and the Nurse's Role

In this study, the participants believed that they had a greater purpose than just assisting their patients with the process of death and dying. While fulfilling their role as hospice/palliative care nurses, they agreed that they also viewed themselves as something more. They described themselves as fellow journeymen, assisting both their patients and family members with the end of life. In their interviews, the participants described themselves as companions, walking beside their patients, assisting them in their end of life journey. They saw themselves as healers and confidants, supporting, facilitating and evaluating the needs of their patients and family members. Throughout the interviews the participants reported feeling honored and privileged to be part of their patients' journeying. This was considered to be a sacred and precious time for all individuals involved. Most of the participants described the end of life process as being loving and joyful as family members came together to celebrate the life of their loved one. Participants agreed that this experience was humbling and informative, as many times they found themselves being the student, not sure of what to say. They concluded that in their uncertainty, silence facilitated wisdom and self reflection.

During their interviews, the participants also stressed that it was their role to only accompany their patients on their journey. It was their senses that as hospice/palliative care nurses, they only supported and befriended their patients, whose journey symbolized the work they still needed to complete before they died. By intervening in patients' journeys, participants thought that this might impede their patients from valuable life lessons; therefore it is their work and only their work to complete.

The Nurse's Journey

It was the researcher's observation that the participants were very comfortable and confident in discussing their role in assisting their patients in their journey, however only one participant (Janie) identified herself as owning her own journey. During the interviews, participants described the journey as belonging to that of their patients, but most often referred to it during their patient's dying process. The journey was not interpreted by the participants as belonging to their patient's life existence; rather it was associated with their patient's terminal diagnosis and their progression towards death and dying.

For Janie, she identified herself as having a journey, but she too had recently been diagnosed with her own terminal illness. The researcher observed that when Janie spoke about her journey, it encompassed her terminal illness and its treatment. Janie's journey was well identified, starting with her day of diagnosis three years ago, to her present state of remission. What was interesting is that her future journey was not of priority, as her current focus was being able to enjoy her children and to teach them what she has learned from her lifetime. In her conversation, Janie had expressed a sense of quickening of her journey, as her terminal diagnosis could be triggered again at any time, therefore putting her closer to death and dying like her patients. It was interesting to see that like the patients they cared for, only one participant identified herself as owning her own journey, but it to was associated with terminal illness.

In the literature, researchers often talk about the importance of nurses supporting their patients' journeys (Kelly 2004, Kociszewski, 2003; LeRoy, 2002; Watson, 2003); however the perspective of hospice/palliative care nurses and their beliefs about their

own journey is still unknown. Albaugh (2003) shares in his implications for future research that “nurses can facilitate and enhance patients’ spiritual journeys by supporting and accommodating them in meeting spiritual needs” (p.597), but does not give example of how this might be achieved. From his research, he supports the findings of this study by stating,

nurses have the privilege and honor of accompanying patients on their unique life journeys. If nurses open themselves to understanding the profundity of patients’ experiences with life-threatening illness, the nurse will learn life lessons of triumph despite tragedy, bravery in the face of fear, and laughter through tears (Albaugh, p.597).

Similar to Albaugh’s findings, Yedidia (2007) studied physician-patient relationships in the field of palliative care and concluded that physicians also “walk with” (p.50) their patients through difficult situations because they care. By walking beside their patients, it is believed that physicians create a sense of trust with their patients and demonstrate care and compassion.

Time

Theme 5: The Impact of Time of Time on the Hospice/Palliative Care Nurse Role

The concept of time in the profession of hospice/palliative care nursing was viewed from two varying perspectives. When exploring time from the perspective of the VA participants, time was seen as being a very strategic component of patients’ and family members’ well-being and coping with terminal illness. These participants agreed that facilitating time for their patients and family members contributed to trusting relationships between nurse, patient and family. These trusting relationships provided

patients and family members the ability to confide in the health care team when sharing their concerns and emotions about dying, asking questions about the dying process, and coming to terms with accepting their newest life journey. By giving patients and family members' time to share, participants believed that this restored their trust in the hospice/palliative care team. This trust was described as a driving force in the creation and rekindling of therapeutic relationships between patients, family and hospice/palliative care nurses.

The CH participants shared an opposing view point. In their perspective, time was viewed as a barrier to the care they wished to provide their patients. They strongly agreed that they did not have enough time in their day to complete their work. It was their experience that patients, family members, middle management and the senior leadership team did not fully understand their role as hospice/palliative care nurses, and the emotional, psychological support they provide both their patients and the family members. They continued to share that it was their belief that the field of hospice/palliative care nursing is misunderstood as it is rarely defined only by nursing tasks. They believed that hospice/palliative care nursing is more focused and specialized, as they took pride in their counseling skills and abilities, listening to and assessing their patients' needs, emotions, and fears. In their nursing work, they agreed that caring for individuals' emotional and psychological needs were of high priority. They prided themselves on seeing their patients from a holistic perspective, but shared that lack of time impeded them from being able to engage in holistic care. It is lack of time and their perceived viewpoint on management's misinterpretation of their work that has contributed to and accelerated their feelings of anger, stress, frustration and in turn job

dissatisfaction. They expressed how difficult it was for them to turn the world of hospice/palliative care nursing off, especially as they got closer to the end of their shift. If they were not able to comfort and spend time with their patients during their shift, they expressed feelings of abandonment and guilt.

The dimension of time was of the utmost importance to both VA and CH participants, however they had opposing perspectives. For the VA participants their perspective of time originated from more of a preventative viewpoint. They saw time as an investment with their patients, encouraging them to be open and honest with each other. VA participants' believed that being patient and prioritizing time was essential in the creation of solid and trusting relationships between patients, family members and the hospice/palliative care team. In contrast, CH participants saw time as a limitation, impeding them from providing the holistic care they wished to give their patients. There was frustration among these participants as they expressed their constant racing against the clock to get their work completed. Knowing that their work was heavily focused in counseling patients, CH participants reported increased frustration with their need to justify, to their managers, the time spent with their patients. There is little research to support either viewpoint; however researchers are recently starting to study the world of palliative care from the perspective of hospice/palliative care nurses. Dougherty, Pierce, Ma, Panzarella, Rodin,& Zimmermann, (2009) just completed a study examining time from the perspective of the hospice/palliative care nurse, and specifically having enough time to grieve the death of their patients. Unfortunately the participants of this study did not reference time from this viewpoint; however it is easy to see that the concept of time

is important in the world of palliative care as it affects patients, family members and health care professionals to varying degrees.

Theme 6: Present Time

The last theme that was identified by the participants was the concept of being present. Yedidia (2007) discovered through his qualitative research that physicians and nurses who provided end of life care valued the concept of being present when caring for others. In his study he discovered that participants reported a need to be present with their patients in order to understand their current situation, their emotions and “to persevere in satisfying the patient’s need for information” (Yedidia, p.50). Yedidia identified that when both the physician and nurse participants were present with their patients; their patients reported a higher degree of trust and confidence in the health care team, as they felt that their concerns and ideas were being acknowledged.

Like Yedidia’s (2007) findings, participants in this study identified the concept of being present from a similar perspective. Participants in this study identified the importance of being present from a physical and psychological dimension. There was agreement from the participants that physically sitting close to and within their patients’ space provided the participants with a better sense of their patients’ experiences. By being close, listening, sharing and holding their patients’ hands, participants reported feeling more knowledgeable about their patients’ situations and how to better help them. From a physical dimension, sitting at their patients’ bedside gave these participants the permission to stop and ground themselves, reflecting and enjoying the present moment with their patient. Being close to their patients was treasured and valued by the

participants, as it was their understanding that the present situation with their patient could never be replicated or replaced.

From a psychological perspective, being present created secure and confident relationships between the participants and their patients. As a result of these relationships, trust, wisdom and comfort were experienced by both parties. Like Yedidia's (2007) physician participants, these hospice/palliative care nurse participants reported mutuality and equality among their patients, as they discovered that their viewpoints and experiences were no different from those of their patients. Being present was described by the participants as a humbling and peaceful experience, as it helped them facilitate clarity, meaning and self reflection as their patients were actively dying. Being present allowed participants the opportunity to grieve and to shed tears, as they often reported feeling affected by their patients' deaths. For some, the tears represented a release of stress, whereas for others, the tears represented the release of their new friend, their patient. The concept of presence was of great importance for all who participated in this study and facilitated life lessons that might have otherwise not been experienced.

Limitations

The limitations of this study were primarily sample related, as the researcher only interviewed six participants until saturation was achieved. The researcher was confident with these six participants' interviews, as they helped elicit a thematic structure of hospice/palliative care nurses perceptions of spirituality when caring for terminally ill patients. Additional interviews are needed to explicate the concept of spirituality for a larger group of hospice/palliative care nurses who care for terminally ill patients. It is only through future studies and interviews that researchers will be able to identify

whether these perceptions about spirituality are represented within the general population of hospice/palliative care nursing. At present there is an inability to establish the frequency with which this phenomenon is distributed.

In addition to limited interviews, there was also limited diversity among the hospice/palliative care nurses who participated in this study. All participants were Caucasian, of Euro-Canadian descent, married, and all identified themselves as belonging to a Christian denomination. The researcher questions whether the lived experience of hospice/palliative care nurses' perceptions about spirituality would differ if they represented different ethnic backgrounds, had unique cultural values and beliefs, and/or did not associate themselves with a religious denomination. In this study the researcher is uncertain whether the participants' religious denominations and Euro-Canadian backgrounds contributed to their perceptions about spirituality. More interviews are needed in order to establish whether this is a possibility.

Another limitation is that this study did not include non-English speaking people and other nursing designations, such as Registered Practical Nurses and Personal Support Workers. Including these individuals in future studies would enhance the transferability of the study and further contribute to the field of hospice/palliative care nursing.

Implications for Nursing Research

This study is a springboard for future research as it begins to explore the concept of spirituality from the perspective of hospice/palliative care nurses. Interviewing hospice/palliative care nurses about their ideas, values and beliefs about spirituality provides researchers, educators and fellow nurses with the opportunity to examine their own spiritual dimension and how they engage in this in their every day practice. This is

important to establish since the profession of nursing has identified nurses as being capable of providing this support for their patients as a dimension of treating the holistic patient.

Education

As a result of this study, it is obvious that the hospice/palliative care nurses who participated in these interviews very much believed in the dimension of spirituality, linked to both themselves and their patients. In future studies it would be interesting to compare the perspectives of different groups of nurses, establishing whether there are common beliefs or factors that contribute to their perspectives. It is unclear whether hospice/palliative care nurses might be more comfortable with the concept of spirituality as they are constantly surrounded by death and dying in their practice. Conducting future research examining the perspectives of different nursing groups would help educators within both hospital and community settings to establish courses and workshops for those nurses who are more uncomfortable with and/or misguided concerning the concept of spirituality.

There is a belief that educational institutions that offer nursing courses and degrees to baccalaureate nurses are not well prepared when providing spiritual education (Hoffert, Henshaw & Mvududu, 2007). To improve nurse's education about spirituality, colleges and universities need to implement spirituality into their programs from the beginning. As an intervention, curricula, text books and projects all need to be evaluated for spiritual content and exercises such as personal reflection, debriefing and journaling should be taught and encouraged in nursing programs, enhancing students' conceptual understanding of spirituality. By asking nurses about their concepts, ideas and

perceptions of spirituality, educational institutions can utilize this information to begin creating future curricula, spending more of a focus on understanding individuals' spiritual domains. After asking practicing nurses about their perceptions of spirituality, this first hand information may assist educators in their approach to facilitating clinical rotations with patients who might be dying. Nursing placements such as palliative care units, hospice and home visits with dying patients should be rotated among students to ensure that everyone has an opportunity to apply and implement spiritual intervention skills. In the future, perhaps nursing students will be able to complete nursing placements at colleges of holistic health, and schools of complimentary therapies. This would be an innovative way for students to get first hand experience with several diverse spiritual modalities and as a result help them facilitate openness and acceptance by practicing being nonjudgmental. There is a belief that educators need to be knowledgeable about their own spirituality as this will assist with the promotion and integration of spirituality throughout the duration of the students' academic career (Swinton, 2006). Educators mentoring spiritual nursing care will positively impact nursing students and the individuals for whom they are caring. It is important to address spirituality in our teachings, both in the classroom and at the bedside.

Nurses develop basic skills for interacting with patients and families in their initial nursing education. Educators can provide baccalaureate nurses with insight, tools and effective communication skills in order to be successful when caring for palliative patients. Nursing students should be encouraged to practice their communication skills using simulation and standardized patients to prepare them for the emotions that may come from the real experience. As outlined by the participants, instructing nurses on how

to engage in attentive listening, being empathetic and being patient, contributes to the techniques of sensitive communication and therapeutic relationships. It is important for nurses to be educated about the spiritual dimension as this directly impacts nurses' abilities to create trusting and meaningful relationships with their patients and significantly contributes to the concept of holistic care.

Practice

The findings of this study showed that there were varying interpretations and perceptions when describing the concept of spirituality. For some participants, spirituality was exemplified through individuals' qualities and behaviours, for others, spirituality came from within oneself, through self exploration and personal reflection. It is important that nurses recognize that spirituality can be practiced in several different ways. Whether spirituality is demonstrated through individuals' religious beliefs and customs, or whether individuals choose to meditate on a long nature hike, all are examples of spirituality. It is important for nurses to acknowledge and accept patients' beliefs and values about spirituality. Nurses must remember that patients might be very sensitive at this time, especially if they have currently received a diagnosis of terminal illness; therefore it is important for nurses to help facilitate their patients' spirituality. By facilitating their patients' spirituality, hospice/palliative care nurses may provide and fortify their patients' resiliency, coping strategies and self reflection during a very difficult time.

As we move into the twenty-first century, nurses should be assisting patients in facilitating their own spiritual practices and beliefs. Knowing that more and more people engage in spiritual strategies and complimentary therapies, modalities that facilitate

spiritual healing, nurses need to be open to individuals' healing practices and include them in their plans of care. Advocating for their patients and inviting spiritual leaders, healers and other individuals who practice complimentary therapies to be part of the person's care helps facilitate healing for both the patient and family members. If nurses are knowledgeable and practice complimentary therapies, workplace policies are in place, and patients wish to receive treatments, nurses should offer treatments to their patients as this may nurture their spiritual domains.

In contrast to the nurse patient relationship, participants in this study described a different type of spiritual collegial relationship that existed with other members of the health care team. This relationship was described as being therapeutic, respectful, joyful and spiritual in nature. All participants shared how much they enjoyed working in these spiritual collaborative relationships, as there was only a handful of staff that really enjoyed participating in this type of teamwork. While experiencing these spiritual working relationships, the participants reported an increased sense of collegiality, comfort and connection with both their work colleagues and their patients and family members. Participants reported an increased sense of empathy, tenderness and caring during their shifts, but most of all described their work as taking more of a spiritual form. For future studies it would be interesting to further investigate these spiritual collegial relationships, to study the mind set of the nurses and health care staff who find themselves in this spiritual space and to study its effects on the nurses, the work environment and the individuals for whom they are caring.

As a result of this study, participants also advocated for the creation of spiritual healing teams whereby different interprofessional members assisted in the facilitation of

patients' and nurses' spiritual needs. Located in both hospital and community settings, it was the belief of the participants that as part of advancing the nursing practice, varying types of nurses should collaborate with other professionals when assessing and evaluating the spiritual needs of others. In their interviews the participants shared that nurses from different disciplines and varying degrees of experience would be valuable assets to this team and the people whom they serve. This team would engage in patient care in both the community and hospital setting, but would also support interprofessional staff, managers and the senior management team with spiritual education, ethical dilemmas and their own spiritual needs. By having the team created from an interdisciplinary perspective, it was thought by the participants that they would have different levels of expertise and viewpoints therefore contributing to thorough but sensitive solutions. This team would mentor a collaborative spirit and be accepting of all who wished to engage them.

The concept of self help and self healing are of high priority, as we have now become more accepting of them as a society. Recognizing that individuals participate in different modalities of spiritual and alternative methods of healing, the nursing profession needs to become aware of these different practices. In this study, participants' believed that nurses need to become more knowledgeable about and open to their patients' spiritual ideas as it is these beliefs that bring them comfort and peace during very chaotic life experiences. By engaging in these types of discussions with their patients, these participants believed this would help them to understand the spiritual domain of others and in turn help them to reflect on their own thoughts about spirituality.

Public Policy

Knowing that several patients and family members engage in complimentary therapies, supporting their spiritual beliefs and values, hospitals and community agencies should consider creating policies to support their use. Ensuring that policies are in place allows for consistent and holistic care of the patients and demonstrates the organization's openness to and acceptance of its community, wanting to help the individuals who belong to it. If hospitals and community organizations engaged in spiritual healing, research teams and individual fellowships could be created to study its effects on the patients, the interprofessional staff and the organization as a whole. It might be in the government's best interest to begin studying the effects of spirituality on patient outcomes and its effects on nursing. It is uncertain if spirituality as a whole positively affects nursing professionals; however, as a result of this study, these participants believed in, and valued the spiritual domain as it positively contributed to their professional and personal selves.

The CH participants of this study reported frustration when having to justify their work. They felt that their daily work was not adequately understood or planned for by their management team. Knowing that hospital organizations have to report cost per weighted case, representing rough estimations of patient care in the creation of their annual budget, the participants of this study agreed that hospice/palliative care should be viewed as a specialty. It was their perception that as a specialty branch of their community hospital, they should have a different annual budget that facilitated more one on one care, allowing them to participate in more counseling and psychological healing. These participants reported feelings of anger and frustration when having to justify their work to their managers as it was their belief that their work is not task focused. They

shared the opinion that if the field of hospice/palliative care was truly understood by government officials, different equations would be applied when creating annual budgets for an organization that provide palliation. It was the participants' belief that if the government were to do this there would be accurate numbers of staff reflecting the appropriate care required for patients and their family members, a balanced workload would be achieved on the units, and most importantly, a happier workplace would exist.

Recommendations for Future Research

In the completion of this study, the researcher discovered important factors that subsequent researchers should considered when further exploring the perceptions of spirituality in nurses and the settings in which they work.

Nurses

As identified in the limitation section, only female RNs participated in this study. Future studies need to consider focusing on male nurses and nurses from other designations, such as Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs). By studying other populations of nurses, researchers may discover similarities or differences in their perceptions of spirituality. There may also be variances in spiritual perceptions when studying participants who belong to different or unidentified theological backgrounds. For future consideration, researchers need to include the identified "angry nurses", to see if their bias, values and beliefs affect their perceptions of spirituality, their personal life and the patients for whom they care. Future research should also include studying nurses from different generational backgrounds, for example Baby Boomers versus the Y generation, to see how spirituality is perceived in these populations. Studies that discover variations in developmental stages should also be

studied. By uncovering and understanding contributing factors that facilitate and promote spiritual beliefs, this may help define developmental stages of novice spiritual believers, versus those individuals who have practiced and believed in spirituality for years.

This particular study has contributed to the suggestion of how nurses might link themselves to spirituality, but further research needs to be conducted in order to fully comprehend nurses' spiritual perceptions.

Health Care Settings

As governments begin to secularize hospital and community health care settings, due to budgetary issues, spiritual support workers, such as Nuns' and Sisters are reassigned to different work environments. Prior to secularization, more studies need to be conducted to examine its effects on the health care system, end of life care, and on the patients and health care providers that are in these environments. With the loss of Nun's and Sisters, we then need to ask the question, "Who supports individuals spiritual needs or provides spiritual teachings?" As suggested by the participants from this study, if Spiritual Healing Teams are the way of the future, should we not consider having Nuns and Sisters share their spiritual wisdom and teachings with the team before they are relocated? Nuns/Sisters and Pastoral services all need to be included in the team, acting as resources, to help support and guide other novice team members? Currently secularization already takes place between pastoral services and bedside nurses, as they see themselves as separate entities in health care profession, providing separate care to their patients and never having to rely or learn from each other. This present reality of healthcare does not support holistic care, nor does it support spiritual growth or learning.

Until further research takes place, identifying the role and expertise of Nun's and Sisters, will we even know if there has been an identified cost savings? To our dismay, secularization might have the opposing effect, where it may contribute to more accrued costs due to spiritual distress, emotional exhaustion and burnout among staff members. The concept of secularization needs further investigation and serious consideration, before it becomes the future of all health care environments.

Different working environments need to also be studied to assess for its ability to support spiritual growth and learning while nurses care for their patients. For example, knowing that there are distinct differences between the VA and that of the CH, employer need to be aware of how they can promote nurses to nurture their patients spiritual dimensions, reduce stress and burnout and promote their staff's spiritual needs. For example, knowing that spirituality is very much connected to Nature and natural environments, for future consideration, might employers, developers and government agencies begin to mandate the creation of atriums, gardens and walking paths within health care organizations. These green spaces would promote and facilitate the connection of spirituality for patients and staff members alike, creating a more inviting and welcoming health care environment for everyone to enjoy.

As the concept of spirituality is explored, there are several questions that remain unanswered. By continuing to conduct future research in spirituality, health care providers, governments, educators and researchers will be better prepared in caring for individuals, understand the spiritual dimension of human beings, and positively contribute to holistic health care, bettering the profession of nursing as a whole.

The Researcher's Spiritual Journey

It has been my pleasure and joy in completing this research study, as the concept of spirituality is very near and dear to my heart. Having experienced several of my own life traumas, I feel that it was these difficult times and challenges that have brought me closer to understanding my own spiritual domain. I feel that spirituality has given me resiliency and fortitude to accomplish goals I have set in my life but most of all has given me calmness, patience and grounding in times of great adversity. It has filled my heart with love and has fueled my fire for caring, making a difference in the lives of others. I believe it is through my ongoing self-reflection that my understanding and comfort with spirituality has become second nature and is very much the focus of my existence.

As I have come to do this research not only have I learned about myself and my own spiritual journey, but I have been blessed to learn about my other colleagues, who value and cherish spirituality as much as I do. I realize that they exude the same passion and excitement when discussing their spiritual ideas; they too find comfort, wisdom and confidence in their own spiritual beliefs. In their sharing, these participants valued, honored and respected their patients' viewpoints about spirituality and saw themselves as essential, key stakeholders when facilitating their patients' spiritual needs. They were open to listening and learning about their patients' spiritual viewpoints and saw themselves as equal to their patients, making them just as vulnerable to illness and death. As a group of professionals they exemplified and glorified nursing, as they all reported how much they loved the field of hospice/palliative care. To my surprise, these participants placed significant importance on the dimension of spirit and saw it as belonging to all individuals, but most importantly to themselves.

For me, these nurses instilled hope that spirituality still exists within nursing. I was pleased to learn that spirituality existed within the hearts of my colleagues as they saw themselves contributing to and facilitating others' peace, love and joy. It warmed my heart to know that they saw themselves as active members, engaging and fulfilling their own spiritual needs. One of my greatest lessons was to be reminded of how connected we are to each other, as nurses and as human beings. As I interviewed these participants, I felt connected to each and every one of them, as I could relate to and understand the depths of their beliefs. For the first time in my nursing profession I felt connected to nurses in a spiritual sense, as they trusted me with their ideas and they helped me to better understand myself and my purpose of being. I was empowered and enriched for having spent time with them but most of all; I felt love, joy and pride in belonging to the profession of nursing and sharing the same viewpoint as my colleagues. In my thirteen years of nursing I have never felt so proud of our profession and so honored to call myself a nurse. It was my joy to learn that the concept of spirituality is deeply seated within hospice/palliative care nurses, as my colleagues saw their spirituality as a gift that is meant to be shared. I too carry this gift, for it is my spirituality that has brought me to explore my colleagues' viewpoints.

In conclusion, by becoming more knowledgeable about the perceptions of spirituality among hospice/palliative care nurses, this study opens the door for educators, policy makers, researchers and fellow nursing colleagues in their understanding of spirituality. Asking hospice/palliative care nurses about their spiritual values and beliefs helps guide educators in their creation of spiritual nursing curricula, allows researchers to compare spiritual perceptions between different groups of nurses and facilitates

professional and personal growth of individual nurses in their care for others. By acknowledging nursing as a holistic discipline, the dimension of spirituality is of great importance, and therefore should be given more attention and focus. Describing and learning about nurses' spiritual ideas and beliefs provides nurses with the opportunity to reflect on becoming kinder, more empathetic, and more caring individuals, thus positively impacting both those they care for but especially themselves.

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Appendix A: The Spiritual Domain in Nursing Theory

The Spiritual Domain in Nursing Theory

Theorist	Theory	The Spiritual Domain
Faye Glenn Abdelah	Twenty-One Nursing Problems (1960)	<ul style="list-style-type: none"> ➤ From her 21 nursing problem list she assumes nursing will “facilitate progress toward achievement and personal spiritual goals” p. (215)
Myra Estrin Levine	The Conservation Model (1969)	<ul style="list-style-type: none"> ➤ Spirituality is an external conceptual factor of one’s environment ➤ She feels that this conceptual level is “characterized by cultural patterns and spiritual existence” (p.215)
Sister Calista Roy	The Adaptation Model (1970)	<ul style="list-style-type: none"> ➤ There are 4 modes identified as coping mechanisms. ➤ The self-concept-group identity mode identifies one “spiritual and psychic integrity” ➤ The mode focuses on one’s spiritual and psychological component of an individuals being ➤ Self has a “moral-ethical-spiritual” component ➤ (p.273)
Betty Neuman	The System Model (1970)	<ul style="list-style-type: none"> ➤ Spirituality is made reference to in her major assumptions of her theory ➤ There are interrelationships between client variables and they are physiological, psychological, sociocultural, developmental and spiritual in nature

		<ul style="list-style-type: none"> ➤ These variables determine the extent and reaction to stress and individual might experience ➤ The spiritual variable is "necessary for a holistic perspective and for caring concern for the client" (p.314)
Imogene King	Theory of Goal Attainment (1964)	<ul style="list-style-type: none"> ➤ Very little mentioned in her theory about the spiritual domain King feels that "individuals are spiritual beings" when describing the paradigm of person (p.342)
Joyce Travelbee	Human to Human Relationship Model (1966)	<ul style="list-style-type: none"> ➤ Makes reference to spirituality during her explanation of suffering ➤ Suffering is "displeasure which ranges from simple mental, physical or spiritual discomfort to extreme anguish" (p.420) ➤ Physical, spiritual and emotional status is identified through one's subjective experience of health however there is a role for "spiritual directors" to evaluate and perform assessments for objective health" (p.421) ➤ She believes all individuals will be confronted by illness and suffering therefore leading them to spiritual, mental and physical suffering ➤ Illness and suffering are described as "spiritual encounters" (p.422) ➤ She believes nurses' spiritual beliefs directly impact individuals and their families

<p>Martha Rogers</p>	<p>The Theory of Unitary Beings (1970)</p>	<ul style="list-style-type: none"> ➤ She views “physical, mental, emotional, spiritual, cultural and social assessment frameworks” as reduction categories of a person (p.233) ➤ By believing that humans and the environment are constructed of energy fields and communicate constantly with each other, this “manifests characteristics of the whole” (p.229) ➤ This theory is used to practice therapeutic touch, meditation, self reflection and guided imagery, all modalities of spirituality
<p>Rosemarie Parse</p>	<p>Human Becoming (1970)</p>	<ul style="list-style-type: none"> ➤ She is influenced by Martha Roger’s ideas and her theory on Unitarian Beings ➤ Like Rogers, Parse too believes in “energy fields, pandimensionality, patterns and openness...people are human beings who relate at multiple realms with the universe and who are irreducible, ever changing, and recognized by patterns” (p.528) ➤ Parse does not define or describe the concept of spirituality in her theory; however she does state that humans are “coexisting while co-constructing rhythmical patterns with the universe and that humans transcend multidimensionally (p. 534) ➤ She identifies and describes three common themes for human becoming, they are: 1) meaning, 2) rhythmicity

		<p>and 3) transcendence.</p> <ul style="list-style-type: none"> ➤ Transcendence is common in spiritual literature, however in her definition she does not refer to the spiritual dimension. She defines transcendence as “the possibilities arise with the human-universe process as options from which to choose personal ways of becoming” (p 534-535). ➤ Uncertain if these options are or could be spiritual in nature? ➤ Parse is vague in her description of transcendence and therefore leaves readers uncertain in their interpretations
<p>Madeline Leininger</p>	<p>The Theory of Cultural Care: Diversity and Universality Theory (1970)</p>	<ul style="list-style-type: none"> ➤ She does not describe or define spirituality specifically however she does identify “religious beliefs, social kinship, political and economic , educational, technological and cultural values as influencing and affecting human behaviour” (p.508) ➤ She does define the concept of caring as “being able to assist, support or enable experiences or behaviours toward or for others or groups with evident or anticipated needs either to ameliorate or improve a human condition, life-way or to face death” (p.508) ➤ It is uncertain whether she is referring to the concept of spirituality in her definition of caring

<p>Em Olivia Bevis</p>	<p>Curriculum Building Framework (1973)</p>	<ul style="list-style-type: none"> ➤ Bevis does not describe or define spirituality specifically however it is uncertain whether she is making reference to the concept of spirituality through her definition of caring. ➤ She describes caring as being self reflective a revelation of self an of a way of achieving self actualization, all concepts that exist within spirituality literature (Mc Mahon, 2009) ➤ More clarification is needed to understand where spirituality fits
<p>Jean Watson</p>	<p>The Theory of Caring (1979-2002)</p>	<ul style="list-style-type: none"> ➤ This theory best describes the spiritual dimension of individuals ➤ Spirituality has more relevance within one's one internal environment ➤ She believes that humankind connects with the universe and divine powers and this type of thinking allow individuals to "acknowledge spiritual dimensions of existence" (p.151) ➤ She believes that there is a path honoring mind, body and spirit and her theory is a reflection of the interpersonal-transpersonal-spiritual aspects of life ➤ The spirit is one's inner self and as individuals come to understand their spiritual domain this may allow them to find meaning and harmony in difficult times

***This table has been created using the reference Marriner-Tomey & Raile-Alligood, (2002)

***Olivia Bevis was referenced by Mc Mahon, (2009)

Appendix B: Recruitment Poster

Appendix C: Research Ethics Board Approval- University of Windsor

Appendix D: Research Ethics Board Approval- Hospital

Appendix E: Letter of Permission- Volunteer Agency

Appendix F: Consent to Participate in Research

1. What is your definition of "spirituality?"
 2. What are your experiences with spirituality in your daily work as a nurse who works in a setting with people who are terminally ill?
- The researcher will ask clarifying or probing questions for a more detailed description by using statements like; "could you tell me more about that" or "please describe what this means to you".

POTENTIAL RISKS AND DISCOMFORTS

The risks of participating in this study are minimal and there are no negative consequences expected. Nothing is being done to you physically and the interview is not expected to cause you any discomfort. However, even though it can be difficult recalling and sharing upsetting stories about clients, you have the ability to guide the interview, selecting what you wish to talk about. If you feel uncomfortable at any point during the interview please notify the interviewer.

Your confidentiality will be maintained and protected through the use of an alternate name in which you will choose to be identified as. No personal characteristics will be attached to your responses.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

You may not directly benefit from this research study however you will be contributing to the profession of nursing by providing knowledge that is not currently known.

PAYMENT FOR PARTICIPATION

As a thank you for your contribution to research, the researcher will provide you with a \$10.00 gift card for Tim Horton's restaurant.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. Prior to the interview, you will be asked to choose a name you would like to use for the duration of the interview. Your identity will be solely known by the researcher for the purpose of further contacts. Once the data is collected it will be kept in a locked filing cabinet and will only be available to the principle investigator. The interviews will be audio-taped and then transcribed word for word. Tapes are filed by number only and stored in a locked filing cabinet. Transcripts will be double checked and verified before being destroyed and all audiotapes will be destroyed immediately after your interview has been transcribed.

PARTICIPATION AND WITHDRAWAL

If you volunteer to participate in this study, you may withdraw at any time without consequences of any kind. At your discretion, you may refuse to answer any questions and still be acknowledged as a participant.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS

Following completion of this study, results will then be shared with you in written form and placed on the University of Windsor research webpage. You will also be invited to presentations in the Windsor area that will share the findings of this study.

SUBSEQUENT USE OF DATA

In addition to using this data in the current study, the researcher intends to archive this information for use in future related studies. The results obtained from the interviews may be used for professional publications by the researcher and you will only be identified by your chosen 'alternate name' in any published findings.

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

SIGNATURE OF RESEARCH SUBJECT/LEGAL REPRESENTATIVE

I understand the information provided for the study **The Nurse's Spirit- The Lived Experience of Spirituality of Hospice/Palliative Care Nurses** as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Name of Subject

Signature of Subject

Date

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

Signature of Investigator

Date

Appendix G: Letter of Information for Consent to Participate in Research

3. What is your definition of "spirituality?"
4. What are your experiences with spirituality in your daily work as a nurse who works in a setting with people who are terminally ill?

- The researcher will ask clarifying or probing questions for a more detailed description by using statements like; "could you tell me more about that" or "please describe what this means to you".

POTENTIAL RISKS AND DISCOMFORTS

The risks of participating in this study are minimal and there are no negative consequences expected. Nothing is being done to you physically and the interview is not expected to cause you any discomfort. However, even though it can be difficult recalling and sharing upsetting stories about clients, you have the ability to guide the interview, selecting what you wish to talk about. If you feel uncomfortable at any point during the interview please notify the interviewer.

Your confidentiality will be maintained and protected through the use of an alternate name in which you will choose to be identified as. No personal characteristics will be attached to your responses.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

You may not directly benefit from this research study however you will be contributing to the profession of nursing by providing knowledge that is not currently known.

PAYMENT FOR PARTICIPATION

As a thank you for your contribution to research, the researcher will provide you with a \$10.00 gift card for Tim Horton's restaurant.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. Prior to the interview, you will be asked to choose a name you would like to use for the duration of the interview. Your identity will be solely known by the researcher for the purpose of further contacts. Once the data is collected it will be kept in a locked filing cabinet and will only be available to the principle investigator. The interviews will be audio-taped and then transcribed word for word. Tapes are filed by number only and stored in a locked filing cabinet. Transcripts will be double checked and verified before being destroyed and all audiotapes will be destroyed immediately after your interview has been transcribed.

PARTICIPATION AND WITHDRAWAL

If you volunteer to participate in this study, you may withdraw at any time without consequences of any kind. At your discretion, you may refuse to answer any questions and still be acknowledged as a participant.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS

Following completion of this study, results will then be shared with you in written form and placed on the University of Windsor research webpage. You will also be invited to presentations in the Windsor area that will share the findings of this study.

SUBSEQUENT USE OF DATA

In addition to using this data in the current study, the researcher intends to archive this information for use in future related studies. The results obtained from the interviews may be used for professional publications by the researcher and you will only be identified by your chosen 'alternate name' in any published findings.

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

Signature of Investigator

Date

Appendix H: Consent for Audio Taping



CONSENT FOR AUDIO TAPING

Research Subject Name:

Title of the Project: The Nurse's Spirit- the Meaning of Spirituality for Nurses who Work in Palliative Care Settings

I consent to the audio-taping of interviews.

I understand these are voluntary procedures and that I am free to withdraw at any time by requesting that the taping be stopped. If the taping is stopped and I withdraw from the study, the researcher will then give me my audio-tape. By choosing an alternate name, I understand that my name will not be revealed to anyone and that taping will be kept confidential. Tapes are filed by number only and stored in a locked filing cabinet. Transcripts will be double checked and verified before being destroyed and all audiotapes will be destroyed immediately after your interview has been transcribed.

I understand that confidentiality will be respected and the audio tapes will be used for professional use only.

(Research Subject)

(Date)

Appendix I: Demographics Data Information Sheet

The Nurse's Spirit- the Meaning of Spirituality for Nurses who Work in Palliative Care Settings

Demographic Data Information Sheet

Name _____ Alternate Name _____

Address _____

Phone _____

Age _____ Marital Status _____

Religious Background _____

Employment

Please circle below:

- a) Hospice Nurse b) Palliative Care Nurse

Current Position _____

Employment Setting (community, hospital, hospice, etc)

How many years have you been nursing for your current employer? _____

How many years have you been nursing? _____

Education

What is your highest level of education completed? _____

Do you have any specialized education/training for your current position? _____

If so what is it? (courses, certificates, etc)

Do you have any training in spirituality? _____

If yes please describe _____

Date of Interview _____

Thank you

Appendix J: Confidentiality Pledge of Secretary Transcribing Interview

CONFIDENTIALITY PLEDGE OF SECRETARY TRANSCRIBING INTERVIEWS

I, _____, pledge to maintain confidentiality of all information discussed on both audio tapes and written transcribed materials as alternate names, provided by the participants, will be used when referring to each participant in the written transcript. Portions of dialogue may seem identifiable with particular participants however I promise not to reveal any phrases or words of the research participants that may jeopardize their anonymity. I will refrain from having conversations with others within or outside of the university about this study.

Signature _____

Date _____

Appendix K: Interview Guide

Interview Guide

Research Question

What is the Meaning of Spirituality for Nurses who Work in Palliative Care Settings?

To answer the research question, each participant will be asked the following:

1. What is your definition of spirituality?
2. What are your experiences with spirituality in your daily work as a nurse who works in a setting with people who are terminally ill?

Triggers and Prompts

Could you tell me more about that?

Please described what this means to you?

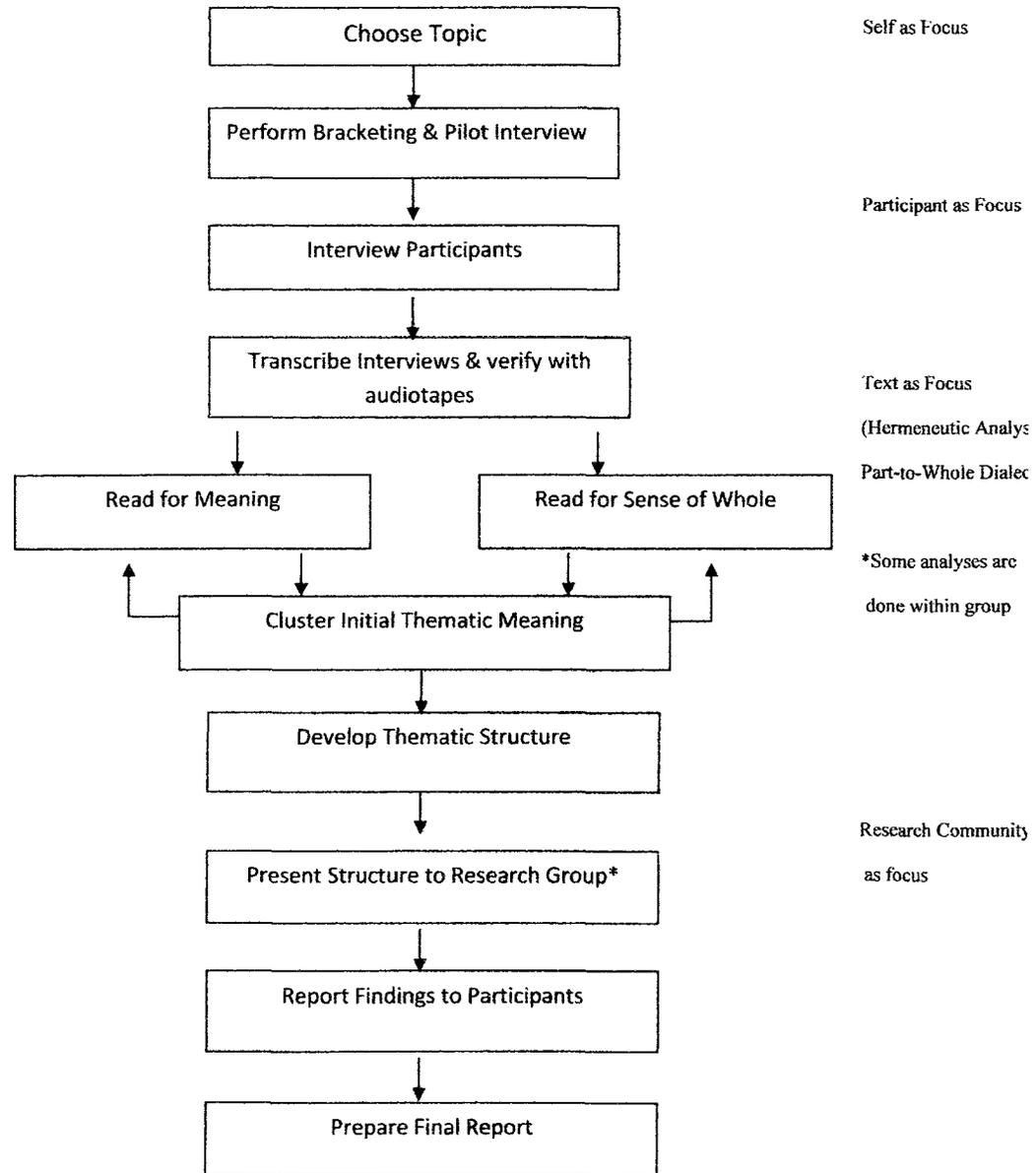
How has this affected your life?

Can you elaborate?

What you just told me is really interesting. Could you tell me more?

Is there anything else you would like to add?

Appendix L: Steps in Conducting an Existential Phenomenological Study



Summary of Steps in Conducting an Existential-Phenomenological Study. From Polio, H.R., Henly, T., & Thompson, C. B. (1997). *The phenomenology of everyday life*. New York: Cambridge University Press. Reprinted by permission

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