

Intensive Care Unit Nurses' Experience of Watson's Theory of Human Caring Caritas Process Three: Cultivation of One's Own Spiritual Practice and Transpersonal Self, Going Beyond Ego-Self

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Boston College

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INTENSIVE CARE UNIT NURSES' EXPERIENCE OF WATSON'S THEORY OF HUMAN
CARING CARITAS PROCESS THREE: CULTIVATION OF ONE'S OWN SPIRITUAL
PRACTICE AND TRANSPERSONAL SELF, GOING BEYOND EGO-SELF

a dissertation

by

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Intensive Care Unit Nurses' Experience of Watson's Theory of Human Caring Caritas Process
Three: Cultivation of One's Own Spiritual Practice and Transpersonal Self, Going Beyond Ego-
Self

Abstract

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Purpose: The purpose of this study was to explore nurses' experiences of Watson's Theory of Human Caring Caritas Process Three: Cultivation of One's Own Spiritual Practices and Transpersonal Self, Beyond Ego-Self.

Background: There is currently an inadequacy of spiritual care provided to patients and families in the ICU despite a significant articulated need. Nurses report discomfort with and a lack of preparation in providing spiritual care competently. Nurses with strong personal spiritual development are more likely to report comfort with spiritual caregiving and provide spiritual care. Watson's Theory of Human Caring Caritas Process Three; Cultivation of One's Own Spiritual Practice and Transpersonal Self, Going Beyond Ego-Self makes explicit the primacy of relationship between nurse spiritual development and transpersonal spiritual nursing care. However, the nature of spiritual development of nurses in the ICU remains unknown.

Methods: A qualitative descriptive methodology with directed content analysis applying Watson's Caritas Process Three was used to analyze data for this study.

Results: Ten ICU Nurses provided evidence of the experience of Caritas Process Three. Five themes were identified in the analysis of data: *Caritas nurses vary in their ability to move beyond ego-self, Personal spiritual practices serve as a barrier and/or facilitator to nurses' ability to provide spiritual care, Critical illness as experienced by patients and families provided the opportunity for nurses to explore spirituality with other, The care environment serves as a barrier and/or facilitator to nurses' personal spiritual growth, and Cultivation of spiritual practice and spiritual identity is integral to a life-long process of consciousness evolution.*

Conclusions: The findings of this study extend and inform Caritas Process Three of Watson's Theory of Human Caring. Nurses in this study provide evidence for the primacy of personal spiritual development for the delivery of spiritual and transpersonal care for patients in the ICU.

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Chapter One: Background and Overview of the Study

Currently, there is a lack of knowledge about the spiritual development of intensive care unit (ICU) nurses and the influence nurses' spiritual development has in addressing the spiritual needs of patients and family caregivers. This qualitative descriptive study seeks to explore the spiritual development of ICU nurses and the meaning of nurses' spirituality in their professional role. Caritas Process Three (CPT) of Watson's Theory of Human Caring (WTHC), Cultivation of One's Own Spiritual Practice and Transpersonal Self, Going Beyond Ego-Self, will frame this study. This caritas process goes beyond a narrow conception of religious affiliation with a broad focus on spirituality to carefully attend to the diversity of humanity. This theoretical lens suggests the potential importance of nurses' spiritual development on the delivery of spiritual nursing care.

This chapter provides an overview of the problem of spiritual distress and the need to enhance spiritual nursing care delivered to patients in the ICU. The potential implications for the findings of this study on the provision of nursing theory based spiritual care and on the patient and family experience in the ICU are outlined. The remainder of the chapter focuses on an overview of the study including background and significance, a statement of the research purpose, research questions, overview of the theoretical framework, definition of key terms, and undergirding assumptions pertinent to the study of CPT of WTHC.

Statement of the Problem

Within the current healthcare environment, nurses understand the purpose of their discipline to be facilitating humanization, advancing the wholeness of the other, providing meaning-oriented conscious care, and promoting health and healing even when cure is not possible (Cowling, Smith, & Watson, 2008; Litchfield & Jónsdóttir, 2008; Newman, Smith,

Pharris, & Jones, 2008; Willis, Grace, & Roy, 2008). The caring-relationship developed by nurses is contextually driven and mutually derived (Litchfield & Jónsdóttir) as nurses provide care for individuals experiencing a variety of spiritual conditions, coming from diverse religious affiliations and spiritual perspectives, or no religious affiliation at all. This requires that nurses be accepting of plurality at its core when caring for diverse populations. However, plurality is poorly understood and this lack of understanding limits the possibility of congruence between religious backgrounds of patients and providers (Fawcett & Noble, 2004). Recent research indicates commonalities of nurse-designed models of healthcare include a focus on holism and spirituality (Mason, Jones, Roy, Sullivan, & Wood, 2015) and yet others describe nurses as not comfortable assessing and/or discussing spiritual care with patients (Cone & Giske, 2017; Wittenberg, Ragan, & Ferrell, 2017), reflecting a dichotomy in practice.

Providing spiritual nursing care from the personal perspective of religious affiliation could dehumanize individuals in the context of a pluralism of spiritual conceptualizations (Pesut & Thorne, 2007). A wide and inclusive conception of spiritual nursing care is called for. Thus, continual growth and exploration of spirituality and spiritual nursing care is required by nurses and other healthcare providers to meet the diverse spiritual needs human beings experience during critical life-threatening transitions.

Currently, the provision of spiritual care is at risk for moving completely out of the purview of nursing into the hands of healthcare chaplaincy. The profession of nursing, particularly when practiced in highly technical care areas such as the ICU must reaffirm and prioritize the inclusion of the spiritual in nursing practice in the face of competing demands. Parse (2013) strongly critiques nurses' delegation of spiritual care to other disciplines and relates

this mishap to the emergence of other disciplines focusing on spiritual care. The call to advocate for spiritual care by nurses has perhaps never been more relevant. Parse states:

Is the emergence of a new discipline a wake-up call for nurse leaders and nurses to capture the opportunity to set the focus of nurses again on the whole person, including consideration of the individual's meaning and purpose in life? Who will answer the call to preserve the uniqueness of nursing as a discipline? (p. 301).

In the face of underdeveloped and insufficient spiritual nursing care, significant spiritual needs exist for patients and family caregivers in the ICU. Concurrent with this call to action by Parse (2013), more than 5.7 million people are treated for critical or life-threatening illness in ICUs annually in the United States (Barrett, Smith, Elixhauser, Honigman, & Pines, 2014). Between 17-22% of Americans die in an ICU each year (Angus et al., 2004; Wunsch, et al., 2009), and patients discharged following ICU admission have an increased rate of mortality when compared to the general public (Wunsch et al.).

The threat of life-threatening illness and the experience of admission to the ICU have been demonstrated to have significant negative effects on patients and their family caregivers. Patients in the ICU are more likely to experience distressing symptoms such as pain, disorientation, fear, and loss of control (Alasad, Abu Tabar, & Ahmad, 2015; Puntillo et al., 2010). Furthermore, family caregivers of patients dying in the ICU experience significant distress with up to 27% being diagnosed with major depressive disorder (Siegal, Hayes, Vanderwerker, Loseth, & Prigerson, 2008), 73% diagnosed with anxiety (Pochard et al., 2005), and 56.8% diagnosed with symptoms of posttraumatic stress disorder (McAdam, Dracup, White, Fontaine, & Puntillo, 2010) following the ICU death of a family member.

Patients and families experiencing critical or life-threatening illness often describe significant spiritual distress and increased spiritual and existential needs during these serious

times when life is tenuous. In a study of hospitalized patients, Williams, Meltzer, Arora, Chung, and Curlin (2011) identified severe pain to be a significant predictor of patient desire to discuss religious or spiritual need. Various spiritual needs have been described by patients and families including expressions of spiritual emptiness, concerns for finding meaning in life and illness, and loss of control and companionship (Hermann, 2001; Johnson et al., 2014; Twibell, Wieseke, Marine, & Schoger, 1996). Despite these expressions of spiritual distress, patients report unease discussing these needs with caregivers and care of these spiritual needs remains unmet (Murray, Kendall, Boyd, Worth, & Benton, 2004). Patients and families, who do express spiritual or religious needs, often receive no response or inadequate responses from providers (Ernecoff, Curlin, Buddadhumaruk, & White, 2015; Narayanasamy & Owens, 2001; Ronaldson, Hayes, Aggar, Green, & Carey, 2012; Taylor & Mamier, 2013). One study found that 41% of inpatients surveyed reported a desire for discussion of religious and spiritual needs and of those only half had a discussion of those needs while in the hospital (Williams et al.).

Physicians and nurses working in ICUs provide further evidence that patient and family spiritual needs go largely unmet, reporting a lack of spiritual assessment and attention to religious needs of patients and families in the ICU (Ho et al., 2011). In a recent study, Bergamo and White (2016) found that 91% of patients and families surveyed did not have a discussion of spiritual needs related to their end of life care. Providers' lack of responsiveness to spiritual and religious needs with patients and families who endorse high levels of religious coping has been found to lead to more aggressive treatments at the end of life in the ICU (Phelps et al., 2009; Shinall, Ehrenfeld, & Guillamondegui, 2014). This occurs in spite of 7 of 10 Americans reporting they would prefer to die at home (Connors et al., 1995).

In addition to meeting an expressed need, evidence supports that the provision of spiritual care can lead to significant improvements in the distress experienced by patients and families. A group of researchers found that spiritual care delivered by medical chaplains to patients and families at the end of life in the ICU increased overall family satisfaction with care (Wall, Engelberg, Gries, Glavan, & Curtis, 2007). Families identified the most important or desired chaplain spiritual care activities included care for spiritual needs, discussion of end of life wishes, and discussion of the impact and meaning of illness in life (Johnson et al., 2014). These family caregivers also reported feeling better prepared to participate in goals of care meetings and more likely to report that care provided was a good reflection of their loved ones wishes (Johnson et al.), suggesting one harm in aggressive treatments at end-of-life may be inconsistency with patients wishes. ICU patients who receive spiritual support from physicians and nurses are reported to be more likely to receive hospice services, receive less aggressive interventions at the end of life, and are less likely to die in the ICU (Balboni et al., 2013). More broadly, religious coping and spirituality has been widely cited as essential to healing for many patient populations including those who have cardiac surgery (Mouch & Sonnega, 2012; Nadarajah, Berger, & Thomas, 2013), survivors of child maltreatment (Glenn, 2014; Willis, DeSanto-Madeya, Ross, Leone-Sheehan, & Fawcett, 2015), and patients facing life-threatening illness (Balboni et al.).

Many barriers to the provision of spiritual care to patients in the ICU and other acute care settings have been cited in the literature. Common findings include providers' perceived lack of time, insufficient training or education, lack of clarity in the definition of spiritual care, and general discomfort with the delivery of spiritual care (Balboni et al., 2014; Kiaei et al., 2015; Naraynasamy & Owens, 2001; Rushton, 2014). Barriers such as perceived lack of time deter

nurses from fully prioritizing and attending to the spiritual and existential needs of patients and families (McSherry, 2006). The patient perception of healthcare provider roles further contributes to a missed opportunity for spiritual care. Although some patients cite discomfort with bringing up spiritual needs to nurses (Murray et al., 2004), others view spiritual care as incongruent with the role of the nurse as they experience it within acute care settings (Cavendish et al., 2006; Davis, 2005).

Despite these persistent barriers, patients and providers consistently report the importance of the inclusion of spiritual care in acute care settings (Balboni et al., 2014). Although research aimed at addressing clinical barriers to spiritual care through both enhanced assessment tools and interventions continues to be a priority (Selman, Young, Vermandere, Stirling, & Leget, 2014), certain characteristics of providers have been identified as associated with an increased likelihood of spiritual care delivery thus serving as facilitators to spiritual care. Religious providers are more likely to provide spiritual care for others who are from a shared religious background, seeing their mutual faith as defining and legitimizing spiritual care interventions (Narayanasamy & Owens, 2001). Several studies point to providers who self-identify as religious or spiritual as more likely to both identify spiritual needs of patients and provide spiritual care (Chung, Wong, & Chan, 2007; Dezorzi & Crossetti, 2008; Narayanasamy & Owens).

These findings have a strong theoretical grounding in WTHC. This middle-range nursing theory has been used widely to guide nursing practice and includes within its theoretical frame both evidence of the importance of spiritual nursing care and nurses' development of spiritual self (Watson, 2008). Watson asserts that to provide spiritual care, nurses must explore their own spiritual beliefs and practice. This process is made explicit through one theoretical component of

WTHC, CPT: Cultivation of One's Own Spiritual Practice and Transpersonal Self, Going Beyond Ego-Self. The *caritas* processes within WTHC have been described as the essential missions defining the discipline of nursing and distinguishing nursing from other cure focused healthcare sciences. Thus, not only is the relationship between personal spiritual development and spiritual nursing care emphasized in WTHC, the development of personal spirituality is defined as essential to caring practice.

Outside of nursing, additional literature supports the influence of a developed spiritual self on both interpersonal capabilities and quality of care. Sometimes referred to as spiritual intelligence (King & DeCicco, 2009; Zohar & Marshall, 2000), the impact of a developed spiritual self has been examined in relationship with personal health (Amirian & Fazilat-Pour, 2016), Iranian nurses' clinical competency (Karimi-Moonaghi et al., 2015), the ability of Malaysian nurses to provide authentic care (Kaur, Sambasivan, & Kumar, 2015), and Iranian healthcare provider and hospital performance (Asghari & Shirvani, 2015). Zohar and Marshall describe spiritual intelligence as the highest level of intelligence, "SQ [spiritual intelligence] allows us to integrate the intrapersonal and the interpersonal, to transcend the gap between the self and other" (p. 14). The care provided by nurses working within a WTHC framework is transpersonal, requiring the nurse to connect with others on a level that transcends individual belief (Watson, 2008). Spiritual intelligence thus could support the nurse in transcending individual personal spiritual beliefs to identify, process, and meet the spiritual needs of the other.

Both spiritual intelligence and CPT present one solution to the challenge of providing spiritual care within clinical settings including the ICU. Despite this, empirical nursing science to describe the spiritual development of ICU nurses is underdeveloped. Further, spiritual development beyond ego self among a population of ICU nurses and the implications for

spiritual nursing care in the ICU are unknown. Understanding the personal spiritual development of ICU nurses could inform and improve spiritual care of patients and families within this environment. To meet this significant nursing mission the aim of this study was to explore the spiritual development of ICU nurses and the meaning of nurses' spirituality in their professional role through the lens of CPT of WTHC.

Significance of the Problem

The quality of the patient and family experience and the humanization of care in the ICU is of primary importance to nursing and its central focus of facilitating wholeness-humanization, meaning, and healing through relationship based nurse caring (Cowling et al., 2008; Litchfield & Jónsdóttir, 2008; Newman et al., 2008; Willis et al., 2008) and are supported by WTHC (Watson, 2008). This study contributes to knowledge needed to facilitate spiritual nursing care broadly and more specifically contributes to the theoretical development of CPT of WTHC. This exploration of CPT contributes to ongoing development of theoretical knowledge for the discipline of nursing. By building disciplinary knowledge, findings from this study could contribute to the improvement of spiritual nursing care in the ICU.

Clinical and economic significance. In addition to the significant spiritual, psychosocial, and physical distress experienced by patients and families receiving care in the ICU, there are serious economic implications related to ICU care. Care choices at the end of life are associated with vast differences in healthcare costs. Spiritual values and expressions increase patient and family comfort and preparation with end of life decision making and can thus be hugely influential (Ankeny, Clifford, Jordens, Kerridge, & Benson, 2005). ICU patients who receive spiritual care from healthcare providers in the ICU are more likely to receive hospice care, less likely to die in the ICU, and less likely to receive aggressive measures such as

mechanical ventilation at the end of life (Balboni et al., 2011 and 2013; Phelps et al., 2009; Shinall et al., 2014). Patients who elect to receive aggressive treatments in the ICU at end of life are spending much more than those who chose less aggressive measures including hospice. The costs associated with aggressive treatment in the ICU at or near the end of life are significant (Gallagher & Krawczyk, 2013; Mularski, Heine, Osborne, Ganzini, & Curtis, 2005). Wang et al. (2016) found ICU admissions of cancer patients within 30 days from the time of death to be the biggest explanatory factor in determining variation in end of life Medicare expenditures. Significant health care costs are associated with Americans dying in the ICU; an inpatient death in a non-ICU area of care costs approximately \$8,548 per person, whereas death in the ICU costs of \$24,541 on average (Angus et al., 2004).

In addition to this potential financial burden, family caregivers witnessing the suffering of their loved ones have experienced their own suffering in response (Schulz et al., 2010). Spiritual care in the ICU has been identified as one indicator to measure the quality of dying, a metric most often drawn from the perspective of the family caregiver (Clarke et al., 2003). Patient and family experiences have significant implications in terms of cost for hospital organizations. Since the passing of the Patient Protection and Affordable Care Act, patient and family satisfaction surveys have been incorporated in calculating rates of Medicare reimbursement. As spiritual care interventions have been shown to increase family satisfaction with care at the end of life in the ICU (Wall et al., 2007), the potential financial implications of spiritual care are further evident. Williams et al. (2011) also found that patients who discussed religious or spiritual concerns with a healthcare provider while hospitalized were more likely to report high rates of satisfaction with their hospital stay, even if this discussion was not desired by the patient. Despite these findings, meeting spiritual needs and addressing spiritual distress for

patients experiencing life-threatening illness remains challenging in current healthcare environments.

Significance to nursing professional practice. Theory developed in nursing and for nursing's purposes distinguishes nurses' goals and outcomes from those in other health disciplines, including medicine. Nursing theory guides nursing professional practice, enables nurses to identify areas of interest for nursing research, and readily identifies the impact of nursing care on patient outcomes (Fawcett & DeSanto-Madeya, 2013). The ongoing development of nursing theory-based care is needed to sustain and grow the discipline of nursing within an increasingly interdisciplinary healthcare environment, as reflected in Parse's (2013) call to action. WTHC as a theoretical guide for the discipline affirms a focus on spiritual nursing care. WTHC goes further in mandating the nurses' spiritual development of self as essential to the provision of holistic and transpersonal care (Watson, 2008). The need for development of nursing theory-based spiritual care is evident in the lack of spiritual care received by patients' and families in the ICU despite a well-documented need. Nursing theory based care and theoretically derived nurse practice models create the basis and support the ongoing development of nursing as a unique discipline. The unique contributions of nursing to patients and families in healthcare settings are identified most explicitly through theory development.

Within the larger healthcare context, interest in spirituality has recently increased significantly. This has been attributed to many factors, including public interest in alternative and complementary care. In addition to public interest, the professional obligation for spiritual nursing care is supported broadly by healthcare standards of care, professional standards, and theoretical disciplinary knowledge. Accrediting bodies such as The Joint Commission shape the delivery of care in healthcare organizations through accreditation procedures and ties to

reimbursement standards. The Joint Commission is one of many accrediting bodies that support the need for spiritual care in acute care settings, particularly with the provision of care at the end of life, mandating hospitals and providers to attend to spiritual needs of dying patients and their families (The Joint Commission, 2017).

Although accrediting bodies have a significant impact on the delivery of care in healthcare organizations, professional nursing organizations also assert the provision of spiritual care as an essential element of nursing practice. The American Nurses Association (ANA) Code of Ethics with Interpretive Statements (2015) serves as an ethical framework for professional nursing practice. The code in its first provision highlights the nurse's duty to care for the whole person with dignity inclusive of physical, social, and spiritual needs, providing further supportive evidence for the necessity of spiritual nursing care. The code in provision five further states nurses' professional duties to self, including "attending to spiritual and religious needs" (ANA, p. 19). This provision supports the affirmation that personal wellness can directly affect the quality and nature of nursing practice. The nurse is obligated to care for self to provide quality patient experiences; as stated, "professional and personal growth reciprocate and interact" (ANA, p. 22).

Although care delivered by hospital chaplains provides for some of the spiritual needs of patients, their work does not address the unique role nurses can fulfill. The most recent data on hospital chaplains indicate 75% of US hospitals surveyed have a chaplain service with the presence of these services significantly affected by location, size, and religious affiliation of the hospital (Handzo, Flannelly, & Hughes, 2017). In their recent survey, Handzo et al. additionally compared results with findings from a 2004 survey, also concluding that the percentage of hospitals employing board certified chaplains is declining across all demographics. In contrast,

the American Association of Colleges of Nursing (AACN) cites nursing as the largest health care profession in the US, with more than 3.1 million registered nurses nationwide. Nurses, by number, are arguably well positioned to lead an increase in spiritual care across healthcare settings. Nurses, unlike chaplains, are direct care providers and are thus available to patients and their families around the clock, available to meet spiritual-existential needs at any given moment. The constant presence of nurses at the bedside both helps to build the relationship needed as the basis for transpersonal spiritual care and creates the availability for meeting spiritual needs as they arise.

However, the spiritual development of ICU nurses and the impact on the provision of nursing theory-based spiritual care in ICU settings has yet to be defined and described in the literature. This lack of understanding presents a significant challenge to researchers who aim to increase the delivery of spiritual care in the ICU with an effort to improve the experience of both patients and families at the end of life. This further presents a gap for nurse educators tasked with preparing student nurses and practicing nurses to meet the spiritual needs of patients and families. Guided by CPT of WTHC, the findings of this qualitative study should make a significant contribution to knowledge needed to expand spiritual nursing care in the ICU.

Purpose of the Study

The purpose of this qualitative descriptive study was to further the understanding of nursing theory based spiritual care in the ICU through exploring nurses' experiences of CPT of WTHC. In order to facilitate rich descriptions of conceptual elements of WTHC, ICU nurses currently practicing within a Watson Caring Science Institute (WCSI) Affiliate hospital, with their unique understanding and experience of Watson's theory, served as the sample for this study.

Research questions.

1. What do ICU nurses currently practicing in a WCSI Affiliate hospital describe as their experience of cultivation of one's own spiritual practices?
 - a. How do these ICU nurses describe their spiritual self?
 - b. What do these ICU nurses describe as spiritual self-care practices?
2. What do ICU nurses currently practicing in a WCSI Affiliate hospital describe as the relationship between spiritual self and professional development?
 - a. How do these ICU nurses view the professional responsibility of spiritual development?
 - b. What do these ICU nurses perceive as facilitators and/or barriers to the exploration of spiritual-self within their professional role and their clinical work?
3. What is the influence of personal spiritual development on spiritual nursing care as described by ICU nurses currently practicing in a WCSI Affiliate hospital?
 - a. What examples of spiritual care reflect the meaning of CPT of WTHC?
 - b. How do these ICU nurses describe the influence personal spiritual development and growth of the transpersonal self?

To answer these questions, data collection and analysis for this study was guided by the qualitative descriptive methodological approach directed content analysis. This qualitative approach is based in a pragmatic or naturalistic perspective and seeks to present the phenomena as a descriptive summary of participant experience (Hsieh & Shannon, 2005; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). In this way, qualitative description as an approach is useful for research questions that aim to build an understanding of a specific experience from as objective a perspective as possible. Directed content analysis provides a deductive approach to analysis of

qualitative data. The directed content analysis uses participant descriptions to enrich, extend, and confirm existing theory. CPT of WTHC was utilized as a beginning theoretical frame for understanding ICU nurses' experience of seeking increased spiritual development.

This analytic approach was appropriate for this study, as it allowed the researcher to explicate a description of CPT as experienced and described by the ICU nurse participants. Participants' descriptions gained through semi-structured open-ended individual interviews were analyzed for description of CPT through use of a theoretically derived coding template (Hsieh & Shannon, 2005). Interviews were digitally recorded and transcribed for analysis. Data was analyzed using directed content analysis (Hsieh & Shannon). With an openness to experience as described by the participants in their own words, qualitative description with directed content analysis allowed the researcher to gain greater clarity in understanding the experience of CPT for ICU nurses.

Overview of Watson's Theory of Human Caring. WTHC has been described as a moral philosophy, paradigm, and theory for the nursing profession (Watson, 2008). Various names have been used to characterize the theory throughout its evolution, including: Watson's Science of Human Caring, Theory of Human Caring, Human Caring Science, Theory of Transpersonal Nursing, and simply Caring Theory (Watson, 2008). WTHC has been referred to in the literature as both a philosophy and a theory, the initial and ongoing purpose of which has been to guide and distinguish the disciplinary practice of nursing from medicine as a curing science and other healthcare disciplines (Watson, 2008). Given the theory's focus on transpersonal caring-healing practices, many hospitals throughout the United States and internationally have adopted the theory and its caritas processes as the foundation of their nursing care and professional practice models (Watson, 2006).

Essential to WTHC is the embracing of the humanity of others and a moral-ethical consciousness approach to human caring as non-objectifying (Watson, 2005). WTHC is oriented toward an understanding of the nurse-patient relationship as focused on the human experience and also preserving the inherent worth of the individual. This human focused approach to nursing presents the practice of nursing as oriented toward humanization and supportive of all aspects of human experience including though not limited to spiritual being. Thus, to provide nursing care that excludes spiritual care would be to reduce the essential wholeness of the person, which would be both non-caring and dehumanizing (Watson, 2008).

Nurses practicing within the framework of WTHC are further guided and have their practice defined by the 10 Caritas Processes. The Caritas Processes define the discipline more explicitly by outlining the actions and goals of nursing practice. The Caritas Processes, transpersonal caring relationship, and caritas consciousness are the essential tenets of nursing care within WTHC (Watson, 2008).

Through the ongoing evolution of the WTHC, its spiritual essence has become increasingly emphasized (Watson, 2008). The 10 Caritas Processes give further evidence to the primacy of spiritual nursing care within WTHC. CPT, Cultivation of One's Own Spiritual Practice and Transpersonal Self, Going Beyond Ego-Self, serves as the central focus of this study. CPT makes explicit the theoretical relationship between nursing spiritual development of self and the ability to provide authentic spiritual care to the other. "Without attending to and cultivating one's own spiritual growth, insight, mindfulness, and spiritual dimension of life, it is very difficult to be sensitive to self and other," (Watson, 2008, p. 67). While practicing as a caritas nurse from within the framework of WTHC, the nurse is called upon to develop a

personal spiritual understanding and practice as experienced through CPT in order to provide authentic, intentional spiritual care.

The Caritas Processes frame two central and foundational features of the theory, caritas consciousness and the transpersonal caring relationship. Caritas consciousness can be described as both the perspective of the caritas nurse, deepened through self reflection and examination of individual practice, and also the intentionality and manner with which the actions of the nurse are linked to this perspective (Watson, 2008). If the nurse practices from an understanding of humanity as mind-body-spirit, with an understanding of self and others as connected, this consciousness is connected to practice and translates clearly through Caritas Process one: the practice of loving kindness and equanimity within the context of caring consciousness (Watson, 2008). The understanding of self and other exhibited through caritas consciousness is further understood through the transpersonal caring relationship. It is through this relationship with patients that nurses express the loving-kindness and compassionate supportive care that is both an extension of caritas consciousness and the philosophical worldview of WTHC (Watson, 2008).

Definition of Terms

- a. **Nursing Theory Based Care:** Nursing care that is rooted in and defined by a nursing theoretical frame. In order to be considered a nursing theory, the theory in question would be rooted in the metaparadigm of nursing, central unifying foci of the discipline, or based on knowledge that is used to define the disciplinary practice.
- b. **Watson's Theory of Human Caring:** The theoretical basis of this study, WTHC is described as a middle range theory of nursing with a focus on the transpersonal therapeutic relationship as a central tenant (Watson, 2008).

- c. **Spirituality:** Spirituality is an innate, universal aspect of human experience that seeks to transcend self and find meaning and purpose through connection with others, nature, and/or a Supreme Being, which may or may not involve religious structures or traditions. It is experienced as both highly subjective, unique to the individual, and multidimensional and may include existential, relational, and expressive dimensions (Barber, 2012; Baumann, 2003; Bruce, Shields, & Molzahn, 2011; Chiu, Emblen, Hofweger, Sawatzky, & Meyerhoff, 2004; Cohen, Holley, Wengel, & Katzman, 2012; McBrien, 2006; Sessana, Finnell, & Jezewski, 2007; Weathers, McCarthy, & Coffey, 2016).
- d. **Spiritual Nursing Care:** Spiritual nursing care is inclusive and supportive of an individual's spiritual needs and may include such interventions as praying with, providing an environment conducive to spiritual practice, and supporting meaning making in illness. As compared to spiritual care provided by healthcare chaplains, spiritual nursing care does not have within its scope matters of spiritual guidance or teaching (Taylor, 2001).
- e. **Intensive Care Unit:** An inpatient area in acute care facilities that is reserved for the care of patients considered to be critically ill. Within the ICU care is provided by nurses as part of a broad interdisciplinary team for patients who require continuous and sophisticated monitoring or interventions due to the severity of their clinical condition.

Definition of Key Concepts for CPT

- a. **Ego-Self:** The ego-self is a self-focused perspective for understanding the world. We look inward for explanations and understandings of truth in the world and in others. The ego-self is a limited and incomplete perspective of self and represents a lack of personal growth. To overcome the ego-self the individual connects with Spirit/Source, seeks source of inner wisdom/truth, and connects with and controls inner thoughts and feelings. "We have

thoughts, we have feelings, we have a body, but we are more than our thoughts our feelings and our body we are embodied spirit.” (Watson, 2008, p. 69).

- b. Transpersonal-Self: Enhanced awareness of personal thoughts and emotions are essential precursors to an openness and receptivity to the other. A reflective self is sensitive to others feelings and spirit and is able to connect in a compassionate human-human way that is beyond ego-self. The transpersonal self is the highest most actualized self and includes a spiritual self that is connected to a higher/deeper Spirit/Source. The transpersonal self is able to be fully present to and receptive of the other person’s thoughts, emotions, spirit, and is fundamental to developing a transpersonal caring relationship (Watson, 2008).
- c. Cultivation of spiritual practices and transpersonal self: Spiritual growth, insight and enhanced mindfulness are necessary to developing the self beyond ego-self orientation to reaching a transpersonal awareness. Spiritual practices nurture individual beliefs and call upon the nurse to pay attention to and understand more fully the internal self, thoughts, and feelings. Spiritual practices facilitate connecting more fully with the self, others, and Spirit/Source. Through seeking a higher understanding spiritual practices lead to the increased maturity and sensitivity essential to being sensitive to others (Watson, 2008).

Assumptions Based on Existing Knowledge

- Patients and families in the ICU have significant spiritual needs.
- Spiritual needs of patients and families in the ICU are not adequately met in current clinical practice.
- WTHC provides a framework for the disciplinary practice of nursing guided by theoretical tenants including the Caritas Processes.

- Caritas Process Three: Cultivation of One's Own Spiritual Practice and Transpersonal Self, Going Beyond Ego-Self, necessitates the personal spiritual development of nurses practicing from the perspective of WTHC.
- Healthcare providers who have achieved personal spiritual growth are more apt to provide spiritual care.
- Nurses practicing within a WCSI ICU can give voice to the individual requirements needed to meet the spiritual needs of patients and families within this environment.

Summary

Utilizing a qualitative descriptive approach with directed content analysis, this study aimed to provide a descriptive summary of ICU nurses experience of CPT of WTHC. The purpose of this study was to fill a gap in the literature pertaining to the spiritual development of ICU nurses. Spiritual development has been identified as one essential characteristic of nurses in the implementation of spiritual nursing care. As supported by the theoretical framework, WTHC, spiritual development of self is an antecedent to the effective delivery of spiritual nursing care. As spiritual nursing care in the ICU has been demonstrated as both lacking and needed for the improvement of patient and family experience, the findings of this study form the beginning steps toward improving quality of care and patient and family satisfaction in the ICU. Further, this study contributes to the ongoing development and clarification of nursing theory to support professional theory based nursing practice.

Chapter Two: Review of the Literature

The purpose of this study was to describe spiritual development of intensive care unit (ICU) nurses from the perspective of Caritas Process Three (CPT) of Watson's Theory of Human Caring (WTHC). The following chapter presents a brief review of literature related to WTHC. A more in depth review of spiritual nursing care will follow with particular focus on defining spirituality in healthcare, barriers to spiritual nursing care, and spiritual nursing care in the ICU. This review also includes a focus on current published evidence that supports increased spiritual awareness or development of the nurse and the potential impact on the provision of spiritual nursing care. This chapter reveals a gap in the literature concerning ICU nurses' spiritual development despite a well-documented need for enhanced spiritual care in the ICU.

Theoretical Frame: Watson's Theory of Human Caring

As discussed in Chapter One, the theoretical frame utilized as the focus of this study was WTHC. This nursing theory has been described as a middle-range theory, conceptual model, philosophy, and worldview, descriptions reflecting the wide-ranging adaptations and applications of the theory since conception (Fawcett & DeSanto-Madeya, 2013; Parker & Smith, 2010). The theory was originally presented in 1979 in Watson's first book, *Nursing: The Philosophy and Science of Caring*. Since this initial publication, the theory has been updated and presented through additional publications including *Nursing: Human Science and Human Care – A Theory of Nursing* (1985), *Postmodern Nursing and Beyond* (1999), *Caring Science as Sacred Science* (2005), and in a revised edition of *Nursing: The Philosophy and Science of Caring* published in 2008. These books in addition to numerous journal articles reflect the refinement and evolution of conceptual and philosophical elements of the theory in the nearly 40 years of work since it

was initially presented. The growth of WTHC has been supported by this continued work developing the theory with both national and international interest (Smith, 2004).

WTHC aims to distinguish nursing as a distinctive discipline with a focus on caring separate from and complementary to the curing focus of medical science (Watson, 2007, 2008). Caring provided by nurses is guided by a fundamental regard for the importance of human life and reverence for the other (Fawcett & DeSanto-Madeya, 2013; Watson, 2006, 2012). Nursing care thus is essentially humanizing and focused on “the human component of caring in the moment-moment encounters between the one who is caring and the one who is being cared for” (Fawcett, 2002, p. 214). Nurses practicing within a Watson framework are further guided by a perspective of health and healing rooted in the perception of the other as indivisibly inclusion of mind-body-spirit. Health as the goal of nurse caring is described as an achievement of harmony with the inner self, congruence with personal meaning, and unity of the whole human being (Watson, 1985, 2006, 2012).

Philosophical basis of the theory. While WTHC has advanced the disciplinary science of nursing, it has also created a philosophical perspective and ethic for nursing practice and beyond. The human caring philosophy essential to Caring Science is informed by many philosophical influences. Influences to Watson’s work are wide reaching, including but not limited to nurse theorists and philosophers Nightingale, Leininger, Rogers, and Gadow (Watson, 1985). Watson discussed the influence of the philosophy of Levinas and Logstrup in her book *Caring Science as Sacred Science* (Watson, 2005). Watson describes the philosophical views of these philosophers as central to the relationship-based ethic of the theory. Levinas highlights that in seeing the other we are open to a window of our own humanity. If the other is objectified thus we are dehumanizing the other and “diminishing our shared humanity” (Watson, 2005, p.

45). Logstrup further highlights the ethical obligation inherent in caring for the other and the trust that is essential in that care. As stated by Watson, “this view is beyond philosophy... it explains how being-for-the-other precedes being-with-the-other” (Watson, 2003, p. 201). The theory has been described as encompassed within the simultaneous action world view (Fawcett & DeSanto-Madeya, 2013), referred to also as the unitary transformative consciousness paradigm (Watson & Smith, 2002). These theoretical perspectives place further emphasis on both the relational element of the theory and also the ethical underpinnings presented.

Major components of the theory. As discussed in Chapter One, the major conceptual elements of the theory include: the transpersonal caring relationship, the caring moment, ten caritas processes, and caritas consciousness. These elements provide a guide to caring provided by nurses. Caring is described by Watson (2008) as both an essential way of being for nurses and also the central focus of nursing practice.

Transpersonal caring relationship. Central to WTHC is the human caring relationship between the nurse and the one being cared for (Watson, 1985). It is through the development of this relationship that nurse caring is delivered. Watson describes the relationship between nurse and patient as transpersonal (Watson, 2002). The transpersonal relationship is a deep connection between nurse and patient and is guided by the authentic intentional presence of the nurse, a sharing of spirit and values, and a rich connection of experience between both parties (Watson, 2002, 2012; Watson & Smith, 2002). This deep connection has the ability to change both nurse and patient and serves as the foundation for nurse caring (Watson, 2008).

Caritas Consciousness. In order to be authentically and intentionally present in transpersonal relationships, Watson describes the concept of caritas consciousness. Nurses who possess caritas consciousness have been described as caring, higher frequency, open and

sensitive (Watson, 2003, 2008; Watson & Smith, 2002). Achieving caritas consciousness requires nurses to have knowledge and understanding of their own experiences, feelings, and culture in addition to having openness to the suffering, feelings and backgrounds of others (Watson, 2012). Caritas consciousness increases the nurse's ability to be "sensitive to what is occurring" (Watson, 2008, p 79.) and contribute to a higher quality and more effective relationship with the other (Watson, 2008). This personal development of self contributes to the relationship and the patient's experience of care, placing emphasis within the theory on the importance of the practitioner (Watson, 2005).

Caritas Processes. The Caritas Processes, previously called the Carative Factors, describe the essential aspects of nurse caring that support the development of the therapeutic transpersonal relationship (Parker & Smith, 2010; Watson, 2008). The change in language from carative to caritas in recent writings serves to capture both a "deeper phenomenon" and "an expanding paradigm for the future" (Watson, 2008, p. 34). Watson describes the Caritas Processes as constantly applied by nurses without awareness. Through deep description, the Caritas Processes both give name to the contributions of nurse caring and give nurses a framework for developing professional practice (Watson, 2008). The 10 Caritas Processes, listed below with brief descriptions, build upon, overlap, and reflect each other in practice (Watson, 2008).

Caritas Process One: Cultivating the Practice of Loving-Kindness and Equanimity Toward Self and Other as Foundational to Caritas Consciousness. Described as the foundational starting point for the theory, this process evokes the importance of the nurse's development of love of/for self and others. This process requires the nurse to engage in equanimity toward self, or the practice of finding inner balance and awareness of personal

suffering and pleasure. With this personal growth, the nurse is more able to practice with loving-kindness and offer compassionate care for others.

Caritas Process Two: Being Authentically Present: Enabling, Sustaining, and Honoring the Faith, Hope and Deep Belief System and the Inner-Subjective Life World of Self/Other. This second process calls upon the nurse to value, honor, and seek to discover the belief systems and personal meanings of the particular person being cared for. This process emphasizes the significant impact that the individual's belief system can have on clinical outcomes and personal healing, and the nurse's role in making these values central to the therapeutic care received.

Caritas Process Three: Cultivation of One's Own Spiritual Practices and Transpersonal Self, Going Beyond Ego-Self. This process serves as the central focus of this dissertation work. This process emphasizes the nurse's need for ongoing personal development to support professional growth. Described as a "lifelong journey" (Watson, 2008, p. 67) the spiritual development of self reflects the increased maturity and personal reflection required of the nurse in order to be genuinely compassionate for the other.

This caritas process builds upon and is rooted in caritas consciousness with an explicit focus on individual spiritual growth. In order to provide thoughtful and open spiritual care, the caritas nurse must first be open to and aware of personal spiritual practice and beliefs. This caritas process is ongoing and evolving and requires consistent attention and focus. The caritas nurse's awareness of and attention to personal development, comes from an understanding of the impact that personal practices and human understanding will have on the transpersonal relationships developed.

Caritas Process Four: Developing a Helping-Trusting Caring Relationship. The nurse is obliged through this process to develop authentic genuine relationships with self, the patient, the

community, and colleagues. Developing an authentic relationship requires the nurse to bring to the relationship a deep respect for humanity and a compassionate awareness in addition to skills including presence and reflective listening. The quality of relationship developed has been identified as one of the most important factors in determining the effectiveness of care.

Caritas Process Five: Being Present to, and Supportive of, the Expression of Positive and Negative Feelings. Over time, Watson (2008) discussed the possibility of combining many of the caritas processes due to their strong relationship with each other. Caritas Process four and five are two that are very closely related. Caritas Process five discusses one nursing action essential to the development of trust in an authentic relationship, being open to and supportive of the other's emotional expressions. In clinical practice, emotional expressions from the patient may include expressions of stress, pain, and fear, which include rational and irrational reflections of healthcare experience. The nurse must be open to listening to and acknowledging all emotional expressions of the patient in relationship building and also to allow the patient to process the emotions positively.

Caritas Process Six: Creative Use of Self and All Ways of Knowing as Part of the Caring Process; Engage in the Artistry of Caritas Nursing. The nurse in order to provide quality care to patients must utilize all ways of knowing, including "theory, ethic, values, and the best personal-professional, empirical-technical clinical judgment" (Watson, 2008, p. 114). This process requires the nurse to utilize creatively varied forms of evidence at multiple levels to inform the nursing process as applied to individual people and circumstances.

Caritas Process Seven: Engage in Genuine Teaching-Learning Experience That Attends to Unity of Being and Subjective Meaning – Attempting to Stay Within the Other's Frame of Reference. This Caritas Process describes an essential component of the nursing practice, patient

teaching. From a Caritas perspective, teaching and learning require the nurse to partner with the other and utilize such knowledge as context and patient readiness to learn. The teaching is both collaborative and requires assessment and connection with the other through the transpersonal relationship. The nurse in caritas teaching moves from teacher to coach as they serve as a resource to the other.

Caritas Process Eight: Creating a Healing Environment at All Levels. Caritas Process eight calls upon the nurse to optimize the physical as well as the nonphysical care environments to promote patient safety, comfort, privacy, and human dignity. The nurse must attend to the physical through assurance of a clean, safe, aesthetically pleasing environment free from noxious stimuli. The nurse must also protect the patient from harm from medical errors and injury. In addition to physical environment, the nurse also must attend to the nonphysical realm of energy and consciousness. The nurse-as-environment must have awareness of and regulate the frequencies from which he/she operates to be part of an environmental field that promotes health and healing.

Caritas Process Nine: Administering Sacred Nursing Acts of Caring-Healing by Tending to Basic Human Needs. In describing Caritas Process nine Watson elevates the physical care provided by nurses by emphasizing the impact of tending to basic human needs, “when touching another person, you are not touching just the body physical but also the embodied spirit” (Watson, 2008, p. 145). As the nurse provides care for basic human needs including need for nutrition, elimination, physical bathing, and activity, they must do so with utmost respect for the intimacy in these interactions. Watson further describes other higher level needs that nursing must consider when caring for patients in a variety of settings including need for sexual expression, achievement, affiliation, and spiritual growth.

Caritas Process 10: Opening and Attending to the Spiritual/Mysterious and Existential Unknowns of Life-Death. The last Caritas Process requires the nurse to be open to unknowns and express comfort with the mysteries of life and the possibility of miracles. The nurse must acknowledge the individual experience of the evolving other whose existential-spiritual-phenomenological reality cannot be fully known to the nurse. Through respect for these unknowns it is possible for both the nurse and patient to find higher order meaning, spiritual growth, and healing.

Spiritual Dimension. One dimension of Watson's work that has become increasingly emphasized is the spiritual element in both the philosophy and language of the theory. The spiritual is discussed as a focus of caring for the other (Parker & Smith, 2010; Watson, 2008) and with regard to personal development of self (Watson, 2008). This spiritual focus is reflected in the explicitly spiritual language of Caritas Processes (two, three, nine and 10) discussed above. In a broader sense, many of Watson's writings discuss the spiritual nature of nursing care and of humanity in general. Watson in older writings often described the person inclusion of mind-body-spirit, while in recent works this language has evolved to view the soul as the essential element and mind and body as instruments of the soul (Watson, 1999). Watson's fifth book, *Caring Science as Sacred Science* (2005) places explicit emphasis on a spiritual orientation of self and compassionate human service motivated by the "Cosmic" or "Infinity" (Watson, 2005). It is suggested that all of nursing care is spiritually oriented both due to the spiritual motivation for care but also as reflected in the spirit-to-spirit connection achieved in the transpersonal relationship (Watson, 2002, 2005, 2012). Watson often references the "higher spiritual sense of human beings" (Watson, 2012, p. 52) in discussions of humanity as the focus of nursing care and spiritual growth and evolved consciousness as an outcome of Caritas nursing (Watson, 2012).

Application of theory to practice. The application of WTHC to clinical practice has been widespread. As healthcare in the United States (US) has shifted to consider human focused care with an emphasis on patient satisfaction, many hospitals and hospital systems have turned to WTHC as a focus for hospital missions and nursing care (Watson, 2006). Several hospitals in the US have used WTHC to develop their nurse practice model as part of seeking or maintaining American Nurses Credentialing Center (ANCC) Magnet® Status. ANCC Magnet® is a hospital credentialing designation that identifies excellence in nursing care. Nurses working within Magnet® hospitals have reported perceived higher quality of patient care versus nurses in non-Magnet® hospitals (Stimpfel, Rosen, & McHugh, 2014). In addition to hospital wide applications, WTHC has been applied in clinical research to improve the care of specific patient populations including women with infertility (Arslan-Özkan, Okumuş, & Buldukoğlu, 2013; Özkan, Okumuş, Buldukoğlu, & Watson, 2013), terminally ill patients (Iversen & Sessanna, 2012), and patients with hypertension (Erci et al., 2003). A brief review of published accounts of the theory's application to hospital environments and patient populations will follow.

Application to hospital environments and nursing practice. Published accounts of the translation of WTHC to hospital wide practice settings describe the model's alignment with hospital mission and philosophy, ease of applying the model across varied practice settings, and relevance of the model to caregivers (Bent et al., 2005; Caruso, Cisar, & Pipe, 2008; Clarke, Watson, & Brewer, 2009; Drenkard, 2008; Durant, McDermott, Kinney, & Triner, 2015; Lukose, 2011; Morby & Skalla, 2010; Pipe, 2007; Rosenberg, 2006; Ryan, 2005). Many strategies and methods for integrating the theory into the hospital environment and nursing practice are described. Several authors focus on the use of educational strategies to inform nursing staff of the key elements of Watson's theory and relationships between theory and clinical practice (Bent

et al.; Caruso et al.; Clarke et al.; Dudkiewicz, 2014; Durant et al.; Iversen & Sessanna, 2012; Pipe; Rosenberg). Other authors discuss the importance of informing proposed practice changes with suggestions or experience from clinical staff (Clarke et al.; Emoto, Tsutsui, & Kawana, 2015), in addition to establishing leaders or champions to spread that theory to practice (Pipe; Ryan).

Changes in hospital environments adopting WTHC reflect the key elements of the theory. One area of focus is the integration of the language of the theory into clinical documentation. Three authors worked to standardize the language of Caritas processes to capture the application of Caritas nursing in electronic medical records (Bent et al., 2005; Rosenberg, 2006; Schlagel, Richards, & Ward, 2013). Development of dedicated theory focused nursing units addressed the environment of care, including a focus on supporting the nurse as environment of care through increased coworker support and time spent with patients, in addition to physical changes in the environment including attention to design, sensory impact in spaces, and openness to inclusion of complementary alternative interventions (Bent et al.; Durant et al., 2015; Hay, Collin, & Koruth, 2014). A large area of focus is the application of Watson's Theory of Human Caring to improving nursing clinical practice. Descriptions of clinical practice changes were varied and included application of the model to peer review (Morby & Skalla, 2010) and use of centering techniques to improve nurse presence in clinical encounters and reduce medication errors (Drenkard, 2008; Nelms, Jones, & Treiber, 2011).

Outcomes in hospital applications. The measured positive effect of the application of Watson's theory to hospital environments is well documented. Durant et al. (2015) measured the relationship between the successful adoption of the model in the clinical setting to patient satisfaction and safety measures outcomes. The level of adoption was measured both by the

degree of awareness and adoption as evidenced in clinical practices and also the degree of integration of the model in leadership and administration practices. They found that high degrees of integration of the model at both practice and administrative levels were associated with increased patient satisfaction and increased patient safety as evidenced by such markers as reduced falls and reduced hospital acquired infections (Durant et al.). Findings from other studies support that adoption of the theory in nursing practice as seen with increased caring behaviors led to an associated increase in patient satisfaction with care (Dudkiewicz, 2014; Vandenhouten, Kubsch, Peterson, Murdock, & Lehrer, 2012). Lastly, published accounts provide evidence that adoption of WTHC in clinical practice has a positive effect on nurse job satisfaction (Drenkard, 2008; Morby & Skalla, 2010), retention (Drenkard; Morby & Skalla), and “perception of having sufficient time to attend to the emotional and psychological needs of patients” (Drenkard, p. 410). The financial implications of these outcomes are evident as insurance reimbursement of hospitals are linked to both patient satisfaction and patient safety indicators and hospitals save significant time and money by retaining talented nursing staff.

Outcomes in patient care. While WTHC is often cited in published studies and Ph.D dissertations as informing the theoretical design or serving as the theoretical framework for the study, few studies have tested the effects of the theory on clinical practice outcomes. Goldin (2014) presented a case study report of ICU nurses’ use of technology to connect a new mother and baby who could not be physically together. The practice of these nurses was informed by WTHC and demonstrated creative use of self to meet the patient’s complex needs. In a phenomenological study, Mullaney (2000) described the lived experience of women with depression receiving therapy informed by Watson’s transpersonal relationship and caring occasions. Participants described their experience as supporting them to stay in treatment and

adopt help seeking behaviors. Erci et al. (2003) utilized a quasi-experimental design to test the impact of nursing in-home care guided by the WTHC on patient quality of life and hypertension. Findings indicated an increased quality of life and decreased systolic and diastolic blood pressure for patients following the intervention. Lastly, in a randomized controlled trial exploring the effects of a nursing intervention based on WTHC, women experiencing infertility who received the intervention were found to have decreased infertility related distress, increased perceived self efficacy in coping with infertility, and increased psychological adjustment to infertility compared to matched controls (Arslan-Özkan et al., 2013; Özkan et al., 2013).

Spirituality and Nursing

Review of the literature supports an ever growing interest in spirituality and spiritual care in nursing as reflected in a marked increase in numbers of articles being published on these topics (Cockell & McSherry, 2012; Harding, Flannelly, Galek, & Tannebaum, 2008; McEwen, 2005). Much of what has been published in nursing related to spirituality and spiritual care has been largely descriptive, with a central focus on developing and refining definitions for practice (Harding et al.; Pike, 2011). McEwen further identified focus on specific topics including incidence and nature of spiritual nursing care, spirituality and spiritual care in nursing education, and specific conceptual topics (i.e. hope) and clinical areas (i.e. oncology). Despite this increased interest, limited studies continue to suggest that delivery of spiritual care is lacking, with patients and families reporting nurses do not adequately deliver spiritual care and do not identify spiritual care within the role of nurses (Bergamo & White, 2016; Cavendish et al., 2006; Ross, 2006). Taylor and Mamier (2013) support these findings by demonstrating that nurses are inadequately responding to patient spiritual needs. Ross in a review of spiritual care research revealed some evidence of increased assessment of spiritual needs but ongoing infrequency of

responding to those needs. Nurses often cite difficulty defining spirituality and identifying spiritual nursing interventions as reasons for not delivering spiritual nursing care (Balboni et al., 2014; Gallison et al., 2013; Rushton, 2014; Tiew & Creedy, 2010). A review of literature aimed at defining spirituality and spiritual nursing care will follow.

Spirituality defined. Spirituality as a specific area of interest for nursing has proved difficult to define throughout the literature. Aspects of spirituality that contribute to challenging definitions include the subjective nature of spirituality and issues related to the separation of spirituality from religion (Sessana et al., 2007). Definitions of spirituality have evolved overtime influenced by cultural changes including secularization in the US, in addition to ongoing refinement informed by patient and practitioner perspectives. The major themes of spirituality found in the review of the nursing literature from the last 20 years are reviewed. Literature reviewed included nine literature reviews (Barber, 2012; Baumann, 2003; Chiu et al., 2004; Cohen et al., 2012; Dyson, Cobb, & Forman, 1997; Flannelly, Jankowski, & Flannelly, 2014; McSherry & Cash, 2004; Reinhart & Koenig, 2013; Tanyi, 2002), seven concept analyses (Buck, 2006; Bjarnason, 2007; Lazenby, 2010; Mahlungulu & Uys, 2004; McBrien, 2006; Sessanna et al., 2007; Weathers et al., 2016), six qualitative studies (Cavendish et al., 2006; Dose, Leonard, McAlpine, & Kreitzer, 2014; Edwards, Pang, Shiu, & Chan, 2010; Egan et al., 2011; Gall, Mallette, & Guirguis-Younger, 2011; Torskenaes et al., 2015), one quantitative study (Migdal & MacDonald, 2013), and two critiques (Bruce et al., 2011; Clarke, 2008).

While varied, definitions of spirituality in the nursing literature share common themes. These include spirituality being individually defined (Barber, 2012; Baumann, 2003; Bruce et al. 2011; Cohen et al., 2012), spirituality as a process/journey/quest seeking and unfolding through ongoing reflection (Barber; Baumann; Chiu et al., 2004; Cohen et al.; McBrien, 2006),

spirituality as a search for meaning and purpose in life (Barber; Baumann; Bruce et al.; Chiu et al.; Cohen et al.; McBrien; Sessanna et al., 2007; Weathers et al., 2016), spirituality as including a transcendent aspect greater than self (McBrien; Sessanna et al.; Weathers et al.), and spirituality as experienced in relationship with self/others/higher power (Barber; Baumann; Bruce et al.; Chiu et al.; McBrien; Weathers et al.).

A proposed definition of spirituality synthesized from the nursing literature follows. Spirituality is an innate, universal aspect of human experience that seeks to transcend self and find meaning and purpose through connection with others, nature, and/or a Supreme Being, which may or may not involve religious structures or traditions. It is experienced as both highly subjective, unique to the individual, and multidimensional and may include existential, relational, and expressive dimensions.

Spirituality and religion. Spirituality has historically developed as a concept within a religious perspective (Barber, 2012; Cohen et al., 2012; Taylor, 2001). Many current nursing definitions of spirituality continue to include reference to religion and discuss the relationship of religious practices and spirituality (Barber; Baumann, 2003; McBrien, 2006; Sessanna et al., 2007). Religion, religiousness, and religiosity while related terms to spirituality, “refers to membership and participation in the organizational structures, beliefs, rituals, and other activities related to a religious faith like Judaism, Islam, or Christianity” (Cohen et al., p. 801). Authors discuss that for some individuals the organized institutional structure of religion provides a mechanism for exploring and expanding spirituality (Barber; Cohen et al.; Sessanna et al.) and spirituality may be considered a driving force behind religious practice (Chiu et al., 2004).

While the inclusion of religious description remains in many definitions of spirituality for clinical practice and research, a definite movement away from religious language is emphasized

in the nursing literature. Inclusion of religious references or language in definitions of spirituality is viewed as potentially excluding persons with increasingly secular and individualistic perspectives on spirituality (Egan et al., 2011). Authors caution that while spirituality may be part of the experience of individualized religion, religion it is not synonymous with spirituality or necessary to achieve spiritual growth (Bjarnason, 2007; Egan et al.). This very personal understanding of spirituality allows for greater individual expression with the exclusion of both religious practice and also traditional belief in God or a higher power (Gall et al., 2011). Current understandings of spirituality may include concepts traditionally not associated with religion, antireligious rhetoric, and even atheist viewpoints, with an effort to express spirituality as a universal phenomenon experienced by all people (Sessanna et al., 2007; Cohen et al., 2012).

Critique and varied perspectives. This shift in nursing literature reflects the increasingly secular perspectives in North American and Western Europe (Gall et al., 2011) and is not entirely inclusive of all patient understandings. Studies looking at patient perspective on spirituality present definitions that are consistent with nursing literature including such ideas as spirituality being connection to others, core self, and God or a Higher Power (Gall et al.), spirituality as a life perspective, sense of meaning and purpose, transcendence, and source of hope (Dose et al., 2014). Yet, patient descriptions of spirituality are often framed in religious language, with patients emphasizing the importance of religion for accessing spiritual growth and as a mechanism for defining core aspects of spirituality (Dose et al.; Edwards et al., 2010; Egan et al., 2011).

In addition to conflict between the nursing literature and patient perspectives, practicing nurses also describe difficulty defining spirituality. Nursing definitions of spirituality are

generally broad and include description of meaning and purpose, values, beliefs (Egan et al., 2011), wholeness, peaceful connectedness with self (Mahlungulu & Uys, 2004), and a belief system (Cavendish et al., 2006). Consistent with patient descriptions, Torskenaes et al. (2015) found nursing definitions of spirituality falling into one of two categories, either a postmodern definition with focus on existential ideas, or a more traditional perspective that included religious and theist forms.

As definitions of spirituality continue to broaden, to be more inclusive of the variety of individual experiences, nursing scholars are faced with the risk of definitions losing meaning both for operational definitions and in patient experience (Clarke, 2008; Mahlungulu & Uys, 2004). Vague and broad definitions lead to confusion in clinical practice, particularly in discerning the difference between psychosocial and spiritual care (Clarke; Mahlungulu & Uys). Clarke further criticizes nursing scholars for creating definitions that would be difficult to understand outside of the nursing literature and by patients. Additionally, complete exclusion of religious discussion in spirituality may for some cause further confusion as the two related concepts are often complementary in both experience and understanding (Clarke; Mahlungulu & Uys). While clarity and consistency are needed in operational definitions of spirituality for scientific rigor, nurses continue to argue that broad understandings of spirituality are needed in clinical practice to remain receptive to varied perspectives in patient experience (Bruce et al., 2011).

Spiritual nursing care. The relationship of spirituality and nursing professional goals are rooted in the theoretical presentation of nursing as defined by numerous nursing theories and conceptual models. Nursing as a theoretically driven practice, includes both a spiritual understanding of the person as the focus of care and also spiritual aims of nursing practice. Early

writings on nursing professional practice by Nightingale emphasize the importance of the spiritual dimension of human life and the spiritual process and moral action of nursing care for humankind (Nightingale, 1969). Examples of the inclusion of explicit spiritual language in nursing theory can be found in nursing theories including, but not limited to, Newman's Health as Expanding Consciousness (Newman, 1994), Neuman Systems Model (Neuman & Fawcett, 2002), Roy Adaptation Model (Roy, 2009), and WTHC (Watson, 2008). Newman described patient experience of transcendence of the spatial-temporal self and movement toward the expanded consciousness and spiritual reality. Neuman included the spiritual, inclusive of spiritual beliefs and influences, as one of the five variables essential to the patient system (Neuman & Fawcett). Roy includes spiritual understandings both in her model's philosophical assumptions and within modes of adaptations including the self-concept model. These theoretical models define the importance of a spiritual dimension for nursing professional goals and practice aims. Nursing theory has identified spirituality and thus spiritual care as central to nursing professional practice.

Spiritual nursing care has primarily been described in the literature from a descriptive perspective with broad descriptions of what nurses do in response to patient's spiritual need. While expanded descriptions and examples of spiritual nursing in the literature will follow in this review, basic descriptions often include reference to such nursing actions as listening, establishing trust in relationships, holding hands, being with, and prayer (Deal, 2010; Grant, 2004; Pesut, & Sawatzky, 2006; Tuck, Pullen, & Wallace, 2001).

NANDA-I, NIC and NOC respectively provide the nursing language for nursing diagnosis, interventions and outcomes within the discipline of nursing. Cavendish et al. (2003) advance a descriptive presentation of spiritual nursing care with the identification of NIC labels

as examples of spiritual care. Identified by practicing nurses through survey, NIC labels such as spiritual growth facilitation, spiritual support, nursing presence, and music therapies were endorsed as exemplars to define spiritual nursing care (Cavendish et al.).

While this descriptive perspective dominates the literature, prescriptive or outcome oriented understandings of spiritual nursing care can also be found. For example, Taylor (2001) describes spiritual nursing care aimed at assisting patients in the construction of meaning in illness. This prescriptive approach, often takes the form of the nursing process including such elements as assessment (Narayanasamy & Owens, 2001), diagnosis (Taylor), and intervention (Van Dover & Bacon, 2001). NANDA- I has identified three nursing diagnoses specific to diagnosis of spiritual needs: spiritual distress, potential for enhanced spiritual well-being, and risk for spiritual distress (Taylor). One likely reason the literature favors description to prescriptive definitions is that prescriptive practice requires expertise (Pesut & Sawatzky, 2006). Taylor presents a view of nurses as spiritual care generalists, emphasizing the more advanced role of chaplains in the delivery of spiritual care. Taylor was careful to identify nurses' spiritual role as specific to spiritual matters related to health and illness.

In addition to descriptive and prescriptive perspectives, therapies identified as spiritual nursing care have been described as falling within two ideologies or paradigms: New Age or Post Modern versus Traditional Religious (Grant, 2004). This paradigmatic organizing schema is reflective of the definitions of spirituality within the nursing literature. "Spirituality has an increasingly wide range of interpretations; the delivery of spiritual care interventions can understandably be equally diverse, comprising existential and religious components," (Cavendish et al., 2003, p. 116). The paradigmatic perspective influences the assessment of spiritual needs. Nurses practicing from a more traditional religious viewpoint utilize religious

practice and beliefs as an essential focus of assessment and care (Cavendish et al.; Greasley, Chiu, & Gartland, 2001). Alternatively, nurses practicing from a postmodern perspective look more to an existential-meaning-oriented frame for guiding spiritual care, resulting in care that is broad, inclusive, and unrestricted by religion (Greasley et al.; Pesut & Sawatzky, 2006).

Nurses across practice areas when surveyed agree that spiritual care is an important component of nursing care, is patient centered, and can be simple to give (Deal, 2010; Pike, 2011). The delivery of spiritual care has been described across various clinical settings (Van Dover & Bacon, 2001), including parish nursing and mental health settings (Tuck et al., 2001). Tuck et al. looked at variation in interventions between parish and mental health nurses. In asking nurses to endorse the likelihood that they would deliver various spiritual care interventions, differences in the spiritual care provided between the two groups were discovered. Parish nurses were more likely to provide care that included “praying, listening, and touching” (Tuck et al., p. 600); while mental health nurses were more likely to provide care that included “referring, encouraging, praying, and listening” (Tuck et al., p. 601). Thus, while nurses across settings agree with the importance of spiritual nursing care, beginning evidence suggests the environment influences the care provided.

Examples of spiritual nursing care. Spiritual nursing care has been described in the literature through both broad and specific understandings of nursing. Some authors see spiritual nursing care as elemental to all nursing care, with the spiritual as an integrative component of nursing’s caring practices (Edwards et al., 2010; Sawatzky & Pesut, 2005; Watson, 2005). Other authors present spiritual nursing care through specific descriptions of nurse practice actions. Nurse presence and empathetic listening is often referred to as an exemplar of spiritual nursing care, resulting in nurses creating a sacred environment that is conducive to patients revealing

spiritual needs (Carr, 2010; Daaleman, Usher, Williams, Rawlings, & Hanson, 2008; Edwards et al.; Govier, 2000; Pesut & Sawatzky, 2006; Ramezani, Ahmadi, Mohammadi, & Kazemnejad, 2014; Taylor, 2001; Taylor, 2011; Tuck et al., 2001). Spiritual nursing care is also described as a mutual activity with nurses and patients co-creating holistic care plans informed by patients' spiritual needs (Burkhart & Hogan, 2008; Daaleman et al.; Deal, 2010; Govier; Ramezani et al.; Van Dover & Bacon, 2001). Spiritual nursing care is delivered through establishing the nurse-patient therapeutic relationship, bridging off such relationship ideals as trust, support, and personal sharing of self (Carr; Sawatzky & Pesut; Taylor, 2008; Taylor, 2011; Van Dover & Pfeiffer, 2007). Underlying all these descriptions is an understanding of nursing as a holistic practice guided by a perspective of the other as indivisibly inclusive of the spiritual (Daaleman et al.; Govier; Ramezani et al.).

Assessment. One key guiding influence on spiritual nursing care is patient assessment (Govier, 2000). "Every nurse understands that appropriate care responds to an assessment of patient problems ... it is unimaginable to support another's spiritual health without first having some knowledge of that person's spiritual perspective and perception of need" (Taylor, 2011, p. 197). Through assessment, nurses can become aware of and thus respond to the spiritual needs of their patients (Narayanasamy & Owens, 2001). Numerous assessment measures have been developed including The Nurse Spiritual Care Therapeutics Scales (Mamier & Taylor, 2014), The Spiritual Distress Assessment Tool (Monad, Martin, Spencer, Rochat, & Büla, 2012), and The Spiritual Needs Assessment for Patients (Sharma, Astrow, Texeira, & Sulmasy, 2012). In addition to formal assessment tools, nurses are cued into moments of anticipated spiritual need, such as moments of great physical and emotional crisis (Cavendish et al., 2003). Through reading of patient emotional responses to crisis, nurses are able to identify and guide spiritual

needs that patients themselves may not even be aware of (Emblen & Pesut, 2001; Van Dover & Bacon, 2001) and create an environment with an openness to spiritual care. Guided by assessment, nurses focus attention to identified elements of patient spiritual identity, including religious orientation and practices, personal meaning in living with illness, and spiritual needs at end of life.

Prayer. The literature supports prayer as a spiritual intervention often provided by and endorsed by nursing professionals (Burkhart & Hogan, 2008; Emblen & Pesut, 2001; Taylor, 2001; Tuck et al., 2001; Van Dover & Bacon, 2001). This example of spiritual care is for many nurses religiously oriented, with the provision of prayer aimed at assisting patient connection with a higher power (Burkhart & Hogan, 2008) and providing ritual to renew faith and commitment to a religious belief system (Emblen & Pesut). Nurses use prayer as a common entry into a spiritual encounter with patients who identify as religious. Nurses may pray with, encourage family to pray, and/or support patients in private prayer (Van Dover & Bacon). Prayer as nursing intervention can take many forms, including intercessory prayer, meditation, and additional alternative forms such as journal writing and appreciation of nature (Taylor). A broad understanding of prayer moving away from the traditional religious perspective, provides an openness to these alternative forms and for the delivery of prayer as intervention for the non-religious.

Barriers to spiritual nursing care. Patient desire for spiritual care and the reality of spiritual care receipt are at odds. For example, oncology patients continue to report that receiving spiritual care from nurses and physicians as part of their care is very important (Balboni et al., 2012). Despite this, limited reports suggest numbers of patients receiving spiritual care to be minimal, with patients reporting from one source that “13% of their nurses

and 6% of their physicians” (Balboni et al., 2012, p, 463) delivered spiritual care and another reporting that “9 of 11 patients did not expect spiritual care from their nurses” (Davis, 2005, p. 129). Nurses and physicians support these findings noting they are providing less spiritual care than desired and citing numerous barriers to provision of spiritual care (i.e. adequate time, lack of training, and misconceptions about their role in the delivery of spiritual care) (Balboni et al., 2012; Balboni et al., 2014).

One barrier to the delivery of spiritual nursing care is continued misconceptions or confusion about appropriate spiritual care interventions. Taylor (2008) specifically highlights these concerns suggesting confusion could lead to nurses providing what they believe to be spiritual care, but what are actually general caring behaviors that have not risen to the level of spiritual care. Further, Taylor expresses concern that confusion could lead to inappropriate delivery of spiritual nursing care or even harm caused by spiritual nursing care. Taylor urges nurses to be sensitive to the environment of care and receptivity of the patient to receiving spiritual care, citing that not all spiritual care is appropriate in the care environment. Lastly, Taylor suggests that in delivering spiritual care interventions nurses who are not adequately trained (i.e. guided imagery) or do not seek appropriate consent (i.e. intercessory prayer) may cause harm to patients.

Ongoing confusion and misconceptions related to definitions of spirituality and spiritual nursing care, is a concern of both Taylor (2008) and others (Pike, 2011). As was noted in the critique of definitions of spirituality in the healthcare literature, McSherry (2006) found further supporting evidence of the potential disconnect between healthcare and patient definitions of spirituality. McSherry emphasized the highly individual experience of spirituality is heavily influenced by cultural background, religion, and personal experience. This individual reality can

appear quite different from healthcare providers' perceptions of spirituality and rendering healthcare definitions meaningless to patients. Definitions of spirituality and spiritual care that are meaningful both to recipients of care and care providers are essential to effective care delivery. Just as patients report a disconnect between individual understandings of spirituality and healthcare ideals, providers continue to cite role confusion as a barrier to care delivery (Balboni et al., 2013; Gallison et al., 2013; Rushton, 2014; Tiew & Creedy, 2010). Provider's note that without a clear shared understanding of what spirituality means and how this meaning is applied to clinical practice, the delivery of care will continue to be hampered. Further, authors cite that this confusion goes as far as nurses' inability to distinguish spiritual care from proselytizing (Gallison et al.) and not seeing spiritual care as part of their clinical role (Balboni et al.; Gallison et al.).

Insufficient training is an often-cited barrier to the delivery of spiritual care (Balboni et al., 2014; Kiaei et al., 2015; Rushton, 2014; Sanders, Kopis, Moen, Pobanz, & Volk, 2016; Tiew & Creedy, 2010; Wu, Tseng, & Liao, 2016). The support for training as a barrier comes from provider report of both a lack of adequate training and a desire for additional training (Balboni et al.; Kiaei et al.; Tiew & Creedy). Additionally, the authors have found a relationship between increased training or education as a predictor of both provider willingness to provide spiritual care (Wu et al.) and the delivery of such care (Balboni et al.; Kiaei et al.). Timmins, Neill, Murphy, Begley, & Sheaf (2015) reviewed 130 fundamental nursing textbooks and found very few to include definitions of spirituality or any specific descriptions of spiritual nursing care.

Other commonly cited barriers paint a picture of a healthcare environment where insufficient time (Balboni et al., 2014; Carr, 2010; Cavendish et al., 2006; Gallison et al., 2013; Keall, Clayton, & Butow, 2014; Rushton, 2014; Sanders et al., 2016) and conflicting priorities

(Carr; McSherry, 2006; Sanders et al.) contribute to a lack of spiritual care. Nurses and other healthcare providers often endorse this lack of time as a primary reason for not participating in spiritual care (Balboni et al.; Carr; Gallison et al.; Keall et al., 2014; Rushton; Sanders et al.). Nurses further describe working in healthcare environments that focus on economic efficiencies and lose sight of the time and space needed to provide holistic patient care (Carr; Gallison et al.; Kiaei et al., 2015; Tiew & Creedy, 2010). Nurses report prioritizing physical care (Tiew & Creedy, 2010), tasks such as medication delivery (Kiaei et al.), and management of numerous healthcare technologies (Carr; Tiew & Creedy) leaving spiritual care unattended (McSherry, 2006). Nurses cite the environment in addition to a lack for training as leading them to be more likely to see spiritual care as the purview of chaplains only and referring care out rather than providing spiritual nursing care (Baldacchino, 2006). Nurses further describe avoiding spiritual care due to fear of the “emotional implications” (Cockell & McSherry, 2012, p. 963) with nursing care moving away from a personal-emotive experience of the other and more toward a medical perception of the recipient of care as object (Carr).

Facilitators to spiritual nursing care. While several authors cited above have explored in depth barriers to spiritual care in healthcare settings, few have identified facilitators to care. Balboni et al. (2013) found the greatest predictor of spiritual care provision to be spiritual care training, demonstrating a strong link between training and practice. This reflects the often cited barrier to spiritual care lack of education. Kiaei et al. (2015) also supported training as a facilitator, with education level increasing the likelihood of spiritual care delivery in Iranian nurses. Keall et al. (2014) found that for Australian Palliative Care nurses, two essential strategies facilitated the delivery of spiritual care. The first was communication skills, with such techniques as active listening and attention to body language identified by nurses as an essential

first step to beginning a dialogue about spiritual needs (Keall et al.). Second, nurses identified attention to the nurse-patient relationship as an essential facilitator to the delivery of spiritual care (Keall et al.). One promising facilitator to spiritual care includes personal aspects/characteristics of the registered nurse, discussed in depth in the following section:

Development of Self and Impact on Care.

Spiritual care outcomes. Limited studies exist related to the outcomes of spiritual nursing care (Narayanasamy & Owens, 2001; Sawatzky & Pesut, 2005). This is in contrast to a broader range of studies that have looked at elements of spirituality and religiosity as predictors of general health and wellness (Sharma et al., 2017; Taylor, 2001; Trevino & McConnell, 2015; Vespa, Jacobsen, Spazzafumo, & Balducci, 2011). It is important then when considering the impact of spiritual nursing care, to distinguish the possible confounding effect that an individual's spiritual practice and beliefs may have independent of nursing care. Outcomes of spiritual nursing care may also be reflective of the prescriptive nature of the interventions undertaken. For example, Taylor describes nurses providing spiritual care through storytelling with the express objective outcome of meaning making. Nurses perceive the impact of spiritual care interventions to include such patient outcomes as "inner peace, strength to cope... relaxation and self-awareness, and help to forgive, connect, and cooperate with others" (Grant, 2004, p. 39). Nurses report belief that such observed outcomes as increased peace may aid in physical healing and recovery (Narayanasamy & Owens), reflecting the broader body of literature linking associated positive health outcomes with patient spiritual practices. Patients and families do report increased comfort and suggest added acceptance within their current health situation following the delivery of spiritual nursing care (Narayanasamy & Owens). In addition to these

patient-family outcomes, nurses also experience positive personal effects from the delivery of spiritual care, including positive emotions and renewed faith (Van Dover & Pfeiffer, 2007).

Development of Self and Impact on Care

While many authors have focused on identifying and describing barriers to the delivery of spiritual nursing care, others have endeavored to ascertain competencies, facilitators, and other associated factors needed for spiritual care to be delivered. Qualities of the nurse that lead to increased delivery of spiritual nursing care have been identified in the literature. Personal spiritual awareness and ongoing spiritual growth, has been consistently identified as associated with increased interest and participation in spiritual care. Spiritual intelligence demonstrates the impact that increased spiritual awareness can have on both thinking and meaningful action. The influence of spiritual intelligence on nurses and nurses' work will be described.

Spiritual nursing care competencies. Two authors have published clinical competencies for the delivery of spiritual care with the goal of guiding nursing education and practice in this area (Baldacchino, 2006; Van Leeuwen & Cusveller, 2004; Van Leeuwen, Tiesinga, Middel, Post, & Jochemsen, 2009). Baldacchino identified spiritual care competencies as part of a qualitative study sampling Maltese nurses working in an acute care hospital. Through this analysis, Baldacchino identified competencies: 1) professional preparation to delivery spiritual care, 2) personal spiritual awareness, 3) use of the nursing process to systematically deliver spiritual care, 4) communication with patients and the interdisciplinary team, and 5) ethical considerations such as confidentiality. Van Leeuwen and Cusveller reviewed published international research to develop competencies essential to the spiritual nursing care and presented three organizing domains with six competencies. The domains included: “the person of the nurse (attitude and personal qualities; professional responsibility,

knowledge and vision); the nursing process (observation, assessment, diagnosis, coaching, information and advice, continuity and coordination of care, and multidisciplinary co-operation); and the institutional context of care provided (fostering institutional conditions)” (Van Leeuwen & Cusveller, 2004, p. 237).

Van Leeuwen et al. (2009) based on these findings further developed The Spiritual Care Competence Scale to evaluate nurses’ attitudes, values, beliefs, and practices necessary for competence in spiritual care. Utilizing this scale, Hellman, Williams, and Hurley (2015) explored associations between competencies and nurses’ abilities to deliver and improve spiritual care for patients in an acute care setting. Hellman et al. found that nurses’ capacity to assess and implement spiritual nursing care was strongly associated with their ability to provide spiritual support, their attitude toward the delivery of spiritual care, their willingness to refer a patient to clergy, and their ability to communicate these matters with patients and the interdisciplinary team.

Spiritual self and the impact on practice. Both Baldacchino (2006) and Van Leeuwen and Cusveller (2004) include in their descriptions of spiritual care competencies consideration for the personal spiritual development of the nurse. Baldacchino explicitly included as a competence the personal spiritual awareness of the nurse. Several other authors have found nurses’ personal spiritual development or religiosity to have a strong influence on the delivery of spiritual nursing care. In their reviews Beckman, Boxley-Harges, Bruik-Sorge, and Salmon (2007), Tiew and Creedy (2010), and Cockell and McSherry (2012), summarize evidence supporting this claim. Beckman et al. emphasized the impact of personal spiritual awareness on the nurses’ ability to assess spiritual needs. Tiew and Creedy suggest that nurses who focus on personal spiritual growth are more comfortable communicating with patients about spiritual

needs. Cockell and McSherry found several studies that support nurses' increased awareness of their own spirituality increasing their ability to provide spiritual nursing care.

Cavendish et al. (2003) used as one measure in their study Reed's Spiritual Perspective Scale to measure spiritual perspective and the degree to which spirituality was influential in participant's lives. In a national survey of practicing nurses, they found that religious affiliation was strongly associated with higher rankings on the spiritual perspective score. Many other factors were found to have no significant influence on the spiritual perspective score, including age, years of experience, and terminal degree. In the qualitative arm of this study, nurses expressed the perspective that personal spirituality supports spiritual nursing practice. Chan (2009) in a survey of 110 hospital nurses, found further support of these findings with nurses who endorsed religious practices or beliefs having increased positive perspectives on spiritual nursing care and more likely to practice spiritual nursing care. Narayanasamy and Owens (2001) in a qualitative critical incidence study of 115 nurses from varied practice areas, found that nurses who shared spiritual and/or religious perspectives with their patients were more likely to provide or find opportunities to provide spiritual nursing care.

With a focus on exploring the relationship between personal spiritual growth and nursing spiritual care, Pfeiffer, Gober, and Taylor (2014) sampled from populations of nurses with strong spiritual and religious backgrounds. In their qualitative study of fourteen Christian nurses practicing in varied clinical settings, several themes supported the strong relationship between personal spiritual and religious beliefs and spiritual nursing care (Pfeiffer et al.). Nurse participants discussed how their personal spirituality set the foundation for providing all nursing care leading them to "give care spirituality" (Pfeiffer et al., p. 2890). Christian nurses also reflected that sharing mutual faith with their patients created a tool to connect with patients

spiritually and increase the depth of the therapeutic relationship (Pfeiffer et al.). Markani, Khodayari, and Yaghmael (2012) interviewed Muslim oncology nurses practicing in Iran. With a large sample of 24 nurses pooled from 12 hospitals and two university medical centers, Markani et al. found key support to the essential nature of personal spiritual growth and clinical practice. Findings included evidence that nurses with poor spiritual health have difficulty meeting patient's spiritual needs, personal spiritual experiences were needed for nurses to support cancer patients search for meaning and purpose in their illness, and oncology nurses found their work to contribute positively to their spiritual growth (Markani et al.).

Barriers to spiritual nursing care also reveal evidence of the impact of personal spiritual growth on care practices. Through a survey of 120 nurses practicing in an academic medical center, Gallison et al. (2013) revealed nurses expressing difficulty providing spiritual care to patients with different spiritual beliefs and practices than their own. This further suggests support for the positive influence of mutual or shared religious background or spiritual beliefs between nurse and patient can have on nurses' ability to provide spiritual nursing care. Balboni et al. (2014) in their survey of oncology nurses and physicians, found that respondents who reported themselves to have limited or no spiritual beliefs/practice were more likely to rate barriers to spiritual care highly and less likely to desire increased spiritual care training.

In addition to practicing nurses, studies exploring the impact of spiritual growth on care practices in nursing students have also provided supporting evidence to this positive association (Beauvais, Stewart, & DeNisco, 2014; Chism & Magnan, 2009). Several studies testing educational interventions to increase knowledge and or practice of nursing spiritual care found that nursing students with high levels of spiritual awareness had a positive effect on their spiritual care practices (Baldacchino, 2008, 2011; Barber, 2012; Lovanio & Wallace, 2007;

Taylor, Mamier, Bahjri, Anton, & Petersen, 2009). Beauvais et al. surveyed undergraduate and graduate nursing students to explore the relationship between emotional intelligence, existential and spiritual wellbeing, and students' ability to manage emotions as precursors to delivery of spiritual care. Their findings reveal spiritual wellbeing and existential wellbeing as correlated with students' ability to positively manage emotions. Chism and Magnan in their study of nursing students also looked at precursors to determine preparedness to provide spiritual nursing care. Utilizing Chism's Middle-Range Theory of Spiritual Empathy, Chism and Magnan revealed students' ability to express spiritual empathy was influenced by their personal spiritual perspectives. Those with more clearly developed spiritual perspectives were better able to express spiritual empathy, a concept the authors used as a proxy for spiritual nursing care.

Spiritual intelligence. Described first in the literature by Zohar and Marshall (2000), spiritual intelligence has been further advanced through both concept and measurement development by King and DeCicco (2009) and Wolman (2001). Intelligence is defined by Merriam Webster Dictionary as both "the ability to learn or understand or to deal with new or trying situations" and "the ability to apply knowledge to manipulate one's environment or to think abstractly as measured by objective criteria." Definitions of spiritual intelligence place emphasis on the capacity or functional aspects of spirituality and its ability to advance deeper insights.

Zohar and Marshall (2000) define spiritual intelligence as the intelligence needed to address and solve problems of meaning and value, needed and utilized by the individual to determine the value of actions and provide perspective of life within a wider context. Their work points to spiritual intelligence or SQ as they refer to it as the highest level intelligence and the necessary foundation for both intellectual and emotional intelligence. Significant continuity

between Zohar and Marshall's descriptions of SQ and Watson's (2008) descriptions of CPT are evident. An excerpt from Zohar and Marshall that follows, echoes Watson's words. "SQ is the intelligence that rests in that deep part of the self that is connected to wisdom from beyond the ego, or conscious mind, it is the intelligence with which we not only recognize existing values, but with which we creatively discover new values" (Zohar & Marshall, p. 9).

King and DiCicco (2009) define spiritual intelligence as a set of mental capacities which contribute to the awareness, integration, and adaptive application of nonmaterial and transcendent aspects of one's existence, leading to such outcomes as deep existential reflection, enhancement of meaning, recognition of a transcendent self, and mastery of spiritual states. King and DiCicco identified specific capacities that individuals with spiritual intelligence are using to achieve these results. They identified four capacities or components: 1) critical existential thinking, 2) personal meaning making, 3) transcendental awareness, and 4) conscious state expansion. In identifying these capacities with increased specificity, the authors provide a framework from which a measure of spiritual intelligence was later developed. The measure called the Spiritual Intelligence Self Report Inventory (King, Mara, & DeCicco, 2012) has been used both in psychology and nursing literature.

Several international studies have explored relationships of spiritual intelligence and other concepts in both student and nurse populations. Main sources of this international research are Iran (Akbarizadeh, Jahanpour, & Hajivandi, 2013; Amirian & Fazilat-Pour, 2016; Asghari & Shirvani, 2015; Karimi-Moonaghi et al., 2015; Sahebalzamani, Farahani, Abasi, & Talebi, 2013), China (Yang & Mao, 2007; Yang & Wu, 2009), and Malaysia (Kaur, Sambasivan, & Kumar, 2013, 2015). Findings from these international reports suggest spiritual intelligence has a strong influence on personal wellbeing (Akbarizadeh et al.; Amirian & Fazilat-Pour; Sahebalzamani et

al.) and clinical performance in registered nurses (Karimi-Moonaghi et al.; Kaur et al., 2013). Studies also advance the association between spiritual intelligence and hospital performance (Ashghari & Shirvani, 2015). While these international reports, reviewed below, give beginning support of the potential influence of spiritual intelligence in the US findings cannot easily be generalized due to significant demographic differences particularly with religious affiliation.

Amirian & Fazilat-Pour (2016) in a large sample of university students found evidence of the positive predictive influence of spiritual intelligence on general health and happiness. In Iranian studies that drew their samples from nurses as a target population, spiritual intelligence was found to have a positive relationship with hardiness and wellbeing (Akbarizadeh et al., 2013), clinical competence (Karimi-Moonaghi et al., 2015), and psychological well being and having a purpose in life (Sahebalzamani et al., 2013). Akbarizadeh et al. found the relationship between nurses' spiritual intelligence and wellbeing was influenced by no other demographic variables explored except the ward the nurses worked on. Further, Asghari and Shirvani (2015) found spiritual intelligence of hospital personnel to be predictive of positive hospital performance.

Kaur et al. (2013, 2015) explored the concept of spiritual intelligence with nurses in Malaysia. Findings revealed the nurses with high levels of spiritual intelligence demonstrated high personal ownership toward their jobs, which led to significantly less job associated burnout. Kaur et al. (2013) also found nurses with high levels of personal job ownership to have increased caring behaviors. Yang and Mao (2007) looked broadly at spiritual intelligence in registered nurses practicing within China and found low levels of spiritual intelligence in the sample surveyed. This work revealed nurses with the highest spiritual intelligence scores were those with religious affiliation (of whom were in the minority 20%), who were older, single, and more

highly educated. Yang and Wu (2009) in a comparison of registered nurses in Taiwan and China found lower spiritual intelligence scores in Chinese nurses. For both of these groups again, those nurses with religious affiliation were more likely to have higher spiritual intelligence scores.

Spiritual Care in the Intensive Care Unit

As discussed in Chapter one, high rates of death in the ICU has significant clinical impacts and economic costs. The cost of death in the ICU is felt in many ways, including in health care dollars at the end of life (Gallagher & Krawczyk, 2013; Mularski et al., 2005), moral distress experienced by the ICU nurses caring for dying patients (St. Ledger et al., 2013), and increased patient symptom burden including uncontrolled pain (Mularski, et al.). Family members of patients who die in the ICU have been shown to experience significant depression, anxiety, and other mental health symptoms following the care experience (Anderson et al., 2008; Azouley et al., 2005; Kross et al., 2011; McAdam et al., 2010; Pochard et al., 2005; Siegel et al., 2008; Wright et al., 2010). Spiritual support for patients and families has been identified as an essential domain of care for patients and families particularly those facing the end-of-life in the ICU (Clarke et al., 2003). As described in Chapter one, spiritual support provided to family members in the ICU has been found to increase satisfaction with care at the end of life (Wall et al., 2007). Patients and families who have their spiritual needs assessed and responded to are less likely to receive aggressive treatments in the ICU and more likely to enroll in hospice services at the end of life (Balboni et al., 2013). Despite this, spiritual needs are reported as one of the least frequently addressed areas of care in the ICU (Clarke et al.). The following section will discuss the spiritual needs of patients and families facing death, perceptions of providers and spiritual care practices in the ICU, the impact of spiritual care on care decisions and outcomes in the ICU, and spirituality and the ICU nurse.

Spiritual needs in the face of death. Patients and families in the ICU are often faced with life threatening critical illness. This experience of facing mortality, presents the patient and family caregiver with the unique spiritual needs. Several studies have explored the spiritual needs of terminally ill patients (Hermann, 2001; Mok et al., 2009; Murray et al., 2004; Vilalta et al., 2014) and patients faced with life-threatening illness (Albaugh, 2003; Young et al., 2015) and provide insight into the experience of patients and families in the ICU.

Hermann (2001) in a qualitative study of 19 hospice patients identified broad descriptions of spiritual needs reflective of a larger need for finding meaning and purpose in the dying process. Spiritual needs were described by Hermann in the following themes: need for involvement or control, the need for companionship, the need to work through unfinished business, the need for religion, the need to experience nature, and the need to maintain a positive outlook. Mok et al. (2009) in a qualitative study of 15 terminally ill patients in China found descriptions of spirituality becoming an essential resource for participants at the end of life. Participants described a greater need for spirituality as they approached death and looked for a reframing of meaning and purpose at this next stage. Participants described this turn toward spirituality as a unique experience and as helpful in providing them with strength and coping skills. They also referred to religious participation as providing a supportive community at a time of great loneliness (Mok et al.).

Murray et al. (2004) conducted interviews with patients diagnosed with end-stage lung cancer or heart failure and their caregivers. Both groups identified spiritual needs as important and often unmet in their experience in healthcare settings. They characterized spiritual needs or spiritual distress as including feelings of loss of control and despair brought on by facing serious illness and mortality. Despite this, participants discussed unease with requesting spiritual

support from healthcare providers and lack of response to spiritual requests (Murray et al.). Vilalta et al. (2014) surveyed 50 oncology patients in a palliative care unit in Spain to identify the most relevant spiritual needs at the end of life. Two spiritual needs emerged as most important for patient, the need to know the truth about their illness and the need to be recognized and treated humanely until the end (Vilalta et al.).

The need to seek out spiritual resources to gain control and purpose in the face of a terminal illness is similarly experienced by those patients and families who face life-threatening illness. While the potential for recovery remains, the experience of facing mortality and the uncertainty of the situation leads to similar experiences. Albaugh (2003) interviewed seven individuals who had self identified as spiritual and had received various life threatening diagnoses including various cancers, pulmonary fibrosis, and myocardial infarction. The participants described the role of spirituality in helping them to find meaning in their diagnosis, providing comfort during a time of great uncertainty, helping them to not feel alone, and giving them strength to face the treatments and illness ahead (Albaugh, 2003). Lastly, Young et al. (2015) interviewed 10 survivors of serious cardiac events and nine cancer survivors to elicit descriptions of the positive impact of spirituality on their experience facing a life-threatening illness. Patients described turning to spirituality in their time of uncertainty and how exploring spirituality led to personal growth through finding meaning and purpose in their illness experience (Young et al.).

In an Iranian study exploring sources of hope for families in the ICU, Gaeeni et al. (2014) found religious and spiritual beliefs as one of the most important sources of hope. This qualitative analysis of 19 family members of patients in Iranian ICUs revealed both internal and external sources of hope. Religious and spiritual beliefs were described as a significant internal

source of hope needed to face the stress associated with the experience of a family member admitted to the ICU (Gaeni et al.).

Healthcare provider spiritual care practices and perspectives in the ICU. Repeated studies of care in the ICU, point to a lack of spiritual care received by patients and families at a time of great need. As one measure of the receipt of spiritual care, Choi, Curlin, and Cox (2015) looked at chaplain visits in the ICU. Their findings revealed the majority of chaplain visits were occurring at end of life, with patients who had cancer, were in a medical ICU, and whose family had requested the visit (Choi et al.). Findings point to the limited use of chaplains as reflecting spiritual needs unfulfilled in the majority of ICU patients.

Often due to the critical nature of illness in the ICU patients are unable to speak for themselves and surrogate decision makers are utilized for identifying important healthcare decisions during care conferences. In a study looking at surrogate decision makers and care discussions with providers, the majority (77.6%) of surrogates reported religion or spirituality as an important consideration in their decision making process (Ernecoff et al., 2015). Despite this, spirituality was seldom (only 16.1% of the time) included in provider care discussions with surrogates. Discussion of spiritual concerns was most likely to be initiated by the surrogate family member rather than the provider (Ernecoff et al.). Providers responses to surrogates who brought up spiritual beliefs included in descending order of frequency, redirecting the conversation to medical topics, offering to refer to healthcare chaplaincy, expressing empathy, acknowledging the statement, or explaining their own religious beliefs. Few providers in response to spiritual expressions in the context of a care conference attempted to explore the surrogates' beliefs further (Ernecoff et al.).

In a study exploring family satisfaction in surgical ICU, Twohig et al. (2015) reported high levels of satisfaction with spiritual care. Findings also indicated that a large percentage of participants did not respond to items related to spiritual care, instead writing “N/A” suggesting significant bias in their results and a need for further exploration of spiritual care within this environment. In response to these findings, the authors describe changes in practice including daily rounds by healthcare chaplain in an effort to address this apparent gap in care delivery. Ho et al. (2011) found in a study about palliative care in the intensive care unit, physicians and nurses both identified spiritual support and assessment of spiritual and religious needs as an area needing significant improvement.

Canfield et al. (2016) interviewed 30 ICU nurses to examine the nurses’ definitions of spirituality, their comfort with providing spiritual care, and their perceived need for spiritual care training. A majority of nurses (75%) reported some degree of comfort with providing spiritual care, but also were hesitant to provide such care. Nurses reported a fear of spiritual care being perceived as proselytizing or offensive by patients and their families and also were uncomfortable providing care when a patient’s belief system was unfamiliar to the nurse. Nurses reported difficulty assessing the need for spiritual care when not directly requested by the patient or family in the ICU (Canfield et al.). ICU nurses reported desire for more education specific to patient religion, culture, and spiritual values, assessment of spiritual need, and how to begin to discuss spirituality and spiritual care with patients and families (Canfield et al.).

Two international studies in highly religious countries, Turkey and Brazil, examined the spiritual care practices and perceptions of ICU nurses. Turan and Yavuz Karamanoğlu (2013) explored the perceptions and spiritual care practice of ICU nurses in Turkey. They found that nurses who were older (over 40), more educated (had a master’s degree), and more experienced

(10 years in nursing or more), were more likely to provide spiritual care and have positive perceptions of spiritual care in the ICU. Perceptions in this study were significantly associated with care practices. Nurses with more positive spiritual perceptions were most likely to provide spiritual nursing care (Turan & Yavuz Karamanoğlu). Da Costa et al. (2014) explored broadly end of life and palliative care perceptions among ICU nurses in Brazil. Nurses described care of dying patients in the ICU to be a significant source of work related stress. Nurses felt unprepared to cope with the emotional toll of assisting patients with facing death in the ICU and experienced this inadequacy as a failure with significant shame (da Costa et al.).

Descriptions of spiritual nursing care in the ICU reflect definitions of spiritual nursing care in the literature. Kociszewski (2004) in the results of a phenomenological study presented ICU nurses' lived experiences of providing spiritual nursing care. Nurses describe spiritual care as often occurring in times of tragedy, being emotionally challenging, and leading to need for ongoing personal spiritual development (Kociszewski). The nurses describe nursing spiritual care in the ICU as care that is religiously centered, incorporates all aspects of care, and centered around spiritual assessment (Kociszewski). Lundberg and Kerdonfag (2010) in a qualitative study sampling 30 nurses in Thailand, provided descriptions of spiritual nursing care in the ICU. Emerging themes included "giving mental support, facilitating religious rituals and cultural beliefs, communicating with patients and patient's families, assessing the spiritual needs of patients and showing respect and facilitating family participation in care" (Lundberg & Kerdonfag, p. 112).

Spiritual support and intensive care. Several studies have pointed to the potential serious consequences of unmet spiritual needs in ICU patients. In a study by Shinall et al. (2014), religiously affiliated oncology patients receive more aggressive care at the end of life

than matched nonreligious counterparts. The study authors found these patients spent longer in the hospital, spent more days on ventilators, and incurred more hospital charges than nonreligious patients under similar conditions. Further their findings suggest that despite increased aggressive care, religiously affiliated oncology patients do not have an increased rate of survival (Shinall et al.). Phelps et al. (2009) presented similar findings through their study on religious coping and aggressive life-prolonging treatments at end of life in oncology patients. Patients in their study who demonstrated high levels of religious coping were less likely to receive spiritual support from healthcare providers, suggesting need for spiritual care intervention. These high religious copers were also found to be less likely to participate in advanced care planning and more likely to seek aggressive measures including mechanical ventilation at end of life (Phelps et al.).

Balboni et al. (2013) helped to distinguish the impact of spiritual support provided to patients from healthcare providers and from religious communities. Spiritual support provided by healthcare providers is essential in helping patients and families negotiate their personal values with complex healthcare decisions. Balboni et al. found that patients who received significant spiritual support from religious communities were more likely to receive aggressive treatments at the end of life. They found that patients who were high religious copers were more likely to die in the ICU and were less likely to receive hospice care, reflecting the findings of other similar studies. Patients who received spiritual support from religious communities were also more likely to be racial/ethnic minorities, less educated, less likely to have adequate health insurance, more likely to be unaware of their prognosis, and less likely to have participated in advanced care planning. In contrast, patients who received spiritual support from healthcare

providers were more likely to receive hospice care and less likely to receive aggressive treatments at the end of life or die in the ICU (Balboni et al.).

Johnson et al. (2014) further explored the impact of spiritual care for family caregivers provided by healthcare chaplains in the ICU. Healthcare chaplains in this study reported providing care to family caregivers in the ICU that included discussions of spiritual needs, family members values, and reflecting on their relationship with the patient (Johnson et al.). They found that family caregivers of patients in the ICU who received a visit from a healthcare chaplain reported higher on measures of satisfaction than patients who did not receive spiritual support. These family caregivers also reported feeling better prepared to participate in goals of care meetings and more likely to report that care provided was a good reflection of their loved ones wishes (Johnson et al.).

The link between increased spiritual needs and increased cost of care in the ICU was made explicit in a study by Balboni et al. (2011). Their work supported findings from other studies reported above, with patients whose religious and spiritual needs were inadequately supported by healthcare providers more likely to receive aggressive care at the end-of-life. Aggressive care in this study was marked by increased ICU care, a higher likelihood of dying in the ICU, and a decreased likelihood of receiving hospice care. Balboni et al. compared the cost of care for patients who reported adequate spiritual care at the end of life to those who did not. Significant differences were found between patients with end of life care costs for patients who received adequate spiritual support averaging at \$2,441 and costs for high religious copers who received inadequate spiritual support averaging \$4,060.

Spirituality and the ICU nurse. Just as patients and families in the ICU experience high levels of stress associated with the weight of critical illness, ICU nurses have been found to

have elevated levels of distress particularly moral distress. In a study exploring the moral distress of nurses working within a medical ICU, many nurses were found to experience moral distress in response to witnessing patients receiving treatments viewed as futile (Elpern, Covert, & Kleinpell, 2005). Moral distress is described in the literature as distress experienced when the perceived right action is known but the individual is constrained from taking it (Epstein & Delgado, 2010). For nurses, there are many sources of moral distress including a belief that a patient is not receiving care that is consistent with his or her values or expressed wishes (Epstein & Delgado). Nurses who experience moral distress are more likely to leave their jobs or even leave the nursing profession. For medical ICU nurses the experience of moral distress was described by Elpern et al. as cumulative and nurses with the most years of experience reported the highest levels of distress.

In a study looking at surgical ICU nurses, moral distress was among additional sources of distress identified including distress from patient death and suffering at the end of life (Mason et al., 2014). Surgical ICU nurses with high levels of distress were less likely to be satisfied and engaged in their work and more likely to experience burnout. Mason et al. found measures of elevated moral distress and decreased work engagement in the surgical ICU nurses sampled. Mealer et al. (2012) in a large scale survey of 744 ICU nurses, found 18% of respondents reporting symptoms of anxiety, 11% with symptoms of depression, and 80% reporting burnout symptoms. Mealer et al. further measured only 22% of ICU nurses surveyed as highly resilient with resilience associated with less distressed symptoms and decreased levels of burnout.

With the significant emotional-spiritual toll experienced by nurses providing care in the ICU, interventions are needed to increase the resiliency of providers at risk for burnout and leaving the profession. Campbell (2013) introduced an intervention aimed at increasing spiritual

practices to critical care registered nurses' in Thailand. The intervention was delivered over a five-day period and was designed to introduce the nurses to Buddhist practices including meditation. The results of the study revealed nurses who were better able to cope with work related stress and in particular the stress of caring for patients with terminal illness. The critical care nurses following the intervention were found to have high levels of spiritual wellbeing, reduced work related stress, and low measures of intent to leave their current position (Campbell).

Summary

WTHC (Watson, 2008) supports the importance of nurses focusing on personal development including spiritual development as a precursor to providing holistic nursing care. WTHC is utilized in many clinical practice settings and is relevant as a model for understanding nursing professional practice. Spirituality plays a prominent role in the nursing literature with particular emphasis on a holistic focus open to subjectivity in the patient experience of spirituality. Despite agreement of the importance of spirituality in clinical practice, nurses and other healthcare providers continue to report difficulties and significant barriers to the delivery of spiritual care. There is a substantial need for spiritual care in the ICU. Patients and families who do not receive spiritual care from healthcare providers are more likely to receive aggressive treatments and die in the ICU. Providers with strong religious practices or spiritual beliefs are most likely to provide spiritual care. Little is known about the spiritual development of ICU nurses and its potential impact on spiritual care of patients and families. Findings from this study build on existing literature and addresses this gap by exploring ICU nurses experience of personal spiritual development from the perspective of CPT of WTHC.

Chapter Three: Methods

The review of the literature revealed that the spiritual development and awareness of nurses in the intensive care unit (ICU) is unknown. This is despite supporting evidence of the influence of provider spiritual awareness on the delivery of spiritual care. Patients and families in the ICU are not receiving adequate spiritual care, despite significant documented need and potential benefit. Knowledge to facilitate spiritual care is needed. ICU nurses experience of spiritual development and awareness and relationship to work environment was described through this qualitative descriptive research. Watson's Theory of Human Caring (WTHC) identifies spiritual development and awareness as essential to nurse caring in Caritas Process Three (CPT), Cultivation of One's Own Spiritual Practice and Transpersonal Self, Going Beyond Ego-Self. This theoretical tenant framed analysis through the use of directed content analysis and provided the beginning coding schema for understanding the experience of ICU nurses.

An overview of the method and procedures of this dissertation study will be described in the following chapter. The methodological approach of the qualitative descriptive design with directed content analysis used in this study will be described. Details pertinent to the study sample will be outlined including sample setting, sampling procedures, inclusion/exclusion criteria, and proposed and actual sample size. This chapter will include information outlining the procedures of the study, including data collection procedures, protection of human subjects, and data analysis. Lastly, elements of research rigor for qualitative research design are discussed.

Study Design

The methodological approach chosen for this dissertation research was qualitative description with directed content analysis. Hsieh and Shannon (2005) described three approaches to content analysis in qualitative descriptive research, including conventional,

directed, or summative. Each of these approaches adhere to a naturalistic perspective, bringing forth descriptions of experience or phenomena from the participant's own words and from their own perspective. Data in this study were analyzed using directed content analysis. The directed or deductive approach to content analysis is useful for areas of inquiry where existing theory may serve as a frame for the qualitative study (Hsieh & Shannon). The theory may be further validated or extended by the findings of the qualitative inquiry.

In this dissertation study, CPT of WTHC was utilized as a theoretical frame for the analysis. CPT of WTHC suggests personal development of self including spiritual development as a necessary precondition for providing holistic nursing care (Watson, 2008). In this way, the theory provided a beginning explanation for understanding the relationship between ICU nurses' spiritual awareness and spiritual care. Using a directed approach, study findings provided a rich description of the experience of CPT as told by the ICU nurses interviewed. The process of analysis brought forth specific descriptions to enrich the more general theoretical knowledge (Elo & Kyngas, 2008). As Watson's theory was used to frame the questions and analysis, directed qualitative inquiry was an appropriate approach to answer the research questions.

Rigor and trustworthiness. Techniques were utilized throughout the process of data collection and analysis to ensure the quality of the research findings. Quality in qualitative research is reflective of both the research process and the creative and representative presentation of the findings (Corbin & Strauss, 2008). Unlike quantitative research approaches, qualitative research is not guided by one standard for assuring quality of findings. While various authors have provided guidelines for measuring quality in qualitative research, their descriptions are reflective of two basic principles: rigor and trustworthiness. Rigor as a general consideration describes the scientific approach to both data collection and analysis (Corbin & Strauss). Rigor

in qualitative design can be ensured through clear explanation and adherence to research procedures, including producing an audit trail for both data collection and analysis.

Methodological consistency is one measure of the quality of qualitative findings (Corbin & Strauss). In this dissertation research, qualitative description with directed content analysis was utilized. The findings derived from analysis reflect both a validation and extension of CPT of WTHC. Thus, the findings are a clear reflection of the research approach and represent one measure of quality.

Lincoln and Guba (1985) present one helpful model for evaluating rigor or determining trustworthiness in qualitative research guided by the principles of credibility, transferability, dependability, and confirmability. Credibility is a measure of the truth of the findings and is parallel to the concept of validity in quantitative research. Credibility was estimated in this dissertation research through the use of member checking and negative case analysis. Member checking is a method of determining credibility by reviewing preliminary findings with study participants (Creswell, 2013). Two participants who are willing to be contacted after the initial interview were presented with the study results through email correspondence with the dissertation researcher. The participants were given the opportunity to review the findings and positively confirmed the findings as both consistent with their personal experience and that observed in their colleagues. Negative case analysis was completed by review of portions of the data that do not support the study's findings. Through this review of contradictory cases, the dissertation researcher added to the credibility of the findings.

Transferability suggests that the findings can be applied to other contexts, reflecting the quantitative concept of generalizability. Lincoln and Guba (1985) describe the use of thick description as essential to transferability of findings. Thick description was achieved through

data saturation. The dissertation researcher further strove to increase transferability through clear descriptions of the sample demographics, site of sampling, and findings.

Dependability is a measure of the degree to which the results can be reproduced and are consistent, reflecting the quantitative concept of reliability (Lincoln & Guba, 1985).

Dependability can be estimated through the use of external audit of findings. For this dissertation research, the dissertation chair reviewed both procedures and findings at various stages of both data collection and analysis, serving as an external auditor of study findings.

Confirmability describes the degree to which the results are reflective of the experience of the participants and not unduly influenced by researcher bias. One way to estimate confirmability of findings is through reflexivity or a measure of self awareness by the dissertation researcher. The dissertation researcher as the instrument of data analysis must continuously evaluate findings for potential bias or intrusion of assumptions (Corbin & Strauss, 2008). Confirmability was accomplished through the use of memoing and tracking of analytic decisions. The dissertation researcher throughout the research process reflected on the possible influence of the researchers' background (Creswell, 2009). Confirmability was further supported by representative quotes from participants used as supportive evidence for research findings.

Researcher bias. The dissertation researcher brought potential bias to the research from personal experience and existing knowledge. The dissertation researcher brought to the research clinical experience as a registered nurse working in an adult ICU. This experience contributed to the baseline assumption that spiritual care is essential to providing holistic care in the ICU. This experience also contributed to the baseline assumption that personal development and spiritual awareness are both influenced by clinical work in the ICU and are essential to providing spiritual nursing care to patients and families. These personal assumptions were further supported by the

theoretical frame of this proposed study, WTHC. This theory, which framed the directed analysis, suggested a relationship between personal spiritual development and awareness and nurses' transpersonal relationship with patients and families. The dissertation researcher was not and has never been an employee at the proposed site of data collection, nor did the dissertation researcher have prior personal knowledge of the study participants.

The approach to analysis, directed content analysis, could have potentially introduced bias to the study. The use of theory to guide interview probes and analytic decisions could have influenced the participants during the interviews and the researcher during analysis (Hsieh & Shannon, 2005). The dissertation researcher designed interview probes to be non-leading including language that was general and non-theory laden. The dissertation researcher utilized analytic memoing throughout analysis to serve as an easy review of analytic decisions, confirming consistency with participant experience. Also, the external audit of findings by the dissertation committee chair enhanced confirmability in addition to dependability as mentioned above. Although the CPT of WTHC was utilized through directed content analysis as a beginning theoretical frame, the dissertation researcher took great care to be open to new and novel findings reflective of the participant descriptions as evidenced in Chapter Four.

Bracketing was utilized throughout analysis in an effort to limit researcher bias. Just as reflexivity was utilized to help the researcher identify personal assumptions, bracketing describes the active process of setting aside personal experience and assumptions throughout data collection and analysis (Creswell, 2013). The researcher took every effort to remain aware of personal assumptions, personal experience, and the potential influence of the theoretical frame, in order to approach data with an open and unbiased approach.

Site and Sampling

Site. The target population for this study was registered nurses currently practicing in an adult ICU within a National Caring Science affiliate hospital in the Western United States. The Watson Caring Science Institute (WCSI) is a non-profit organization founded by Jean Watson to promote WTHC in both national and international healthcare systems. One mission of the WCSI is to support hospital systems' efforts to design and implement practice guidelines reflective of and informed by WTHC. WCSI provides training and support to hospitals within the United States to become National Caring Science affiliates, in addition to international organizations that become WCSI Global affiliates. As stated on the WCSI website:

To become a National Caring Science Affiliate, an organization must demonstrate deep-rooted and sustainable commitment to integrating caring science within practices and policies, seeking to transform and broaden the notion of health and healing for its staff as well as the patients, families and communities it serves
(<http://www.watsoncaringscience.org/national-wcsi-affiliates>, 2018)

Nurses practicing within a National Caring Science affiliate hospital provide nursing care informed by WTHC. The sample hospital had been a member of the WCSI since 2010 and is a university acute care center in the Western United States. There were approximately 300 nurses practicing in adult ICUs in the identified sampling site at the time of recruitment. Recruitment for the study occurred in three ICUs.

Sampling. Participant sampling was guided by purposive and snowball sampling. Informed by the principle aims of the study, purposive sampling allowed the researcher to choose those participants who are most knowledgeable of the topic being explored (Creswell, 2013). For this purpose, registered nurses practicing within adult ICUs in a WCSI were purposefully sampled. Although the aim of this study was to reveal the ICU nurses' experience of CPT, it is possible that purposive sampling led to under representation of specific genders, ethnic groups, levels of experience, or religious and spiritual perspectives in the study sample.

This potential bias is a possible limitation of study design and will be addressed in the discussion of findings.

In addition to purposive sampling, the study also utilized snowball sampling. Snowball sampling was utilized by asking individual nurse participants already enrolled in the study to identify additional potential participants (Creswell, 2013). Enrolled nurse participants shared the researcher's contact information with ICU nurse colleagues, who directly contacted the nurse researcher for additional information if interested in participation.

Sample inclusion criteria.

The following criteria were used by the dissertation researcher to determine who was eligible for study participation:

1. Registered nurse
2. Current nursing practice within an adult ICU
3. 21 years of age or older
4. Agree to audio recording of the interview
5. Functioning telephone

Sample exclusion criteria.

The following criteria were used by the dissertation researcher to determine who was not eligible for study participation:

1. Are unable to speak or understand English and
2. Self-report a practice in adult ICU for less than six months

Sample size. Sample size in qualitative research design is determined by data saturation, which means that no new or novel information is being added with additional participant interviews (Creswell, 2013). Because the point of data saturation was not clear a priori,

estimates of sample size were initially based on previously conducted qualitative studies found in the literature. Sullivan-Bolyai, Bova, and Harper (2005) described a sample size of 20-50 as moderate for qualitative methodology. Kim, Sefcik, and Bradway (2017), in their review of published studies utilizing qualitative description, reported sample sizes ranged from 8 to 1,932, with the majority of published studies reported a sample size between 11-20 participants. Two recently published accounts of directed content analysis report sample sizes of 24 (Durepos et al., 2017) and 71 (Liljeroos, Ågren, Jaarsma, & Stromberg, 2017).

Guest, Bunce, and Johnson (2006) found data saturation of 92% of the findings through analysis of 12 participant interviews. They also pointed out many factors that contribute to achieving data saturation with a smaller sample size, including interview structure, interview content, and homogeneity of the study sample. Guest et al. suggested that an interview that is structured such that all participants consistently receive similar questions will facilitate achieving data saturation with smaller sample sizes. Further if the interview content is based on a common experience with a shared domain of knowledge, participants are more likely to provide similar responses. Lastly, homogeneity of the sample contributes to data saturation with a smaller sample.

Based on these multiple sources a sample size of 15-25 participants was initially proposed for this dissertation study. Informed by recommendations from the dissertation chair, the dissertation researcher determined final sample size during data analysis through data saturation. In the end, data saturation was achieved with 10 participants reflecting a smaller than proposed sample size, but consistent with the literature (Kim et al.).

Procedures

Participant recruitment. Recruitment of participants began following approval by the Institutional Review Board (IRB) at Boston College. Potential participants were recruited at a WCSI National affiliate medical center in the Western United States. The dissertation researcher worked in collaboration with a nurse scientist employed by the healthcare organization who served as the recruitment gatekeeper (Creswell, 2009) on site and coordinated distribution of the study flyer (Appendix A). Study recruitment occurred in two phases. The first phase occurred with the organization's nurse scientist through electronic mail (email) contacting ICU nurse managers. All ICU nurse managers in response posted the study flyer for public view on the ICUs. Nurse managers additionally emailed out the study flyer to ICU staff nurses at their discretion. The email contained introductory information and invitation to participate in the dissertation researcher's study with attached study flyer. The second phase of recruitment was facilitated by a clinical nurse educator and included email to both ICU nurses and Caritas Coaches. The second phase email again included introductory study information and the study flyer. Caritas Coaches were invited by the clinical nurse educator to further distribute the flyer to potentially interested parties.

Enrollment and informed consent. All interested potential participants contacted the dissertation researcher by email through provided contact information on the study flyer. During initial contact, the dissertation researcher confirmed eligibility of the potential participant, answered any questions relevant to study participation, and sent out the study consent form (Appendix B) for review. Nurses who decided to participate then scheduled an appointment for a telephone interview at a date and time convenient for both the study participant and dissertation researcher. An email reminder confirming the date and time of the interview was sent out prior to the scheduled interview time.

Participants were formally consented at the beginning of the scheduled telephone interview. The participants had the opportunity to review the consent form sent out with the initial email contact. The dissertation researcher at the beginning of the telephone interview reviewed pertinent study objectives, risks to participants, and benefits for participation. Each participant then gave oral consent.

Enrollment for the study continued until data saturation was achieved. At this point the study flyer was removed from public view and ICU nurses were contacted via email informing them that the enrollment period had closed. Upon completion of the interview, all study participants were offered a \$25.00 Amazon gift card. All interested parties were sent the gift card through email.

Data collection. This study employed a directed qualitative descriptive approach and as such the data collection process adhered to the broader literature describing qualitative description. The principal form of data collected was participant interviews. The interview was conducted with a semi-structured interview guide (Appendix C) informed by the theoretical structure and concepts of CPT of WTHC. The semi structured interview guide was developed under broad theoretical categories and informed by the study research questions. Participants were asked seven primary questions with up to 14 subquestions. Sub-questions were utilized as needed based on the depth of participant response. Additionally, the researcher utilized further probing questions as needed to elicit depth in key participant responses.

Interviews were conducted via telephone utilizing two digital recorders. The dissertation researcher conducted the interviews using speaker phone and voice recorder application to capture both parties. The recordings began following consent, collection of demographic data, and an initial introduction with the interview participant. The dissertation researcher again

reviewed instructions with the participant, including permission to omit response to any question, estimated length of interview, and use of recording device during the interview. The dissertation researcher confirmed the identity of the participant prior to initiating the recording, in an effort to leave identifying information off of the recorded record. The dissertation researcher then began recording with the use of two digital recorders. The purpose of dual recording was to ensure quality and completeness of the interview data in the event that one of the recording devices should fail. Following completion of the interview, the dissertation researcher informed the participant that the recording was stopped and allowed the participant an opportunity to ask any additional procedural questions in addition to thanking the participant for participation. The dissertation researcher also asked participants at the completion of the interview if they would be willing to be contacted to participate in member checking.

Telephone interviewing was chosen as the mode of data collection for several reasons. Telephone interviews provide synchronous communication allowing the interviewer and the interviewee to respond to each other in real time. This form of interviewing also allows ease of recording, increasing the rigor of the data collection (Opdenakker, 2006). Telephone interviews, unlike face-to-face interviews, allow for asynchronous location of the interviewer and participant. This benefits the researcher by allowing broad geographic access to participants with limited expense (Novick, 2008; Opdenakker). This form of interview also increases access to hard to reach populations, such as shift workers (Novick; Opdenakker). Lastly, telephone interviews may allow the interviewee increased comfort in discussing potentially sensitive topics due to increased anonymity in addition to increasing the ease of the interviewer, with the result of improved rapport and decreased social pressure (Novick; Opdenakker). Although some authors suggest telephone interviewing may have a negative effect on data collected due to the

absence of non-verbal cues and observations, Sturges and Hanrahan (2004), in a study that included both in person and telephone interviews, found no difference between interview modes. Novick, in a review of use of telephone interviews in qualitative research, found limited evidence to support the bias against telephone interviews.

Data management. Interview recordings were transcribed verbatim by a professional transcription service. The recorded interviews were uploaded to Rev.com. Rev.com is an online service that offers transcription of audio recordings, caption for video recordings, and translation of documents. In addition to transcription services, Rev.com offers document security with TLS 1.2 encryption and requires employees to sign confidentiality agreements, ensuring a high level of confidentiality to their clients. Rev.com identifies parties within the audio-recorded interview in a de-identified fashion. The dissertation researcher upon receipt of the transcripts provided pseudonyms for each participant.

All data was stored on a password protected and encrypted computer, including raw recording data, transcriptions, field notes, coded data, codebook, and data analysis log. The description of data reviewed for analysis is further described in the data analysis section of this chapter. All study materials, including recordings, transcripts, consents, demographic data, participant names and contact information, will be stored for a period of five years, following which they will be destroyed.

Measures/Instruments

Demographic data. Demographic information was obtained from all participants. Demographic information was collected at the beginning of the telephone interview following the consent procedure. The demographic questionnaire followed the template developed by the dissertation researcher (Appendix D). Demographic information collected included age, gender,

highest completed level of education, race/ethnicity, years of nursing practice, and years of nursing practice in ICU.

Interview guide. The research questions and the theoretical frame provided the basis for the development of the interview guide (Appendix C). The guide was developed by the dissertation researcher based on CPT of WTHC and reviewed with members of the dissertation committee. The interview questions were open-ended in nature, allowing the participants to elaborate as desired to provide descriptions of experience from their own perspective as suggested by Hulley, Cummings, Browner, Grady, and Newman (2007). The interview guide was reliably used in an effort to increase consistency across interviews to avoid introducing interviewer bias (Hulley et al.).

The interview approach utilized was essential in keeping with the naturalistic frame of the qualitative descriptive methodology. The used of a semi-structured interview guide also allowed the researcher to build interview questions based on previous knowledge. In doing so, the interviewer was able to guide the interviewee to provide description of spirituality a phenomena that is complex or difficult to describe (Kallio, Pietilä, Johnson, & Kangasniemi, 2016). Follow-up or probing questions were used as needed to encourage participants to clarify and provide additional description to given responses (Hulley et al., 2007). Follow up questions were targeted to the coding template to aid in the exploration of theoretical concepts (Hsieh & Shannon, 2005).

Cognitive interviews. Prior to beginning the study, the interview guide was piloted through cognitive interviews. Three ICU nurse volunteers participated. The participants were all masters prepared and all currented worked in a critical care educator or leadership position. The dissertation researcher recorded the cognitive interviews and took notes following interview

completion. Additionally, the participants were given the opportunity to offer feedback to the dissertation researcher. The cognitive interviews were used to evaluate the participants ease in understanding the questions asked and to estimate interview length. The dissertation researcher also evaluated the content of the responses in relationship to the research questions they are intended to answer. With the information obtained through the interviews and in collaboration with the dissertation chair changes were made to the interview guide. The interview guide found in Appendix C reflects the changes made following the completion of cognitive interviews.

In addition to changes in the interview questions, the cognitive interviews provided an estimate to the length of the total interview. While initially the interview was estimated to take 30 to 60 minutes, the cognitive interviews revealed interview times ranging from 15-30 minutes. Subsequent changes were made in the study flyer (Appendix A) to reflect the shorter estimated interview time. Interview time was calculated by recorded time only, thus excluding time spent collecting study consent and demographic data. Interview times through the entirety of the study ranged from approximately 19 to 44 minutes, with an average length of 26 minutes.

Coding template. A coding template is utilized in directed content analysis as a beginning guide for approaching the transcription data. The template designed for use in this study (Appendix E) was created and informed by the essential concepts of CPT of WTHC. CPT served as the frame for this study and essential concepts that support the meaning of CPT were identified and defined in the development of the coding template.

Data Analysis Plan

Data were analyzed using directed content analysis. Directed content analysis, also referred to as deductive content analysis, is an approach to qualitative descriptive research that allows for analysis of data from the context of preexisting theory (Elo & Kyngas, 2008; Hsieh &

Shannon, 2005). The goal of directed content analysis is the extension or validation of existing theory that has yet to be adequately described in the literature or is to be extended into the study context (Elo & Kyngas). Theory was utilized in the development of the research questions, used as a guide for data analysis, and provided beginning explanations of the relations between concepts (Hsieh & Shannon).

The data analysis plan followed the methods for qualitative analysis presented by Miles, Huberman, and Saldana (2014). The analysis further was guided by essentials for conducting a directed content analysis as presented by Hsieh and Shannon (2005) and Elo and Kyngas (2008). The data analysis plan was divided into four phases: data processing and preparation, first cycle coding, second cycle coding, and data display.

Iterative process. Although the phases of analysis are presented in sequential order, the phases informed and advanced each other in an iterative and cyclical process culminating in the presentation of final conclusions or results (Miles et al., 2014). The iterative process of data analysis was essential in evaluating for data saturation. Data saturation has been described both as the realization of no new information being derived from the data and also a detailed description of the concepts of interest, such that a complete description has been obtained (Corbin & Strauss, 2008). It was through this analytic technique that the decision to stop data collection was made and the final sample size reached.

Analytic memoing. Throughout the process of data analysis analytic memoing was utilized. All memos were saved and dated to serve as a historical record of analytic decisions throughout analysis (Miles et al., 2014). Analytic memos captured important decisions in analysis such as coding choice and operational definitions, in addition to providing a reference for beginning understanding of higher order organization and direction of analysis (Miles et al.).

This use of memoing served to increase rigor of the study design through enhanced confirmability of the findings.

Data processing and preparation. In preparation for data analysis, the dissertation researcher first developed the coding template (Appendix E) based on CPT of WTHC (Watson, 2008). The coding template was based on the essential constructs of CPT (Hsieh & Shannon, 2005). The concepts identified for inclusion in the coding template included Ego-Self, Transpersonal Self, and Cultivation of Spiritual Practices. The coding template included operational definitions of these concepts in addition to a beginning hypothesis of the relationship between the concepts. The coding template was utilized to form the initial coding categories (Hsieh & Shannon).

The unit of analysis was identified as each transcribed interview text (Elo & Kyngas, 2008). Prior to analysis, the dissertation researcher verified the interview transcripts with audio recordings by reading the transcript while listening to the recording. A complete read of the transcript data began the process of immersion in the data, through which the researcher gained a sense of the whole of the interview (Creswell, 2013; Elo & Kyngas). In addition to transcript data, the dissertation researcher included field notes including observations or summary thoughts with the stored data for later analysis.

First cycle coding. First cycle coding began concurrent with the start of data collection following preparation of the first transcripts. The first cycle coding phase consisted of three primary modes of coding the data, provisional, subcoding, and descriptive coding (Miles et al., 2014; Saldana, 2009). Provisional coding is described as an approach to the data with a starting or provisional set of codes. The provisional coding for this directed analysis was the coding template. The dissertation researcher began by coding data for corresponding fit or

exemplification of the identified concepts (Elo & Kyngas, 2008; Miles et al.). The provisional coding was utilized as first round coding, referred to as deductive coding (Miles et al.). This approach to coding provided the researcher with a more structured focus on codes and variables essential to the theoretical structure explored.

Following the initial coding for the broad theoretical concepts the next phase of first cycle coding involved the use of subcoding and descriptive coding (Miles et al., 2014). The dissertation researcher began with subcoding by developing second order descriptive codes. Subcoding provides an additional layer of description and richness to broad coding categories, such as those created with provisional coding schema. These supportive codes aided the researcher in identifying nuance of categorization of the broader conceptual frame (Miles et al.).

Lastly, the dissertation researcher developed descriptive codes for the remaining data that do not fit within the preliminary coding template. Descriptive codes summarize the content of a phrase or passage capturing the essence of the meaning being presented by the participant (Saldana, 2009). The researcher remained open to data that do not reflect preconceived codes throughout the process of first cycle coding. This openness to data outside the beginning coding template was essential for identifying context specific factors not identified a priori (Elo & Kyngas, 2008; Miles et al., 2014). These data also served to represent subcategories of the key theoretical concepts and new conceptual elements of the theory (Hseih & Shannon, 2005).

Codes were maintained and organized through the use of a codebook. The codebook served to track and describe codes that are identified, serving both as a guide for analysis and as part of the audit trail. The codebook included definitions of concepts from the initial coding template and any codes that emerged inductively throughout analysis. The beginning coding template served to structure the codebook displaying the relationship of subcodes to broad

concepts and codes identified outside the theoretical frame (Miles et al., 2014). The codes were continuously reviewed and refined throughout first cycle coding.

Second cycle coding. When the first six interview transcripts were reviewed using first cycle coding, the dissertation researcher began the process of second cycle coding. Second cycle coding involved the categorization or patterning of codes identified in first cycle analysis. Miles et al. (2014) describe four guides for identifying patterns in coded data: 1. Categories or themes, 2. Causes or explanations, 3. Relationships among people, or 4. Theoretical constructs (p. 87). The process of second cycle coding took first cycle coded data and further condensed the data into emerging themes. Second cycle coding resulted in detailed descriptions of themes from constructs identified through first cycle coding, providing higher order understanding. Second cycle coding also served to create a guide for further data analysis, focusing on review of the remaining transcripts. This also served as a guide for within and across case analysis. Each piece of coded data were reviewed for consistency within identified categories.

Data display. Miles et al. (2014) describe numerous methods for displaying data for further analysis. Data display is an analytic step during which the researcher makes additional analytic decisions to organize and represent the data. The dissertation researcher utilized a matrix display for this study. Matrices are structured representations of the data in rows and columns. The matrix served to display the data and include themes, definitions, subthemes, and direct supporting quotes. The matrix display in addition to the themes generated in second cycle coding served to provide the basis for reporting findings.

Rigor in analysis. As mentioned in the section of this chapter discussing elements of rigor in qualitative design, member checking was used to enhance credibility of the findings. Preliminary findings following second cycle coding following review and approval by the

dissertation chair, were reviewed by two study participants and a member of the dissertation committee during the process of member checking. Participant observations and comments were reviewed and incorporated into the reporting of the findings by the dissertation researcher.

In addition to member checking, the dissertation researcher also conducted a negative case analysis to estimate credibility of the findings. Throughout analysis the researcher evaluated for participant responses that appeared contrary to preliminary findings, or inconsistent with other participant responses. The negative case responses served to offer an alternative explanation or description of participant experience and incorporated in the discussion of the results. Identification of a negative case provided a more complete and fuller understanding of the dimensions of the phenomena of interest (Corbin & Stauss, 2008).

The dissertation committee chair served as a theory expert providing essential input in coding of theoretical concepts. The dissertation committee chair also served as an external auditor of findings increasing the confirmability of the findings. All findings from the data analysis were reviewed with the full dissertation committee and dissertation chair.

Institutional review board approval. The research proposal was reviewed and approved by the IRB at Boston College prior to any recruitment of participants or collection of data. The IRB at Boston College additionally reviewed changes made to materials informed by the cognitive interviews including the recruitment flyer and interview guide. The study site nurse scientist in collaboration with their Director of Research provided approval to the dissertation researcher for third party access to the site for the purpose of recruitment only. No formal review of the study proposal was required by the healthcare organization which served as the site for data collection. Study materials were reviewed by the nurse scientist at the healthcare organization prior to dissemination of flyer for recruitment purposes.

Ethical Issues

Consent. A statement of consent to participate in the research study was forwarded to all interested participants by email. Participants were encouraged to review the consent prior to contacting the dissertation researcher at the scheduled interview time. At the beginning of the telephone interview the dissertation researcher again reviewed the consent and allowed the participant the opportunity to address any concerns. An oral consent for study participation was then obtained. A waiver of written consent was obtained through the IRB at Boston College.

Participant privacy and confidentiality. To reduce risk to participants, data were handled in a manner to increase participant confidentiality. All electronic data was stored in files on a password-protected and encrypted computer. The researcher made every effort to minimize identifying information on recorded materials sent to third party transcriber. As described in the data collection section of this chapter, recordings began following consent and collection of demographic information. The third party transcriber offered secure handling of researcher materials. Pseudonyms were chosen for each participant. All identifying data, including demographics, were separately stored and password protected.

Burden on participants and anticipated harm. The primary anticipated burden to participants related to this study was time demand. The participants were asked to complete a consenting procedure, collection of demographic information, and participate in an interview during the course of one telephone conversation. The estimated time for the consent and demographic questionnaire was 15 minutes. The interview was estimated at an additional 30 minutes with individual variability related to depth and length of responses anticipated. In response to this time burden, the dissertation researcher in appreciation for participation offered a gift in the form of a \$25.00 Amazon gift card to all participants who completed the interview. A

lesser gift of a \$15.00 Amazon gift card was offered to any participant who withdrew from the study prior to completion. All participants completed the study and were eligible to receive the \$25.00 gift card.

The interview process was unlikely to cause other burdens or harm to participants. The dissertation researcher remained open and sensitive to the possibility of interview questions resulting in participant expression of emotional and/or spiritual distress. Participants were reminded that response to all questions and continued participation in the interview was voluntary. No participants expressed distress during the course of data collection.

Summary

This chapter provided an overview of the study design and methods utilized for this research. A description of procedures including recruitment, sampling, data collection, data management, and analysis were reviewed. Considerations for study rigor and trustworthiness and procedures for the protection of human subjects were described. Chapter four provides a presentation of the results.

Chapter Four: Results

This chapter provides the findings of the analysis as described in Chapter Three. It will include a description of the study sample and a discussion of demographic data. Next, a description of the findings as they relate to the initial coding list from the directed content analysis will be provided. Lastly, a detailed description of the major themes with representative quotes is offered.

Purpose

The purpose of this qualitative descriptive study was to advance understanding of nursing spiritual care in the intensive care unit (ICU) through an exploration of ICU nurses' experience of Caritas Process Three (CPT) of Watson's Theory of Human Caring (WTHC). The study aimed to address the following research questions:

1. What do ICU nurses currently practicing in a Watson Caring Science Institute (WCSI) affiliate hospital describe as their experience of cultivation of one's own spiritual practices?
 - a. How do these ICU nurses describe their spiritual self?
 - b. What do these ICU nurses describe as spiritual self-care practices?
2. What do ICU nurses currently practicing in a WCSI affiliate hospital describe as the relationship between spiritual self and professional development?
 - a. How do these ICU nurses view the professional responsibility of spiritual development?
 - b. What do these ICU nurses perceive as facilitators and/or barriers to the exploration of spiritual-self within their professional role and their clinical work?

3. What is the influence of personal spiritual development on spiritual nursing care as described by ICU nurses currently practicing in a WCSI affiliate hospital?
 - a. What examples of spiritual care reflect the meaning of CPT of WTHC?
 - b. How do these ICU nurses describe the influence personal spiritual development and growth of the transpersonal self?

Study Sample

All ICU nurses currently working in one WCSI national affiliate medical center in the western United States were invited to participate in this study. All nurses who expressed interest in this study and met inclusion criteria were considered for inclusion. Of those who reached out to the researcher to participate in the study, one nurse who initially contacted the researcher for participation did not reply to follow-up contact and thus did not participate in the study. In total, 10 nurses who contacted the researcher with expressed interest in the study were included as participants.

Sample demographics. The ICU nurses included in the sample represented two inpatient ICU units, a cardiac ICU and a mixed medical and surgical ICU. The units were equally represented with 5 participants from each included within the sample. Saturation of the findings, as described in Chapter 3, was obtained by the tenth interview. Demographic information about the sample was collected and analyzed using descriptive statistics and is summarized in Table 1.

Table 1

Sample Demographics

Variable	N	Range in years	Mean	Percent
<u>Age</u>		24-54	35.9	
<u>Gender</u>				

Male	2	20
Female	8	80
<u>Race</u>		
Black	0	0
Asian	4	40
Caucasian	6	60
<u>Ethnicity</u>		
Non-Hispanic	10	100
Hispanic	0	0
<u>Highest academic degree</u>		
Bachelor's	6	60
Masters	4	40
<u>Years worked as a RN</u>	2 - 27	9.4
<u>Years worked as a RN in an ICU</u>	2 - 20	6.9
<u>Years worked in a WCSI affiliate hospital</u>	< 1 - 11	4.1

The mean age of the sample was 35.9, with a range of 24 to 54. Eighty percent ($n = 8$) of the participants self identified as female. Sixty percent ($n = 6$) of participants identified as Caucasian, with the remaining 40% of the sample ($n = 4$) identifying as Asian. All participants identified as non-Hispanic. All participants had a minimum education at the level of bachelor's degree, with 40% ($n=4$) of the sample reporting their highest level of education completed as a master's degree.

The mean length of time worked as an RN in years for the sample was 9.4 years with a range of 2 to 27 years. The amount of ICU RN experience was measured by years of RN work in the ICU. The mean length of time worked as an RN in the ICU for the sample was 6.9 years with a range of 2 to 20 years. The mean length of time the participants worked in a WCSI affiliate hospital was 4.1 years with a range of less than 1 year to 11 years.

Findings

The analysis both confirmed and extended the understanding of CPT of WTHC as experienced by nurses in the ICU. ICU nurses provided evidence of the experience of CPT as evolutionary and offered descriptions of care that reflected varied states of growth from ego-orientation to transpersonal relationship. Using the directed content analysis approach as discussed in Chapter Three, data were initially analyzed utilizing a coding template designed to represent the major organizing concepts of CPT. The coding template categories of ego-self, transpersonal-self, and cultivation of spiritual practices and transpersonal self, were both represented and enriched through the analysis of participant experience. In addition to these initial codes, new concepts of mutuality in relationships, nature of critical illness, the care environment, and influence of spiritual ritual emerged as essential themes in the findings.

The analysis of the data revealed five major themes. Two of the themes are further supported by subthemes. The five themes with associated subthemes are:

1. Caritas nurses vary in their ability to move beyond ego-self
 - a. Self preservation serves as a way to maintain ego
 - b. Mutuality creates opportunity to expand beyond ego
 - c. Nurses' ability to transcend ego-self is reflected in transpersonal relationship
2. Personal spiritual practices serve as a barrier and/or facilitator to nurses' ability to provide spiritual care
3. Critical illness as experienced by patients and families provided the opportunity for nurses to explore spirituality with others

4. The care environment serves as a barrier and/or facilitator to nurses' personal spiritual growth
5. Cultivation of spiritual practice and spiritual identity is integral to a life-long process of consciousness evolution
 - a. A commitment to individual spiritual practice cultivates ongoing growth
 - b. Coming to a personal definition of spirituality reflects spiritual growth

Themes are described and defined below with supporting quotes from participant data.

Participants have been de-identified and are represented by initials, AE, BF, CG, etc., chosen at random by the researcher. All 10 participants have been represented with the inclusion of quotes throughout the reporting of the themes. Quotes that represent negative case have been included in the findings as appropriate to provide a representation of all participant experiences.

Theme one: Caritas nurses vary in their ability to move beyond ego-self. This first theme captures the overall ability of nurses to express and practice spiritual nursing care and in the process move beyond ego self. While the nurse participants provided descriptions of moving beyond ego-self in a variety of successful ways, they also described times when self preservation was more dominant. The need for self preservation of the ego-self served as a barrier to spiritual practice and the development of self beyond ego. One participant (BF) offered a description of the connection between personal development and nursing professional practice; "Everything. I think, that's like, the wake up moment, for nurses. When you actually realize there is a connection there, and you decide to cultivate that. We all affect each other." The dynamic nature of caring for others was described by participants at the level of ego-preservation, mutuality, and transpersonal. The ability to move beyond ego was continuously informed by

personal spiritual perspective, experience, and self reflective practice. Three subthemes as described below clarify the variations in nurses' ability to move beyond ego self.

Self preservation serves as a way to maintain ego. For nurse participants, the drive to preserve self and maintain the ego was apparent and visible in their description of experiences providing patient care. The ego is a self-focused perspective or self-driven mode of behavior that some participants identified as important to maintaining a sense of self while working in a stressful environment. For a nurse focused on maintaining ego through self preservation, descriptions of patient care were characterized by the nurse distancing themselves or superficially connecting with patients and their loved ones during times of intense spiritual and existential need.

Participants who created a distance between themselves and the patient or family as recipient of care were able to protect themselves and preserve ego. This behavior limits their ability to experience personal growth or change. Participants practicing from ego-orientation described difficulties assessing spiritual needs in patients and their loved ones, frequently deferring or referring care to chaplains, and providing intercessory prayer. Some participants described limits to assessment of spiritual needs of the patient, including one participant (GJ) who used a personal perspective in determining which patients had spiritual needs rather than conducting a more formal assessment with a spiritual need assessment tool. "But I do if I feel it can be beneficial for the patient and helpful, I will ... touch upon spiritual thoughts and spiritual feelings with the patients."

Although collaborative work with hospital chaplains is an essential component of effective and patient centered spiritual care, some participants discussed referral to chaplains or deferral of spiritual care to others as the essential or only mode of spiritual care provided. One

participant (FI) describes utilizing chaplain services to address spiritual needs at end of life, “And that's the time you can intervene, and that's why we got all these chaplains in the hospital.” Another participant (CG) offered a similar response to an assessment of spiritual needs, “And I called the chaplain because I felt like the family needed a little more support.”

One participant (DH) described praying for patients as a primary mode of providing spiritual care. Prayer for others, often referred to in the literature as intercessory prayer, in this case however was done without consent of the patient or family and when it was clear that the patient would not want to participate in prayer. As described by the participant (DH), “We pray, sometimes, if the patients are open to that. But if they are not, then I just don't say anything about it, and I just do a silent prayer for them, on my own.”

Half of all participants discussed experiencing negative emotions as consequences of a failure to preserve ego-self and also as a manifestation of ego-protective behaviors. Participant descriptions include expressions of feeling “frustrated” (AE), “uncomfortable” (DH), and “burnout, fatigue” (BF). Participants reported both personally experiencing these negative emotions and observing them in nurse colleagues.

Nurses reported experiencing negative emotions when there was a conflict between personal values or beliefs and those of the patients or care team. Nurses described feeling distraught when they disagreed with either care decisions made by patients and/or providers. One participant described an experience providing care to a patient who refused a treatment that was necessary to sustain life, reflecting this participant's valuing of life but feeling as if ‘hands are basically tied’. As described by FI, “... it seems like you can help. But you just can't. Your hands are tied basically.” Another participant (AE) described the impact of observing a surgeon recommending care options that were inconsistent with what this nurse believed to be in the best

interest of the patient, “...the family member was just not on board. They really decided, no, this is not what our loved one would want ... I was very frustrated, I was like why would they even consider doing this.”

Participants describe experiencing these negative and distressing emotions at a time when their spiritual self was not fully appreciated or developed. The participants felt unprepared to cope with the stressors of the environment and observed themselves distancing from patient relationships and experiences to preserve the ego-self. The experience illuminated for one participant (BF) a need for deeper self reflection and commitment to spiritual growth to continue to function within the ICU environment and more completely care for the complex needs of the patients encountered. BF described,

I think a lot of times many nurses choose consciously or unconsciously to cope with high levels of stress, conflict, responsibility, suffering, morality by avoiding or distancing ourselves from emotions that arise... It might make some nurses experience burnout, fatigue... The experience their clients have is worse... Ultimately one cannot give what one does not have.

In addition to those who experienced their own distress, participants described observing burnout in nurse colleagues. Participants observations of others were mentioned in contrast to their own resiliency in the face of job stressors. Nurse participants suggested that “younger nurses” (IL), those who lacked social or spiritual support (AE), and nurses who did not value self reflection (HK) were viewed as being most susceptible to burnout. Participants also discussed the ICU environment including the stress associated with patient care, the pace of care provided, and the weight of responsibilities as contributing to nurse burnout, as highlighted by one participant (HK).

Working with my co-workers, I see a lot of ... some burn out, like empathy gets fatigued but you have to like, to survive in the ICU and this stressful environment, kind of have to distance yourself and kind of like take things at face value. If someone dies or your all-in

and you fail, you have to start over again. I see some nurses just kind of like, oh that's how it works. So it's kind of like distance yourself.

Mutuality creates opportunity to expand beyond self. Mutuality describes the process of the nurse moving into a mutually beneficial relationship with the other. Participant perspectives and actions provide examples of mutually beneficial relationships where the nurse and the patient both have the possibility of gaining from the exchange. Nurses identified in their experience the importance of developing patient relationships. This is further clarified in the words of one participant; "I think it's really important to connect to people. I feel like just a soul to soul connection between people, and developing a special bond" (KN). One nurse (JM) further described the impact on personal growth that providing spiritual care had.

But working with him and with his family that day, well I worked with him for like, three days in a row. Really strengthened me. But also, at some point, kind of broke me down emotionally. Now I feel like I'm stronger from that.

This mutual exchange served as an opportunity for participants to gain a deeper understanding of themselves and move their perspective and focus of care beyond ego-orientation. For nurses practicing in the ICU, this experience involved a focus on the irreducible value of the other and reflected care focused on the humanization needs of patients and their loved ones. As described by one participant:

It's part of being human. I think there's a lot of meaning in what we do and what I do. When I see ... I just don't see them as patients. We're all part of human kind, the human community. It's just brings so much meaning and it's kind of life defining (HK).

This participant and others described moving into mutual relationship and providing care informed by a spiritual perspective that values the humanity of the other. To be in mutuality as an ICU nurse was to provide care that was relationship based and holistically focused.

Mutuality was informed and supported by the descriptions of spiritual nursing care provided by participants. Participants described spiritual nursing care as essentially relationship

based. The care they provided was centered around an acknowledgement of a shared humanity or a shared belief system. In seeing self in other, one participant described engaging the patient and family with open communication, empathetic presence, and a general openness to meeting spiritual needs.

Just being open to having a conversation with them. Or even if they don't ask that question, but just being open about sharing about myself and then open to listening to them... Sometimes just the physical presence, even if you can't have that conversation (JM).

Spiritual nursing care was often described as provided as part of a holistic perspective. As stated by one participant (FI), "I just have the belief that I told you when you take care of patients you take care of them totality." Participants discussed prioritizing meeting all the needs of the patient, including spiritual needs. This perspective on spiritual nursing care paints a picture of spiritual care as part of complete nursing care. Many participants discussed spiritual nursing care as caring for the patient beyond their diagnosis or illness. This holistic perspective valued individual experience, was essentially patient centered, and placed emphasis on patient involvement in care.

I think it comes down to my personal practice in nursing care is providing that holistic care, I think that spirituality, finding that person's direction allows patients, as equally as maybe an epinephrine drip, honestly, to get through the hardships or the situations the stress whatever it may be that came upon with their surgery. I think that spirituality or spiritual care is equally as important as psychosocial and physical and mental care as well (AE).

In the participant interviews a discussion around prayer as a spiritual care intervention was limited. Two participants did include descriptions of prayer as an example of spiritual nursing care. One provided spiritual care coming from a place of ego as discussed previously whereas the other provided spiritual care in mutual relationship. Mutuality of relationship was achieved through prayer that was delivered with patients. The participant described a patient

experience where the patient initiated a need for prayer and the nurse prayed with the patient.

This participant (AE) also described providing space and time for patients to participate in prayer independently.

... and she was so she started crying and she was saying the name of the Father, the Son and the Holy Spirit and was praying thank you God, so I kind of just took that situation and that time and we held hands and we prayed together and allowed her to she kept talking to God and praying and thanking Him... We kinda just had a little moment of prayer, I think that was huge for her.

Nurse's ability to transcend ego-self is reflected in transpersonal relationship.

Although most participants' description and experience of self in practice occurred at the level of mutuality, a few transcended ego-self to relate to their patients in transpersonal relationship. Examples of transpersonal relationship and transpersonal care emerged from participant descriptions revealing the collective unity of self and other as the singular motivation for action, devoid of outcome orientation. This recognition of shared unity and oneness with the other (patients and their loved ones) as part of an essential whole, was central to achieving transpersonal relationship. It was only through this understanding that the motivation of actions could transcend individual or even mutual benefit and exist on a transpersonal plane.

So if I'm looking beyond myself... I feel like that creates a sense of awareness for that interconnectedness and sort of kinda strengthens and enhances my feeling for that and the sensation that provides for me... That kinda then influences my practice and what I say and what I do and how I perceive those things (GJ).

One participant provided a description of the individual as part of the collective whole as consistent with her spiritual perspective and translates this into providing transpersonal care at the bedside. Participant (HK) shared, "A huge part of it... is being there for them, seeing them as we are part of whole." This nurse viewed her spiritual perspectives as essentially interconnected to her everyday way of living including though not limited to her clinical work.

The care she provided patients is greater than self and others, as self and other are viewed as one.

Theme two: Spiritual practices serve as a barrier and/or facilitator to nurses' ability to provide spiritual care. The spiritual practices of the nurses' in the study served both as a barrier and a facilitator to their ability to provide spiritual care. Personal spiritual perspective for many provided the basis for spiritual assessment and delivery of spiritual nursing care. For some, an open and evolved personal perspective facilitated an approach to spiritual care that was inclusive of patient and family needs. For others, a spiritual perspective that was either underdeveloped or rigid was a barrier and contributed to limiting the depth of the spiritual nursing care provided.

Some nurse participants described spiritual practices that were rigid and included dedicated religious practice. Other nurses described spiritual perspectives that were underdeveloped and spiritual practices that were inconsistent or not well developed. Many of the participants who experienced spiritual practices as a barrier to nursing spiritual care were practicing from an ego-focus. Participants with immature spiritual perspectives describe being constrained by ego preservation and hesitant to provide spiritual care due to risk to self. As offered by one participant, "if .. it's clear that they have spiritual needs or they might need a little more catering to in that area, I don't usually go too far into that" (CG). Participants with a limited personal spiritual perspective avoided providing spiritual care and attempted to limit spiritual interactions with patients.

Participants with rigid spiritual or religious perspectives also reflected difficulties relating to others from a different spiritual background and describe a focus on spiritual benefit to self through nursing care. As an example, one participant (DH), described a uniquely devote

religious perspective that resulted in numerous barriers in the provision of care in the ICU and also put the ego-self at risk.

But there are some times where I feel like there are things that it's kind of uncomfortable for me like especially at end of life. And it's always very uncomfortable for me to have to participate in that aspect because I'm giving medications that I know will hasten that person's death. ... there's some conflicts ... because, as a Catholic, we have this thing called redemptive suffering where suffering can be... a joy in itself because you could be participating in Jesus's suffering and others' redemption by your suffering.

Another participant (FI) reflected the ease experienced in providing spiritual care to someone from a shared background, "...sometimes they feel like you have the same religion, seems like they feel like they got some help." For these participants, religion was the means to their personal spiritual understanding and religion was thus the frame for their provision of spiritual care.

Contrary to the barriers described by some participants were participants who described facilitators to the ability to provide spiritual care. These participants' spiritual perspectives were informed by what they viewed as important in forming relationships with patients. This included setting priorities in care and reflecting on the success of care outcomes. As stated by one participant (AE), "I think that my spirituality personally, has kind of helped shape my career choice and my interactions with others on a daily basis." Another participant (GJ) discussed how spirituality served as a guiding force for nursing actions.

So I feel like I am almost continuously connecting to my spiritual mindset or spiritual self leading to nurses providing nursing care from a caring perspective focused on seeking comfort and peace for patients and families as they experience pain, suffering, and the fear of death in the ICU.

Spirituality in participant descriptions contributed to nursing care focused on seeking comfort and peace for patients and families as they experience pain, suffering, and the fear of death in the ICU.

Participants described entering into relationship with the patient informed by their personal values related to quality of life and meaning in the experience. They also experienced personal gain in this relationship through affirmation of their personal spirituality and personal spiritual growth. One participant (DH) shared the experience of providing spiritual care, “I really try to engage with them, and I think it helps them. It helps me.”

Many participants discussed creating a meaningful connection in relationship with others as a spiritual value, that then translated to their clinical work. Participant descriptions offered examples of spiritual care that focused on building connections including, “talking with the patient” (GJ) and “being present” (CG). Another participant (KN) shared, “I try to connect because I think it’s really important to do that with your patients.” Important spiritual perspectives described by participants and drawn upon in their clinical relationships included a belief in a higher being and belief in the shared value and humanity of the other. As stated by one participant, spiritual perspectives and beliefs provided foundational support to the participant in reaching mutuality in relationship with the other.

So to me, it must be ... any of the times when I'm actually able to connect with the person in the bed, their energy, their spirit, who they are, those are the times that I think my spiritual beliefs and practices have allowed me to give better care (BF).

Theme three: Critical illness as experienced by patients and families provided the opportunity for nurses to explore spirituality with others. Critical illness as experienced by patients and families was described as having a strong influence on participants’ ability to practice spiritual care. Participants described the experience of critical illness as necessitating a spiritual approach with both themselves and their patients. One participant described how critical illness experienced by patients influences the approach to patient care.

These people are the sickest they've ever been in their lives, and they're in such a vulnerable place that we have to learn to care for more than just the illness because a

huge part of the person laying in that bed is someone with more than just physically ill, they're also hurting and feeling very scared and that has to be catered to as well (CG).

Most participants discussed the risk of death and provision of end of life comfort care in the ICU as resulting in the essential need for a spiritual approach to care. Participants describe patients approaching the end of life as having increased spiritual needs, needs that in the ICU were accentuated by the critical nature of illness. One participant described how the intensity of care delivered and received leads to the need for spiritual support:

I think especially I would think in the CCU, cardiac ICU, because sometimes they feel like this is the end. When a patient's having a heart attack, definitely they want ... they believe like in something more powerful that will help them (FI).

Nurses identified other aspects of the care received in the ICU as leading to patients need for spiritual care. One participant discussed how a “painful procedure” (DH) can contribute to intense anxiety in the patient’s experience. Another participant (FI) discussed how the stressful nature of critical illness can reveal, “those patients that have some real issues with their psyche, psycho-social.” Nurses further describe the patient experience of critical illness in the ICU leading to questions of quality of life. One participant (GJ) identified the focus of providing nursing care to critically ill patients as, “ ... matters of kinda survival or not, and then also trying to enhance and maintain a certain or minimal level of quality of life.”

Providing care to patients experiencing critical illness provided nurses with the opportunity to explore their own spirituality. As described by one participant, “It's been one of the number one factors in my life that's helped me to grow spiritually. I think it's because of the end of life care that we provide” (JM). Another participant described how observing death and dying in participants, led to the need for personal spiritual reflection.

I would say, I find that it's important to be in touch with what my personal and my spiritual values are. Because in a lot of instances on the job, especially in dealing with end of life, those times can kind of come out. It's hard to really express, but I've just

found that it's good to have to know what your beliefs are and then to be able to be present for other people (CG).

Participants also viewed their spiritual self as needed to sustain and maintain the work of a nurse in the ICU and also to meet the unique needs of patients and families in this environment. Participants emphasized the impact their spiritual self has on their capacity for caring for patients during high-stress clinical situations. Participants reported personal spiritual practices including use of “devotionals” (CG), “self-reflection” (GJ), and “prayer” (AE), as essential to sustaining self within the clinical ICU role. As described by one participant:

I think that I kind of use that source of spirituality and comfort, we go through hard times and we see all different ages of patients, struggling or doing really well regardless of that really. ... I think my spirituality allows me to do that (AE).

Self-reflection was highlighted by many as a way of processing difficult clinical situations and utilizing clinical experiences to advance or affirm their personal spiritual perspective. This experience is described in the following quote:

I feel like for me, I benefit from and get better results and feelings from being a little spiritual and going through that sort of ongoing self-reflectiveness and having that better understanding of self helps guide me through more difficult situations, whether it be something physical or emotional (GJ).

In addition to coping with personal stress, participants also perceive their spiritual self as needed to effectively connect with patients in the ICU who are both highly vulnerable and have significant spiritual need. The care they provided was perceived as more effective, receptive, and higher quality if supported by a personal spiritual perspective.

I think that it's very important for us to be in touch with our spiritual side or have another aspect of our lives to lean on and draw some support from. And draw peace from. Because it's obviously really, can get very emotional. It can be emotionally and physically taxing (JM).

In identifying spiritual needs of patients and family experiencing critical illness in the ICU, some participants discussed the observed benefit of spiritual nursing care. Nurses discuss

observing spiritual nursing care as being “helpful” and “healing” for patients and overall contributing to both better patient outcomes and a more positive experience for patients and families. In this way, spiritual care is seen as substantially contributing to the plan of care in the ICU.

I think that spirituality, finding that person's direction allows patients, as equally as maybe an epinephrine drip, honestly, to get through the hardships or the situations the stress whatever it may be that came upon with their surgery (AE).

Participants describe providing nursing care informed by their personal spiritual perspectives and their spiritual perspectives being informed by nursing care. One participant shared the experience of growing spiritually as a nurse in the ICU and how that growth led to mutuality in nursing care.

I believe that my personal spirituality helps me to take better care of my patients and their families. When I first started in the ICU, I wasn't as spiritual, I was still kind of exploring that aspect of my life. I mean, that's an ongoing thing. But now that I am more spiritual or in touch with my spiritual side, I think my perspective has shifted and I'm able to just be more open with them and have those conversations. And I think I can better support them (JM).

Theme four: The care environment serves as a facilitator and/or barrier to nurses' personal spiritual growth. Participants in this study described their work in the ICU and the ICU care environment as both facilitating and presenting challenges to personal spiritual growth. The ICU care environment as experienced and described by nurse participants included descriptions of clinical work with patients, working with co-workers, interactions with managers, and influence of institutional care goals. Participants from both of the two ICUs represented in the sample endorsed both facilitators and barriers to their personal spiritual growth in the work environment. The experiences described were shared across units and were not unit specific.

In terms of the ICU environment serving as a facilitator, participants discussed observing the suffering and death of others as facilitating their personal growth. More than just observing,

the nurse is taking part in the care of the dying patient and is instrumental in the experience of suffering and possible death for both the patient and the family. The nurse's experience is greater than observation, it is participatory. Full participation and presence during this time requires the nurse to be fully open and vulnerable. One participant described how the experience of caring for patients at the end of life affected her personally, "when I started as a nurse and over the last four years, I've had to confront a lot of things with dealing with death and just how fragile life really is" (JM)

Participants also described observing strong supportive families and patients with positive outcomes as facilitating personal spiritual growth. One participant (CG) described the personal strength gained from observing others:

...for me, when I've had lots of instances where there's a lot of family members present, or they'll use music and prayer, and it's just like such a peaceful, wonderful experience that's when I feel the most strongest about it.

For these participants the positive strength observed in others led to personal reflection and desire for increased personal resolve and spiritual exploration. One nurse (IL) described the impact of observing strength in patients; "I just can't imagine having to do all the things they have to do every, single day, all day and how they're still so resilient and how they're still fighting so hard. Those ones really get to me."

A few participants described observing patients survive despite near impossible odds of doing so. This experience of observing what could be labeled 'a miracle' led to both questioning of preconceived notions and affirmation of the strength and possibilities of prayer. This is captured in the following quote.

And also, there has been several times, where I feel like a person is, well they're really, they're just gonna die, but they keep going. They keep going, and they're able to, well, live and survive, and sometimes even go home, when their chances of survival are really, amazingly nil, almost. But they're still able to go through (CG).

Other participants described observing patients and families with strong faith and spiritual rituals, including prayer, as having a positive influence on their approach to their spiritual self. As described by one participant (CG), “When we pray for them, or when others pray for them, I feel like they are given hope, and it's not as difficult for them to endure whatever it is that they're enduring, at that time.”

Several participants discussed the work environment and their peers in the ICU as providing “support” and “encouragement” for spiritual growth. Participants described both building strong relationships with peers over time and working in an environment that encourages peer support as essential to individual growth and success. “Just by getting to know people over the years as individuals, I get some of that energy back and that encouragement from them” (BF). One participant (GJ) described how peer support was essential for processing difficult clinical situations, “these very difficult and dramatic things that happen, and kinda processing through them so that we can help guide one another through these difficult times.” In addition to peer support, participants described observing the work of peers as facilitating individual spiritual growth. Observing peer responses to difficult clinical situations, perceived as both positive and negative, led participants to critically reflect on their own work. One participant (HK) described responding to observing burnout and compassion fatigue in co-workers.

When I see that I start looking inward and notice that it's really being face to face with the human suffering, it makes me more human ... I find so much meaning in what I do, just being vulnerable, being there, open-heart with my patients and their families and I think it's nourishing.

Participants also described more broadly a work environment that prioritized spiritual and holistic care. This observation was highlighted by the experience of two participants working as

traveling nurses, who recounted a significant difference between their current work environment and other work environments they had recently experienced. In describing their current work environment, one participant said, “I feel like this is a vibrant community... they have this helpful attitude.... and that makes you feel good at the end of the day” (FI). These participants further described their current work environment as having a culture of sensitive and transpersonal care and which was observed as being both protective of individual burnout and supportive of spiritual growth.

Lastly, participants described a work environment that provided professional support toward the advancement of individual nurses. “I’ve had a lot of opportunities for personal growth and professional growth... professionally trying to do the best I can to take care of my patients has been really rewarding for me” (KN). Professional support provided by the nursing leadership in the ICU and the medical center ranged from financial support to seek outside growth experiences to support for personal professional advancement in the ICU.

Just as the environment of care in the ICU served a facilitator for spiritual growth for some, others experienced the environment as a barrier to spiritual growth. Participants described experiencing both a lack of support from management and coworkers as personally detrimental to self. One participant discussed feeling judged and unsupported by co-workers in situations where nursing care was in conflict with personal spiritual beliefs.

I had this patient, who was also gonna be on comfort care, and I kind of mentioned to two other nurses, and I'm just like, "I'm not comfortable doing this." And I felt like they were ... Maybe I shouldn't have said anything out loud, because I was thinking in my head, and they kind of gave me that impression or that look like you're such a mean person (DH).

Participant experience reflected management styles that did not value the holistic work of nurses and treated individuals as commodities. Unsupportive management styles led one participant to

reflect on an environment of care that did not value personal spiritual development. As offered in the participant's words (HK):

I feel like nurses are always under a lot of stress. And the management will ask for more and more... I feel commodified, like I'm just a worker, just like labor and a number. Just a number that we can get rid of and replace.

Participants also discussed the work of the nurse in the ICU as a barrier both to individual spiritual development and also the delivery of spiritual and holistic nursing care. The time constraints, volume of tasks and physical demands of work, in addition to the high stress nature of the work being provided, led to personal dissatisfaction in the care that was provided and had a negative effect on the spirit of the nurse. One participant (JM) described the negative effects of demands of working as a nurse in the ICU.

Because we actually have to physically take care of people and support them physically, that can be very time-consuming ... sometimes you can get wrapped up in that and get focused on the task at hand ... and sometimes we just kind of withdraw and just go into that mode in terms of just taking care of your patient in that physical sense.

Theme five: Cultivation of spiritual practice and spiritual identity is integral to a life-long process of consciousness evolution. Cultivation of spiritual practice and spiritual identity are essential processes needed in the development and evolution of consciousness. Participants in this study described spirituality and spiritual practice as essential to their journeys of personal growth. Their descriptions of their understanding of spiritual identity and spiritual practices present a characterization of spirituality as influential in relationship with others and a higher power, daily practices and interactions, in addition to a deeper understanding of self.

Central to this theme is an understanding of self as essentially spiritual and a belief in the importance of spirituality to support personal growth. In identifying with and dedicating themselves to their spiritual development, participants have the beginning guide needed in the journey of consciousness evolution. Most participants (n= 8) identified as spiritual and

discussed the importance of spirituality in their understanding of self and the world. The spiritual self for many was viewed as integral in all aspects of life and perceptions of identity. As stated by one participant (GJ), “I feel like I am almost continuously connecting to my spiritual mindset or spiritual self.”

Participants discussed the presence or absence of spirituality in their daily lives and their dedication to ongoing spiritual growth. Many described incorporating daily spiritual practices, including “reflection”, “meditation,” and “prayer,” with the goal of sustaining and growing their spirituality. Some participants described their spirituality as burgeoning, whereas others perceived their spiritual beliefs as well established. Despite this difference, all participants discussed the value of an ongoing focus on growing or sustaining their spiritual values and self both for their personal fulfillment and also for success in their clinical work. This dedication to ongoing spiritual growth was reflected in awareness of the influence of spirituality to all aspects of their life including professional relationships. As stated by one participant (BF), “I think the better I explore my spirituality, and am able to just integrate that into who I am as a person that comes through at work, with my patients.”

A small number of participants (n= 2) did not view themselves as spiritual or did not identify with the term spirituality. One of these participants described self as devoutly religious and viewed spirituality as a secular term, inconsistent with her religious beliefs. As stated by the participant (DH), “I guess it’s just the term spiritual is not really a word I use a lot.” The other participant described a more humanistic/existential philosophy with an openness to searching for and finding meaning and purpose through relationship, exploration of self, and self reflection. Following an affirmation that spiritual is not the way they see themselves the participant stated,

“most of my energy is more towards just being loving and kind and right and treating other people and the planet with respect” (IL).

Two sub themes provide further evidence of spiritual practices and spiritual identity as essential to the journey toward consciousness evolution. Spiritual practices in the first subtheme, described the spiritual work of nurses committed to spiritual growth. Spiritual identity, as described in the second subtheme, presents a spiritual philosophy or faith perspective of the nurse that reflects a commitment to an understanding of self as essentially spiritual.

Cultivation of spiritual practice through commitment to individual practices. A deeper understanding of the participant dedication to spiritual growth was evident in their descriptions of spiritual practices. All participants described spiritual practices that they participated in on a regular basis. Although practices varied in description, they often included a general focus on ongoing reflection of self, daily life, and meaning in experience, mirroring participant definitions of spirituality. Spiritual practices were often described as occurring daily and as being essential to sustaining self in daily life and in clinical roles. Spiritual practices identified by nurses included *meditation and prayer, being in nature, religious involvement, and seeking social support.*

Meditation and prayer. Most participants described the use of meditation, self reflection, prayer, or devotionals as essential to sustaining and growing their spirituality. The language of meditation, self reflection, prayer, or devotionals was offered by the participants and was reflective of their spiritual or religious frame. Meditation or prayer was often described as useful as a source of self reflection and was needed to allow participants to process daily experiences. One participant described the enhanced understanding of consciousness achieved through reflective practice.

Any kind of like, really genuine self reflection I can do for myself that ... almost in a way where I'm looking at breaking things down and separating myself from everything, and seeing what lets me connect without barriers, more to other lives (BF).

Being in nature. Nature was mentioned by participants both as an environment and/or catalyst for self reflection or meditation, but also as a spiritual source itself. In describing her spiritual practice one participant (JM) stated, “I make sure I’m in touch with nature... I like to run and go for hikes and be outside.” Another participant (GJ) discussed being in nature as inspiring deeper connection, “I’m going for a walk in the woods and I find a great place to stop and I feel connected to nature.” Nature was described as a source of peace and a place to get away from the everyday distractions. One participant (BF) stated simply, “oh getting outside in nature, too... that's a big one,” emphasizing the importance of being in nature in connection with spiritual practice.

Religious involvement. A small number of participants (n= 4) describe religious involvement and practice as central to their spiritual development. Participants discussed utilizing religion as a frame for understanding their spirituality and spiritual self. Their religion was both part of their identity and a tool for accessing and understanding themselves. Most of these participants self-identified as Catholic and highlighted religious activities as central to their spiritual identity, including attendance in church services “I go to church every Sunday” (FI), participation in the church community “I have gotten involved in different... worship groups” (AE), and observation of religious practice within their family life “I do daily rosaries with my family” (DH). One participant discussed Buddhist philosophy as a guiding principle in meditative practice and value system. This nurse discussed the influence of Buddhist principles in interactions with others and way of being.

So going from Buddhism again it's a sense of compassion. You know how charity versus compassion, charity it's like you are giving to something that's in need whereas

compassion is working toward my patients and I are the same and we're equals and it's like care for them at a time when they're sick (HK).

The remaining participants indicated in their discussion of spiritual self that they were non-religious or included no mention of religion. As stated by one participant (IL), "I don't believe in one organized religion." Of those who identified as non-religious, two discussed a historical involvement in religious life. "I don't attend a church right now, mostly everything I do is on my own. I grew up in very strict Catholic home, and ... kind of got away from that" (CG). Since religious affiliation was not included in the demographic questionnaire, all information about religion is derived from participants who organically included discussion of religion in their interview. For the two participants who included no mention of religion in their discussion of spiritual self, one can conclude that religion is likely not an essential aspect of their spiritual practice but can not decisively rule out religious affiliation or practice.

Seeking social support. All the participants who self-identified as practicing Catholics included in their discussion emphasis on the social nature of their religious practice. Participants discussed practicing their religion as supported by a religious community, their families, and significant others. Others discussed spiritual growth with others in a non-religious context. One participant discussed involvement in professional organizations with like-minded peers as an important catalyst for exploring spiritual self. "I found my tribe, ultimately. A group of other nurses who were looking for more" (BF). Others discussed the value of exploring spiritual self with family and friends. "I also think it doesn't have to be just on my own... sometimes I like to talk to close friends or family about it" (JM). For all, the support of others in this process of self exploration led to a deeper exploration and refinement of spiritual self.

Cultivation of spiritual identity by personally defining spirituality. Participants further clarified their spiritual identity through personal definitions of spirituality. For the nurse

participants in this study, a definition of spirituality emerged as a relationship with self, others, and a higher power, and as a source of meaning and purpose.

Almost all participants defined spirituality in terms of a relationship with or belief in a higher power or something greater than self. Some participants, including those who identify as non-religious, specifically refer to the higher power as God. Others use more general language, including “the world as a whole” and “something greater than yourself.” The participants include general descriptions of relating to or connecting to a higher power in a personal way. Some offered prayer as a method of achieving this connection. Some of the participants discussed spirituality as having a deeper understanding or relationship with self. They understood their spirituality as part of themselves and exploration of spirituality thus as one path for gaining a greater appreciation for who they are. One participant (KN) defined spirituality as, “just connecting with yourself in a meaningful way.”

Although relationships with self and a higher power were the more prominent findings, some participants also included relationships with others as a focus of their understanding of spirituality. The participants discussed having a good relationship with others and exploring and reviewing this relationship as an essential component of their spiritual perspective. For one participant (IL), relationship with others was the central focus, “Most of my energy is more towards just being loving and kind and right and treating other people and the planet with respect.” Being in right relation with others was both individually motivated and influenced by religious doctrine. As stated by one participant (DH), “as Jesus has told us, and I have to relate back to my religion, is that we are to love one another as our God has loved us.”

Spirituality and religious beliefs were expressed as a guide for daily actions that gave life meaning, purpose, and direction. One participant (AE), who self identified as religious talked

about God's plan as serving as a major source of direction, "I find peace and comfort in just knowing that I believe that God has a plan for everyone." Many discussed finding meaning and direction as an essential tenant or outcome to their spiritual lives, as stated by one participant (FI), "it makes your life worth living" and "creates direction in your life."

Summary

The five themes and supportive sub-themes developed from the analysis of the data reveal ICU nurses experience of CPT of WTHC. Theme one: *Caritas nurses vary in their ability to move beyond ego-self* describes the nurses' ability to provide spiritual care and experience personal growth beyond ego-self. Theme two: *Personal spiritual practices serve as a barrier and/or facilitator to nurses' ability to provide spiritual care* revealed how nurses' personal spiritual practices both supported their ability to provide spiritual care and also limited their ability to care for their patients' spiritual needs. Theme three: *Critical illness as experienced by patients and families provided the nurse opportunity to explore spirituality with other* described how caring for critically ill patients and families in the ICU led to exploration of spirituality as nurses managed the spiritual needs of their patients and themselves. Theme four: *The care environment serves as a barrier and/or facilitator to nurses' personal spiritual growth* revealed the influence of the ICU care environment, including patients, colleagues, and leadership, on the nurses' ability to achieve personal spiritual growth. Lastly, theme five: *Cultivation of spiritual practice and spiritual identity is integral to a life-long process of consciousness evolution* discussed the nurses' essential commitment to spiritual growth both through practice and spiritual identity as essential to personal growth toward consciousness evolution.

The findings of this study both inform the research questions and enrich a deeper theoretical understanding of the experience of CPT. For participants in this study a description

of their spiritual self revealed an essential aspect of self needed to sustain and maintain their clinical role in the ICU. ICU nurses discussed needing to continue to cultivate their spiritual self through dedicated spiritual practices. Nurses who endorsed strong spiritual identities in their descriptions were able to provide spiritual care that reached patients' spiritual needs more individually and at a deeper connection than could otherwise be achieved. The ICU environment or care served both as a facilitator and also as a barrier to growth. The intensity of care and the frequency of life and death situations forced nurses to address their own spiritual values and beliefs to attend to the spiritual needs of the other. The ICU environment also at times left little time or space for deep spiritual connection amidst the hectic pace of care delivered.

The participant descriptions offered increased clarity and richness to the nurses' experience of living WTHC CPT in an ICU clinical role. For nurses in this study, the ongoing journey of consciousness evolution moving from ego-orientation to transpersonal self, required a deep exploration of self. The findings suggest moving beyond ego-self occurs as a continuous and dynamic process. In this process, the nurse journeys toward deeper understanding of self in relationship with other and self as one with other. This knowledge of self is facilitated through spiritual practices and continuous self reflection. The nurses described this experience as strongly influenced by their environment of care. Faced with spiritual need and opportunity for spiritual connection, the nurse must seek this journey of personal growth to provide exceptional nurse caring and to sustain themselves in their role without experiencing compassion fatigue or burnout.

Chapter Five: Discussion

In Chapter One, the purpose and significance for this study was identified, *Intensive Care Unit Nurses' Experience of Watson's Theory of Human Caring Caritas Process Three: Cultivation of One's Own Spiritual Practices and Transpersonal Self, Going Beyond Ego-Self*. Chapter One included discussion of a significant need for spiritual knowledge and practice in the intensive care unit (ICU) and a gap in knowledge related to spiritual perspectives and practices of ICU nurses. Caritas Process Three (CPT) of Watson's Theory of Human Caring (WTHC) is described in Chapter One as a frame to understand the importance of knowledge related to nurses' spiritual practices and perspectives for the provision of spiritual care. Chapter One also included a definition of terms, research questions, and an overview of WTHC as the essential frame of the study.

Chapter Two provided a review of the literature and covered topics central to this study including: WTHC, spirituality in nursing, spiritual self and the impact on practice, and spiritual care in the ICU. The review of the literature supported the use of CPT of WTHC as a frame for this study. The review of the literature presented evidence of personal spirituality as one important precursor to meeting patients and families' spiritual needs in the ICU. The review of literature also provided further support of the significant need for an expansion of spiritual care in the ICU.

Chapter Three included discussion of the research method utilized for the study. The rationale for the directed qualitative descriptive design was established and the steps for recruitment, data collection, and analysis were discussed. The analysis plan, directed content analysis, and the coding template also were discussed. Additionally, Chapter Three provided procedures essential for establishing trustworthiness and rigor in the study design; these included

such elements as member checking, negative case analysis, and bracketing. Procedures needed for the protection of human subjects were also discussed including consent procedures, IRB approval, and data management and protections.

Chapter Four is a report of the data analysis and study findings. The sample demographics were discussed for the 10 eligible study participants who were all ICU nurses currently working in a WCSI affiliate medical center. Through analysis of the data, five major themes were identified, two of which were further represented by subthemes. The themes were described with exemplar quotes to illustrate participant experience of the findings. The themes were also described in the context of the theoretical frame that guided the directed content analysis, CPT of WTHC.

This chapter will present a discussion of the findings that were presented in Chapter Four and how they answer the research questions. The findings are further presented within a theoretical representation and in relation to the relevant literature. Implications for nursing education, practice, policy, and research are offered. Lastly, limitations and recommendations for future research are discussed.

Demographics

The demographic data presented in Chapter Four offer a depiction of a sample that is not entirely representative of all registered nurses (RNs) in the United States. When compared with the results of the 2017 National Nursing Workforce Study (Smiley et al., 2018), a randomized national survey of RNs and licensed practical nurses (LPNs) most recently conducted in 2017, the sample mean age (35.9 years) was younger than the national average of 51 years of age. The study sample had a larger representation of males (20%, $n = 2$) than is representative of the national average of the total male nursing workforce of 9.1%. This study also had a greater

representation of minorities, with only 19.2% of the total US nursing workforce identifying as a member of a minority group and 40% ($n = 4$) of the study sample identifying as Asian.

Although varied from the National Nursing Workforce sample characteristics, the study sample is representative of both the region where the sample was drawn and the specialty area where the nurses were recruited. National government census data (U.S. Census Bureau, 2018) reports the highest representation of Asian Americans residing in the western United States. Also, the American Association of Critical-Care Nurses (AACN) reports their total male membership at 14% (AACN, 2015). In a study of male nurses in the workforce, male nurses are most likely to work in acute care hospital settings, particularly in critical care areas. Male nurses have greater representation in hospital settings with 70% of all male nursing working in hospitals versus their female counterparts (61% of female nurse work in hospitals) despite being a smaller percentage of the national nursing workforce (Auerbach et al., 2017).

Lastly, 40% of the study sample ($n = 4$), reported their highest level of education as a master's degree, with the remaining sample ($n = 6$) reporting the highest level of education as a baccalaureate degree. As compared with the 2017 National Nursing Workforce Study (Smiley et al., 2018) where 17.1% of respondents reported a master's degree and 45.2% reporting a bachelor's degree as the highest level of completed education, the study sample are more highly educated than the national average.

Theoretical Representation of the Findings

The findings presented in this study are best understood from the perspective of the theoretical frame they represent, CPT of WTHC. CPT of WTHC is described as cultivation of one's own spiritual practices and transpersonal self, moving beyond ego-self. The purpose of this study was to describe ICU nurses' experience of CPT. Through this description the

researcher aimed to increase knowledge supportive of spiritual nursing care in the ICU and factors that influence spiritual care delivery. The sample recruited for this study was purposefully drawn from a Watson Caring Science Institute (WCSI) affiliate medical center with the goal of gaining insights from nurses' practicing from a WTHC perspective. The choice of directed content analysis and the use of a theoretically derived coding template further intimately situated study findings in the perspective of WTHC.

Directed content analysis. Directed content analysis (Hsieh & Shannon, 2005) was the method of analysis utilized for this study. This approach aims to extend and expand upon existing theoretical knowledge and required the researcher to approach data analysis with a theoretical lens. The theory was utilized throughout the design of the study and informed research questions, the interview guide, and created the beginning structure of data analysis through a theoretically derived coding template. The data in this study were initially coded utilizing a coding template designed to capture the essential concepts of CPT of WTHC.

Caritas Process Three of Watson's Theory of Human Caring. WTHC is a middle range theory of nursing that distinguishes the central focus of the discipline of nursing as human caring that acknowledges the essential humanity of the other and is directed toward health and healing. The major theoretical components of WTHC include the transpersonal caring relationship, the caring moment, ten caritas processes, and caritas consciousness. The findings of this study expand and extend the understanding and application of this theory by providing a description of ICU nurses' experience of CPT.

In developing the initial coding template for analysis, the researcher identified ego-self, transpersonal-self, and cultivation of spiritual practices and transpersonal self, as key concepts for understanding the experience of CPT for ICU nurses. The initial coding template further

attempted to describe the relationship between these concepts from the perspective of personal growth with ego-self being experienced in a stage of limited growth and transpersonal-self experienced at a stage of consciousness evolution. The theory and coding template further suggest that this growth is mediated by cultivation of spiritual practices.

The analysis of the data offered description and explanation of these key concepts, provided data supporting the relation between key concepts, and offered descriptions of new concepts. The a priori concepts identified in the coding template received further depth of description through data analysis. Ego-self and transpersonal self are described in the theme *Caritas nurses vary in their ability to move beyond ego-self*. This theme described the varied experiences of nurses' practices ranging from practice with a focus on preservation of ego-self to practice that has moved beyond ego-self to transpersonal relationship. The theme also expressed the experience of growth as participants described achieving an expanded knowledge of self and others. The a priori concept, cultivation of spiritual practices and transpersonal self is also clearly evident in the findings described in the theme *Cultivation of spiritual practice and spiritual identity is integral to a life-long process of consciousness evolution*. Participants in their descriptions of this theme offered beginning explanations of the relationship between these key concepts. Participant experience supports the need for ongoing and sustained spiritual practice for personal growth and for expanded consciousness. These themes in supporting the concepts identified in the coding template, provide a depth of explanation of CPT informed by participant experience.

Other concepts were discovered and described in the themes were not identified in the initial coding template. These findings offer greater understanding and explanation of the ICU nurse experience of CPT. These new concepts are captured in the themes *Personal spiritual*

practices serve as a barrier and/or facilitator to nurses' ability to provide spiritual care, Critical illness as experienced by patients and families provided the nurse opportunity to explore spirituality with other, and The care environment serves as a barrier and or facilitator to nurses' personal spiritual growth. These themes offer extension of the understanding of CPT through the added layer of the experience of the study sample. Experiences offered in the discussion of these themes present an initial understanding of the situational experience of CPT for ICU nurses and nurses working in a WCSI affiliate medical center.

Discussion of Research Questions

The themes identified offer answers to all of the research questions proposed. Data were not analyzed from the perspective of the research questions, but rather from the perspective of the participant experience. The resultant themes represent the ICU nurses' experience of CPT of WTHC. The following section will discuss the findings in relation to the three research questions.

RQ1: What do ICU nurses currently practicing in a WCSI affiliate hospital describe as their experience of cultivation of one's own spiritual practices? The first research question is best answered with the findings in Theme Five: Cultivation of spiritual practices and spiritual identity is integral to a life-long process of consciousness evolution. The findings in this theme described ICU nurses as committed both to their personal spiritual growth and to the ongoing process of cultivating or refining their personal spiritual identity. The first research question included two sub-questions, the results of which will be discussed separately.

A. How do these ICU nurses describe their spiritual self? The nurse participants described their spiritual self through descriptions of personal perspectives of spirituality. Descriptions offered by ICU nurses provide a shared perspective of spirituality as a relationship

with self, others, a higher power, and as a source for meaning and purpose in their lives.

Personal spiritual identity was described by ICU nurses as strengthened, supported, and drawn from clinical experiences in the ICU.

B. What do these ICU nurses describe as spiritual self-care practices? ICU nurses also identified and described dedicated spiritual self-care practices. Participants described participating in spiritual practices daily and reflected on the need for practices to sustain self within their clinical role. Spiritual practices described included both reflective practices and also examples of exploring spiritual self with others. Reflective practices described by ICU nurse participants included meditation, prayer, devotionals, and being in nature. Others described exploring spiritual self with others in both religious and non-religious communities. Participants described their spiritual practices as essential for ongoing spiritual growth and also as a reflective tool on their journey toward consciousness evolution.

RQ2: What do ICU nurses currently practicing in a WSCI affiliate hospital describe as the relationship between spiritual self and professional development? The second research question included two sub questions, the results of which will be discussed separately.

A. How do these ICU nurses view the professional responsibility of spiritual development? ICU nurse participants described the professional responsibility of their spiritual development in the findings of both Theme Two: Spiritual practices serve as a barrier and/or facilitator to nurses' ability to provide spiritual care and Theme Three: Critical illness as experienced by patients and families provided the opportunity for nurses to explore spirituality with others. Both of these themes describe the nurses' perception of the relation between the professional role and their own spiritual development.

In Theme Two, nurses described drawing upon their personal spiritual beliefs as a basis for providing spiritual care for patients and families in the ICU. The personal spiritual beliefs of the ICU nurse served both as a barrier and/or a facilitator for providing spiritual care that met that spiritual needs of both patients and families. ICU nurses with open and evolved personal spirituality were better able to assess for and provide spiritual care for patients and families. ICU nurses with rigid or underdeveloped personal spirituality provide limited spiritual care or spiritual care that was restricted by their own personal values. This theme clearly described the influence of personal spiritual development on ability to meet care needs within the nurses' professional role.

In Theme Three, nurses described how their professional role influences their personal spiritual development. ICU nurses identified that patients who are critically ill and their families experience significant spiritual needs, particularly at the end of life. These needs require the nurse to take a spiritual focus in the nursing care provided. ICU nurses also identified that providing care for the critically ill pushes them to explore their personal spirituality both to continue providing spiritual care and to sustain themselves within their professional clinical role.

B. What do these ICU nurses perceive as facilitators and/or barriers to the exploration of spiritual-self within their professional role and their clinical work? The barriers and facilitators to the exploration of spiritual-self within their professional role and their clinical work were best identified by ICU nurses in Theme Four: The care environment serves as a barrier and/or facilitator to nurses' personal spiritual growth. Nurses from both sampled units identified both barriers and facilitators in their environment.

Examples of the ICU environment as a barrier to personal spiritual growth included a sense of not enough time and unsupportive colleagues, both peers and management. Nurses

discussed the time demand of caring for the physical needs of patients who are critically ill and the feeling of not having enough time to provide spiritual care. Nurses also discussed the perception of unsupportive management and peers. Nurses also discussed conflict between their personal care priorities and values and those of peers and management as a barrier. They expressed that environments that lacked a holistic focus on patient care as a barrier to the exploration of their personal spiritual self.

Nurse participants also described the ICU nurse environment as a facilitator of their personal spiritual growth. Participants described the work environment as having a supportive holistic focus and provided the time and support needed to meet the patient and family's spiritual needs. Two nurse participants who were temporary traveler employees specifically reflected on the difference between their experience working in a WCSI affiliate medical center and other hospital environments. For these participants the perception of the WCSI affiliate hospital as supportive of a holistic focus and spiritual care goals is clearly articulated.

RQ3: What is the influence of personal spiritual development on spiritual nursing care as described by ICU nurses currently practicing in a WCSI affiliate hospital? The third research question included two sub questions:

A. What examples of spiritual care reflect the meaning of CPT of WTHC?

B. How do these ICU nurses describe the influence personal spiritual development and growth of the transpersonal self?

The answer to the broad research is captured most clearly in Theme One: Caritas nurses vary in their ability to move beyond ego-self. This theme articulates the relationship between personal growth, movement beyond ego-orientation, and connecting with patients and family through intentional nurse-patient relationships. Spiritual care examples provided a window into

understanding the ability of the nurse to move beyond ego-self. Nursing spiritual care provided from an ego-orientation included care that limited to shared beliefs, including frequent referrals to Chaplains, or was entirely avoided. Nursing spiritual care provided from a perspective of mutuality included care that was relationship based and holistic. Nursing spiritual care provided from a perspective of transpersonal perspective was provided a perspective of all nursing care as spiritual.

The answer to the broad research question and the sub questions is also found throughout the findings. The relationship of personal spiritual development on spiritual nursing care is found across several themes. Personal spiritual development is essential to assessing spiritual needs, providing spiritual nursing care, and sustaining self in the role of a nurse in the ICU.

Discussion of Themes

The themes identified as a result of the data analysis process are discussed in detail with supporting representative participant quotes in Chapter Four. The following section will discuss the thematic findings in relation to relevant literature.

Theme One: Caritas nurses vary in their ability to move beyond ego-self. This theme was supported by three subthemes, which collectively represent a range of experience in the ICU nurses' growth in their perception of self, their intentionality of nurse caring, and their capacity to relate to patients and family in transpersonal relationship.

One significant finding identified in the participants' descriptions of ego-preservation is the experiencing and observing of negative emotions. The experience as described by participants aligns with descriptions in the literature of moral distress and compassion fatigue. Participants identify the experience of moral distress as ego-protective and observe the distress experience as a failure to protect the ego. The literature supports the significant experience of

moral distress in ICU nurses with studies reporting high rates of moral distress in this population (Mealer et al. 2014). ICU nurses who experience moral distress cite witnessing the suffering of patients and family as one significant factor in their experience (Elpern et al., 2005; Epstein & Delgado, 2010). Mealer et al. also found that ICU nurses who experience distress are more likely to report low levels of workplace engagement.

The participants in this study suggest that having a personal spiritual practice is protective against the experience of moral distress. This finding supports a need for increased spiritual support or intervention for ICU nurses in an effort to reduce and address the experience of moral distress. One example of such an intervention is found in the literature. Campbell (2013) reported the results of an interventional study that offered ICU nurse participants a spiritual intervention. The intervention involved many components with the overall aim of changing of the culture of care to more inclusive of meeting the spiritual needs of patients and addressing the stressors of nursing staff. One nursing specific intervention including a “Nursing our needs” (Campbell, p. 81) was a forum for nursing staff that allowed them to discuss personal and spiritual issues both in small group and also one on one with a Chaplain. After participating in the intervention, ICU nurses in this study reported increased spiritual wellbeing, reduced work related stress, and increased capacity to continue working in the ICU environment. The range of experiences described in the first theme, suggest interventions such as this are needed to sustain and promote nurse caring beyond ego-self.

Theme Two: Spiritual practices serve as a barrier and/or facilitator to nurses’ ability to provide spiritual care. In this theme, participants provide examples of nurses’ personal spiritual practices serving as either a barrier and/or facilitator to their ability to provide spiritual care. Many participants described their spiritual perspective serving as a basis or starting

point for spiritual care assessment and spiritual practice. Participants described drawing upon their own spiritual beliefs to determine when spiritual care was needed and how spiritual care should be delivered. Findings further suggest the personal spiritual development of the nurse must include an openness to a varied experience of spirituality for the nurse to meet the varied spiritual needs of others. Nurse participants whose personal spiritual perspectives were rigid or underdeveloped were unable to fully identify or meet the spiritual needs of patients and family. For these nurses, their own spiritual perspective was a barrier as it limited their ability to fully assess and meet the wide range of spiritual and religious experiences of their patients and family.

These findings are consistent with findings in the literature. A review of the literature provides evidence of personal spirituality as a facilitator of nurses' ability to provide spiritual care. Several authors point to personal spiritual awareness or development of personal spiritual practices as a precursor or competency essential to the provision of spiritual nursing care (Baldacchino, 2006; Beckmena, Boxley-Harges, Bruik-Sorge, & Salmon, 2007; Van Leeuwen & Cusveller, 2004). Van Leeuwen and Cusveller discussed the importance of nurses' personal spiritual practice as supportive of their ability to assess the spiritual needs of patients and family. Tiew and Creedy (2010) further identified nurses with a focus on personal spiritual growth were more able to communicate with patients about spiritual needs. Some other authors (Cavidish et al., 2003; Chan, 2009; Narayanasamy & Owens, 2001) provided evidence that nurses with strong spiritual perspectives were more likely to provide spiritual care than those lacking in personal spiritual development.

Although many nurses in this study experienced their personal spiritual self as a facilitator of spiritual nursing care, others experienced this relationship as a barrier. For some nurses, a rigid religious perspective resulted in a limit to their ability to meet the spiritual needs

of their patients and family. A rigid perspective limited the nurses' ability to relate to the spiritual perspective or needs of patients and family that were different from their own.

Participants in these situations described being most able to provide what they deemed to be spiritual care to those who had perspectives like their own. In a qualitative study of Christian nurses, Pfeiffer et al. (2014) found evidence that shared beliefs were used as a tool to provide spiritual care. The Christian nurses in this study defined spiritual care as involving "religious practices" and being a "reflection of the spirituality of the nurse" (Pfeiffer et al., pg. 2890). In a quantitative study of acute care nurses designed to identify barriers to the delivery of spiritual care, Gallison et al. (2013) also found evidence of nurses who expressed difficulty reaching or meeting the spiritual needs of those whose beliefs are different from their own. Lastly, some study participants with immature spiritual growth experienced their limited beliefs as a barrier to their ability to provide spiritual care. Balboni et al. (2014) reported similar results among nurses and physicians surveyed with those whose spiritual beliefs were less developed reported they were less likely to provide spiritual care.

Theme Three: Critical illness as experienced by patients and families provided the opportunity for nurses to explore spirituality with others. Nurses identified that caring for critically ill patients in the ICU environment as influencing both their spiritual care and ability to explore personal spirituality. Nurse participants described caring for patients with critical illness and their families as necessitating a need for a spiritual approach. Nurses further described end of life care being an essential time for spiritual care delivery.

The literature supports a significant need for spiritual care at times of critical illness and at the end of life. Albaugh (2003) and Young et al. (2015) both present findings from studies of critically ill patients who emphasize the positive impact of spirituality and spiritual care in their

care experience. The literature also suggests spiritual care delivery may be limited to end of life for many ICU patients and families (Choi et al., 2015).

Although the ICU nurse may readily identify the spiritual needs associated with end of life care, the literature and the findings of this study suggests a gap in care delivery leading to spiritual needs being neglected at other times. Spiritual needs of ICU patients and families are not limited to end of life. Spiritual care in the ICU has been reported to have a positive influence on the experience of care for patient families (Johnson et al., 2014). A more standardized approach to spiritual needs assessment with the use of spiritual assessment tools is needed to fully capture and meet the spiritual needs of patients and family in the ICU.

In addition to spiritual needs of critically ill patients and their families, theme three identified that nurses in caring for critically ill patients experienced increased spiritual needs for themselves. Nurse participants described needing to take the time to explore and strengthen their own spiritual perspectives particularly related to end of life. They emphasized the need to explore and strengthen self to continue to provide care and be fully present to patients who are critically ill. This experience further reflects findings in theme one and theme two, emphasizing the dynamic relationship of self in the nurse patient relationship. As discussed earlier, the literature documents ICU nurses' experience of moral distress. ICU nurses in particular when caring for patients at end of life (Elpern et al., 2005). Nurses in this study emphasized the need to actively grow their spiritual self to continue to provide care the intensive care needed by the critically ill.

Theme Four: The care environment serves as a barrier and/or facilitator to nurses' personal spiritual growth. Caritas nurse participants described the ICU care environment as serving as a barrier and/or a facilitator to nurses' personal spiritual growth. The majority of

participants discussed the ICU environment serving as a facilitator to their spiritual growth. These participants discussed an environment of care that was supportive of holistic and spiritual care goals. The participants also described co-workers and managers as being supportive of their personal growth.

The participants in this study were recruited from a specific care environment, an ICU within an WCSI affiliate hospital. In addition to the WCSI designation, this hospital also carried a Magnet® designation. The literature provides evidence that patients who are cared for in a Magnet® hospital receive a better quality of care (Stimpfel et al., 2014). The literature also provides evidence that patients cared for by nursing practicing from a WTHC perspective have higher levels of satisfaction and safety (Durant et al., 2015). In addition to patient outcomes, nurses practicing in hospitals that utilize WTHC report increased job satisfaction (Drenkard, 2008; Morby & Skalla, 2010), higher rates of retention (Drenkard; Morby & Skalla), and a feeling supported to provide patient care consist with their values (Drenkard).

These descriptions of the environment as a facilitator were emphasized by a small subset of participants who identified as working in the environment as nurse travelers, nurses on a temporary assignment to the unit. These nurses discussed how their current work environment was in their experience dramatically different than other places they had recently worked. They described their current work environment as one that focused on providing the nurse with the time to adequately care for patients holistically. They also described an environment that emphasized peer support and high regard for nurse satisfaction and success. Hence, these participants gave more evidence to a WTHC environment creating more support for nurses .

Although most participants cited the ICU work environment as a facilitator of their personal spiritual growth, a few participants discussed the environment as a barrier to personal

growth. Of those who described barriers to care, one concern was the time demand of caring for patients who are critically ill. Nurses described feeling unable to focus on spiritual needs of patients due to the demands of meeting patients' physical needs and providing lifesaving drugs and therapies. These nurse participants described feeling as though they were unable to provide the care they wanted to provide. One of the most often cited barriers to the delivery of spiritual care in acute care settings is the perception of lack of time (Balboni et al., 2014; Carr, 2010; Cavidish et al., 2006; Gallison et al., 2013; Keall et al., 2014; Ruston, 2014; Sanders et al., 2016). One participant also discussed unsupportive management as a barrier to spiritual development and the delivery of spiritual care. The literature indicates working in a healthcare environment that has conflicting priorities, including efficiency, cost, in contrast to a holistic approach to patient needs, as yet another barrier to the delivery of spiritual nursing care (Carr; McSherry, 2006; Sanders et al.). These findings suggest that even in theory laden care environments, there remains work to be done to create atmospheres and a workflow supportive of meeting the spiritual needs of patients and for nurses to continue to grow spiritually.

Theme Five: Cultivation of spiritual practices and spiritual identity is integral to a life-long process of consciousness evolution. In the fifth theme, nurse participants described a commitment to spiritual growth through spiritual practices and a cultivated spiritual identity. Participants described a personal commitment to regular spiritual practices many of which were reflective in nature. Participants described practices such as meditation, prayer, being in nature, and participation in religion as essential to their ongoing spiritual growth. Participants also described personal perspectives of spirituality as a relationship with self, others, a higher power, and as a source for meaning and purpose in their lives.

The findings in this theme are theoretically grounded in WTHC. Nurses practicing from a WTHC perspective strive to provide care from a place of Caritas consciousness. It is in this higher of level of consciousness that nurses are able to meet patients in a transpersonal relationship (Watson, 2008). The road to achieving Caritas consciousness is supported by numerous paths, including a personal reflective practice. The spiritual practices discussed by participants centered on reflection, through meditation and prayer to support continued personal growth.

Implications

The following section will discuss the implications of the findings of this study for nursing education, practice, policy, and research.

Implications for nursing education. There are several implications for nursing education. One is the focus in nursing education on personal self-care and spiritual knowing. As discussed in Chapter One, the American Nurses Association (ANA) Code of Ethics (2015) with Interpretive Statements included in its provisions emphasis on nurses' obligation to care for self, including care for their own personal and spiritual needs. Nurses in this study emphasized the need for personal self care to sustain themselves within their clinical role and provide adequate spiritual care for patients and family.

Studies of practicing nurses provide evidence supporting the importance of and need for self care practices. Implications of the study findings extend beyond nursing education into nursing practice and policy. Numerous studies point to high rates of markers of poor health in nurses. In recent studies it was found that 24.9% of nurses sampled reported frequent alcohol consumption (Hurley, Edwards, Cupp, & Phillips, 2018), 4% are current smokers (Hurley et al.), 34% are overweight (Hurley et al.; Ross et al., 2019), 23.4-30% are obese (Hurley et al.; Ross et

al.) and 70-80% have sedentary behaviors (Hurley et al.; Ross et al.). These indicators of poor health in nurses are coupled with reports of low levels of health responsibility (lack of personal accountability for health behaviors) (Kurnat-Thoma, El-Banna, & Oakcrum, 2017). Although these findings are consistent with health status and behaviors of the broader US population, nurses possess more health related knowledge than the average American (Hurley et al.; Ross et al.). Despite this, nurses view themselves as role of models of health, responsible for promoting healthy behaviors and lifestyle for the patients they serve (Hurley et al.).

The work of nursing also has significant effects on the mental health of nurses. Nurses are reported to experience depression at twice the national rate (Letvak, Ruhm, & Gupta, 2012). Younger nurses and those who work in acute care settings including ICU are at increased risk for developing symptoms of depression (Ohler, Kerr, & Forbes, 2010). In a survey of 283 nurses working in acute care settings, 42% reported considering leaving the job because of moral distress (Lusignani, Gianni, Giuseppe, & Buffon, 2016). National nurse turnover rates are on the rise particularly among new graduate RNs with nearly 1 in 5 leaving their job within the first year of work (Kovner, Brewer, Fatehi, & Jun, 2014).

Given the significant risks that the work of nurses has on physical and mental health nurse educations should provide and prepare student nurses with self care strategies. Spiritual and religious practices are one example of self care strategies found to be important in protecting nurses against health risks (Batalla et al., 2018). Spirituality and strong spiritual practices have been shown to protect against depression in nurses (Batalla et al., 2018). These authors further identified that spirituality increased in times of heightened occupational stress, demonstrating the strength of spirituality as an aid in work stress management. Nurse educators create the basis for nursing practice through student nurse education. By creating a beginning culture of personal

self care with emphasis on the importance of ongoing personal development, it is possible for nurse educators to create a generation of nurses empowered to care for themselves.

While a broad focus on self-care in general is important, the findings of this study specifically relate to and mandate a spiritual focus. Spiritual knowledge of self and others is evident throughout the findings. This knowledge is needed to provide adequate care to patients and families. Spiritual knowledge is different from religious beliefs. Nurses in the study point to the limits of religious beliefs in meeting the spiritual needs of others. Spiritual beliefs and a spiritual focus move nurses beyond a religious frame to respect other traditions and find commonalities in the spiritual experience of all people. Achieving this knowledge requires a dedication to lifelong spiritual learning and a focus on reflective personal discovery. Nurse educators have the power to identify and build a nursing curriculum focused on essential knowledge for nursing practice including spiritual knowing. As advanced most recently by Willis and Leone-Sheehan (2019), spiritual knowing is an essential pattern of knowing for nursing practice. Nurse educators are called upon to prepare nurses to meet the spiritual needs of patients and family. Lack of training or education in spirituality and spiritual care is often cited as a significant barrier to the delivery of nursing spiritual care (Balboni et al., 2014; Kiaei et al., 2015; Rushton, 2014; Sanders et al., 2016; Tiew & Creedy, 2010; Wu et al., 2016). Educational interventions including content specific to spirituality are needed to prepare students with the focus and knowledge needed to evaluate and meet these spiritual needs.

Implications for nursing practice. The implications for nursing practice include a focus on the practice environment. Participants in this study provide evidence of the influence of the ICU work environment both facilitating and serving as a barrier to their personal spiritual growth and their ability to have a spiritual focus in patient care. Work is needed to address barriers to

spiritual care identified by these participants and supported by the current literature. One often cited barrier to spiritual care delivery in acute care settings is the perception of not having enough time (Balboni et al., 2012; Balboni et al., 2014; Carr, 2010; Cavendish et al., 2006; Gallison et al., 2013; Keall et al., 2014; Rushton, 2014; Sanders et al., 2016). In addition to perceiving inadequate time, nurses indicate work environments that prioritize economic efficiencies over other care values can lead to a significant barrier to spiritual care (Carr; Gallison et al.; Kiaei et al., 2015; Tiew & Creedy, 2010). A focus on creating workplace environments that provide the time, space, and education and training are needed to support nurses in spiritual care provision and spiritual development of self.

Just as a focus on self care is needed in nursing education, nurse self care has important implications in clinical practice. Nurses' health has significant effects on patient care outcomes with nurses' who report worse physical and mental health having a 26% to 71% greater likeliness of performing a medical error than healthy nurse colleagues (Melnik et al., 2018). The physical and mental health of the nursing workforce most significantly affects patient outcomes through presenteeism. Presenteeism is defined as, "the practice of coming to work despite illness, injury, anxiety, etc., often resulting in reduced productivity" (Dictionary.com, 2019). As discussed earlier, nurses experience rates of depression at twice the national average and depression is significantly associated with presenteeism (Letvak et al., 2012). Letvak et al. also identified chronic pain, specifically musculo-skeletal pain, as associated with high rates of presenteeism demonstrating the relation of both the physical and mental toll of nurses' work. Presenteeism has been found to lead to increased rates of patient falls, increased medical errors, and decreased quality of care scores (Letvak et al.).

One way to address the issue of presenteeism is by identifying protective factors. Rainbown, Drake, & Steege (2019) found psychological well-being and a strong team-work environment were both protective against presenteeism. Research addressing nurse engagement further bridges the discussion of individual nurse self care and work environmental factors. Engaged nurses describe being active participants in their work, feeling included in organizational decision making, and report access to opportunities for professional development (Carthon et al., 2019). Nurses who report higher levels of work engagement have more favorable perceptions of patient safety including decreased reports of medical errors and less perceived threats to patient safety (Carthon et al.).

The psychological, physical, and spiritual health of nurses and the ability of the nurse to engage and be satisfied in the work environment have significant implications for nursing practice. Findings from this study point to one possible solution to these problems through an ongoing focus on nursing theory based care. Findings from this study support the positive impact of Magnet® and the utilization of WTHC as a nurse practice model on nurse participants. Magnet® hospital designation is focused on the creation and support of a strong nursing work environment and has been shown to have positive effects on both the nursing workforce and patient outcomes (Stimpfel et al., 2014). Nurses who work in Magnet® hospitals have lower rates of turnover, greater job related satisfaction (Kutney-Lee et al., 2015; Park, Gass, & Boyle, 2016), and report increased quality of patient care (Kutney-Lee et al.). Patient care is measured as better quality in Magnet® hospitals with many nurse sensitive indicators, including lower rates of central line infections (Barnes, Rearden, McHugh, 2016) and decreased mortality from preventable hospital associated causes (Kutney-Lee et al.).

Hospitals that have adopted WTHC as a nurse practice model both for Magnet® designation and also in general to guide theory based practice, see similar indicators of improved patient outcomes. Nurses working in hospitals that have adopted WTHC report increased job related satisfaction (Drenkard, 2008; Morby & Skalla, 2010), higher rates of job retention (Drenkard; Morby & Skalla), and the perception that they have enough time to meet the holistic needs of patients and families (Drenkard). Healthcare settings must continue work to strive to provide nursing theory based care. Theory based care must be measured and extended to reach all patients and families both to improve healthcare outcomes and experience. Further, theory based care is needed to help retain and sustain practicing nurses who are at risk for leaving the discipline. Theories such as WTHC that support a focus on self provide nurses with the tools needed to prevent burnout and remain at the bedside.

Implications for policy. The practice environment implications can be extended more broadly to implications for healthcare policy. As healthcare policies are designed with a focus on patient care outcomes and experiences, structures must be put into place that will afford the highest level for all outcome measures. Chapter One included discussion of the economic implications of not providing spiritual care; additional significant economic implications are associated measures of hospital based quality. Patient satisfaction and adverse hospital events including medical errors and falls have a significant impact on rates of reimbursement from the Centers for Medicare and Medicaid (Lembitz & Clarke, 2009). Theory based care environments that support nurse professionalism lead to increased patient engagement, nurses job satisfaction, and improved patient outcomes (Barnes et al., 2016; Kutney-Lee et al., 2015; Stimpel et al., 2014). Theory based nurse work environments improve the lives of nurses, the care received by patients, and potentially increase the rate of reimbursement for the hospital system overall.

Additionally, for providers in the ICU, a focus on providing spiritual care is needed to improve care outcomes and patient and family satisfaction with care (Wall et al., 2007).

Continuing education requirements from state boards of nursing are one area where professional support could prioritize growth of nursing spiritual and theoretical knowledge. Requiring or simply being broadly inclusive of continuing education hours from specific areas of nursing knowledge, including spiritual knowing, would support practicing nurses' focus on spiritual growth. Work environments must also be able to provide structures needed for ongoing professional growth to support nurse engagement. The findings of this study revealed personal spiritual growth as needed for professional development. Findings of one study describe this relationship and the impact on care most explicitly. Spiritual health also has been shown to have significant effects on care outcomes, with spiritual health having a positive effect on nurses commitment to professional nursing care (Chiang, Lee, Chu, Han, & Haiiao, 2016). The relation between personal and professional growth must be supported.

Implications for research. One major research implication from the findings of this study is the use of directed content analysis as a method useful for the evaluation of theory integration in clinical practice. Findings from this study inform and extend WTHC and provide an understanding of this theory as practiced by nurses in an ICU. Knowledge of how nurses participate in and practice nursing theory based care is needed both to evaluate the effectiveness of the integration of the theory in the practice setting and also to continue to grow the nursing theory for practice.

More work is needed to address and support nurses' personal spiritual development. Next steps include a focus on development of spiritual knowing for nursing education and practice, to develop a workforce prepared for the task of spiritual self care and spiritual care of the other.

The spiritual knowledge needed for practice goes beyond personal spirituality. Spiritual knowing for nursing (Willis & Leone-Sheehan, 2019) must be further advanced to create the tools needed to educate, foster, and support spiritual growth and perspectives needed for nursing practice.

Findings begin to inform a situation specific theory by providing information about how nurses in the ICUs in the institution studied have spiritual practices guided by CPT. Thus, the findings of this study set the stage for the development of a situation specific theory of CPT of WTHC. Situation specific theories are focused on unique nursing phenomena, are contextually informed and provide a clear connection between theory and practice (Im & Meleis, 1999). Through exploration of ICU nurses experience of CPT, the findings of this study provide an explanation of CPT that is clinically informed and contextually relevant for nurses practicing in an ICU. Further advancement of these findings through theory development, will aid in the translation of the findings to the clinical setting. This supports WTHC, but more work across other ICUs in WCS institutes is needed. To further understand if in fact it is the theory guiding the spiritual practice, it would be important to replicate this study in ICUs that are not WCS institutes. Additionally, to understand if this is unique to ICU settings, it would be important to replicate this study on general care units.

Limitations

The study design serves as both a limitation and a strength in the understanding and description of the findings. Qualitative methodologies offer data that is rich in participant description and experience. This methodology was essential in informing and expanding the understanding of the WTHC in the ICU practice setting, as was the aim of this study. The qualitative design does however provide a limited picture of ICU nurse experience. Although

commonalities in experience found across study participants, the experience of ICU nurses in varied practice settings remains unknown.

The generalization of study findings is limited both by the sample size and sampling plan. Study recruitment aimed at developing a sample that met specific characteristics, including though not limited to current employment in a WCSI affiliate hospital. Although many hospitals utilize WTHC for their nurse practice model in Magnet® designation, there are likely differences in the degree of integration of the theory in an WCSI affiliate organization. This variation in the degree of integration between WCSI affiliates and other Magnet® designated organizations is unknown, yet hospitals that receive WSCI affiliate designation must have reported integration of WTHC throughout their organizations. The full integration of the theory in the WCSI affiliate hospital provided a beginning model to understand nurses practicing from a theoretical perspective. In addition to the setting, the small sample size (n=10) and demographic data present a sample that is unrepresentative of the total population of US registered nurses. As was discussed in Chapter Four, the demographics of the sample are representative of both the region where the sample was drawn and the area of care in which the nurses currently work (ICU). These factors further limit the generalization of the study findings.

Conclusions

Patients and family in the ICU have a significant need for spiritual nursing care, and earlier studies have revealed nurses with a spiritual perspective are more likely to deliver spiritual care. This study advances nursing knowledge through an exploration of the ICU nurses' experience of CPT of WTHC further identifying and clarifying the relation of ICU nurses' personal spirituality and spiritual nursing care. The findings of this study identified five themes: *Caritas nurses vary in their ability to move beyond ego-self, spiritual practices serve as a barrier*

and/or facilitator to nurses' ability to provide spiritual care, critical illness as experienced by patients and families provided the nurse opportunity to explore spirituality, the care environment serves as a barrier and/or facilitator to nurses' personal spiritual growth, cultivation of spiritual practices and spiritual identity is integral to a life-long process of consciousness evolution.

The findings of this study advance nursing knowledge by extending the theoretical understanding of CPT of WTHC. By sampling Caritas nurses, the findings present an exemplar of nursing theory based care. The findings of this study reveal Caritas nurses have varied levels of success moving beyond ego-self to reach patients and family in mutual relationship. The path beyond ego self is supported by the nurses' personal spiritual development and a life-long commitment to spiritual practice. Caritas nurses in the ICU may experience increased opportunity for personal spiritual growth through caring for patients who are critically ill and with the support of their peers and hospital leadership. Personal spiritual practice to serve as a path to meet the spiritual needs of patient and family should include an appreciation of the differences and similarities of the spiritual being of the other.

The findings of this study have significant implications for nursing education, practice, policy, and research. More work is needed to advance nursing theory based care and spiritual knowing for nursing practice. Additional research is needed to meet the significant spiritual needs of patients and families and to support the spiritual knowing of nurses in the ICU.

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Appendix A. Study Recruitment Flyer

Seeking ICU Registered Nurses to Participate in a Qualitative Research Study

Study Topic

ICU nurses' personal spiritual development Exploring Watson's Caritas Process 3: Cultivation of One's Own Spiritual Practices and Transpersonal Self, Going Beyond Ego-Self

What's Involved?

- 1 telephone interview
- To be completed outside of work hours
- Estimated time commitment **30 minutes**

- In appreciation for your participation, all participants are eligible to receive an Amazon gift card immediately after your interview
- Amazon gift card value is based amount of interview completed
 - Partial completion \$15 gift card
 - Full completion \$25 gift card

For more information and to see if you qualify, please contact the principal investigator:

Danielle Leone-Sheehan MS, RN at (978) 621-2575
or email leoned@bc.edu

This study is being conducted as partial fulfillment of the requirements for the degree of
Doctor of Philosophy in Nursing at Boston College.

Appendix B: Study Consent Form



Boston College Consent Form

Boston College William F. Connell School of Nursing

**Informed Consent to be in study ICU Nurses' Experience of Watson's Theory of Human Caring
Caritas Process Three: Cultivation of One's Own Spiritual Practice and Transpersonal Self,
Going Beyond Ego-Self**

Researcher: Danielle Leone-Sheehan MS, RN

Adult Consent Form

Invitation to be Part of a Research Study

You are invited to participate in a research study. You were selected to be in the study because you are currently working as a registered nurse in an adult intensive care unit at a Watson Caring Science Affiliate Healthcare organization. Taking part in this research project is voluntary.

Important Information about the Research Study

Things you should know:

- The purpose of the study is to further the understanding of nursing theory based spiritual care in the ICU through exploring the ICU nurses' experience of Caritas Process Three of Watson's Theory of Human Caring. If you choose to participate, you will be asked to participate in a telephone interview. This will take 30 to 60 minutes.
- The study will have no direct benefit to participants.
- Taking part in this research project is voluntary. You don't have to participate and you can stop at any time.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why are we doing it?

The purpose of the study is to further the understanding of nursing theory based spiritual care in the ICU through exploring nurses' experiences of Caritas Process Three of Watson's Theory of Human Caring, Cultivation of One's Own Spiritual Practice and Transpersonal Self, Going Beyond Ego-Self. Expanded knowledge of nursing theory based spiritual care has the potential to inform and improve nursing spiritual care in the ICU. Additionally, this study will expand and extend theoretical knowledge essential to supporting nursing professional practice.

The total number of people in this study is expected to be 25.

What will happen if you take part in this study?

If you agree to take part in this study, you will be asked to participate in a telephone interview. The interview will include questions about your experience of spiritual care in the ICU. The interview will also ask about your personal experiences with spirituality. The interviews will be recorded. The interview may last up to 60 minutes, though length will vary based on depth of participant response. The interviews will include questions about basic demographic information.

How could you benefit from this study?

Although you will not directly benefit from being in this study, others might benefit. The study will improve knowledge of Watsons' Theory of Human Caring. This knowledge will be specific to the nurses working in the ICU. This specific knowledge of the nursing theory could improve nursing spiritual care in this area.

What risks might result from being in this study?

There are no foreseeable risks to study participation.

How will we protect your information?

The records of this study will be kept private. Any published reports will include no identifying information. Research records will be kept in a locked file.

All electronic information will be coded and secured using an encrypted and password-protected computer.

We will assign to each participant a unique, coded identifier that will be used in place of your name or other identifying information. There will be no record linking the coded identifier to a participant's actual name. A separate record of participant name and contact information will be maintained for the purpose of follow-up and distribution of gift cards. This record with actual identifiers will include no research data.

All audio recordings will be stored on an encrypted and password-protected computer. Access to these recordings will be limited to the primary investigator and the dissertation committee members. The recordings will be maintained for a period of five years and then erased.

Mainly just the researchers will have access to information; however, please note that a few other key people may also have access. These might include government agencies. Also, the Institutional Review Board at Boston College and internal Boston

College auditors may review the research records. Otherwise, the researchers will not release to others any information that identifies you unless you give your permission.

What will happen to the information we collect about you after the study is over?

I will keep your research data to use for future research or other purpose. Your name and other information that can directly identify you will be deleted from the research data collected as part of the project.

I may share your research data with other investigators without asking for your consent again, but it will not contain information that could directly identify you.

How will we compensate you for being part of the study?

You will receive a \$25 Amazon gift card for your participation in this study. The gift card will be distributed following the completion of the interview portion of this study. If you need to stop the interview prior to completion, you will receive a \$15 Amazon gift card as a gift for partial participation in the study. You will receive your gift card immediately following your interview through electronic mail.

What are the costs to you to be part of the study?

There is no cost to you to be in this research study.

Your Participation in this Study is Voluntary

It is totally up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer. If you decide to withdraw before this study is completed, your interview recording will be erased and all data removed from the study record.

If you choose not to be in this study, it will not affect your current or future relations with the University or Stanford Health Care.

Getting Dismissed from the Study

The researcher may dismiss you from the study at any time for the following reasons: (1) it is in your best interests (e.g. side effects or distress have resulted), (2) you have failed to comply with the study rules.

Contact Information for the Study Team and Questions about the Research

If you have questions about this research, you may contact Danielle Leone-Sheehan, MS, RN, leoned@bc.edu, (978) 621- 2575 and Jane Flanagan, PhD, RN, AHN-BC, ANP-BC, FAAN, jane.flanagan@bc.edu, (617) 552-8949.

Contact Information for Questions about Your Rights as a Research Participant

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the following:

Boston College
Office for Research Protections
Phone: (617) 552-4778
Email: irb@bc.edu

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. We will give you can print a copy of the document for your records. If you have any questions about the study later, you can contact the study team using the information provided above.

I have read (or have had read to me) the contents of this consent form. I have been encouraged to ask questions. I have received answers to my questions. I give my consent to be in this study. I have received (or will receive) a copy of this form.

Appendix C: Interview Guide

Interview Guide

Start of interview/introduction.

Hello my name is Danielle Leone-Sheehan a nursing doctoral student at Boston College and I am calling to talk with [participant name]. Is now a good time to talk with you? Please verify your name for me. I am interested in learning about ICU nurses' experiences of their own spiritual awareness. [Participant name] you had expressed interest in my study, would you still like to participate in this study? [Thank you for being willing to participate or Thank you for your time.] I want to remind you that at any point you can stop the interview or withdraw from the study completely. Your confidentiality is very important to me and it will be maintained throughout this study. As a reminder, I am audio recording the interviews. I will not use any specific name including places in reporting what I learn from the interviews or identify you or anyone you mention in any way. I will not share this information with anyone except individuals who are consulting on this study with me. If at any time during the interview you have questions or concerns please let me know.

The interview may take 30 minutes to an hour, is that okay? Do you have any questions for me before I start the interview and the recorder is turned on? Okay let's get started.

Interview questions.

1. Please describe what spirituality means to you. (RQ1)

Probing/clarifying questions.

a. Do you consider yourself spiritual?

a1. If so, please describe.

a2. If no, can you describe any experience of spirituality as part of your life?

2. What do you do to strengthen your spiritual life? (RQ1)

a. What spiritual practices are important to you? Why?

a1. Some examples other people have offered include.

3. What, if any is the relationship, between your professional obligations as a nurse and your spiritual development? (RQ2)

Probing/clarifying questions.

- a. How do you practice spiritual nursing care with your patients?
- b. Please provide an example of how you provide spiritual care.
- c. Why is spiritual care important in your practice of nursing?
- d. Do you see any relevance to your spiritual development and the code of ethics in

nursing?

4. Has there been anything about working in the ICU that has helped you to grow spiritually as an individual? (RQ2)

Probing/clarifying questions.

- a. Would you please provide an example of an experience at work that resulted in personal spiritual growth?
- b. How did this facilitate your spiritual growth?

5. Has there been anything about working in the ICU that has made it more difficult to grow spiritually as an individual? (RQ2)

Probing/clarifying questions.

- a. Would you please provide an example of an experience at work that had a negative effect on your spiritual growth?
- b. How was this a barrier to your spiritual growth?

6. What is the relationship between your personal spirituality and the care you provide to patients and families in the ICU? (RQ3)

Probing question(s)

a. In what ways does providing spiritual nursing care to patients and families in the ICU inform and or deepen your spirituality?

7. Jean Watson's Caritas Process Three is Cultivation of One's Own Spiritual Practice and Transpersonal Self, Going Beyond Ego-Self.

- a. What does this Caritas Process mean to you?
- b. How do you live this Caritas Process in practice?
- c. If I were to see you in practice, how would you look different as a Caring Science nurse from a nurse practicing from a different perspective?

Appendix D: Demographic Questionnaire
Demographic Questionnaire

Section A: Interview details.

Date and time:

Participant identifier:

Section B: Demographic questions.

Start of questionnaire: The following will be a series of questions related to demographic information. Please answer each question as accurately as possible. You are free to omit responses to any item.

Age

In what year were you born?

Gender

How would you describe your gender?

Race/Ethnicity

How would you describe your ethnic background?

Do you identify as Hispanic or non-Hispanic?

Level of education

What is your highest completed level of education?

Nursing experience

How many years have you worked as a registered nurse?

How many years have you worked in a Watson Caring Science Affiliate Hospital?

How many years have you worked in the ICU as a registered nurse?

Appendix E: Coding Template

Coding Template

Ego-Self: The ego-self is a self-focused perspective for understanding the world. We look inward for explanations and understandings of truth in the world and in others. The ego-self is a limited and incomplete perspective of self and represents lack of personal growth. To overcome the ego-self the individual connects with Spirit/Source, seeks source of inner wisdom/truth, and connects with and controls inner thoughts and feelings. “We have thoughts, we have feelings, we have a body, but we are more than our thoughts our feelings and our body we are embodied spirit.” (Watson, 2008, p. 69).

Transpersonal-Self: Enhanced awareness of personal thoughts and emotions are essential precursors to an openness and receptivity to the other. A reflective self is sensitive to others feelings and spirit and is able to connect in a compassionate human-human way that is beyond ego-self. The transpersonal self is the highest most actualized self and includes a spiritual self that is connected to a higher/deeper Spirit/Source. The transpersonal self is able to be fully present to and receptive of the other person’s thoughts, emotions, spirit, and is fundamental to developing a transpersonal caring relationship (Watson, 2008).

Cultivation of Spiritual Practices and Transpersonal Self: Spiritual growth, insight and enhanced mindfulness are necessary to developing the self beyond ego-self orientation to reaching a transpersonal awareness. Spiritual practices nurture individual beliefs and call upon the nurse to pay attention to and understand more fully the internal self, thoughts, and feelings. Spiritual practices facilitate connecting more fully with the self, others, and Spirit/Source. Through seeking a highest understanding spiritual practices lead to increased maturity and sensitivity essential to being sensitive to others (Watson, 2008).

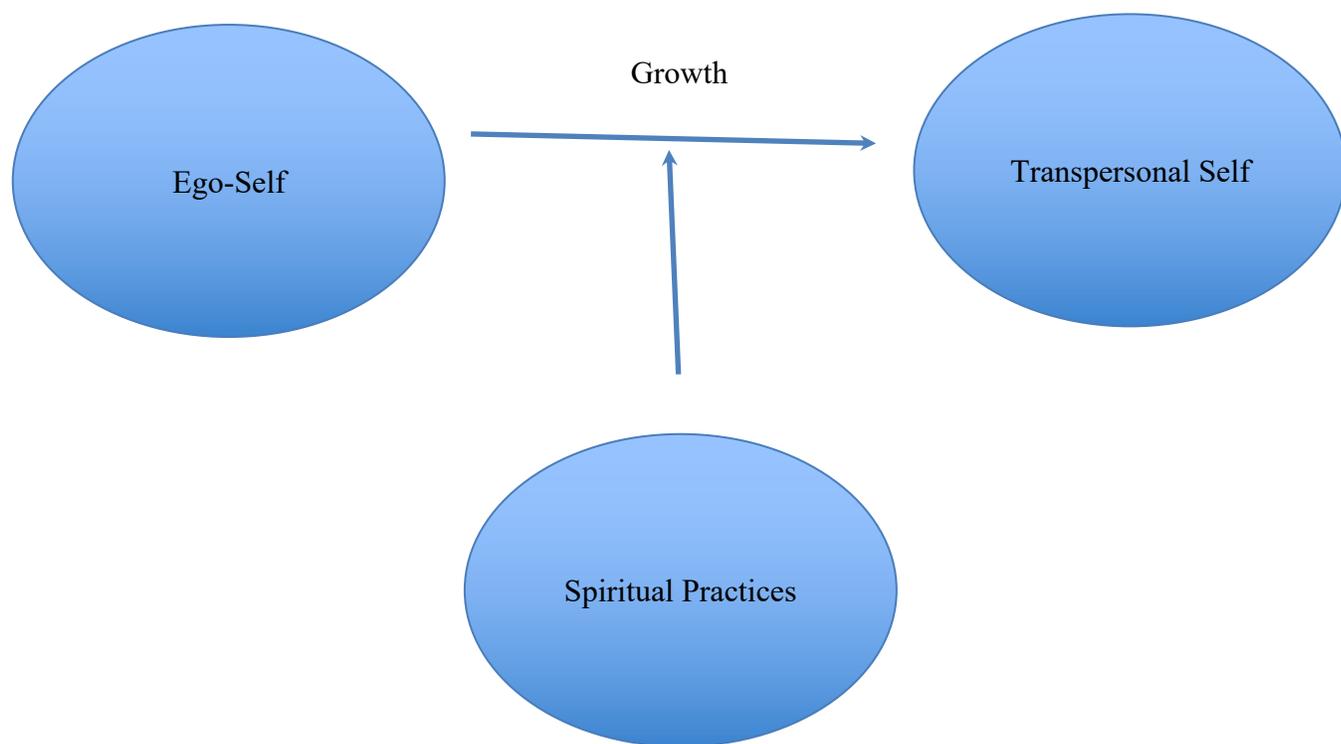


Figure. Caritas Process Three: Cultivation of One's Own Spiritual Practices and Transpersonal Self, Going Beyond Ego-Self (Watson, 2008)