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**SPIRITUAL CARE IN NURSING:
A GROUNDED THEORY ANALYSIS**

By

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ABSTRACT

There is scientific evidence that the spiritual well-being of a person can influence the quality of life lived and the general responses to life's crises of illness, pain, suffering and even death (Ross, 1994). The problem that was identified in this study was the absence of an explicit description of the phenomena of spirituality and spiritual care in nursing within a South African context. Concept clarification was imperative if nurses, patients/clients in South Africa were to realize spirituality and spiritual care within a broader context of holistic nursing. The purpose of the study was to conceptualize the phenomena of spirituality and spiritual care from the perspectives of nurses and patients/clients with an aim of generating a middle range theory of spiritual care in nursing that explained the phenomena by utilizing data that were grounded in the participants' experiences.

A qualitative mode of inquiry using a grounded theory method was applied. A sample of 56 participants composed of 40 nurses, 14 patients and 2 relatives of patients was recruited by theoretical sampling procedure from two hospitals, and one hospice settings. Data were collected by utilizing focus groups interviews followed by one to one in depth interviews and observations. An audio tape recorder was used to record the conversation, field notes and memos were also kept to strengthen the data, and to ensure trustworthiness. Data were collected and analyzed simultaneously. A software called Nvivo was used to code data into different levels of coding. The results were rich descriptions of the phenomena in question and a development of a theoretical model for spiritual care. The concept of spirituality was described as a unique individual quest for a transcendent relationship by establishing and maintaining a dynamic relationship with self, others and with God as understood by the person. The ability to establish and maintain a meaningful transcendent relationship seemed to be related to the person's beliefs, faith or trust. 99% of the participants expressed their quest for a transcendent relationship through organized religion while 1% claimed to have their spiritual fulfilment outside an organized religion.

The phenomena of spirituality and spiritual care were conceptualized as occurring in phases which begin with a comfortable zone, trigger-response and spiritual caring. The nurses role in spiritual care was perceived as based upon the principles of ubuntu, compassion for human suffering and pain and acceptance of a patient/client as a unique being. Nurses carried their spiritual care roles by accompanying, helping, presencing, valuing and intercessory roles. The outcomes of spiritual care were cited as hope, inner peace, finding meaning and purpose in life, illness, and in death.

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Sarah N. Mahlungulu.

DECLARATION

I, Sarah. Nomalizo Mahlangu declare that:

this dissertation, Spiritual Care in Nursing: A Grounded Theory Analysis is my own work and it has not been submitted to any other university other than the University of Natal (Durban). All sources of information that have been utilized or quoted have been acknowledged by a complete reference.



Sarah N. Mahlangu

February 20, 2001

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CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1 Introduction

Nurses describe their professional uniqueness in patient care as embedded in the concept of holistic caring in which a person is viewed as a unique bio-psycho-social, moral, and spiritual being (Oldnall, 1996). The central tenet of holism is unity of all aspects that make a human being. Holism is based upon the premise that the whole is greater than the sum of its parts (Goddard, 1995). The opposite of holism found in nursing practice is the fragmentation of a person into a body in bed, a case for surgery, a disease for pathological investigations (Salladay and McDonnell, 1989). In response to the challenge of caring for the person as a whole, the International Council of Nurses (ICON) code of ethics (1973) incorporated spiritual care as part of the nurses' responsibilities (Bradshaw, 1994).

Over the past two decades there has been a growing increase in speculating the concepts of human spirituality and spiritual care in relationship to holistic caring. The recent upsurge of interest in matters of spirituality is not only in the nursing profession, but also in politics, education, theology and in other health related professions. Carr (1996) argues that this recent attention to matters of spirituality can only be associated to the urgent need for a rigorous philosophical analysis in a realm where the bulk of the talk is notoriously fast and loose. Indeed, by far the most pressing problem concerning the construction of a plausible account of spirituality relates precisely to the looseness of every day language of spirituality (Carr, 1996).

Defining human spirituality is not an easy task, and let alone spiritual care. Nursing literature reveals that there is a plethora of definitions which include a need for meaning and purpose in life, a need for hope, trust, faith in self, others and in a power beyond self, a need for forgiveness, a need to establish and maintain a dynamic relationship with self, others and the Ultimate Other (Shelly & Fish, 1988; Carson, 1989; Sardana, 1990; Goddard, 1995; Golberg, 1998). There is scientific evidence from North American and British studies and literature that the spiritual well-being of a person can influence the quality of life lived and the general response to the life's crisis of illness, suffering, pain and even death (Ross, 1994). The manner in which spirituality

is conceptualized and defined will have significant implications for professional nursing practice, nursing education and further development of the ontology and the epistemology of nursing (Goddard, 1995).

1.2 Statement of a problem

The problem was identified in this study was the absence of an explicit description of the concepts of spirituality and spiritual care in nursing within a South African context. Concept clarification is imperative if the South African nurses and patients/clients are to recognize the spirituality and spiritual care within a broader context of holistic nursing care. The implicit nature of spirituality and spiritual care needed to be explicated from the perspective of those who give and receive nursing care. Concept clarification could be achieved if there was a general agreement between patients/clients and nurses about the essential constitutive elements of the two concepts in question.

1.3 The purpose of the study

The purpose of this study was to analyse the concepts of spirituality and spiritual care from the perspectives of both patients/clients and nurses, with the aim of discovering a shared meaning of the phenomena by capturing all variations and also examining the conditions under which the phenomena occurred. There are no research studies which have been reported in South Africa on human spirituality and spiritual care in nursing, therefore there is a need to share views about the phenomena in order to access them for holistic nursing care.

This study therefore aimed at achieving two major goals. (1). To conceptualize the phenomena of spirituality and spiritual care from the perspectives of patients/clients and nurses. (2). To generate a middle-range theory of spiritual care that explains the phenomena and the related concepts by utilizing data that was grounded in the participants' experiences.

1.4. Objectives of the study

In order to achieve the broad aim mentioned above, the researcher had to achieve the following objectives;

1. Identified the descriptive words used by patients/clients and nurses to describe the phenomena of spirituality and spiritual care.
2. Identified the similarities and differences in the use of concepts in order to discover the basic social process or a core variable.
3. Discovered how patients and nurses expressed their spiritual experiences.
4. Identified nursing activities which are classified by both nurses and patients as spiritual care activities.
5. Described the processes involved in the provision of spiritual care.
6. Analysed the concepts of spirituality and spiritual care with an aim of identifying the cause, context, covariance, consequences, contingencies and conditions under which the phenomena occurred.

1.5. Research questions

The research questions that this study endeavoured to answer were;

1. What were the descriptions given by nurses and patients /clients for the concepts of spirituality and spiritual care?
2. What concepts were used by patients/clients and nurses's to describe their values of spirituality and spiritual care?
3. What are the properties of spirituality and spiritual care as described by the research participants?
4. How did patients/clients respond to their illness, pain suffering and death?
5. Under which conditions, and with what strategies and consequences were the phenomena of spirituality and spiritual care experienced?
6. What were the patterns, variances, complexities and diversities inherent in the descriptions of spirituality and spiritual care as experienced by both patients/clients and nurses?

1.6. Significance of the study

Although there is an increasing recognition of the spiritual dimension of a person and a need for spiritual care to be incorporated in patient care, there is still obvious conceptual disparity, vagueness and ambiguity in the descriptions given by different authors (Goddard, 1995). Several factors have been identified as the cause of this ambiguity and vagueness in descriptions of the concepts of spirituality and spiritual care. Piles (1986) found that spiritual needs were often confused with psychosocial needs. Goddard (1995) also argues that the inability to distinguish between the psychosocial and spiritual needs and spirituality and religiosity have potential results of either neglect or inappropriate response to the patients' spiritual needs.

The manner in which spirituality and spiritual care are conceptualised and defined will have significant implications for professional nursing practice, nursing education and for further development of the ontology and the epistemology of nursing (Goddard, 1995). This study uncovered new dimensions of spirituality and spiritual care as used in the nursing profession. The studies that have been done in United States of America and United Kingdom have not paid much attention on the analysis of the concepts of human spirituality and spiritual care. They have all made an assumption that they understand the meaning of these concepts.

Since no studies have been reported in South Africa on the topic of spirituality, this investigator has sensitized the South African nurses to this topic which has suddenly become the academic focus in the Western world. When nurses are sensitized to the spiritual expressions of patients and they also agree on some common defining concepts, then total patient care would be improved. Nurses like McConochie (1994) purport that the reality of spiritual care is more of a challenge to nurses dealing with patients suffering from terminal illnesses such as Acquired Immune deficiency syndrome (AIDS). Often these patients feel that they have let their families, friends and God down and that they have not lived up to the standard of their own cherished values. If nurses and patients/clients shared a common understanding of the concepts of spirituality and spiritual care, the implicit nature of these concepts would be explicated.

Studies relating to spirituality date as far back as 1960's (Ross, 1994). Research relating to patient's perception of spirituality was first reported by Stallwood-Hess (1969), Kealey (1974), Martin (1976) Chomicz (1984), Simsen (1985), in these studies it was found that hospitalization can become a spiritual encounter. A significant number of patients reported experiences of finding meaning in their illness, a need for a fulfilling relationship with God and others, relief from fear and forgiveness as spiritual encounters (Ross, 1994).

Ross, (1994) reports that research relating to nurses' perception of the patients' spiritual needs dates as far back as 1957. Kramer, 1957, Kealey, 1974, and Piles, 1986 (cited by Ross, 1994) found that while almost all nurses perceived providing spiritual care as an important part of their role, only about half of the group were able to provide such care. Nurses reported that they were not adequately prepared in the nursing schools to provide spiritual care (Piles, 1986). Ross (1994) study also sought to identify nurses' perception of patients' spiritual needs. Hall and Lanig (1993) focused on self professed Christian nurses and how they integrated spiritual care in their daily activities. A significant number of nurses reported to be providing spiritual care, but this care appeared to be easily provided for peers and colleagues than for patients (Hall and Lanig, 1993). Studies that are reported in literature all seemed to have used quantitative designs of descriptive surveys using mailed questionnaire. This researcher preferred to approach the problem in context. The topic of spirituality needed to be understood contextually.

1.7. Definition of terms

The purpose of this study was to identify the defining concepts used by patients and nurses for the phenomena of spirituality and spiritual care. Therefore, the definitions given below were just working definitions. They were replaced at the end of the study by the definitions which have emerged from the data.

1.7.1 Spirituality

In this study, spirituality was viewed as an aspect of the total being inseparably integrated to all other aspects of the being. Spirituality has to do with how the person experiences himself or her

self in relationship to what he or she considers as the source of ultimate power and meaning in life. Spirituality is the integration of one's experiences of God (as understood by the person) in relationship to one's self and the effects this relationship has in the individual's value system and total philosophy of life (Kretzschmar, 1995). Spirituality is a broader concept than religion. Spirituality includes religion but the two terms are not synonymous (Golberg, 1998).

1.7.2 Spiritual care

In this study spiritual care referred to all nursing activities which are directed towards assisting a person to establish and, or maintain a dynamic relationship with God as understood by the person. Spiritual care includes all nursing activities which will promote inner peace within an individual and with his or her significant others and with God (according to that individual's definition of God).

1.7.3. Patient/ client

Patient/client referred to any person sick or well who benefits from nursing care. In this study the concept of "patient" was used to refer to the person who is sick and undergoing some medical treatment and subjected to nursing care in a hospital or hospice setting. The concept of "client" was used to refer to the person who was not claiming to be sick, but has been at one stage subjected to nursing care. The concept of client was also used to refer to the relatives of patients.

1.7.4. Nurse

In this study the term "nurse" was used to refer to a professional nurse who is registered as such with the South African Nursing Council and is providing direct patient care either in a hospital or hospice setting. "Nurse" was also used to refer to an enrolled nurse who was providing direct patient care and was also enrolled with the South African Nursing Council as such.

CHAPTER TWO : LITERATURE REVIEW

2.1 Introduction

This literature review covered the following areas:

1. Philosophical background about human nature and human spirituality.
2. Religious perspectives on human nature and human spirituality.
3. Human spirituality and spiritual care as part of total patient care.

2.2 Philosophical background

Philosophy is a term which comes from the Greek word which literally means, “love for wisdom.” This term has been defined differently by different writers. For this reason this writer adopts the Oxford Dictionary definition which defines philosophy as “the use of reason and argument in seeking truth and knowledge of reality, especially of the cause and nature of things and of the principles governing existence, the material universe, perception of physical phenomena and human behavior.” (Fowler and Fowler, 1990).

Philosophy addresses fundamental questions, the most crucial of all being, who am I? Where am I? What is the nature of reality? What is the ultimate reality? What is wrong? How do I understand the disorder, pain and evil that I observe and experience? How can I explain it? What is the solution? (Sire, 1988).

This literature review therefore, aimed at finding philosophical answers about human nature with specific reference to the human spirit or soul as some writers often do not make a distinction between the spirit and the soul. This literature review has in no means attempted to exhaust the subject of philosophy and human nature, but it has only made specific reference to Rationalism, Empiricism, Marxism, and Existentialism. Even though not much reference will be made to the Ancient philosophers like Socrates, Plato and Aristotle, their philosophical views have a great influence on their successors up to this day.

This researcher tends to agree with Socrates when he said “true knowledge is more than simple an inspection of facts. Knowledge has to do with the power of the mind to discover in facts the abiding elements that remain after the facts disappear” (Stumpf, 1966:43). Are there any abiding elements which remain after the facts we already know about human nature disappeared? The philosopher therefore, emphasized that the person who wants to find knowledge about reality must go deep to the roots of facts through dialogue.

2.2.1 Rationalism

Rationalism is a philosophical thought which arose during the seventeenth century of which its tribute is attached to Rene Descartes as the founder. Descartes likened himself to an Architect designing a town from scratch (Sorel, 1993). Descartes and his colleagues’ Spinoza and Leibniz fashioned a new ideal for philosophy. Their outstanding contribution to philosophy was their emphasis upon the rational capacity of the human mind which they considered the main source of truth about reality. The fundamental questions attacked by Descartes were on the nature of knowledge and the nature of man.

Descartes’ philosophical position is summarized in what he calls “Rules for the direction of the mind.” To mention, just but, a few; rule one states that the aim of our studies should be to direct the mind with a view of forming true and sound judgement about whatever comes before it. Rule two - we should attend only to those objects of which our minds seem capable of having certain and indubitable cognition. Rule three - concerning objects proposed for study we ought to investigate what we can clearly and evidently intuit, or deduce with certainty, and not what other people have thought, or what we ourselves conjecture. For knowledge can be attained in no other way. Rule four - we need method if we are to investigate the truth of things. Rule five- the whole method consists entirely in the ordering and arranging of the objects on which we must concentrate our minds’ eyes if we are to discover some truth. We should be following exactly this method if we reduce complicated and obscure propositions step by step to simple ones of all, try to ascend through the same steps to a knowledge of all the rest.

Rule six- in order to distinguish the simplest things from those that are complicated and to set out in an orderly manner, we should attend to what is most simple in each series of things in which we have directly deduced some truths from others, and should observe how all the rest are more, or less or equally removed from the simplest (Descartes, 1911).

Descartes' understanding of human knowledge is expressed in his statement when he said "knowledge of self is prior to knowledge of God, and both the self and God are prior to knowledge of the external world." Looking at human nature, Descartes takes a dualistic view in which body and mind exist independent of each other. The many activities of a person are as mechanical as those of animals (Descartes, 1911). The activities of the human body are simply reduced to physics. From his own existence, Descartes had proved the existence of God by his rational thinking. But his dualistic ideas made him to argue that "to be thinking does not of itself prove that my body exists, for my thinking self is entirely and absolutely distinct from my body and can exist without it." (Stumpf, 1966: 253).

Even though Descartes believed that God exists and had understood that everything else is dependent upon him, he still argued that "for them who are believers, it is enough to accept on faith that the human soul does not die with the body and that God exists, but in the case of non-believers, it seems that there is no religion, and practically no moral virtue, that they can be persuaded to adopt until these two truths are proved to them by natural reason." (Descartes, Vol 2, 1984:3).

Despite his denigration of history, history is highly relevant to Descartes' system. For in history is God's will, revealed, and truth in science depends on God's will. Descartes held that all truth is created, that it depends upon the utterly unconstrained will of God (Sorel, 1993). But for Descartes logic reasoning rated higher than God (Vessey, 1986).

Spinoza is another rationalist philosopher who was influenced by Descartes even though not a true follower. Spinoza emphasized the principle of geometry as a methodology in finding truth. Unlike Descartes, Spinoza identified God with the cosmos. His famous formula was Deus Sive, nature or God, God or Nature. For him these two concepts are interchangeable. Learning more

about things around us and about ourselves will make us understand God. The nature of reality is a single substance which has an external cause within itself. Spinoza identified three levels of knowing which he called (1) imagination (2) reason (3) intuition which he considered to be the higher level where we become more conscious of God in us. For Spinoza, mind and body are the attributes of one substance, the human being is part of nature and is God and God is nature. If the human being is God, and God is nature there is no good or bad because our desires are determined by laws of nature, and so are our judgements. Therefore, ethics has no place in Spinoza's rationalism.

Leibniz accepted Spinoza's single substance reality. It was a vital principle of Leibniz' rationalism, that philosophy, whether natural or metaphysical, should offer explanation only in terms of intelligible notions (Sorel, 1993). Leibniz acknowledge the individuality of persons, the transcendence of God and the reality of purpose and freedom in the universe. In his explanation of a single substance reality he says "true substances are monads, souls to emphasize their non material nature." Leibniz rejected the idea of matter as the prime reality. He argued that the truly simple substances are the monads. Leibniz described the monad as being force or energy, as having no shape, no size. The monads are windowless and they function in an orderly manner which denotes their preestablished harmony (Stumpf, 1966).

For Leibniz the order and harmony of things proved the existence of God. The final reason, or the sufficient reason, for all things is found in a substance whose own existence is necessary, whose existence requires no cause or further explanation, a being, whose essence involves existence. A being whose very nature or essence is a sufficient reason for its own existence, requiring no prior cause and this being is God (Stumpf, 1966).

Rationalism as a philosophical argument has made a great contribution to the field of modern philosophy. The rationalists' emphasis upon the reasoning capacity of the human mind to argue human existence was greatly influenced by their metaphysics background. They purported that the human mind if used accordingly can discover the truths about reality. Reasoning out about reality was placed higher than God. Actually human reasoning was considered independent of the supernatural (Stumpf, 1966). The three rationalists referred to above both reasoned their own

existence including the existence of God. That is why Vessey (1986) says about Descartes “In his metaphysics, his views of the fundamental nature of the world, God stands high but the simple logic truths stand higher.” Rationalists explained the reality after the mechanical model of physics and they ascribed determinism to all physical events.

Basically, these rationalists do not go beyond a reality that is beyond physical. Descartes’ attempt of dualism in which he viewed reality in two forms i.e. thought and extension or body and mind, still does not provide us with a firm base for human understanding, particularly because his two forms function independently. It is clear that Descartes equates the mind with the spirit or soul. Yet now we know the human person is more than his body and or mind. Spinoza argued on monism in which there is one reality i.e. God and nature or nature and God are one. This view does not provide us with answers about human spirituality either. Even Leibniz’s monad reduces human nature to force or energy which can also be argued out. Maybe the empiricist will provide us with answers in this puzzle of human nature and of spirituality in particular,

2.2.2 Empiricism

Empiricism is the branch of philosophy which challenged the modern philosophers’ optimistic views about the capacity of the human mind to find truth about reality through reasoning. Empiricists may differ in the account they give of the sense experience and also in the inferences that they draw from them, but they all agree that unless knowledge is validly based upon our sense experience we can have no sufficient ground for maintaining any proposition about reality. (Locke, Berkeley, Hume, Reid, 1952).

The main objective of empiricism was to enquire into the nature and origin of human knowledge and to explain how this knowledge can be known. As Locke (1952) proposes that all our ideas without exception come to us from experience. Experience may take the form of sensation which gives reality to simple ideas such as yellow, heat, soft and bitter. According to Locke what we can know depends upon our understanding of the inter-relationship of our ideas to one another (ibid).

Berkeley agrees with Locke on perception as the basis for all existence. As he argued “To be, is to be perceived”. This meant that, if something was not perceived then it would not exist. For him all knowledge depended upon actual vision or other sensory experiences. (Stumpf, 1996). Therefore, what is real according to Berkeley is that which can be perceived. This philosophy sets up the basis for scientific investigation for truth about reality.

Hume (1927) viewed the scientific methods as the means for solving all the problems of the universe. He believed that such methods could lead to clear understanding of human nature and in particular of the human mind. Hume concluded that “all the perceptions of the human mind resolve themselves into two distinct kinds”. Which he called “Impressions and Ideas” (Hume, 1927). Hume concludes that if we take seriously the premise that all our ideas come from experience, we must accept the limits to knowledge that this explanation of ideas forces upon us. The content of the mind can be reduced to the materials given to us by senses and experiences.

For Hume, the ideas and impressions are related by cause and effect. This stands to reason that the order of the universe is simply an empirical fact, we cannot infer from it the existence of God (Stumpf, 1996). The ideas and impressions come from repeated observation of the contiguity, priority, and constant conjunction of the two things. Hume asked “how can we assign any cause to the universe when we have never experienced the universe related to anything we might consider the cause”. He goes on to say “If every thing must have a cause, it follows that upon the exclusion of other causes we must accept of the object itself or of nothing as cause. According to all just reasoning, it ought never to be taken for granted”. (Hume, 1927: 31). Commenting on the human soul or spirit, Hume said, as an empiricist philosopher he was unable to arrive at any satisfactory notion of substance to which the rationalists like Leibniz referred. For him that was a sufficient reason for utterly abandoning the dispute concerning the mortality or immortality of the soul. (Hume, 1927).

Concerning human nature, Hume adopts a metaphysics view of limiting human nature to primitive elements. He suggests that all sciences, ethics included rest on human nature, and it would be poor philosophy that attempted to carry the explanation of human nature to unobserved principles or causes allegedly more ultimate than this nature as it is observed (Norton, 1993).

In short Hume suggests that his philosophy cannot be effectively utilized in answering questions about human nature.

The rise of empiricism marked a critical period in the history of philosophy. It somehow provided the scientific world with the tools of gathering knowledge about reality. Empiricism strongly challenged the notion held by the rationalists that we can find truth about reality through logic reasoning. Empiricism provided a more practical way of finding truth about reality, i.e. The sensory perception of our ideas as they relate to one another through cause and effect. The empiricists like John Locke, Berkeley, Hume etc were mainly concerned about the nature of human knowledge and how this knowledge can be found.

For empiricism existence can only be explained by cause and effect. This philosophy gave rise to a positivistic view of reality, not only as a pattern of thinking but also as a major solution to the problems of science. August Comte is the founder of the positivism in France. Positivism rejects the assumption that nature has some ultimate purpose or end. Positivism studies facts by observing the constant relations between various phenomena and then formulate laws of science based upon the observed relationships.

Empiricism with its positivistic view of nature emphasize the objective world. It is utilized a lot in the scientific world though not so effective in explaining human phenomena. Empiricism, sometimes called positivism does not provide us with answers concerning questions of human nature and human spirit particularly because these are not observable, they cannot be explained by direct observation of cause and effect.

2.2.3 Marxism

Marxism refers to a philosophical argument founded by Karl Marx. Its presuppositions are that there is only one reality to discover and that is the material world. For Marx history was to be understood as a movement caused by conflict in the material order. That is why he referred to history as a dialectical materialism. This was to show that since the basis of reality or the prime

reality is the material world, there are no fixed points in reality. Everything is involved in the dialectic process of change. (Conforth, 1953).

Marxism holds the notion that all things are related to each other through cause and effect. History displays a law of determinism. That is why he could predict the future of the society. According to his predictions history would have ended with the emergence of socialism and finally communism. Concerned about the gross inequity between the rich and the poor in a capitalist society he said “the ethics of a social group is the expression of the concrete nature of their freedom and their aspiration for freedom which has its basis in the place they occupy in social production (Conforth, 1954).

For Marx the source of ideas was seen as rooted in the material order. Such factors as justice, goodness and even religious salvation were only various modes of realizing the existing order. The dialectical process has its material aspects and also its ideological aspects. For Marx, “Ideas are particularly useless when they bear no relationship to the economical reality”. (Stumpf, 1966: 429).

Marx’s philosophy about human nature is greatly influenced by his view of dialectic materialism. Struck by Hegel’s method of identifying the person with God and God with humans, Marx thought that the reality was not the spirit, not god, but the human being and his or her material world. Marx strongly believed that, the world should be changed in order to facilitate man’s self realization. For Marx when the appropriate social change will be implemented and the ideal society created, then reality would have been discovered (Conforth, 1954).

Marxism as a philosophical thought purports that there is only one reality and this reality is the material world. This reality can be known through co-operate efforts because to know the material world requires that individuals in a society should work together. Therefore, knowledge is a social product (Conforth, 1954). For Marxism history is a process of development and change from less to more perfect forms of reality. The so called knowledge of God is man’s knowledge about himself. God plays no part in dialectic materialism because history is determined by laws of cause and effect. Basically no room for human spirituality in Marxism.

2.2.4 Existentialism

This philosophical thought emerged in the 20th century. It placed great emphasis on human existence. This existence meant being a certain kind of an individual. An individual who constantly strives to create meaning for him/herself, an individual who makes choices and considers alternatives (Stumpf, 1966). Sartre responding to the presuppositions of materialism, he said “the effect of all materialism is to treat all man as objects, that is as an ensemble of determined reactions in no way distinguished from the ensemble of phenomena which constitute a table or a chair or a stone”. (Stumpf, 1966).

In their criticism of the previous philosophers who placed greater emphasis on the objective nature of reality, the existentialist emphasized subjectivity of human reality. An ensemble of values distinct from the material realm (Kern, 1962). Sartre quoted by Sires (1988) further states that, “If God does not exist, there is at least one being in whom existence precedes essence, a being who exists before he can be defined by any concept... and this being is man”. This is actually the core of the definition of existentialism. “For human being alone existence precedes essence, people make themselves who they are” (Sire, 1988).

In describing the human being’s existential state, Kierkegaard (1941) distinguished between the human’s present state, what he or she is now and what he or she ought to be or what he or she is essentially. Then he said, there is a movement in the life of a person from essential to existential condition, a movement from essence to existence (Kierkegaard, 1941).

The existentialists accept that there is an objective world and a subjective world, but they emphasize the disunity of the two worlds and opt strongly in favor of the subjective world. Their point of departure is the subjectivity of the individual, the absolute truth of self consciousness (Vessey, 1986). In the subjective world we are free within, we can create our own values by affirming self worth. We are not bound to the objective world as the materialists and empiricists would say. “Value is inner and inner is each person’s own” (Sire, 1988).

The inner awareness of the mind is a conscious present, a constant now. Science and history have no meaning, for the subject is always present to itself, never future. Science and logic reasoning have nothing to say about the subjective world. The subjective world is understood by one who experiences it (Sire, 1988).

The existentialist hold the notion that the highly organized objective world stands against human beings and appears absurd. The concept of absurd is used here to denote the absence of correspondence and congruity between the person's need for coherence and the incoherence of the world the person experiences (Cruickshank, 1959). The objective world is orderly, bodies fall if not supported. The subjective world knows no order. As subjects, human beings are all strangers in a foreign objective world. The sooner they learn that, the sooner they transcend their alienation and pass through the despair. In full recognition of the objective world and its absurdity, the authentic person must revolt and create meaning and value (Sire, 1988).

Existentialism provides us with an important aspect of reality, which is the subjective world. By grounding human significance in subjectively, it does place it in a realm divorced from reality. The objective world keep on intruding into our subjective world. As Camus (cited by Sire, 1988) says "we must ever live in the face of the absurd. We must never forget our bent towards non-existence, but live out the tension between the love of life and the certainty of death".

Death, the ever present possibility and the ultimate certainly puts a halt to whatever meaning might otherwise be possible. It forces an existentialist to forever affirm and affirm; when affirmation ceases, so does authentic existence. Blackhan, in Sires (1988) argues, "yes, death indeed does end it all, but every human life is more than itself for it stems from a past humanity, and it affects humanity's future. More over there is heaven and there is hell in the economy of every human imagination". Philosophers have raised questions about reality. These questions still need to be answered. The arguments raised this far do not address the question of spirituality, but they do give us some direction on asking further questions.

2.3 Religious perspectives

Religion is a difficult concept to define, and even more so in the African context, in a multicultural South African society with its varied traditional beliefs and western influences. This literature review has speculated religion from the perspective of traditional African, Christianity, Islamic and Eastern religions. These religions have been chosen because of the relevance they have on the study of spirituality in the South African context. These religions will be analysed and compared in relationship to their philosophy of human nature and spirituality.

The meaning of religion has been explained by O'Brien (1982) to mean a conscious system of beliefs, practices, and codes of ethics associated with groups and organizations. Religion identifies one with persons from whom one may get support in times of uncertainty. Religion may be an expression of one's spirituality, nevertheless, being religious may not necessarily mean being spiritual. For some people religion may be extrinsic, a religion of convenience to be used but not to be lived. For others, religion may be intrinsic, a commitment to a system of beliefs. Religion and spirituality are not synonymous concepts, though some people may use them interchangeably (O'Brien 1982).

2.3.1 The Traditional African Religion.

Traditional African religion refers to the set of beliefs which explain natural phenomena not only in terms of physical laws, but also in terms of the activities of gods or spirits (Kalumba, 1996). Many traditional Africans still believe in gods or spirits and they also believe in God who created the heavens and the earth (Mbiti, 1969). There is a clear distinction between the two forms of Gods. The God of heaven is referred to as "Unkulunkulu" which means the great of the great. Unkulunkulu is the Zulu name for God. The Xhosas say "Uthixo" to refer to God, and "izithixo" to refer to the small gods (Mbiti, 1969).

In the traditional African religion God is the ultimate reality. God is not only the ultimate ontological principle, but also the ultimate epistemological reality as well (Lang, 1991). According to Perry, (1997) God is that hermeneutic principle which is not interpreted any

further, yet in the light of which every thing else is interpreted. In the light of this explanation God is the prime reality (Lodzinski. 1995).

According to Mbiti, (1969) the traditional African religious ontology is divided into five anthropocentric categories which reflect that everything is seen in terms of its relationship to the human being. In the first category God is the ultimate explanation of the genesis, and He is also the sustainer of all things. In the second category are the spirits which are the extra human being and the spirits of the people who died some years ago. These spirits are said to be having a direct communication with God. The third category is the living human being and those about to be born. The fourth category is the animal and plant kingdom. The fifth category is the objects with out biological life. In addition to the five categories mentioned above, there is a power or energy which permeates the whole universe. God is said to be the controller of that power or energy. On the other hand the spirits and a few human beings have access to this power (Kalumba, 1996).

The expression of the spiritual experiences has been reported in research. In the early 1960 s Kieman in Davis (1982) conducted a study among the Zulu Zionist church in Kwa-Mashu, Durban. The church members professed to be a religion of the spirit “umoya” which literally means breath, air, or wind. The spirit or umoya is inspirational, random and it promotes freedom of expression on the part of a person who has it. The spirit filled person exhibits this freedom of expression in prophetic proclamations and denunciations in trance, visions, glossolalia, in witnessing in vigorous dancing and other exuberant and even violent forms of movements and music.

The explanation of the way in which spiritual symbolism is experienced may yield insight into the nature of symbolism in general and the religious symbols in particular (Eades in Davis, 1982). Within the traditional African life the individual is immersed in a religious participation which begins before birth and continues after death. Actually, to live is to be caught up in a religious drama (Mbiti, 1969). The expressions of religious experiences observed in the Zionist church are not limited to this particular church, they are found in most South African churches.

The traditional African religion strongly believes in life after death. The spirits of the dead are said to exist somewhere in the air (Vilakazi, 1962). They are the channels of communication between the living and God. They may be displeased about the family members and send calamity to the family. At times they may send the blessings (Vilakazi, 1962). The family has the responsibility of bringing the dead back home to continue looking and watching over the family. This service of bringing the dead back home begins where the person died. If he or she died in the hospital the relatives will go to that hospital and tell him or her that “now X we are taking you home” when the corps arrives at home, then again the elder of the family talks to it “now X you have arrived at home” “ufikile ekhaya” In short, the communication with the dead confirms the belief that he or she is not actually dead. At times there are reports that the ancestors are cold or hungry. At this point, we can agree with Mbiti (1969) in traditional African religion, one is involved in a religious drama from before birth until after death.

The above discussion has revealed that, in a traditional African religion there is more emphasis on the dead person than on the living. When a person dies he or she becomes a stepping stone in reaching God. God is the ultimate reality, but the spirits of the dead people stand between the human being and God. To communicate with God one must go through the spirits of the ancestors which have the authority to approve or disapprove of the request made (Hexham, 1987).

Communicating to the spirits may be satisfying in times of distress to those who share the belief system. At times, this form of belief may be very discouraging when the spirits are not pleased, when they are hungry and when they are cold. When they are not happy, they send disasters in the form of illness to the family. The spiritual fulfilment in this African traditional religion comes from satisfying the spirits (Hodgson, 1982).

2.3.2 The Christian Religion

The concept of Christianity can be traced as far back as the time of the disciples of Jesus Christ. “The disciples were called Christians first in Antioch” (Acts 11: 26). Since then the people who believe and follow Jesus Christ have always been called Christians. There are now many

different forms of Christians. There may be some intellectual squabbles between these Christian religions, but they all subscribe to similar set of propositions (Sire, 1988).

The first proposition that all Christian religions uphold is that, God is infinite, personal, Triune, transcendent and immanent, omniscient, sovereign and good. This implies that God is the ultimate reality, not only personal but Triune. Triune means within one essence of the Godhead, there are three distinguished persons who are coequal and coeternal and yet remain One God (Thiele, 1998).

The second proposition says, God created the universe ex nihilo to operate in uniformity of natural causes in an open system. Emphasis is placed on God as the creator of the universe and God creating the universe out of nothing. Human beings are therefore created in the image of God. The human beings possess personality, self-transcendence, intelligence, morality and creativity. The fact that human beings are created in the image of God gives them the value higher than any other creature in this universe (Taylor, 1986).

The third proposition says, the image of God in human beings has been marred by sin as a result of the fall of the first human creatures. Along with this belief is the plan of saving the human creature from the bondage of sin through the life, death and resurrection of Jesus Christ. The fourth proposition is related to the third proposition. Christian religions believe that ethics is transcendent and is based upon the character of God which is righteous, holy and loving. God is therefore, the moral standard (Thiele, 1998). History is linear, a meaningful sequence of events leading to the fulfilment of God's purpose for humanity.

The fifth proposition says, death is either a gate to God and His people or a gate to the eternal separation with God. Christian religions differ greatly in the point of what happens during and after death. The traditional Christian belief is that life continues after death. There is hell to burn the bad people, there is also purgatory to purify the bad people until they are fit for heaven, and there is also heaven for the good people. These beliefs all agree that the soul is immortal and it continues to live after death (Sire, 1988; Schaeffer, 1972).

The second Christian view about death is based on the two equations “and the Lord God formed man of the dust of the ground and breathed into his nostrils the breath of life and man became a living soul” (Genesis 2:7). The equation is simple, body (dust of the ground ; the earth’s element) plus breath of life (spirit of God) equal a living soul or a living being. The reverse action occurs at the time of death “then shall the dust return to earth as it was; and the spirit shall return to God who gave it” (Ecclesiastes 12: 7). The two text describe the making and the unmaking of the human being (Blanco, 1999). For these Christians death is like a sleep which will end on the resurrection day (Nelson, 1994). The resurrection of Christ is the basis for believing that there will be a resurrection of the dead; “the last enemy that shall be destroyed is death ... For the trumpet shall sound and the dead shall be raised incorruptible ... For the corruptible must put on incorruption and this mortal shall put on immortality” (1 Corinthians 15: 26, 52, 53). Nelson, (1994) states that the Bible is unequivocal concerning the human state at death. He cites the following texts; the dead can not remember or give thanks (Psalms 6: 5) cannot praise God (Isaiah 38: 18) cannot think(Psalms 146:3,4) cannot hate or love, cannot function in any way (Ecclesiastes 9:5, 6).

The basic Christian belief is that there is only one God who is the Ultimate Reality. The God who knows the end from the beginning. This God is the Creator of the universe. This God created a human being in his own image. God therefore continues to desire that the human beings may reflect His image in their every day life. The criteria for judging what is right and what is wrong is the character of God which is good, holy and loving.

Spirituality therefore, may be summarized as the individual desire to reflect God s character into one s own. To love God as He loved us, and to love our neighbours as we love our selves, and to commit our lives totally under His care (Blanco, 1999). True spirituality is not achieved by one’s efforts but by the power from God through Jesus Christ (Schaeffer, 1972; Walsh, 1984).

2.3.3 The Eastern Religion

The Eastern religion is very complex compared to the two religions discussed above. Its complexity may be associated with its multicultural and political history (Dalmia and

Stietencron, 1995). Nonetheless, this paper will endeavour to describe the basic assumptions underlying the Eastern religion from a global perspective. There are many religions in South Africa that are of Eastern origin, they may differ in their technical approach to religion, but they all subscribe to the similar belief system. This religion holds the notion that, Atman is Brahman which means the soul of each person is the soul of the cosmos (Sire, 1988). Atman is the essence, the soul of any person. Brahman is the soul of the whole cosmos. Each person is God and God is each person. God is all that exists, there is nothing that exists which is not God (Sire, 1988). The ultimate reality is One and it is beyond distinction.

The second proposition says some things are more One than others. This is another way of saying, reality is a hierarchy of appearances. Some appearances are said to be closer to oneness with the One. There are those who are close to pure beings such as Buddha. The third proposition says, many if not all roads lead to One this proposition places emphasis on different technical methods used by the Eastern people to experience their oneness with the One. Getting to oneness with the One is not a matter of finding the true path, but a matter of using different techniques such as chanting, meditation, contemplation of Zen Koans until the self leaps to sudden experience of unity with One. Other techniques involve repetition of prayers or acts of obeisance. All these techniques require quietness and solitude until the person experiences oneness with the One (Sire, 1988).

The fourth proposition holds that, to realize oneness with the cosmos is to pass beyond personality. Atman is impersonal, therefore, human beings in their truest, fullest being are impersonal (Sire, 1988). The last proposition states that death is the end of the individual personal existence, but it changes nothing essential in a person's nature because Atman is impersonal. When Atman is reincarnated it becomes another person. All human beings in the sense of being human cannot survive death, but death is no big deal because only Atman is valuable. Only the soul is of value. The body has no value because it is perishable. In a way death may be desired. To realize oneness with the One is to pass beyond time because time is unreal (Sire, 1988; Lambek, 1981).

From the above discussion, we have learnt that the soul is the ultimate reality. The soul of a person is one with the cosmos and also one with God. The soul is impersonal and is the only valuable entity of the person which continues to exist after death. Hinduism subscribes to at least three exclusive holy ends. The first one is the rebirth to a temporary life on the earth. Rebirth in paradise occurs with the same provision as earthly rebirth. A second possible holy object is the unlimited admission to the blissful presence of the supra mundane God, hence immortality of the individual soul. The third holy object is the cessation of the individual existence and the unification with the One (Weber, 1958).

2.3.4 Islamic Religion

Islamic religion, though Eastern in its origin, it is now a world wide religion. It has infiltrated the whole of Africa and South Africa included (Nadivi, 1982). The term Islam means to enter into peace with God and man. Peace with God implies complete submission to God's will. Peace with other humans does not only imply refrain from evil or harm to the other, but also to do good to all humans (Muhammad, 1950). Muslims hold the notion that revelation is a necessary factor in the evolution of a person to higher stages of life. Nadivi (1982) argues that "It is only revelation which discloses God in the full splendour of His light".

Death, in the light of the plain teachings of Holy Quran is not the end of life, but it opens the door to another form of life which is much superior than the present. The highest spiritual level is attained through prayer. Prayer prevents a person from doing evil and enables the person to attain perfection to realize the divine in him or her (Nadivi, 1982). In the light of the Islamic religion, spirituality is realized when a person has peace with God and peace with other fellow human beings.

Contrasting and comparing the three religions one will notice that all three religions recognize the existence of the super natural being. God is this supernatural being. The definition of God is different in these four religions mentioned above. For the traditional African religion, God is the ultimate reality, but there are other gods or spirits between the person and God. For the

Christians God is Triune, any one can approach God directly. To the East God is the soul of each one of us.

According to Shute, (1993) “religion is that human activity (understanding activity as including our cognitive, volitional and emotional powers) that has the fulfilment of the whole of our life as its concern”. All religions see God as defined by them as the source of power to achieve their goals. God however is defined as transcendent, immanent and sovereign. In all these religions discussed above, there is an obvious desire on the part of each person to maintain a relationship with his or her God.

2.4 Human spirituality

Throughout the history of Nursing as a profession, nurses have been attempting to formulate a universally accepted way of describing the complexity of an individual human- being so that the nursing profession can identify its relationship to this being. One description currently accepted by many nurses and other professionals is that a human-being is a biopsychosocial, moral and spiritual being (Carson, 1989). This complex being functions as a united whole. Disruptions in one or more aspects of a person affect the functioning whole. Therefore, nurses and other health professionals recognize that a human being needs a comprehensive approach to health care which will also include the spiritual aspects (Stoter, 1995).

A recent study done by Cawley (1997) exploring the concept of spirituality in nursing as used in literature, Cawley (1997) discovered that the concept is used in three different ways namely: the spirit as the noun - a life principle, animating body, disposition, liveliness, courage, frame of mind, essential character or meaning, soul, ghost or emotional state. The second usage of spirit as a noun refers to distilled liquid, solution of a volatile material in alcohol. The third usage refers to the Western doctrines that interpret the spirit as an actualization of the person's ability to transcend. The Eastern, African and Asian doctrines perceive the spirit as the “spiritus creator”, the source and ground of all life rather than simply a formalized religion. Cawley (1997) identifies spirituality as an adjective which qualifies an individual's interest in the things of the spirit. Secondly, spirituality refers to a person's sensitivity or attachment to religious values and

things of the spirit, rather than material interests. Spiritual care is viewed as an aspect of health care that attend to spiritual and religious needs brought about by an illness or injury.

Spiritual care is concerned about assisting a person to function as a whole in accordance with God's will. It involves the restoration of a person to wholeness in which the spirit, mind, body, bio-energy and emotions are in perfect balance. Spirituality is classified under three categories. The first category is spirituality relating to religious connotations such as a belief in God or another formalized religion. The second category refers to spirituality relating to non religious connotations such as the source, principle, essence of life, the soul, the characteristics or attributes of a person. The third category, which is of less interest in this study it refers to the spirit as the distilled liquid. Cawley (1997) looked at spirituality as depicted in the theories of nursing. She found that nursing theories do not necessarily define the spiritual aspect of the person. There were differences between the way they defined and incorporated spirituality in the nursing theories. The existing nursing theories give very little and almost insignificant guidelines as to what is spirituality and how to provide spiritual care in nursing.

Carson (1989) states that the art of caring is based upon a conscientious commitment to serve others. True service responds to the physical, psycho-social and spiritual needs of clients. Nurse therefore, assist individuals sick or well with those activities which contribute to health and its recovery, or to a peaceful death (Searle, 1989). These activities may be of a physical, social, emotional or spiritual nature. Nurses committed to total patient care realize that human nature is composed of all four aspects of the being (Bradshaw, 1994). These cannot be separated when providing nursing care.

The purpose of this section is to explore the concepts of human spirituality and spiritual care as described by nurses and other health professionals. The concepts which will be scrutinized are those relating to spirituality, spiritual dimensions of the human person, spiritual needs, spiritual wellness, spiritual distress, and spiritual care.

Spirituality is defined in terms of personal views or behaviours that express a sense of relatedness to a transcendent dimension or to something greater than the self (Reed, 1987). Carson (1989)

defines spirituality as a basic human drive for bonding with the transcendent, while she refers to the human spirit or soul as the Imago Dei (Image of God) within every person, making one a thinking, feeling, moral, creative being able to relate meaningfully to God (as defined by the person) self and others (Louw, 1980).

The human spirit provides one with a framework of values, a philosophy of life to live by and being understood (Carson, 1989). Spirituality is described by several nurses as the aspect of a human-being which involves the personal quest for meaning and purpose in life (Benzein, Norberg and Saveman, 1998). Spirituality is viewed as an integrating factor of the human person (Goddard, 1998).

Wagner (1988) states that "If spirituality is understood as having to do with fundamental matters, with our lives at their deepest, with what counts most for us, it cannot be segregated from any aspect of our existence".

Labun (1988) searched for a broader meaning of the concept of spirituality. Then she argues that, spirituality encompasses that which inspires in a person a desire to transcend the realms of the material world. She then chose to define spirituality as "an aspect of the total person that influences as well as acts in conjunction with the other aspects of the person". She goes on to explain spirituality as follows:

1. Spirituality is an aspect of the total person which is related to and is integrated with the functioning and expression of all other aspects of a person.
2. Spirituality has a relational nature which is expressed through interpersonal relationships between persons and through transcendent relationship with another realm.
3. Spirituality involves relationships and procures behaviours and feelings which demonstrates the existence of love, forgiveness, faith, hope, and trust therein providing meaning to life and a reason for being (Labun, 1988).

The above definition tallies well with the definitions given by Ross, 1994; Goddard, 1995; Oldnall, 1996; Golberg, 1998 and many other nurses who have demonstrated their interest on

matters of spirituality. Even other non-nursing writers like Stoter, (1995) have identified spirituality as an aspect of a person which encompasses the whole range of a person's life experiences and is influenced by those experiences. Stoter (1995: 3) argues that "the spiritual nature of Man is the total personality which links aspects together".

The definition of spirituality sometimes includes religion. While some authors may make no distinction between religion and spirituality, nurses and other health personnel have tried to make a distinction between the two concepts. The two terms have commonalities. They both have to do with values and meaning which surpass the material and physical realms (Benzein, et al 1998). Maslow (1964) described the difficulty of defining spirituality without using the vocabulary of the traditional religion as a definite lack of other satisfactory languages. The use of religious language leaves the spiritual dimension of a person as a vague aspect of human life. Religion may be an expression of one's spirituality, but being religious does not necessarily indicate that religion is the motivating force of meaning and purpose in life (Tripp, 1977). Religion for some people is extrinsic, a religion of convenience to be used and not to be lived. For others it may be intrinsic (O'Brien, 1982). It may provide a direction for one's spirituality, but the two concepts are not synonymous (O'Brien, 1982).

Stuart, Deckro and Mandle (1989) give the following concluding definition of spirituality. "Spirituality involves the personal quest to find meaning and purpose in life and a relationship to the mystery Divine in the universe, which can transcend a religious denominational connotation". Spirituality can be viewed as a process of coming into a relationship with reality and may differ according to the life's experiences and developmental level of the person (Carson, 1989).

2.4.1 Spiritual Growth and Development

Carson (1989) views spirituality as a dynamic process of growth and development which continues throughout the lifespan. The dimensions of this spiritual growth and development are both horizontally and vertically. During this process a person becomes increasingly aware of the meaning, purpose, fulfilment and values in life. The horizontal process increases the person's

awareness of his or her relationship with other people. The vertical process moves a person into searching for a closer relationship with a higher being as defined by the person (Carson, 1989).

Meaning, purpose and fulfilment are dynamic processes which tend to increase as the individual moves up on the growth and developmental ladder. Ross (1994) quoting Yura and Walsh (1982) says "the greatest task of human kind is to determine the meaning in life. Human beings need reasons for living and if there are none they begin to die" (Ross, 1994). Illness and other stressors of life such as death of the loved one or a severe loss of the body part or serious accidents constitute a threat to the individual's total integrity and force a person to begin to question the purpose of life (Labun, 1988). This makes spirituality an important aspect of care for the elderly, the dying, the ill and the families involved.

Although humans have the capacity to live with some degree of ambiguity and incoherence, McGrath, (1998) argues that humans generally do not tolerate chaos. When confronted with uncertainties or perceived paradoxes we respond by inventing cultural patterns to bring order to the world that appears meaningless and disorderly. We all have a general picture in our minds as to how we would like our lives to progress. This may not be a detailed mental picture, but just a general idea. Events such as one's own illness or death of the loved one are all problems of meaning and they call for an explanation. They threaten our integrity. McGrath, (1998) suggests that it is an important strategy to consider the drive to find meaning in illness a commonality we share across cultures. So, finding meaning is achieved through one's spirituality.

The person's spirituality can be a source of strength for coping with life's threatening situations. If a person's spiritual resources are dry, the person may get into a state of spiritual crisis. A study done by Mishel and Jo Braden (1988) on finding meaning antecedents of uncertainty in illness on hospitalized adults supported the generally accepted notion that, uncertainty with life's events increases one's arousal level to sensitivity of meaning in life. In this study antecedents of uncertainty in illness were tested. The antecedents of uncertainty tested were the stimuli from variables of symptom patterns and events, familiarity and the structure provider variables of education, social support and credible authority. Data were collected from a convenient sample of 61 women with gynaecological cancer at the time of major treatment effects. The findings

were that social support, familiarity and credible authority had the greatest influence on lowering the level of uncertainty (Mishel and Jo Braden, 1988). From this study we can deduce that when one is faced with uncertainties in life, one needs a credible authority to lean on, to trust and to give meaning.

Reed (1987) conducted her initial research into the significance of spirituality among terminal ill adults. In this study it was found that terminally ill hospitalized adults showed a greater spiritual perspective than non-terminally ill hospitalized adults and healthy non-hospitalized adults. Secondly, a significant group of terminally ill adults indicated a change towards increased spirituality than did non-terminally ill adults and healthy adults. These three groups of 100 adults were compared on the basis of age, gender, education and religious background (Reed, 1987).

Newshan (1998) examined the nature of the spiritual dimension of pain in patients who had cancer or acquired immune-deficiency syndrome (AIDS). The discrepancies in the results between the two groups are quite interesting. The patients with cancer perceived pain as a punishment from God and it was seen as God's will. The patients with HIV/AIDS reported that pain made them stronger and ready to face death. Non of the patients with AIDS saw pain as a punishment from God (Newshan, 1998). Even though the results could not be generalized due to the sample size and the type of the study, the author concludes that patients are struggling to find meaning in pain. For some, pain is a gift, for others it is a punishment. This researcher would assume that patients who are emotionally and spiritually prepared for death are able to accept it in a more positive manner. It seems that AIDS patients were better prepared for death through counselling than cancer patients. Spirituality is a potentially significant variable in the experience of pain with patients with HIV/AIDS or cancer (Newshan, 1998).

Golberg (1998) puts it this way, "spirituality is my being; my inner person. It is who am I, unique and alive. It is me expressed through my body, my thinking, my feelings, my judgements and my creativity. I am driven forward sometimes because of pain, sometimes in spite of pain..." Reed (1987) concluded that, the idea of spirituality as relatively significant among the terminally ill adults is derived from a broader concept of transcendence as a human phenomena associated with the end of life. The concept of transcendence reflects the human capacity to extend self beyond

the common boundaries of materialism and to achieve new perspectives and experiences with the Superior Being as understood by the person. Reed (1987) postulates that spiritual transcendence does not imply that a person is detached from other aspect of life, but that the person is open to life beyond the material realm.

Carson (1989) views the concept of spirituality along with hope and faith. Though the concepts are not synonymous, it does appear that hope and faith are the prerequisites for spiritual development. Faith is a complex concept that refers to belief in someone or something or to assent to something that cannot be seen or even scientifically proven. Faith is a universal phenomenon for both religious and non-religious individuals. Faith is developed from infancy to the end of life. Carson (1989) refers to Fowler's seven stages of faith development, Aden's eight stages, Westerhooffs' four stages and Erikson's psycho-social developmental stages throughout the life span.

The four developmental theories view faith as beginning from infancy in the form of trust, that is trusting one self and trusting others. During early childhood faith is courage. The child learns when to let go and take hold and affirm self in an undifferentiated way. Aden says this primitive faith allows an adult to feel affirmation of self in relationship to a higher being. Faith as obedience is seen during preschool age. Faith as assent, during the school going age. An understanding of the supreme being is increased. Faith as identity is seen during the adolescent stage. The successful accomplishment of this task of identity allows the adolescent to view self as worthy in relationship to a supreme being. The young adult expresses faith as surrender. At this time the individual learns to give himself or herself whole heartedly in a reciprocal relationship. This type of faith is viewed as unconditional caring. In relationship to a higher being the individual loves the being with all his or her heart. Finally faith is viewed as unconditional acceptance. At this stage the individual is faced with the challenge of finding meaning in the presence of the inevitable physical decline. It is then at this point that faith must emerge as the affirmation of both the finite and the eternal value (Carson, 1989).

The origin of faith ought to be analyzed from the perspectives of those who experience it. What is the source and the origin of faith? According to the Bible, faith comes alive and can grow

throughout life as a result of the interplay between divine and human factors. Faith is both a gift of God and a human response to God's trustworthiness (Rasi, 1993). For realizing and maintaining a transcendent relationship, a person must exercise faith. That is why faith is depicted in this study as an important factor in spirituality.

Faith is a gift that God grants to each human being that comes to this world, which is what makes spirituality to be a universal phenomenon, though it is experienced in a unique manner. "In accordance with the measure of faith God has given you"(Romans12:13). God has set eternity in the hearts of every human being. Human being have an inborn psychological make-up that naturally tends to select an object, a value or a person to whom one makes a total commitment and pay supreme allegiance (Rasi, 1993). Faith develops in human beings as they respond to God's self disclosure and trustworthiness as they pass through the various stages of life. It grows as we make sense of the experiences of life and place our trust on something or someone. Faith is not a concept that is tied to Christianity. Every human being has some form of faith to operate from.

Rasi (1993) argues that faith is found in the stories we tell to bring coherence to what happens to us in life. It is this faith that has the power to sustain us in an imperfect, world. Faith is nurtured through a relationship with a person or persons that are worthy of trust. Faith is knowing that God is both near and concerned, but also above and beyond (Rasi, 1993). As spirituality has a vertical and a horizontal dimension, so is faith. Faith has a vertical and a horizontal dimension. It connects each individual with God and with fellow human beings. It reveals itself in actions motivated by the decisions to fulfill the wishes to the trustworthy person. A dynamic faith is key to spiritual victory for both the nurse, the patient and family (Carr,1996).

Spirituality is perceived as sublime, ineffable, attitudes as well as effective responses and intellectual capacity. Literature also shows that religious beliefs seem to have a powerful effect on the mind and the spiritual aspects of the people. The belief in God, a sense of meaning, prayer, Bible reading and the support of religious friends are most valued tools in coping with pain of illness and dying. A recent survey of the service users by the Mental Health Foundation (1997) revealed that religious or spiritual beliefs played a part in the lives of over fifty percent

of those who were coping with either their own mental illness or the illness of their loved ones (Foskett, 1999). In this study, the role played by faith in coping with uncertainties of life was clearly described. Spirituality has also become a major concern in the field of education.

Rasi (1993) argues that "In accordance with the measure of faith God has given you" (Romans 12:13). God has set eternity in the hearts of every human being. Human beings have an inborn psychological make-up that naturally tends to select an object, a value or a person to whom one makes a total commitment and pay supreme allegiance (Rasi, 1993). Faith develops in human beings as they respond to God's self disclosure and trustworthiness as they pass through the various stages of life. It grows as we make sense of the experiences of life and place our trust on something or someone. Faith is not a concept that is tied to Christianity

To espouse this phenomenon of spirituality, it is quite appropriate that at this point we look at hope as another concept related to spiritual growth and development. Hope is a concept that has led to much speculation. There are several descriptions of this concept. Hope has been associated with suffering or trials. Hope is defined by Farran, Salloway and Clark (1990) as a rational thought process based on the probability of achieving goals that are important to the individual's welfare. Hope is viewed as an active process of combining the subjective desires with the real objective possibility. Hope transcends all possible disappointments because of a security in the Being who is the source of hope. Hope transcends imaginations and goes beyond circumstances (Simsen, 1988).

Simsen (1988) argues that, "the patient's ability to make sense out of their predicament seems to greatly depend upon their abilities to know, trust and hope. Learning to trust in an environment where all those around us are strangers, or to hope when the activities of tomorrow are unknown and threatening is an enormous task". From the above argument, it is clear that faith and hope are the important variables of human spirituality. Nurturing hope and faith are viewed as integral parts of providing spiritual care. Hope produces vitality and a will to live (Benzein, Norberg and Saveman, 1998). There is considerable evidence from studies done on humans that without hope death may result (Ross, 1995). Hopelessness is viewed by Ross (1995) as passive suicide. The study done by Renetzky, (1979) as reported by Ross (1995) revealed that, the will to live and the

degree of meaning, purpose and fulfilment were increased significantly when belief in God existed. Belief in God as understood by the person has a greater influence on the quality of life lived and the person's state of health. This is actually what makes understanding of human spirituality so significant in total patient care.

2.4.2 Spiritual well-ness.

Spiritual well-ness is described by Burkhard (1989) as "life affirming relationship or harmonious interconnectedness with deity, self, community and environment ... the health of the totality of the inner resources of a person ... a perception of life as having meaning". This definition does not imply that spiritual well-being is a fixed point. Like other definitions of health and well-ness, one may postulate that spiritual well-ness is a dynamic process of moving from a state of relatively complete well-being (not that there are no spiritual threats) to a total spiritual despair (Labun, 1988).

2.4.3 The spiritual distress

Spiritual distress is a nursing diagnosis which was first recognized and put on the list of the approved nursing diagnoses in 1971 by the North American White House conference on Aging. In their third conference on classification of nursing diagnosis in 1978, the three concepts ie, spiritual concerns, spiritual distress and spiritual despair were approved. In 1980 on the fourth conference on classification of nursing diagnosis, the three concepts were combined into one nursing diagnosis which is now known as "spiritual distress" (Frank-Stromborg 1988 and Ellerhorst-Ryan, 1985). Spiritual distress was then defined as, "a disruption in the life principle which pervades a person's entire being and which integrates and transcends one's biological and psycho-social nature" (Frank-Stromborg, 1988:142).

Burnard (1987) defines spiritual distress as a failure to invest life with meaning. Carpenito (1989-1990) also identifies spiritual distress as patient's problem that is related to three important factors. These factors are; 1. Inability to practice spiritual rituals, 2. Conflict between the spiritual beliefs and the prescribed health and treatment regimen. 3. Crisis of suffering illness, or

impending death. Carpenito (1989-1990) goes on to list the defining characteristics of spiritual distress which are cited as the experiences a disturbance in belief system; questions about the credibility of a belief system; inability to practice usual spiritual rituals, ambivalence of feelings or expressions of doubts about belief; expressions of having lost the purpose and reasons for life; feelings of spiritual emptiness; accompanied by emotional detachment from self and others; anger; resentment and fear over meaning of life. Sometimes the person may request spiritual assistance for a disturbance in the belief system.

Having identified the spiritual distress as a nursing diagnosis, the nurse needs to provide an appropriate intervention by using the nursing process. An appropriate intervention begins with appropriate assessment of spiritual needs.

2.4.4 Spiritual needs

Spiritual needs are factors necessary for establishing and maintaining a fulfilling relationship with the Supreme Being as defined by the person (Frank-Stromborg, 1988). These factors are identified as hope faith unconditional love, forgiveness, relatedness and a sense of meaning and purpose (Goddard, 1995). Nurses are capable of identifying spiritual needs of clients. Krohn (1988) suggests that nurses should observe patients for clues of spiritual needs through a careful assessment of the patient and his or her environment. Spiritual needs may also be identified through planned interviews.

2.4.5 Spiritual care

Care is expressed in nursing as an art of being concerned about another person's needs, being present all the time to assist or guard the patient from danger, providing for the other person what he or she cannot do for himself or herself. Caring involves an art of therapeutic use of self by being compassionate, loving, accepting and respectful (Piles, 1990). Spiritual care is an integral part of total patient care. It is described in nursing literature as a systematic process of assisting and guiding a person in establishing and, or, maintaining a dynamic personal relationship with God (Shelly and Fish, 1983; Piles, 1990; Ross, 1994; Golberg, 1998).

Ross (1994) conducted a study which explored some spiritual aspects of nursing care. This study was conducted in Scotland. A sample of 655 nurses who were caring for the elderly in the nursing homes responded to the postal questionnaire. 76.8% said they had identified some spiritual needs at some point in their practice. As a group these nurses perceived the concept in terms of individual need for belief and faith, peace and comfort, meaning, purpose and fulfilment, hope and creativity (Ross, 1994). From this study Ross (1994) also reports that nurses perceived providing spiritual care as part of their role and responsibility.

Golberg (1998) reports that many nurses are carrying out spiritual care on an unconscious level, she then purports that if spiritual care could be brought into conscious level by education and wider dissemination of research, patient care could be dramatically improved. Even though nurses perceive providing spiritual care as part of their responsibility, there is obvious lack of such care in the nursing care plans (De Young, 1986; Carson, 1985). Sims (1987) states that providing spiritual care does not necessarily mean that the nurse must share the patient belief system, but it does require sensitivity, empathy, concern, a willingness to listen and a non-judgmental attitude.

Piles (1990) poses a question to all nurses who share a holistic belief system. She says the question facing nursing today is "Does the patient agree that his or her greatest needs are met?" Piles (1990) relates her personal experience that most nurses would easily identify with. As she worked as a clinical supervisor in a critical care unit, one patient went into a ventricular fibrillation. The critical care unit code team was summoned immediately. The team quickly rushed into the ward. One member pounded the chest and started sticking needles to open a central line. The patient asked "Am I going to die?" As every one was doing what they thought was the right thing to do, no one responded to Mr X's question except saying "Breathe Mr X, Breathe". Mr X asked the same question again which had no response. At last he said "I am going to die". In about 15 minutes he was pronounced dead. The code team left the ward convinced that they had done all they could do to save Mr X's life, but Mr X died alone in a crowd needing somebody to share his fears with (Piles, 1990).

The question again which Piles asks is; has the science of nursing overshadowed the art of caring? Sardana (1990) state that, the essence of the art of caring is not doing or manipulating, but it is being open to whatever arises in the interaction with the patients or clients. The art of caring is opened to any challenge brought by the patient's condition. It includes being fully present with an unconditional acceptance of the patient's experiences (Newman, 1989). Providing spiritual care is a skill which can be learned and developed (Simsen, 1988). Spiritual care skills are described in literature as the abilities of a nurse to identify spiritual needs, diagnose spiritual distress, plan the appropriate intervention.

Several nurses like Shelly and Fish (1988) and others view spiritual care as inherent in the nursing profession. The role of nurses in health care is to prevent illnesses, to restore health, alleviate suffering and pain. This pain may be in the form of physical, emotional, social and or spiritual in nature. Shelly and Fish (1988) argue that nurses have a responsibility to care for the whole person. Often nurses are challenged by such questions as; why did God allow this to happen to me?, does God really care about me nurse? Should the nurse respond to such questions or should she or he simple say "wait, that is out of my scope of practice I will call you a hospital chaplain or your pastor"?

Research reveals that nurses are aware of their role in spiritual care but they feel inadequately prepared for such a role (Ross, 1995). Nursing education curricula do not give guidance in teaching spiritual care. Actually giving spiritual care is often left on the nurse's intuition level (Piles, 1990). Relying only on intuition is a heavy responsibility particularly for the novice nurse. Nurses in the clinical practice reported a narrow range of what they would classify as spiritual care activities as compared to nurses who were more senior in administration or education (Golberg, 1998). This reveals the importance of guiding nurses in providing total patient care which incorporates spiritual care.

Other constraints in providing spiritual care identified by Stoter (1995) are limited resources in terms of personnel expertise, differences in perspectives between the health personnel and patients. The health staff has spiritual needs too because they are also spiritual beings. Shelly and Fish (1988) argue that "nurses can only continue to meet the needs of other people if their own

needs are being met. Unless we are constantly refuelled, spiritual care can be so personally draining that we either collapse in exhaustion or withdraw from the people who need us". We need to view nurses' spirituality not as unprofessional bias, but as sources of contributions to the best possible care (Ross, 1995).

Nurses seem to agree that such activities as nurturing hope and faith, providing an atmosphere in which patients can freely express their spiritual needs, prayer and reading scripture for the patient, being present to the other in such a way that the patient will feel empowered to accept to live or die peacefully are aspects of spiritual care (Golberg, 1998). Nurses are responsible and accountable for total patient care. Cusveller (1998) argues that professional recognition requires willingness to account for one's performance of nursing care. Therefore, spiritual care cannot be left at the nurses' intuitive level only, it needs to be brought to the surface of the nursing profession.

Stoter (1995) a chaplain at Queen' Medical Center in Nottingham views spiritual care as a team responsibility composed of nurses, medical physicians, chaplains, patients, their families and support groups. In view of spiritual care as team work, nurses will always play a vital role because they are with the patient for twenty four hours per day. Nurses are always available to the patient at all times. This is the reason that the issues of spirituality can not be ignored by nurses.

Stoter (1995) further identifies several situations in which spiritual expertise are important. These include bereavement in obstetrics, paediatrics, accident and emergency units and in intensive care units. In these areas the nurse should be prepared to provide spiritual care to the patient who is faced with sudden or unexpected illness. Spiritual care is also essential when caring for the patients suffering from long term illnesses like degenerative conditions of the elderly, cancer, acquired immune-deficiency syndrome (AIDS), alcohol and drug dependency and other psychiatric conditions (Stoter, 1995).

According to Stoter (1995: 156) easing the disease requires a loving and a trusting partnership relationship between the patient, his or her family and the care giving team. He concludes by

saying “Working together by sharing skills, personal expertise and sensitivity enhances the whole process which becomes greater and stronger than the sum of each individual’s contribution”. This statement confirms that providing spiritual care is a team responsibility, the nurse being an active member of the team as she or he identifies spiritual needs.

The nurses’ professional role is to relieve pain and suffering of any nature. To deal effectively with the suffering person is not an easy task (Lanara, 1981). Caring does not come to the nurse naturally or simply out of good intentions, it requires hard work, learning, practice and a constant sensitivity to the other person’s pain and suffering (Lanara, 1981). The nursing profession has begun to raise questions about the spiritual nature of the human being. These questions are beginning to move spiritual care from an intuitive level to a more scientific level. Rew (1989) argues that what we need now is to develop ways to enhance our intuitive abilities and communicate more clearly about both intuitive and spiritual experiences.

Nurses need to develop an awareness of spirituality in order to support patients (McSherry, 1996). To assist patients in finding meaning, hope and fulfilment in spite of pain is a skill that needs to be learned by all those who subscribe to total patient care. Human spirituality is broadly defined in the nursing literature. It is viewed as a universal phenomenon which is a basic human need for bonding with the transcendent Being as understood by the person. Spirituality is also referred as an individual quest for meaning and purpose in life (Sims, 1987). Spirituality is also identified as an aspect of every human being religious or not. It is a part of a person which grows and develops like any other aspect of human nature (Carson, 1989). The individual search for meaning and purpose of life is intensified by illness, suffering, loss, or any other life crisis (Reed, 1987). The crisis in life forces a person to question the meaning of life and to search for solutions which come from a power greater than his or hers (McGrath, 1998).

Nurses have indicated that their role includes assisting individuals sick or well in finding meaning and making sense out of their suffering. Nurses may do this through providing spiritual care which is defined in nursing literature as an art of assisting a person in finding meaning in life illness and suffering. Widerquist and Davidhizar (1994) quoting Donley (1991), say “The crisis in health care is one of finding meaning and values”. These two authors view nursing as

a ministry. Lanara (1981) also put an emphasis on the nurses' role in nurturing value of life in patients. She says, caring supports a person and assists him or her in finding meaning in the painful experiences of life.

2.5 Chapter summary and conclusion

From the discussion above, one may deduce that philosophy, religion and the human spirituality are essential concepts in the study of human nature. The epistemological debates about reality seem to be rooted in the same debates which perplexed Plato and Aristotle about the nature of reality, the source of knowledge and the truth about reality (Bradshaw, 1994).

The nature of the human being was the starting point for philosophical inquiry. The origin, the purpose and the human destination have always been a cause for concern to those who love wisdom. In spite of Descartes' emphasis on logic reasoning, he could not deny the existence of God. For Descartes, the thinking self was the prime reality. Pure knowledge was to be found in a mathematical proven way. What could not be proven by logic reasoning was not reality. (Vessey, 1986). The empiricists trying to counteract the reasoning philosophy of the rationalists came up with reality that is rooted upon the laws of cause and effect.

Understanding human nature in terms of cause and effect also did not provide satisfactory answers about humanity. Marxism does not also give realistic answers as it places great emphasis on the material aspects of human nature. Now we know that the whole is greater than some of its parts. So human nature cannot be explained on the basis of its physical aspect only. There is psycho-social and the spiritual parts which cannot be understood through studying causal-effect relationships alone. The existentialists also place more emphasis on the individual self. The subjective world is threatened by the objective world which keeps on intruding into the peaceful subjectivity causing imbalances and speculations.

What can be deduce from this literature search is that a human-being needs power beyond himself or herself to cope with the daily demands of life. This power is found in the person's spirituality. From the literature, it has been realized that every human-being has a natural

inclination or desire to maintain a relationship with the higher being. This desire to maintain a relationship with the higher being is increased by life threatening situations. This is actually what makes the study of human spirituality such a vital component of total patientcare.

CHAPTER THREE : RESEARCH METHODOLOGY

3.1 Introduction

This chapter will give an overview of the research process that was followed in developing the grounded theory of spiritual care in nursing. The research design that was found to be appropriate for this study was the grounded theory design. The principles of a grounded theory mode of inquiry were followed. This chapter will give a brief description of the research settings, sampling procedure, characteristics of the sample, data collection and analysis, dissemination of findings and ethical considerations. This chapter will also explain the methodology as applied to this study.

3.2 Research design

The research design that was therefore appropriate for this study was a qualitative grounded theory design. Qualitative grounded theory design is a mode of scientific inquiry oriented towards understanding human beings and the nature of their interactions in their natural setting (Brink & Wood, 1989). The qualitative method of inquiry examines phenomena outside the context of the existing gestalt or sedimented views (Burns & Grove, 1987). The purpose of a grounded theory method is to form new gestalt in order to generate new theories. Burns & Grove (1987) argue that the researcher needs to step out of the sedimented views and be open to new gestalt that will emerge from the data and from the researcher's abstract thinking.

The purpose of this study was to analyse the concepts of spirituality and spiritual care with an aim of discovering a shared meaning of the phenomena by capturing all variations, consequences, causes, context and conditions under which the phenomena occurred. To conceptualize spirituality from the perspective of patients/clients and nurses required an approach that was going to allow the researcher to step out of the existing gestalt about these phenomena. The grounded theory method explores the social psychological process that is found within human interaction (Streubert & Carpenter, 1995). Grounded theory approach to research explores the

richness, complexity and diversity of human experiences and contributes to the development of middle range theories or substantive theories (Streubert and Carpenter, 1995).

Grounded theory method is appropriate when studying areas in which very little or no research has been done in the area and when new viewpoints or gestalt are needed to describe the familiar phenomena that are not clearly understood (Cheniz & Swanson, 1985). The phenomena of spirituality and spiritual care fit the criteria mentioned above. There is very little research that has been done on this topic and obviously not in South Africa. Even the research done outside South Africa still showed some ambiguity in the use of these concepts (Golberg, 1998). In this study there was a need for concept clarification through careful analysis of the data that were grounded on the experiences of those involved in the social process of spiritual care.

3.3 Setting description

The settings that were found to be appropriate for this study were the hospitals and hospice settings. The hospitals of choice were Addington general, St Mary's hospital and Highway hospice. These settings were chosen because the researcher believed that she would be more likely to access many patients and nurses who could provide data that were rich, complex and diverse in describing the phenomena of interest. The grounded theory method is not limited to the primary area of study. When the theory developed, and the need to fill gaps in the emerging categories and concepts became evident, the researcher moved to other settings as directed by the data gathered. These settings allowed the researcher to collect data that were context bound. Context accounted for the setting as well as the events impinging on a particular setting (Chenitz & Swanson, 1985).

3.4 Sampling procedure

A purposive theoretical sampling procedure was followed. Purposive sampling refers to the process of selecting participants who are rich in information needed by the researcher (Morse, 1994). Theoretical sampling on the other hand refers to the method of data collection whereby the researcher is guided in his or her choice of participants by previous answers received from

the participants, and by the need to fill the gaps in the emerging categories and concepts (Glaser & Strauss, 1967). This meant that the researcher would not begin with the fixed number of participants, but would continue selecting and adding participants until the theory was fully developed and saturation of categories was reached (Chenitz & Swanson, 1985).

This study focussed on patients/clients and the nurses who were providing direct patient care on the units. The patient participants were chosen on the basis that they had a chronic and or terminal illness, they were adults who could give a voluntary consent, they were well oriented, fully conscious, mentally sound and aware of the clinical prognosis of their illness. This group was selected for the study because research has revealed that terminal illness tends to increase the patient's vulnerability to spirituality (Reed, 1987). These patients were more likely to seek a relationship that was beyond the material realm (Ross, 1994).

The second group of participants that was included in the study was a group of patients who suffered from acute or chronic illness that may be life threatening but not terminal. This group was selected on the basis of the similarities it might have with the first group to minimize the differences in the data, and to maximize similarities that bear on a category (Glaser and Strauss, 1967). The third group of participants that was selected was a group of healthy mothers who had just given birth to healthy infants in the hospital. The reason for selecting this group was to provide the researcher with a variety of data that were rich, complex and dense in order to verify categories and their properties as they developed. As the categories developed and the concepts emerged, the researcher continued with theoretical sampling until all gaps were filled and a theory based on different levels of conceptual generality was developed (Glaser and Strauss, 1967).

The fourth group of participants that was selected was a group of nurses who gave direct patient care either in the hospital or hospice settings. This group was also chosen so that the differences between what the nurses say and what the patients say could be maximized to strengthen the theory. Finally the researcher included the relatives of some patients as the patients themselves felt that their relatives should be involved. Interviews with relatives increased the richness of the

data. The Professional Nurses who were on duty at the time the researcher came to the units were very helpful in assisting the researcher to identify patient participants.

3.5 Sample description

The sample was composed of 56 participants recruited from the three settings mentioned above. Of the total number of participants, 71.4 percent of them were nurses, 25 percent patients, and 3.6 percent relatives of patients. The reason for having more nurses as compared to patients and their relatives is that nurses were mainly interviewed in focus groups while patients were only interviewed on one to one interviews. Since the nursing profession is a female dominated profession, 80.4 percent of the participants were females and 19.6 were males. Eighty two percent of participants claimed to be Christians, 12.5 percent Hindu, 2 percent other forms of religion and one percent claimed to belong to no formal organized religion (figure3). The 2% that indicated that they belonged to other religions other than Christianity, Hindu or Islamic reported to belong to Shembe.

Eighty six percent of the participants had tertiary education. 12.5 percent had secondary level of education and 1.8 percent had primary education (figure2). Their age range was between 21 and 60 years (figure1). Most patient participants had been in the hospital or hospice for no more than two weeks except for two patients who had been in the hospital for 2 months because of severe burns. Nurse participants reported varied experience of nursing practice, the mean of which was 10.75 years of experience. Patient participants were admitted for various reasons which included burns, accidents, laparotomy, cancer, tuberculosis, diabetes mellitus, immune deficiency related conditions delivery and postnatal complications.

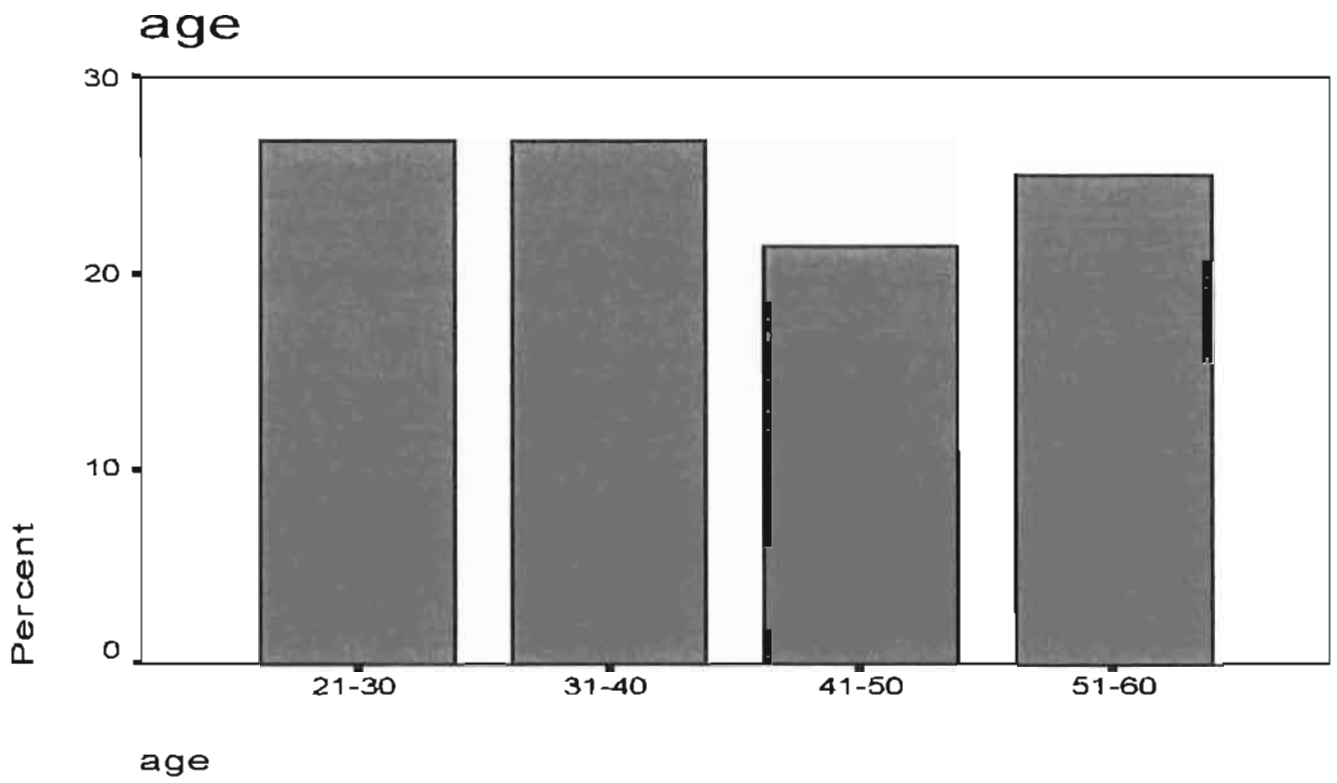


Figure 1 : Age of participants

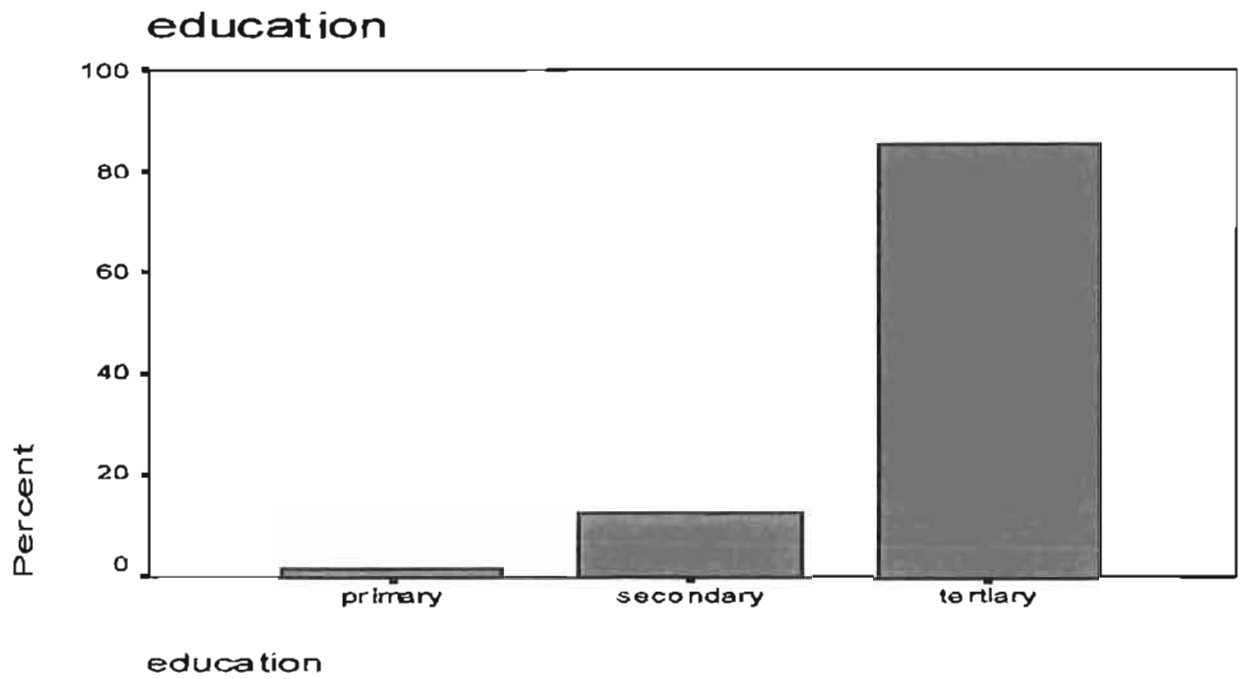


Figure 2: Education of participants

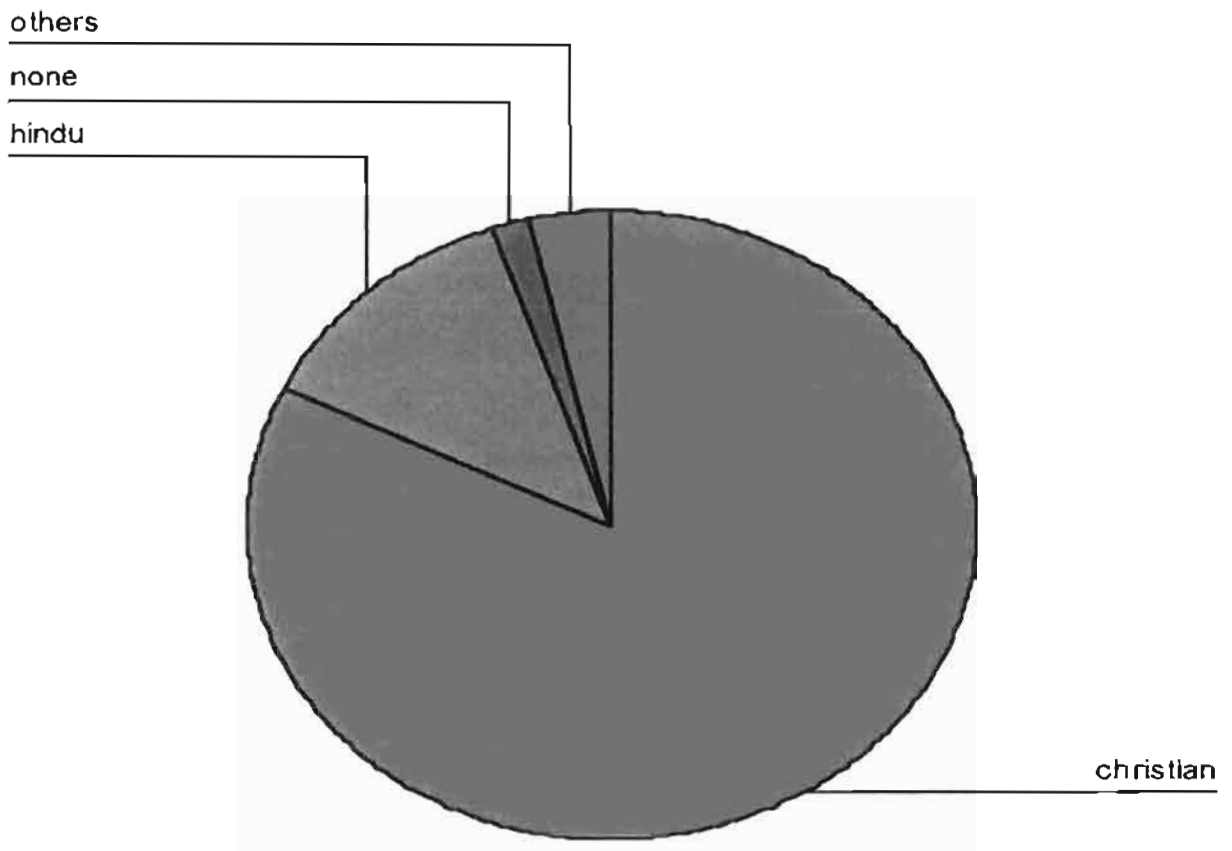


Figure3: Religious affiliation of participants

3.6 Data collection

Data collection and analysis were done simultaneously over a period of six months from middle of April to middle of October 2000. In order to collect data that was rich and diverse, a variety of data sources were utilized. In-depth semi-structured interviews were conducted with both nurses and patients participants on a one to one basis. The researcher also conducted small and large focus groups interviews with nurses and with patients' relatives. The interviews were audio tapped and then transcribed into a text by the researcher. Hand written notes and memos were also utilized to provide back up information. In addition to one to one interviews, seven focus groups were conducted with nurses from all the settings. Two focus groups were conducted at the Hospice centre. One group was composed of three nurses who were working in the units with in patients.

This focus group was followed by individual interviews which were scheduled at a time convenient to each nurse. Two more nurses who did not attend the focus group but were working at the hospice units with in patients were also interviewed at the time that was convenient to them. The second focus group conducted at the hospice was the group of nurses who worked with home health care. Because most hospice patients are nursed at home, there were eleven (11) nurses who were in this focus group. Each focus group lasted for approximately, 30-45 minutes, but because of the size of the group working with home health care, the home health care focus group interview continued for two hours. Because the researcher followed a theoretical sampling method of data collection, she then conducted interviews with two families of patients who were at the hospice. In the public hospital it was difficult to get nurses on one to one interview because they were often very busy, the researcher decided to interview them in small groups of 2,3,4,5 or 6 during their tea or lunch breaks when they could get together. There were five focus groups conducted in this hospital. These groups were composed of nurses who were working in medical, surgical, labour delivery and post natal units. Patient participants were interviewed on a one to one basis in all settings. In a private sector, the nurses were interviewed in one focus group composed of nine (9) nurses. This focus group was then followed by one to one interviews with each individual nurse. Patient participants were also recruited from medical, surgical, and postnatal units. One focus group that was held at the beginning of data collection was to

introduce the topic and it also allow brainstorming. This helped to identify areas of importance in the phenomena under investigation and it also acted as a means of developing rapport with the participants. The subsequent interviews with all participants focussed at their personal experiences with the phenomena of spirituality and spiritual care and also verified categories and concepts that emerged from the data.

The third method of data collection that was utilized was observation. The researcher observed the unit environment noticing some books, magazines, or other symbols which were around the patient's bed. Most Christian patients had Bibles on their bed side lockers, while Hindu patients had their Hindu magazines with different types of gods. All interviews were conducted in the language the participants felt comfortable with. Zulu and Xhosa speaking patients were interviewed in their language and the recorded information was translated into English by the researcher.

3.7 Data analysis

Data collection and analysis were conducted simultaneously. The data were analysed using the editing style. According to Crabtree (1992) editing style of data analysis is an appropriate approach when analysing data for developing a grounded theory. The guidelines that were followed were extracted from Cheniz and Swanson (1985), Tesch (1992), Wilson (1988), Glaser and Strauss (1967), Morse (1994). The software that was utilized is the Qualitative Research Solutions Non-numerical Unstructured Data ways of Indexing Searching and Theorizing modified as NVIVO QRS NUD*IST. Richards (1998) developed this software to assist researchers in handling and managing complex non-numerical data. To describe the sample composition, the researcher utilized SPSS for Windows. This software was useful in handling quantitative demographic data (Clarke, 2000).

As data collection and analysis were carried out simultaneously, the researcher read every piece of data as it came to her line by line and paragraph by paragraph identifying words or statements made by the participants about their experience of the phenomena of spirituality and spiritual care. Wilson (1988) calls this process substantive coding, while Glaser and Strauss (1967) refer

to the same process as concept specification. Substantive codes are used to describe dimensions, properties and consequences of the phenomena under study. With the help of Nvivo software, the researcher coded every statement as she read the text over and over, line by line. Every piece of data was coded as free nodes. The free nodes looked like a shopping list of words or phrases used by participants to describe the phenomena of spirituality and spiritual care. Later, the free nodes were joined to form tree nodes. Tree nodes started showing some relationships between the words or phrases used by the participants. Tree nodes were also linked together according to the relationships they had. The linked tree nodes formed parent nodes and the parent nodes when linked according to their relationships formed grand parents. It was from the grand parent nodes that the themes for this study were developed.

The researcher joined the substantive codes together according to their relationships to form categories that were related. The substantive codes in this case were the free nodes. When free nodes were joined together they formed the tree nodes. This was the second level of coding called the selective coding (Wilson, 1988). The third level of coding is called theoretical coding. Theoretical codes were developed from the researcher's interpretation of the data using the selective codes, memos and field notes to discover the main story line or a basic social process in the phenomena of spirituality and spiritual care.

The researcher utilized theoretical sampling to fill the gaps which develop in the emerging categories and concepts. This called for rephrasing of questions to validate responses and even moving from one setting to another to find different participants. The researcher went back and forth into the data verifying them with the participants, carefully reading and analysing them until all categories were fully developed and the relationships between categories and their properties were identified. The theory which was grounded on the data was developed through the use of both inductive and deductive modes of reasoning (Cheniz and Swanson, 1985).

3.8 Academic rigour

Academic rigour is measured in quantitative studies by their trustworthiness or their being true to the data and their context (Lincoln and Guba, 1985). The potential strength of a qualitative

research theory may be lost if appropriate strategies are not followed to reduce careless handling of data and researcher's biases (Khalifa, 1993). Trustworthiness refers to the quality value of the final results and conclusions reached in a qualitative research (Lincoln and Guba, 1985). Trustworthiness is composed of four main aspects which will be discussed separately. The first aspect of trustworthiness is credibility. Credibility means being authentic to the data. To achieve this the researcher utilized several measures. She utilized peer debriefing which involved discussing the process of data analysis with the colleagues and with the research supervisor. The data and categories discovered were also discussed with the research supervisor at regular intervals.

Secondly, the researcher used triangulation which refers to the use of different methods of data collection to enhance credibility. Triangulation was achieved by use of one to one interviews, focus groups interviews, and observations. Thirdly, the researcher utilized membership check which refers to the researcher's ability to check back with the participants to validate accuracy of information given and recorded. The researcher validated information by playing the tape back to the participants and by reading her written notes back to the participants. Where possible, the participants were visited few days after the interview to validate the accuracy of information recorded and transcribed.

Transferability is the second aspect of trustworthiness (Lincoln and Guba, 1985). Transferability refers to the application of the study findings to the context in which the data were derived and to other similar context depending on the degree of fittingness between context. To ensure that the grounded theory of spiritual care can be applied to all nurse/patient interactions in all settings, the researcher utilized a variety of participants as stated under sample selection. She used patients from different units, nurses who were also from different units and relatives of patients. These participants differed in age, sex, diagnoses or experience in nursing, religious affiliation and cultural background.

The third aspect of trustworthiness of a qualitative research is its dependability (Lincoln and Guba, 1985). Dependability is concerned with the stability of data in the study. The process of data collection, analysis and interpretation needs to be monitored by experts in the method of

grounded theory studies (Khalifa, 1993). To ensure dependability, the researcher used the dependability audit trial technique whereby the external experts were utilized in analysing data and interpreting them. The external expert who was mainly utilized in this study is the research supervisor.

The fourth aspect of trustworthiness that was ensured in this study is confirmability. Confirmability refers to the degree at which the data confirm the findings (Lincoln and Guba, 1985). To ensure that the findings represent the data, the researcher went back and forth into the data, field notes, memos audiotape and participants to confirm that the findings will reflect the participants' responses not the researcher's own constructions and biases. When this was done, the findings were written in a descriptive form indicating the major themes, categories, concepts and their relationship with one another. The theory of spiritual care in nursing emerged from the data that was grounded in the participants' own experiences. This theory was then organized into a conceptual model.

3.9 Dissemination of findings

The researcher has an obligation to inform the participants about the findings. Therefore a summary of findings will be sent to the units in which participants were recruited. This will be done in the form of a written report and in-service education to the nurses. Secondly the findings will be submitted to the nursing department of the University of Natal-Durban in a written report form and also verbal presentation to the peers and the supervisor during class sessions.

3.10 Ethical considerations

Qualitative research like all forms of research is subjected to codes of ethics for the protection of human subjects (Wilson, 1989). All forms of research subscribe to similar internationally accepted codes of ethics (Wilson, 1989). Ethical codes are standards or guidelines for making ethical choices. Ethics on the other hand is a general term which refers to several ways of examining moral life (Beauchamp and Childress, 1987). Ethical codes are based upon a few generally accepted moral values of respect for individual autonomy (respect for another's

independence), non-maleficence (refrain from harming others), beneficence (helping others or benefiting the other), non-deception (being honest, true to one self and to the research participants), justice (treating others fairly) (Beauchamp and Childress, 1987).

In view of the above moral values and codes of ethics in research, the emphasis is that research studies must be done on the basis of their ethical and scientific acceptability. The benefits from the research study should unquestionably justify any discomfort or risk involved (Klockars and O'Connor, 1979). Concern for protecting human subjects has been extended beyond protecting research participants from bodily injury or harm to include protecting research participants from any research activity that threatens their self worth, values, privacy or even religious freedom (Wilson, 1989). Actually there are no non-risk research studies. All research involves some form of risk to the participants, plants or animals and the environment (Beauchamp and Childress, 1987).

In this study the following guidelines were utilized to protect the rights of the participants; The first consideration was to encourage independent individual decision making. To encourage independent decision making, the researcher explained to the participants the purpose and the process of the study and the possible outcome. The participants were not forced, bribed or threatened otherwise to participate in the study. Participation was purely voluntarily.

The second consideration was protecting the participants from harm. This study was conducted in the natural setting to ensure data that were rich and complex, The main focus groups were patients and nurses. Patients by virtue of their illness needed extra protection. Before the study was conducted, it was first approved by the university research committee and the regional department of health of KwaZulu Natal region and by the hospital authorities. The participants were given a written informed consent or informed refusal. The information about the purpose of the study, the process of data collection and analysis and how the results will be disseminated was discussed with the participants. The discussion included the risks involved in the study. For this study there were no physical risks involved, but there were emotional discomforts associated with the nature of the topic. Some people consider spiritual issues to be private and not to be discussed in open. To overcome this problem, the researcher first established a positive rapport

with the participants. The researcher introduced herself to the participants and explained her objectives for being with them. The participants were given opportunity to ask questions about the research procedure and purpose before giving a consent to be part of the research study. During interviews, the researcher ensured privacy by conducting interviews in a side ward that was empty. In other setting there were patient counselling side rooms. These side rooms were used to interview both nurses and patients participants. Some patients were alone in their wards. In that case the ward was used for the interview. For patients who were bedridden, a curtain was pulled around the patients to ensure privacy. The participants were informed that they were free to discontinue their participation at any time during the study.

The third ethical consideration was maintaining truthfulness and honesty to one's self and to the participant. To achieve this principle this researcher handled in confidence all personal information given to her by the participants. The researcher did not hold back or hide from the participants information about the study and its intentions.

The fourth ethical consideration was to ensure that the research benefited the participants. The benefits to the participants could not be immediately recognized, but in a long run both patients and nurses will benefit from the study. Research should contribute to the welfare of the participants and be applicable to other settings. This study encouraged the participants to express their spiritual values and they realized the role these values could play in relationship to nursing care. The nurses also benefited from an open discussion of this topic which has always been left on individual nurse's intuition. Both nurse, patient and relatives felt that it is a high time that we talk about spirituality.

The fifth ethical consideration was maintaining justice and fairness to all participants. Bulmer (1982) states that the well-being of the participants must take precedence over the investigator's self interest. The researcher is free to pursue the truth, ask any question and attempt to obtain any answer, but within certain boundaries (Klockars and O'Connor, 1979). In this study fairness and justice was maintained by keeping to all promises made to the participants. The promises included anonymity and confidentiality regarding personal information received from the participants. The researcher treated the participants with respect, dignity and empathy. The

interviews were discontinued if the patient demonstrated signs of distress or discomfort. The comfort of the patient took precedence over research inquiry.

3.11 Conclusion

This chapter has outlined the methodology and the basic principles which were utilised in developing the grounded theory of spiritual care. The methodology that was appropriate was the grounded theory method of qualitative research. The method was found to be appropriate because of its practical applicability to the type of study. The participants were recruited from three settings. Some were recruited from the hospice setting, while other participants were recruited from two hospitals one of which was a private hospital and the other one was a public hospital. Data was collected by utilising one to one interviews, focus groups interviews and observations. The information was recorded using an audio tape recorder on the original language used. To strengthen data collection filled notes and memos were also utilised. Data were analysed using the new Newdist programme called NVIVO (Richard, 1988). The credibility was maintained by collecting data in the natural setting, and by analysing data as it came. Theoretical sampling was continued throughout data collection and analysis. Participants were clearly informed about the purpose of the study and the process that was to be followed in the research.

CHAPTER FOUR : THE RESEARCH RESULTS

4.1 Introduction

The purpose of this study was to analyze the concept of spirituality and spiritual care in nursing with an aim of discovering a shared meaning for the phenomena and also generating the middle range theory of spiritual care in nursing that is grounded on the data from both patients and nurses participants. The results that are displayed in this chapter reflect on these two major goals for this study. The basic social process was uncovered by sorting and comparing categories and memos and by finding relationships between the developed categories (Brink and Wood, 1989). Using both the inductive and deductive methods of data analysis the researcher identified five major concepts which were grounded upon the participants' descriptions of the phenomena in question.

The first concept that emerged from data analysis was the concept of spirituality. This concept was developed from various definitions of spirituality given by the participants. The concept of spirituality as a quest for a transcending relationship was discovered to be the core variable since all other variables seemed to impact on the quest for a transcending relationship. A quest for a transcending relationship was perceived as having two phases, that is, a state of equilibrium which was sometimes referred to as a comfortable zone whereby the participants were content with what was going on in their lives and were less concerned about their relationship with God/Supernatural Being or with others. The second phase was characterized by trigger-response, in which the comfortable zone was disturbed by a factor which caused uncertainty about future due to illness, approaching death or death of loved ones.

The third concept that emerged was the perceived and expressed spiritual needs. Perceived spiritual needs were classified as self oriented needs whereby a person desired to be comfortable with himself or herself. The second category of perceived spiritual needs was the people centered spiritual needs. With people centered spiritual needs, a person quests for a relationship with significant others. The third classification of perceived spiritual needs was God centered spiritual needs in which the person desired a relationship with God as understood by the person.

The fourth concept that developed was the concept of spiritual care in nursing. The concept was developed by the participants' descriptions of the concept of spiritual care, the principles of spiritual care, the factors which influence spiritual care, the nurses' role in spiritual care and finally the outcomes of spiritual care. These five concepts put together describe the grounded theory of spiritual care in nursing. The rest of the chapter will show the analysis of the concepts and how each concept was developed. It will also reflect on other concepts utilized by the participants in their descriptions of the phenomena of spirituality and spiritual care in nursing.

4.2 The concept of spirituality

This concept emerged from data analysis of 28 interviews composed 40 nurses and 11 patients. The participants were asked to describe the concept of spirituality from their own perspectives. A variety of 20 interrelated definitions were given, see annexure B. The definitions are not to be viewed as mutually exclusive, because the participants used some concepts interchangeably. The table in annexure B gives an outline of the coded definitions, the number of passages coded on a particular definition and the number of interview documents from which the definition was extracted. Since the definitions given by the participants were not exclusive, the data analyst grouped them according to their similarities and their differences. This classification assisted the researcher to develop subcategories for the main category labeled as "the concept of spirituality."

4.2.1 Spirituality as an integrated whole

A person as an integrated whole consists of physical, social, emotional, intellectual, moral and spiritual aspects. Spirituality therefore was described by some participants as the entire being, the emotional part, the inner part, the soul or energy force. All these definitions described the spirituality as the part of an integrated whole or as the whole. The definition of spirituality as an entire being describes spirituality as the integrating principle in a person. This definition was very direct and specific as to what the participant meant by the entire being as she said,

“Spirituality is the entire being. The mind the emotional state, the body the whole physic, how the entire being functions, it reflects on the inner being of the person. That is my understanding”

Having described spirituality as the entire being, the same participant also refers to the inner part of this entire being when she said “it reflects on the inner being of the person.” This inner being of the person was described by other participants as the soul or the inner part or energy force,

“Something to do with the soul, like your soul, the soul being that inner part that has to do with the superior being. They don’t believe they just came, they know there is a force greater than they.” Another participant said, *“the person usually attaches his or her entire existence on that something that he believes in, that power that he thinks or she thinks she gets her strength from.”*

In these definitions, the entire existence of a person is linked to what the person believes. This explains that what the person believes involves the other aspects of the total being and on the other hand what the person believes affects his or her entire being. Another aspect of the entire being that was repeatedly mentioned in the definitions given by the participants is the emotional aspect of spirituality. The emotional aspect of spirituality was illustrated in this statement, *“I think spirituality is the emotional belief of a person regarding the religion.”* Other participants call it the God feeling *“there is a feeling like God’s feeling as some people call it.”*

Linked to the perception of spirituality as “the whole person” is the approach of seeing spirituality as one’s identity. This view states that a person is known and also knows by his or her spirituality. In a way to describe spirituality as one’s identity is saying spirituality is one’s philosophy of life. Spirituality tells who you are as one participant said,

“It’s part of who you are, it’s part of who you are, it’s definitely part of who you are. You can be a Christian and spiritual and therefore the way you are spiritual, part of it is your religion, is part of my belief system that will flow out of me in all these areas of my life creating the spiritual being I am”

Spirituality as part of an integrated whole identifies one person from the other. This identity comes from several sources such as what a person believes, his or her religion, culture, and the person's own perception of things, people and situations. Even though people can be in the same congregation, or religious affiliation, they do not share the same spirituality. Spirituality is defined as the identity for the person as an individual not as a group though the group may influence the person's spirituality. One participant gave the following rationale for saying spirituality is one's identity;

“But I still think you can be part of a congregation in the church, but each person in that congregation has individual spirituality, even though you are sitting in the church listening to the same sermon, each person totally attack it at a different way that is you.”

4.2.2 Spirituality defined as a quest for a transcendent relationship

A quest for a transcendent relationship refers to the desire to have a relationship with God and other significant others. Spirituality was viewed as that aspect which quests for a relationship. These respondents defined spirituality in relationship to either a person seeking a relationship with God as the superior being or a relationship with other people in order to reach out to God. This relationship is sought through belief, faith, and/or, religious practices. A quest for a transcendent relationship has been identified in this data as the basic social process and a core variable.

The participants who defined spirituality as a relationship were often specific to a relationship with God/supernatural being and a relation with other human beings. This showed that spirituality as a quest for a transcendent relationship has a vertical direction and a horizontal direction. Vertically, the relationship is directed to the supernatural being. Horizontally, the relationship is directed to other human beings. To illustrate a horizontal relationship one participant said,

“Well with me spirituality means the person's relationship with the supernatural power, the power that person thinks it is above his or her own ability” Another participant said, *“That is just the person's relationship with*

God, or sometimes it is not God. The person's relationship with some type of like a Prophet or whoever they see as a spiritual leader. I think is universal."

The second quotation includes a relationship with the human person who is thought to represent the superior being. This is an example of a horizontal relationship of which the aim is to reach out to a vertical relationship. Sometimes the horizontal relationship was described by the concept of "abend"

"Ubuntu" is the African word which describes the socially desired relationship of a person to other people. "Ubuntu" is to be a human being, loving and being concerned with another person as described by the community members. It is a concept difficult to translate to English. One participant maintained that spirituality is "ubuntu"

"Spirituality is what I consider to be ubuntu (being human to the person). To be human is to do something good to another person, helping a person who is in need, like the person who has a problem needs someone to talk"

The above statement infers that being a spiritual person involves being part of the community and being concerned about other people's affairs. The same participant further explained what she meant by saying spirituality is "ubuntu." For her to be "ubuntu" is to know God and to live in accordance to His laws.

"To be a human (ubuntu) is to know God, is to live in accordance to God's laws. There are laws of nature and there are laws of God. That is why we need to help this person spiritually. This person must have some spiritual care"

Linked to the concept of "ubuntu" is human value. Value to the participants referred to respect that ought to be given to the person as a human being. When these concepts were raised there were stated in relationship to the patient respected by the nurse. To value human dignity is another concept which describes a person's relationship with another. Valuing a patient's belief and valuing a person's religion was also mentioned.

“Ok, I don’t know how you see it but in simple English it is to value a patient’s dignity. So spirituality is valuing somebody’s dignity, somebody ‘s beliefs and leave them to do what they want to do”

4.2.3 Spirituality as a religious belief

Defining spirituality as the religious belief means that spirituality is a belief and is also a religion. Defining spirituality as belief means that the person must take something as true. Defining spirituality as belief is the most referred to definition. Sometimes belief and religion were linked with faith, hope, peace, meaning and purpose for life. Whether it was in conjunction with other definitions or not. There are nine documents and 17 paragraphs which directly describe spirituality as belief. Sometimes belief was mentioned with reference to religion, sometimes some participants stated that belief and religion are related but are not the same, for these participant, spirituality is belief.

“I see spirituality as a belief system for a person. It involves what you believe, it grows from there on, it grows to include who you are and how you perceive things” Another participant said *“I think spirituality is a belief that human beings are being ruled by a certain supernatural power of which they are of different kinds”*

This participant views spirituality as belief in the supernatural and further stating that there are different kinds of supernatural powers which people believe in. Another participant making her point clear that spirituality is not religion she said,

“I think what happens is religion puts people in different brackets. Religion brackets people, you are a Christian, I am a Hindu, that’s an example I am giving you. I think religion each person has their own practice but they all believe in the supernatural, they all believe that but they have different means of getting to it. So religion, is like it limits people. It’s practices that are handed down from generation to generation, from fore fathers to fore fathers. So if we

believe, we all believe in some type of supernatural, so we have different ways of showing it by having a religion

Whereas, most participants saw a difference between religion and spirituality, some participants saw no difference. There are two documents and two paragraphs which have coded spirituality as religion.

“There is no difference. For you to have spirituality you have to believe in something religiously.” Another participant said, *“The word spiritual just means religion to me I don’t even think” (interrupted by others who disagree with her)*

Faith is closely linked to religious belief and to a transcendent relationship. Faith can simply be translated to mean trust. One participant puts it this way,

“it’s faith in the supernatural, it’s when you understand that you cannot rely upon your self to overcome everything, you need help from outside and you need a supernatural Being.” “His connection, his relationship to something that he has got his faith, his absolute faith in that person or something”

Along with faith is the concept of hope. Hope refers to an assurance that the present situation though may be gloomy will have a solution

“To me spirituality is giving hope to someone, like when the person is sick or discouraged then you tell them not to lose hope so to me spirituality is hope that God will not leave me alone in whatever”

Hope wherever is mentioned is in reference to belief or religion, or to God or that supernatural being the person worships or is perceived as the source of hope. What the participants believed gave them hope. In a way hope is derived from belief. One participant said;

“After praying I feel better because I have hope that all will happen. That which I ask for I have hope that it will happen, even health I have hope that when I have put everything in His care, I will recover”

The hope of knowing that the person was not alone in the struggle with illness or death gave inner peace. Inner peace refers to peace that is found within a person whether that person is in good health or not. It comes from knowing that a person has made things right with the one claimed to be the source of power and also with the significant others. The inner peace can be drawn from the person's religious beliefs and from knowing that one has a reliable relationship with God and with others. Some participants defined inner peace this way,

“It means what the patient sees as the inner peace. From the spiritual point of view, the inner peace that the patient gets, whether is from his religious background. Inner peace is reconciliation with the self, the acceptance of the self for me, it is also very important, the relationships with other people”

When things go wrong in life as they sometimes do, when tragedy strikes in the family, or a person finds himself or her self faced with life threatening situations, the meaning for life is usually lost and the person begins to question the purpose for life. The participants cited their spiritual resources such as their religious belief and their relationships with God or the Supernatural power as the source of meaning. The following are the few examples of statements given by participants in reference to spirituality as giving meaning,

“It is anything that the patient believes is meaning to life or gives meaning to their suffering. That's what I consider spirituality 78: It's just anything that gives meaning to the fact that one has a life and may be his death”

The above statement refers to the facts that not only do people need meaning in life, but they also need to find meaning in death. Spirituality was viewed by the participants not only as a religious belief that gives hope, peace and meaning, but also as dynamic, universal and unique experience. The dynamic spirituality refers to the power of spirituality in changing the person. Whenever a reference is made to spirituality as dynamic, it was further describe as based upon an individual's belief system. The uniqueness comes from the fact that each and every individual has a different relationship with his or her God or supernatural being. Though people may share the same

religion, they may not also share the same spirituality. It is unique for each person and it is universal meaning that every human being has some form of belief. This was clearly stated by the participants.

“Spirituality is something that is within a person whether a person is in church or not or with the people that she fellowships with or not, that spirituality is there all the time in what the person believes in whether among the people or all by herself, spirituality is always there.” “It’s very hard to define the spiritual part of a person, but we all have it whether we want to or not. Whether we acknowledge that we have the spiritual part” “You can change your spirituality you can be a spiritual person in a certain way according to your environment, according to the way you were brought up, your schooling, your parents, but through the passage of life you as an adult can change it, it is not something that is static, you can increase it or change it or make it deeper, it is not something that is just there. It is something that grows. It grows in you. You can grow in spirituality along with indifferent things that happen to you in life, it changes your spirituality, it makes you see things in a more.. . It involves what you believe, it grows from there on, it grows to include who you are and how you perceive things.”

4.3 The spiritual trigger response

4.3.1 The triggers

When the participants were asked to relate the experiences they perceived as spiritual encounters, they reported that when they were faced with crises of uncertainty about the future due to illness or impending death or the death of their loved ones, they became more and more aware of the need for the power above their own and the need for a credible authority from someone they can completely rely upon when their own human resources fail them. They needed someone whose resources never run dry. It was at that moment that they began to search for a meaningful relationship that transcends the human realms. One participant puts it this way

“Some people I have had when they were involved in an accident they start going to the church and they say, God has helped me I must repent. It’s like that with the terminal illness”

The participants ‘s personal experiences with death were repeatedly mentioned as the main trigger. The reasons for this were that death alienates people from their loved ones and most people were afraid of death. One participant reported that

“I think the main thing on death people are afraid, they are lonely, they feel alone, they are alone basically, you die alone, the only thing you can count on is God, what else? Beside, your family you can’t take them with you when you die. The only person you have with you is God. So, if someone feels that death is approaching, the person they turn to is God.”

Other factors which were mentioned by the participants as triggers for a search for a transcendent relationship were those associated with difficult situations. These may not be death but the person’s inability to solve a problem. At times the person may be in a tight corner not knowing what to do, as one participant said:

“So, in that case when people are really in a corner sort of in a tight corner and they don’t see any way out that’s when their spirits are crying out to God and that’s when they need people who know how to pray to help them through that.”

These factors were then labeled as “the triggers.” A trigger is therefore defined as any factor or any situation that stimulates the person to respond to the limitations of the reality of human helplessness and powerlessness in dealing with crisis inherent in life. When everything seemed to be going smoothly, people were able to meet their own needs and wants and those of their own families, those people often assumed a meaningful relationship with God. It appeared like sometimes the people may be in a state of spiritual contentment and integrity with some degree of spiritual equilibrium until a trigger disturbed that spiritual equilibrium. One participant

described this state of spiritual equilibrium as a comfortable zone. This comfortable zone was also associated with material wealth as one participant said:

“You find that people who are status oriented do not care about spirituality. They feel that because they are financially comfortable, they have the status they are on the comfortable zone they do not need spiritual care, until the day dawns on them, they are lying on the sick bed, they are now needing spiritual care ... suddenly they find that, that comfortable zone has become uncomfortable.”

Other triggers which were identified were also associated with tragedy. Tragedy could be either physical social or emotional in its origin. This implies that the person was experiencing either a physical pain and/or a psycho- social pain.

Physical triggers were identified as those factors which affected the person physically and made him or her to see his or her physical body deteriorating to the point of death. That experience of being physically sick triggered a certain response as one participant reported;

“I think a lot of times when people are sick, they want God. Beside, your family you can't take them with you when you die. The only person you have with you is God. So, if someone feels that death is approaching, the person they turn to is God.”

Illnesses such as immune-compromised diseases, carcinogenic disorders, chronic conditions such diabetic mellitus, tuberculosis and other acute conditions related to accidents and other normal life processes like labor and delivery were cited by the participants as triggers. Below are the participants' experiences working with patients who are in labor

“I have had many experiences when a person in most cases, when a person is in trouble, then, they remember, they remember God. When a person is in a point of near death they ask, “can you please pray for me, can you pray with me”When, say, a person has been exposed in a difficult situation like a difficult labor, you hear a person crying “o! God, help me, which means that at that

stage a person realizes that there is nothing she can do in her own power, but she relies on the supernatural power.”

When tragedy strikes whether it is social, physical, emotional, or a natural disaster then people begin to think about their future and also begin to question their relationship with God. This participant stated that the triggers vary in intensity. For example the person may be exposed to more than one trigger at a given time.

“It’s like at that time when so much of tragedy experiences happen. I mean just in one family you find that within one family for example, I am thinking about a forty-year-old lady with a four year old child, she is young she has got to leave behind a four old child and her husband”

The tragedy of HIV/AIDS has added to the complexity of life and has actually triggered more questions. One participant lying on her hospital bed related her pathetic experience as her young husband died at the same time as her three-year-old boy and she herself was sick facing her own death with courage and hope leaving a ten-year-old daughter. It was about two weeks after the death of her husband and her son when the researcher had this interview with her. This is the way she related her story;

“I was very sick when my husband died. I don’t know how things happened, but I also heard that my child has also passed away at three years. My child was with my mother. The child was in Shepstone and he died before the father was buried, I did not see them, the way I was sick..... It is only when I get discharged that I will go home and ask how they buried them.... My child and my husband both of them at the same time.”

In some cases a patient was hospitalized presenting a physical problem, yet the actual problem was psycho social. These psycho social problems were referred to as the psycho social triggers. The psycho-social triggers reported as challenges which disturbed the individual’s spiritual integrity included factors like: unemployment, poverty, crime, family disintegration, political unrest and wars.

“Poverty, sickness, when you are very sick, the loss of the loved one, blaming the superior being, like I believe in God and now you say oh, God how can you do this to me or whatever, problems of unemployment, crime, family problems...”

The state of spiritual equilibrium masks the reality about one’s dependence upon power beyond self. When tragedy strikes the credibility of the supernatural power is also questioned. If God is really powerful why did He allow this to happen? Tragedy comes to all human beings and regardless of their belief. The difference lies in the way people respond to these triggers. The pain and suffering challenged the participants to search for the meaning of life. For some, pain and suffering made them to back off spiritually as one participant reported.

“And they can back off spiritually and say ‘I won’t believe in anything anymore. I am spiritually low, I won’t do anything which will kind of...’ They won’t want to relate to anything spiritually. They are so upset, I have met cases like that, you talk about Jesus and they say ‘what? Don’t even talk about that, I don’t want to hear about it’ but guess what? On the dying day they call on Jesus.”

The above quotation states that when persons back off spiritually they may be responding to their predicament with anger, but when they are over their anger, they come back to terms with their reality. The trigger response action is a two-way process. The responses are not predetermined. Since people are unique individuals, their responses are also unique.

4.3.2 The response

The triggers stimulate responses which are often unpredictable because of the differences in individual perceptions and also because of the differences in the intensity of the triggers. A response therefore is defined as any reaction that occurs as a result of the triggering factor that poses a threat to the person’s spiritual integrity and thus disturbing a person’s spiritual equilibrium. These responses were classified by the researcher in a hierarchical order, not necessarily meaning that an individual had to go through all the steps of this hierarchy in this order before reaching the last step. The first phase of the response hierarchy was labeled the

“grieving process” This process is characterized by fear, guilt, shock, denial, anger, bargaining and acceptance. The second phase of response was classified as the “coming to terms” and thirdly, the last phase is called “the search for a transcendent relationship.”

4.3.2.1 The grieving process

Of the stages of grieving mentioned above, the one mostly mentioned as the major reaction experienced by the participants was anger. Anger was defined by the participants as a spiritual pain. The anger was mainly perceived as anger directed to God, perhaps because the person’s expectations have not been met. Sometimes these were unfinished businesses that the person wanted to accomplish before death. Most participants reported that anger was a major issue with patients facing death. One reason mentioned that was associated with anger was that;

“Maybe he was owning a company or may be he just got married and staff and he is angry why now, why do I have to die now? You know, because let alone it is scary. They are scared”

Anger was described as directed toward either God, self, or ancestors if they were regarded as able to help or protect a person from illness or death.

“If you are angry and you are not angry with God, you can be angry with your ancestors. It depends sometimes you have killed so many goats, so many cows and there is no reply. Things don’t go your own way, so you can be angry with your ancestors, because they are supposed to be protecting you.”

Along with anger the participants expressed a bargaining response whereby they were arguing with God and questioning as to why now? What have I done? Here is one example of a young lady two week post delivery who was in a surgical unit because of Deep Venous Thrombosis. She was concerned about amputation of her limb as she expressed her reaction.

“I was praying to God and saying, how can God do that to me my baby can be born normally but I am going to have one leg and how am I going to work for

this small baby, I was asking God what really did I do, what have I done wrong that He can punish me like that? I was asking Him."

Bargaining was also associated with feeling of guilt that perhaps God was punishing the person because of wrong doing as this participant continued;

"I think it is a punishment because I was thinking it is a punishment because it would be better if it was a car accident or something like that, than when I can sleep and wake up in the morning which is the thing I don't understand and my leg gets cut I think God is punishing me maybe I did something wrong"

When participants believed in the punishing God, then their conscious often condemned them. Both nurses and patients participants expressed their feelings of guilt. For nurses if they did not do what they thought was the right thing to do for the patient, for example one nurse participant stated that if she promised to do something for the patient that the patient asked for and after that she got caught up doing other things and she did not go back to the patient to fulfill her promise, if that patient died before she could do that, then she would feel guilty the rest of her life.

"Because you promised, she didn't, you promised him. It's not about seniority or about what you are giving to the patient, because this patient can die and terminate and you feel guilty the rest of your life."

A patient participant also stated that guilt works in a very strange way. This participant claimed no religious affiliation even though he reported to subscribe to the Buddha philosophy. For this participant guilt did not come from fear of punishment from God, but guilt comes from his mind, because his own understanding of what he has done. This is the person who perceived spirituality as the inner peace, peace with one self and peace with others. This participant perceived guilt as actually undesirable and unhealthy as he reported;

"There seems that your mind works in strange ways. One of the ways that I find it works and it's funny is the guilt, the guilt you always have the feeling of

guilt and that is...that is very bad. You must take that guilt away, you must be able to openly speak with say I have done something to you I am your boyfriend something I was not suppose to do and now I am feeling guilty. The thing is now I must be able to face you and say I am sorry for what I have done, so that forgiveness is different from religious confession”

The positive aspect of guilt is that the person begins to make things right with others, self and with God before the dying day. The negative aspect of guilt is that the participants also experienced fear. Fear was associated with death and punishment. One nurse participant related her experience about a lady who was admitted in the hospital 25 years ago with burns. Her mother assisted her to abscond from the hospital when she was better. Later her mother died. This woman came to the hospital in the year 2000 to pay the hospital bill which she had ignored for 25 years ago. When she came, she told the nurses that her mother came in a dream and told her to come to the hospital to pay R100 for the treatment and hospitalization she received 25 years ago. There were no more records of 25 years ago bills yet the woman insisted that the hospital must take the R100. This money was accepted as a donation. The point here was that, the woman who is still alive was guilty of what she did with her mother and she was also fearful that her mother may not be accepted by God. This also brings a point of fear associated with a punishing God particularly if people believe that death is a road to God’s judgement. This participant also believed that when people die they face their judgement as this is noted in the following statement;

“You see now I gave you two examples of spiritual, the man of 1948 and a lady of 25 years ago burns. This one was guilty because I think now on the other world that we don’t know there was no settlement for this old lady who helped the daughter to escape now she felt so guilty. I think she died guilty, now she is coming back in a dream”

Sometimes participants reported to have responded with shock as one participant explained her experience after the death of her husband and her child at one time.

“I was shocked, my mind was confused, all this time I just did not know what was going on. But now I am getting better and I am beginning to think about them and how they were buried.”

As nurse participants reported their experience with clients who deny their pregnancy, one participant related the following experience.

“I just had a case I had done everything, palpated had to tell her mother I am sorry you are pregnant. I even said this is the new millennium it means ... if somebody can say I don't have a child, I don't have a husband I don't have anything and I am not pregnant. I said to her, this is the baby and I had to take her to the ultrasound, she saw the baby And I even told her things which don't matter like the sex of the baby. Even when she saw the baby she still denied”

Because deny is a common feature of unwanted pregnancies the researcher asked whether the participant made any distinction between denial as a psychological response to unwanted pregnancy and denial a spiritual response. The answer given is that it was first psychological and later spiritual because of belief, because she had gone to the inyanga (traditional healer) and the traditional healer told her that she was not pregnant but she had an abnormal growth which needed traditional medicine. This participant said our spirituality is also part of our psychology.

“No it was first denied and secondly it was spiritual because she believed that she was not pregnant and ... So spirituality is part of our psych.”

This statement agrees with the definition of spirituality as an integrated whole. The shock that goes with denial is a psychological response as well as a spiritual response. Denial is not only a response to pregnancy, but it can also be a response to a diagnosis. This response is very common with life threatening diagnosis such as HIV/AIDS, cancer, diabetes mellitus.

Another response mentioned by the participants as part of the grieving process is dependence. The participants reported that when they were ill they felt vulnerable. They needed someone else to rely upon. The immediate person to lean on was the nurse as one participant mentioned;

“I think when people are sick they always feel vulnerable, they feel dependent upon somebody else. You find them very dependent upon nurses they ask them anything, even something simple they won’t just do it they will ask a nurse can we do this. They feel very vulnerable at that time. That is why they need God”

The dependence phase is followed by the phase of coming to terms where by a person realizes that the condition she or he is in cannot be solved by humans alone, but there is a need for supernatural intervention. All the anger, fear, guilt, bargaining, denial and shock are followed by experience of over dependence as a result of realizing one’s helplessness in dealing with the situation imposed by the triggers

4.3.2.2 Coming to terms

The second phase of responses is labeled “coming to terms” Coming to terms is the stage of spiritual responses whereby a person realizes his or her own inability to cope with life threatening events and then begins to accept the fate of humanness and search for power above their own. Coming to terms phase is characterized by (1) Acceptance, (2) Finding meaning and purpose in death and suffering and (3) peace making process with its search for forgiveness from self, others and from God. Coming to terms is a very essential phase of responding to the triggers because one must come to the realization of the fact that they are helpless and mortal as one nurse participant said,

“if they haven’t come to terms with their own spirituality and where they are for example think they are immortal, they are not going to die, and when they are to face their own death, it’s a huge surprise and they are very angry”

This was repeatedly said that coming to know yourself is a vital part in the process of coming to terms. Another participant said,

“You know who you are, you know the road going down in life, you know you are going to die someday, you know you are not immortal, and you will die someday, you accept that you are not immortal.”

When a person comes to terms they accept their diagnosis, the process of illness, and the ultimate reality of death. They also accept that they may not have all the answers to their question about human suffering, but they may have hope that one day they will get the answers when God Himself will give the answers. The following participant gave this comment about the process of coming to terms,

“Some of them come basically to terms I think the most beautiful experience is when they come to acceptance part of it, and say despite what is happening to me, I know that one day I will understand when God Himself will give the answers to all the questions”

At times they increased their will to live by accepting what they have as a diagnosis and they begin to value life as precious. Acceptance should therefore not be seen as a resignation or passivity. One participant reported;

“But you have got to have it in you. You got to decide yourself you that you have got a lot to live for in life, you just cannot just give up, because life is precious.”

Acceptance was identified as having many facets. The participants mentioned the acceptance of self, at times they referred to acceptance of the diagnosis and the illness.

“You got try and make sure that, you get them to accept the diagnosis, so they don’t feel guilty about it and make sure that the family accept them. A lot of people reject them. So, you have got to walk down that road with them, keep their dignity”

At times they referred to acceptance of the patient as he or she is and acceptance of other people’s religion. Both nurses and patient participants were actively involved in the process of acceptance. When there was acceptance there was peace even when the patient was informed of his fatal condition.

“Even if you explain the results or explain about his condition, he will accept it more easily and you can see that this somebody is having the spirit, he or she is accepting whatever you are telling him or her”

Another step of coming to terms is the peacemaking process. During this peace making phase a person is aiming at renewing his or her relationship with self, significant others, and with God or whoever is considered to be supernatural according to the individuals definition of the supernatural being. One participant mentioned that her goal in terminal care was to assist the patients to have peace with themselves and peace with others. She found that this was the greatest need in the care of the terminal as she reported;

“I would like to see them having peace with themselves and accepting their own death...peace with their family and making peace with people they happen to be angry with”

Nurse participants reported that some patients begin to make peace,

“Mr D. is a very good example of that, he has now realized that he is a step father, he has made peace with some of them, but he has not made peace with all of them. He has started making peace”

4.3.2.3 Searching for transcendent relationship

The final phase of the responses and highest level in the hierarchy is “searching for a transcendent relationship.” A relationship with what the person thinks it is above his or her own abilities. This phase is characterized with more flight to religion which refers to a situation whereby a person begins to search for some tangible religious affiliation even when this person had never been religiously affiliated before.

“They may have gone thought the whole life without knowing about religion and not thinking very much about religion and it all of a sudden become very important to them and you’ve got to make sure you find one”

Another participant relates this phase to the time of search for a spiritual bond with God as understood by the person.

“I said I think it is when the patient needs that spiritual bonding with God, I don’t know whether is God or the priest, but he is on his last minute and he needs to say something to someone like may be the priest.”

As mentioned before when people have somehow escaped death, may be they were involved in an accident and they survived, they start going to church. Coming to terms therefore may involve accepting even the belief that a person has often thought it was not really important as this participant reported;

“Have you seen the rich people in churches? Have you heard them praying? But when they are in the hospital they want nothing, and you say “we are praying” and they say “who are we praying? I have got so many things”and when things do change they ask for the ministers of religion, have you seen them? Why? Because they have a spiritual need even if a person can suppress it, the last day will come”

4.4 Perceiving and expressing spiritual needs

4.4.1 Perceived spiritual needs

Spiritual needs are defined as a human quest for establishing and/or maintaining a unique, dynamic, and meaningful relationship with God /Supernatural Being, when the participants were asked what they perceived to be spiritual needs and how they expressed the spiritual needs, their responses ranged between their vertical and their horizontal relationships. The needs were either a need for human relationship or a need for relationship with God or whoever they considered as the source of hope and strength in times of distress. The main theme of spiritual needs lies in searching for a relationship as one participant said:

"I think it is when the patient needs that spiritual bonding with God, I don't know whether is God or the priest, but he is on his last minute and he needs to say something to someone like may be the priest."

The above description reveals that a person has a need for bonding with God, as the supernatural being and also with other human beings, like the Priest, thought to represent God. The spiritual needs intensified when a person was sick and hospitalized. Participants expressed that lying in a sick bed is a lonely experience, and they needed someone to be there with them. They needed an assurance that they were not alone, and that there was someone with them who could help them go through their illness. This patient participant expressed her loneliness in the following statements;

"... we lie here 24 hours in this room and you know there is no one really to talk to and to enlighten us."

Another participant expressed her understanding of the concept of spiritual need as the need for support from the one more powerful than self. *"Spiritual need is where the person needs support from that power she or he believes in that is governing him or her."* For other participants spiritual needs were associated with their creator as this respondent said; *"a need to be with their creator, a need for God"*

The basis of spiritual needs is to affirm a relationship mainly with God. This may be achieved through other human beings thought to represent God. As stated before, when people are ill they are lonely, they want to be accepted and supported by God and their fellow human beings.

"they need to know that their Creator is there for them. A lot of people when they are ill they feel deserted, they need to know they are not deserted."

When the participants had affirmed a relationship particularly with God, they reported that this made them ready for whatever comes, including death. The following respondent expressed how she experienced spiritual needs as she was facing her own fears of death.

“I think for me to be at that moment with God, to confess, ok, may be I was not supposed to confess to the Priest, but to talk to God via the Priest, tell the Lord that I’m ready if He wants to take me now, now I’m ready.”

Even though the above respondent has doubts if she was supposed to confess to the Priest, at that time, the Priest met her needs. Whenever the respondents described their perceptions of spiritual needs, their description centered around searching for a transcendent relationship. The participants gave a varied list of what they perceived as spiritual needs. These were classified into three subcategories which were labeled as:

4.4.1.1 Self oriented spiritual needs

A self oriented need is aiming at self acceptance, self forgiving, self loving, and achieving peace with one’ self. One participant expressed his need for love and self forgiving and acceptance in this way:

“I contemplate on what happens to me, I meditate on what happens to me and I accept and I have to have love for myself and acceptance, love of acceptance that I have not. You see that is difficult. If I sit here now and meditate with you I will close my eyes. I can sit here for 10hours and spend those 10 hours just with myself because myself, because myself not selfish, myself is what I must love the most.”

Understanding, accepting, loving and forgiving oneself leads to accepting, loving, and forgiving others. The above participant made a distinction between being selfish and self loving as noted on the last two phrases as he said loving himself not necessarily being selfish. Linked to self acceptance and love, other participants viewed, love, faith and hope as interrelated needs as this participant mentioned:

“Spiritual need will be faith, hope, and love. You know, on the outside world if there is no love, things are just like what they are now because if one has got love, God’s love you won’t see them doing the bad things to the next one. That can be avoided. So you must first have this love, love one another, then you get

hope, through hope, love will succeed, and then through, love and faith will also grow.”

The participants expressed their need for hope. They need words that would inspire hope to them in spite of their situation. The Priest, other people and nurses were identified as appropriate people in giving hope.

“I would like people to come to the hospital and pray, give us advice, if not the nurses other people trained, you know Priests, whatever. To come in and give us the enlightenment because sometimes with the pain we just lose hope and we become depressed and we want to give up because the pain is too intense... we really need that to come and spend time with us, boost up our ego, tell us you are going to live, you are going to make it and we will eventually start believing it.”

Forgiving self and forgiving others was repeatedly mentioned by the participants in conjunction with approaching death. When people were in the point of nearing death and they were feeling guilty for whatever they thought they did that may interfere with their relationship with God, they started searching for forgiveness. The need for giving and receiving forgiveness from self and others was expressed by the patient participant as he related the experiences he gained from reading the book which he says is like the Bible to him.

“You must get that book I have got it on my side table all the time. I’m not religious but Carolyn’ book is like the Bible to me I read it all the time... She relates that healing of guilt, she says it is essential for forgiveness on yourself and forgiveness of other people. This is not a religious forgiveness... you understand that is different, it is the forgiveness that includes the understanding of your will in acts of something that you have done wrong. It sits with you as guilt now you must take that guilt away”

4.4.1.2 The people centered spiritual needs

Spiritual needs were said to be people centered when the participants expressed their needs for establishing and/or maintaining a relationship with others. The people centered spiritual needs were characterized by a need to be accepted, forgiven and forgiving others, receiving and giving love to others. Being accepted, forgiven and loved by others was like a progressive step from self loving to others loving. The participants expressed their needs for other people in different ways. At times they needed just the company of another for companionship and at times for counseling as the following participant report;

“Other spiritual needs? ...the patient is dying the patient needs someone to be with him or her. Others do ask for a priest to come even if is not a priest, the relatives to be with him or her.”

The need to be with other people was repeatedly mentioned by the participants. One participant who has been in the hospital for almost three months said;

“Just by listening to us because sometimes you feel there is so much we want to talk about, you know because it’s so frustrating to be in one room and we need people, that is why there are visiting hours so that people can come and talk to us, but is too short”

Another patient expressing his desperate need for people said;

“I need people, I need people because I believe God took on flesh and His spirit dwells among us, the spirit, if I haven’t got people, I haven’t got God.”

4.4.1.3 The God centered spiritual needs

Often the participants expressed their spiritual needs as needs for establishing and maintaining a relationship with God or the supernatural being. The central focus of seeking this relationship is to affirm that God is still with the person and that God will accept, forgive and love the person unconditionally. Again, a need for forgiveness was greatly expressed during the terminal phase of life as this nurse participant said;

“They ask for forgiveness from whoever they pray to they ask for forgiveness especially in their dying stages, most patients in their dying stages, if they have done wrong throughout their lives or they feel they have done wrong, they want to rectify that spiritually by asking for forgiveness and praying more often toward the end may be if they are in the terminal stage.”

Linked to forgiveness were the concepts of confession and repentance. The participants reported a need to admit that they had done wrong and also turn away from their wrong by repentance. One participant defines confession as: *“A need to talk about one’s mistakes”* Sometimes participants confessed to other people who would then help them work through their problem by communicating to God.

“... sometimes people talk of confession, confession can also be telling whoever you are telling about your wrongs and asking that person to help you to pray together. Some do it in an open prayer to ask for forgiveness”

4.4.2 Expressing spiritual needs

Expressing spiritual needs refer to the way the participants showed that they had a spiritual need. There were many ways of expressing spiritual needs reported by the participants. The main and the commonly utilized method of expressing spiritual needs was through communication with God as understood by the person. Participants communicated their spiritual needs through prayer, meditation, reading the Bible or other spiritual literature, worship services, religious affiliations, participating in some spiritual rituals like the holy communion services. Communicating with

God/Supernatural Being through prayer was one of the frequently mentioned means of expressing one's spiritual needs.

“But sometimes you find a patient who during that short period will ask a nurse “please pray with me” and during that short period of time. If the nurse knows how to pray, then the nurse prays with the patient.

One participant mentioned that even the patient who does not know God will ask for prayer: *“Even a person who does not know God he will say please pray for me.”* Prayer was noted as a way of communicating one's spiritual needs to God/Supernatural Being as to a friend. When patients were in their terminal stages as noted in the above quotation, they prayed more often. Linked to prayer was the concept of meditation. Meditation was defined as a quiet time the person needs to think and contemplate upon his/her relationships with self, others and God or whoever is considered the supernatural being as this participant mentioned:

“You know when you are quiet you can think about something nicely, you can meditate if you want to... You can meditate on a certain god and you know they are going to help you, and you can feel it in your life, you can feel it and you carry”

Another aspect of meditation that was mentioned by one participant was in connection with his need for inner peace and self forgiveness as he contemplates on what happened to himself.

“I contemplate on what happens to me, I meditate on what happens to me and I accept and I have to have love for myself and acceptance, love of acceptance that I have not. You see that is difficult, if I sit here now and meditate with you I will close my eyes. I can sit here for 10 hours and spend those 10 hours just with myself because myself, because myself not selfish, myself is what I must love the most.”

As the participants stated their communication to God through prayer and meditation, they also expressed the need by reading their Bibles.

“If I sit here now and meditate with you I will close my eyes. I can sit here for 10 hours and spend those 10 hours just with myself because myself, because myself not selfish, myself is what I must love the most.”

Sometimes they read other books or magazines which facilitated their communication with God or gods as one respondent mentioned: *“I just want to keep quiet, just read my paper, just go over it until I sleep over it.”*

Other participants read their Bibles: *“Sometimes I read my Bible, at times I go to church and I pray at times after doing all that I find that my problem is solved.”*

From observation the researcher noted Bibles on the side bed lockers of the participants. Other books noted were books of the special gods and goddess for specific problems as this participant explained. Linked to prayer, meditation and scripture the respondents reported that they expressed their spiritual needs through certain spiritual rituals, e.g., the communion services, sometimes called the last holy communion for the terminally ill.

“I think the significance of spirituality like there are these patients like the Roman Catholic patients, those patients when they are terminal ill they really need their priest for things like holy communion, the last holy communion.”

Other participants mentioned that they would use a flower or anything that is natural as they prayed or meditated upon God.

“Just a flower just an ordinary flower or something you see what I mean, the nearest and the cheapest you can use a flower for anything, God is in everything. When you pray just think of a certain saint...you can see that this flower is nice and you can say in your mind oh, I love you but you are not here now you are away now you must try to help me to do this, you see what I mean.”

There were diverse ways of expressing spiritual needs. The diversity noted was associated with the participant's religion as one participant mentioned:

“Spiritual needs of the patient, it can be making sure that you find a particular religion, if they are Methodist, then you find Methodist minister, if they are Catholic, then you find catholic minister, if they are Hindu, then you go get a Hindu priest, if that's what they need.”

Along with expressing spiritual needs in various way was the concept of worship. Worship is a religious expression of a spiritual need as one respondent reported:

“I think religion is centered around worshiping some superior being. Whatever you worship. The basic thing is that everybody believes that there is some superior being. I go to church, I pray and worship and do everything, even when I am at home before I sleep, I pray.”

4.5 Spiritual care in nursing

4.5.1 Definitions of Spiritual Care

Spiritual care in nursing was defined in various ways which were related to the definition of spirituality. Most participant viewed spiritual care as an aspect of nursing care that is integrated in total patient care. As spirituality was defined as a personal quest for a transcending relationship and as an inseparable part of the total being, spiritual care was also defined as part of total patient care that is aiming at assisting a person in establishing and/or maintaining a unique and a dynamic relationship with God as understood by the person and with other human beings. This type of nursing care cannot be separated from other aspects of care as this participant stated;

“Spiritual care is caring for the patient in totality, in the sense that you care for the patient physically, emotionally, psychologically...so I can say is the whole of

the patient or an individual because you are nursing the patient as a whole. I can say that”

Another participant from a different setting also defined spiritual care in the same way as defined by the previous participant as she said;

“In hospice we are always told about spirituality, which there are several different parts of a person which is physical part, the emotional part, their social part and their spiritual part. So there are four aspects that we care for in hospice”

Spiritual care was also defined as an integrated whole that is unique to each person as this participant said; *“It’s recognizing the individuality of each person. That’s is what is it”* Another participant gave more emphasis on the individuality of each person as she said;

“Spiritual care is looking after the person’s mind, body and soul... you approach each person, each patient differently and you treat them all differently, you don’t treat them like bodies in the bed all the same.

Other aspects of spiritual care mentioned were those associated with faith, hope, belief, love and ubuntu. Spiritual care was specifically noted as an expression of unconditional love and concern for other human beings and acceptance of a patient as a unique valuable person as this respondent stated;

“Spiritual care, is to care you know, is loving a person and caring for a person not only physically, but encouraging the person to see his/her mistakes and accept God when he or she is in the hospital even after hospitalization when the person is well”

Another participant also put an emphasis on love that if a person claims to be providing spiritual care without love, that is empty care. Complete spiritual caring should include love.

“It’s love, caring supportiveness and physically and mentally caring that’s nursing the spirituality. It’s love and it’s psychological, it includes everything, but love must be there, because if you leave everything if you do everything and you call it spirituality without love that is empty.

The concept of love goes hand in hand with the concept of “ubuntu” as some participants said, *“Spiritual care is ubuntu, respecting and accepting a person as she is”* Linked to the concepts of totality is the consideration of a person’s religious beliefs. Some participants defined spiritual care as a way of considering the patient’s beliefs.

“Spiritual care is the way of treating a person according to the belief may be some patient believes in praying at any time if the patient wants to do so, so I think that this spiritual care is regarding to that we must allow them to do whatever if the patient request to verbalize religious beliefs.

Sometimes spiritual care was defined as giving hope to the person who has lost hope and to nurture faith and trust as the following respondent said;

“Spiritual care is the care that is given to one who has already lost hope ...and to strengthen those who already have faith”

Spiritual care is therefore aiming at assisting a person in establishing and/or, maintaining a dynamic relationship with God as understood by the person and with others. Any nursing action that would help the patient to achieve the above aim was then considered spiritual care.

4.5.2 Principles of Spiritual Care

Participants repeatedly mentioned some guidelines which they thought were essential in providing spiritual care. These guidelines explained how nurses should provide spiritual care. Both nurses and patients participants contributed in different words and statements in describing these guidelines. The statements were thus combined to form five (5) interrelated principles.

The first principle stated that, spiritual care should be patient centered. Patient centered spiritual care means that, the care must be patient focused and it must consider the uniqueness of each person. It should be based on the needs of each person as an individual. Participants repeatedly referred to the patient centered spiritual care as this participant said;

“I have some cases when the patient is dying and he says, I have never been in the beach in my life, I would love to go to the beach. In here they are sent to go to the beach. Things which you think are impossible they make the dreams come true before the dying day.”

The above example of patient centered care gives a guideline that in caring for the patient spiritually, the nurse need not necessarily open the Bible or pray for the patient, even though these are important aspects of spiritual care, the nurses may also fulfill the spiritual needs of a patient by taking the patient out. One patient who had been in the same ward for more than two months said, *“Nurses must take us out, I have been in this ward for more than two months, we need to be just taken out.”* Taking a patient out may sound too simple and insignificant to someone who is up and about, but to a patient who is confined to bed this is very important and may be meeting his or her spirituality.

The second principle states that spiritual care should be built on a trusting relationship between a nurse and a patient. The nurse and the patient were perceived to be needing a trusting relationship for effective spiritual care. A trusting relationship is not developed in one encounter with the person. It takes time. So from the first meeting with the patient, a trusting relationship must be started. It may take days, weeks and even months for some patients to learn to trust strangers. As each patient is unique, and each nurse is unique, so are their skills in developing a trusting relationship. The respondent below gave the following suggestions on developing a trusting relationship.

“You must stay with the person, talk to the person until that person leans to trust you” Another participant said; *There must be a close relationship between you and a patient so that you can be able to talk about spiritual things.*

The third principle said, spirituality care should be driven by compassion for human needs. Compassion was explained in different words such as sympathy, empathy, sensitivity to human pain and ubuntu. All these concepts were used to describe the principle of compassion that should guide nurses in providing spiritual care. Compassion incorporates all the above-mentioned concepts. To be compassionate refers to a state of complete emersion in suffering with another person in an effort to alleviate human pain and suffering as the following respondent said;

“Be with the patient involve yourself, feel her pains, feel her pains” Another participant expressed the need for sympathy as a way of demonstrating that the person cares as she said; *“You can express it by giving sympathy to a person who needs sympathy or by advising the person who is in need of advice.”*

Compassion also includes being sensitive to another person’s needs. So nurses need to be sensitive to patient’s needs if they are to provide effective spiritual care as this participant reported; *“I think the nurses should be sensitive to the spiritual needs of the patient”*. Compassion goes beyond just being sensitive, but to being actively involved in helping the other person as this participant said; *“By doing good things to others I think and by being kind to other”*

The fourth principle closely linked to compassion is that spiritual care should be based upon unconditional love for individual patient. Unconditional love is what is known as the Agape love in the Christian tradition which means God’s love to the people. This refers to loving the unlovable. The unconditional love comes from the value a nurse has for his or her patients, not because of what the patient has done but because the patient is a human being worthy of being loved and cared for unconditionally. One patient participant describing his perspective about nurses’ love said;

“A nurse is like a light on the table. His or her brightness cannot be hidden, love for people love for people shines wherever she or he is”

Another participant said

"We still need the Florence Nightingales, we still need people who are like that, who love in spite of."

The fifth principle is what was termed participatory spiritual caring. This means that, the spiritual care should be a communal activity, not just a nurse and a patient, but a nurse, a patient and the significant others including the church members. One participant reported the role played by the patient's church members in nurturing hope and faith as she said;

"Her members wherever she goes to the church they usually come for her just to comfort her to give her payers so that she can feel better, make her not to lose hope"

Another participant mentioned that we need to include the patient as well she said; "So I say it is right to include our patients and make them feel free when they are in the hospital"

The family was perceived to be very effective in spiritual care because they have been with the patient for a long time they may assist the nurse in helping the patient spiritually as this participant said;

"What you have to put in mind is don't misjudge what the family is saying, because they have been with the person for years and we are only here with him for two hours, three days or week.."

Another participant pointed out that spiritual care should be everybody's responsibility. That includes the patient, the nurse and all those significant to the patient as he said;

"No, all of us you see, all of us should be responsible for spiritual care, that is nurses and patients, everybody, you know,"

4.5.3 Factors perceived to influence spiritual care in nursing

Informants mentioned certain factors which were influential in determining the what, when, why, where, who, and the how of spiritual care. These factors came from both patients and nurses participants. There were factors related to the patients and the nurses' religious beliefs, cultural diversity, patients' ability to express the spiritual needs, the experience of a nurse in recognizing patients' spiritual needs, and the nurse's compassion for patient needs.

The first factor was related to the religious beliefs. Sometimes participants mentioned that the patients, nurses and the family do not always share the same religious beliefs. This nurse participant expressed that to her spiritual care is a real challenge because of diversity in religious beliefs as she said;

“It 's a tough ground it covers a lot, it covers a lot because there is the patient herself and there are relatives and there is the nurse who is nursing them. We all have three different spiritual beliefs. If you take the patient, the relative and the nurse three, I might have my own religious background with my own spirituality”

The second factor which was also linked to diversity of religious beliefs was the diversity of culture that nurses have to work with when providing spiritual care. Nurses found a real challenge when dealing with patients and their families regarding cultural practices. The cultures that were repeatedly mentioned as a challenge were the traditional African ancestor worship whereby relatives of the person who died some years ago came to the hospital ward where that person was admitted to take his or her spirit home. This nurse participant reported;

“I have seen Zulu people coming to the wards a year later or a month later in the same room where the patient died, they come and take his spirit, so spiritually is their belief it's not his belief, it's spiritually us believing who are doing that”.

Traditionally, the dead person is supposed to be brought back home after one year, but at times the relatives would not have the money for the rituals that have to be done for that occasion, this practice would be postponed for years when there would be enough money to feed all those who

will attend the services. One nurse participant related how she dealt with a man who came to the ward to collect the spirit of his father who died in 1948. The nurses did not know how to handle that because the physical structure of the hospital had changed they did not know where was a male ward then. She related her story this way;

“There was a patient in this hospital who died in 1948, so it was only last year when his son who was a baby at that time came and said, there is a demand that we need to do this for my father (we need to make a feast and take him home).” We explained to him that the structure of the hospital has changed, but we will take you to the ward where it was then, so they went there with their branch, they put it down and they talked they said “Mister so and so we are now taking you home to the family” They believe in that so it worked. I think some people believe a lot on the dead”

So, the above scenario shows the challenge facing nurses regarding religious beliefs and cultural beliefs. Other cultural beliefs mentioned were those associated with Indian practices as this nurse said;

“Indian patients they keep the poster or a picture frame of Sayi baba sometimes they have a bowl of fruit. It must be kept even if we complain that there are flies, .. they want to keep the fruit there for x amount of days because they have prayed on the fruit, then it needs to stay on the locker and all that. Unfortunately it causes fruit flies but we are to leave the fruit”

Nurses deal with diversity of cultures particularly in a South African context where there is so much diversity. The following participant reported her experience with cultural diversity in her nursing practice,

“There are Hindus, there are Muslims there are people like Jehovah’ Witnesses who don’t want blood transfusion. We respect them, so if she doesn’t want that she doesn’t want. So every culture we respect.

Those who worked in obstetric units also reported their encounter with women in labor as this participant said;

“Others they have these strings, the red and green strings tied around their waists. Those strings for them they serve as Shirodkar stitch, you know when these patients have miscarriages, so these patients believe that if they have these strings around their waists they will never have miscarriages and they don’t because it’s what they believe in. But now the problems come when they are to deliver. At times time when they have to deliver if they don’t remove those because sometimes when they are in labor they forget about the strings and they get obstructed labor”

The researcher asked if the nurse participant believed that the string around the waist could in any way obstruct labor. The participant said she did not believe but because the woman in labor believed, then it happened as she continued with her explanation;

“If they don’t remove them, the baby doesn’t come we end up having delayed second stage, poor progress, but if the patient remembers because we nurses we are now used to this if we remove that the baby pops out immediately”

The third factor that was perceived to influence the provision of spiritual care was the patient’s ability to express the spiritual needs and the nurse’s experience in identifying patient’s spiritual needs. Some patients were able to express their needs with ease while other patients were said to be shy. *“You know some people are very shy they don’t want to join you, you know about this class thing.”*

Though spirituality was not always linked to religion, when it came to spiritual care, religion played an important role because spirituality is often expressed through religion and there are many religions in South Africa as this participant reported;

“Even the nurses have got their own religion, and because we leave here in South Africa there are so many different religions”

From the discussions above it was then apparent that nurses needed to be aware of different religious and cultural practices to be able to recognize the expressions of spirituality on patients. The nurses' experience with patients helped them to identify patient's spiritual needs. Junior nurses were reported to be lacking expertise in recognizing spiritual needs as this participant reported;

"Sometimes it's difficult, because some junior nurses do not know whether the patient is struggling and they say this patient is restless and confused, but you as an experienced nurse you can tell that this patient is in need of a prayer.

The recognition of the patient's spiritual needs and the attention given to the spiritual needs greatly depended on the expertise of a nurse. The religious beliefs, the cultural diversity, the patient's ability to express the spiritual need and the nurses ability to recognize the spiritual need were all important factors in the provision of spiritual care. In spite of all the factors mentioned above which influenced the provision of spiritual care, participants still perceived a vital role which nurses played in providing spiritual care to both patients and their families.

4.5.4 The Nurses' Role in Spiritual Care

It would seem that nurses played five major roles in providing spiritual care to both patients and their families. These roles were labeled as accompanying, helping, presencing, valuing and the intercessory roles. Each role will be briefly described in the following few pages.

4.5.4.1 The accompanying role of a nurse

The accompanying role of a nurse refers to the nurses' ability to identify the patient's spiritual needs and to walk with the patient wherever the patient leads. The nurse therefore will assess the patient's readiness for company and then takes the patient from where the patient is to where the patient is going. When accompanying the patient, the nurse would not walk with the patient faster than he or she could follow. The accompanying role of a nurse includes accompanying the patient on the rough road of illness and death, assessing the patient's readiness to be guided,

communicating the progress of the journey to the patient and family, coaching about the illness whenever is necessary, facilitating and supporting the patient and the family at large.

Sometimes nurse participants mentioned that they would walk with the person wherever the person led. Both patients and nurses respondents expressed the need for accompanying the sick person in his or her spiritual journey. The journey was perceived to be from birth to death as one participant felt that since most people are born in the hands of nurses and often, they die in the hands of nurses as this nurses participant stated:

“They come through the nurses when they are born, and they leave the earth in the hands of nurses when they die. So nurses should have something to contribute toward the spiritual needs of the patient”

The accompanying part of the nurse involves walking with the patient from life to death and from death to life after death. Most participants believed that death is not necessarily the end of the person, they believed that there is life after death as this participant mentioned;

“So our role is to help them on their journey from life into the other world to facilitate the journey to make it as easy as possible ...and to help them die peacefully because as they are dying they are going into a tunnel that’s what I believe. They believe they are going into another world we just help them along the way”

Facing the end of life was perceived as the most difficult journey to walk as the person may be scared that is why they need company particularly when they feel condemned because of the stigma attached illnesses such as HIV/AIDS. Most participants expressed their concern about this category of patients because they are often rejected at times they are even rejected by their loved ones. One participant expressed her concern when she said; *“A lot of people reject them. So, you have got to walk down that road with them, keep their dignity”*

The nurse needs to walk with the patient wherever the patient leads as this nurse participant said; *“It is very important to consider where the patient is and to take the patient from there and to*

walk with them, and walk where he leads not where you lead as a nurse” The journey is not only for the patient, but, even the family members are in need of company as they also walk with the patient as this participant said;

“sometimes it can take 2-3 weeks, and you have got to pick up where the family is, where the patient is and you have got to stay there, and try to grow with them, whichever way they grow”

One participant expressed that the nurse walks quietly with the patient.

“Talking to them without them knowing and getting to know that person and you find if they are afraid of dying or they are afraid of something, you try and encourage them every day. It’s a huge journey for the two of us”

As the nurse walks with the patient, she or he assesses the patient and the family at the same time.

4.5.4.2 Assessing patient’s spiritual needs

Assessment is the first phase in any nurse/patient interaction. It involves the deliberate systematic collection of data to determine the patient’s current spiritual status and to evaluate the past and present coping patterns. The nurse may need to record both objective and subjective data about the patient’s spiritual condition. When assessing the patient for spiritual need identification, the nurse should be alert to identify the expressions of spirituality as mentioned earlier in the chapter. The nurse participants mentioned several methods they use to assess for spiritual needs. These included interviews. Observations and collaboration with colleagues, family and religious leaders. One respondent put an emphasis on assessment as she said;

“Oh! As we say there is anxiety, there is fear of unknown, and there is maybe loneliness as well and the family may not be coping and they are scared and as a nurse you can evaluate and see ok, what can I do? ... You go out there and assess, do your nursing assessment and see what can I do”

Nursing assessment of a patient was also mentioned to be including history taking, determining the patient's religious beliefs so that the patient may be assisted appropriately as this participant said;

“I must ask first what he believes on then I can find a way of helping that person spiritually”

Spiritual assessment was also identified by the participants as part of the initial assessment of the patient. *“Well during our interview of the patient we always ask the patient about their religious beliefs”* Another nurse participant expressed that assessing a patient for spiritual needs makes it easier to care for the patient. Some patients may be sharing the same belief as the nurse, and the nurse may be familiar with some religious practices of that particular patient, if that has been identified during assessment, then spiritual care will be much easier. If the patient presents with problems the nurse cannot cope with because of differences in belief, then the nurse appropriately refers the patient as this nurse stated;

“I must find out if he or she does not have the same belief I have got I must find out who is the person that can come and help her, because I can give her what I believe in at that stage, but if she does not want that, she wants what she believes in, I must be sensitive to the patient's needs and help her find whatever she believes in and help her according to that, rather than trying to help her when I don't even know”

Another nurse participant mentioned that in addition to patient spiritual assessment the nurse should also assess the family coping pattern, the financial position of the patient, the funeral plans and the unfinished businesses as stated below'

“It is important for you to assess how healthy is the family relationship, or is this patient alone and also assess the financial situation and whether there is a funeral benefit, may be that is what is bothering them. Find out before they get very, very ill”

In order to perform an effective spiritual assessment, a nurse should be able to communicate well with both the patient and the family. Effective communication was perceived as an essential

element of building a trusting relationship and a tool for assessment as this respondent said; *“You do not quickly find out the problem of a person. You must stay with the person, talk to the person until that person leans to trust you”*

The communicating role of a nurse involves the nurses' ability to use both verbal and none verbal communication skills. The nurse talks to the patient and to the family and also the nurse listens to what the patient and family say. Active listening is an important skill in communication and in spiritual assessment. As the nurse accompanies a patient she or he communicates with both the patient and the family as this nurse states;

“So whatever it is tell them what is going on, because you are going to tell them that their mother is fine and one second later she dies, so whatever happens here tell them the truth, be honest, be very honest about what is going on and involve the family from step one to step C”

Not only does a nurse talk to the patient and the family, he or she also listens to what they are telling him or her. Not only does she or he listens but listens with sensitivity and listens between the lines as this participant said; *“my role was just to listen and I think that is the way to help anyone spiritually our role is just to listen and to listen with sensitivity and listen between the lines”* Another nurse said;

“So the role really there for us as nurses is to listen and to understand the existence and the meaning of that particular power for that person.”

The fear of a new hospital environment coupled with fear of the approaching death was often mentioned as one reason for the nurse to stay and communicate with both the patient and the family.

“And these patients being in the hospital is a new environment they are not used to, so is the nurses that must bring them nearer to that by coming in contact with them, talking, listening to their needs, answering to questions.”

Linked to accompanying the patient and the family in their spiritual journey was the role of facilitating spiritual growth and development. The nurse was perceived by the respondents as the spiritual facilitator.

4.5.4.3 The facilitating role of a nurse

Facilitating role refers to the nurses' ability to assist the patient and family in achieving what they want to achieve spiritually. For example if the patient, or the family would like to pray or read some encouraging words from the Bible or whichever book they prefer, the nurse should be there to help them to provide what they need as this participant said.

“So in a nutshell, the nurses when they care for the spirituality they only act as facilitators to make sure that patients are provided with what they believe in” Another participant said; “It is facilitating the patient’s spiritual beliefs. Even the material we give to patients to read and find comfort and solace and all that is to facilitate their beliefs” Another participant said; “We assist them in whatever they believe spiritually and we allow them to pray if they want to pray, we offer them books to read like Bibles spiritual magazine”

4.5.4.4 The mentoring function

The mentoring function of a nurse refers to the teaching and learning transaction that go on between the nurse and the patient as they interact in the spiritual caring process. Patients often direct their questions about God and His involvement in their pain and suffering to nurses. For example, they would ask a nurse, “Do you think I am going to make it?”. “Do you think God still loves me?”. “Why do I have to die now and leave my newborn baby?” etc? Nurses often have to respond to such questions and these questions do not come during a formal educational session, they come at random demanding a response. That is why this subcategory is labeled “the mentoring role”. Participants expressed their involvement in spiritual education in different ways. This participant reported how she would initiate a conversation on spiritual issues with patients;

“I would ask questions like, do you believe in God? Do you believe that God exists? What do you think is the cause of all the suffering and death that is present? Do you believe that God has brought all this to us? What do you think?”

The above participant used open and closed ended questions to lead a patient to an open discussion. Her questions were also assessing the patient's beliefs about the cause of pain and suffering at the same time determining the patient's interpretation of his or her illness.

The same participant further stated that spiritual education is a responsibility of a nurse not only when a nurse is at work but even outside the working place.

“Like I have said, if all of us not necessarily in our work, because we interact, we need to educate people to be conscious of spiritual care needs”

Spiritual education was also stated to be part of family teaching especially in guiding the young generation toward the socially accepted moral behavior. One participant expressed how she taught moral values to her children.

“In fact, we actually use topics like, do you think there is something that God if He had the power to operate immediately on that. If God was present governing us will He allow the wickedness to carry on? We get key questions to ask them for example, what do you think about smoking, alcohol, drug abuse, even peer pressure, abuse of language? What do you think about slang? Is it something that reflects on the personality... because we know that by doing the wrong we are going to receive punishment. So we cannot continually put the blame on Satan, because we have principles and guidance set from the Bible, you know it in your heart, your mind, and the soul and you are governed by it”

At times the need for coaching was identified when there was a conflict between what the patient believed was the cause of illness and what nurses perceived as the cause of illness as this nurse participant said;

“You can’t force them to change their beliefs, but you can give them information, actually looking at their physiology you must educate them about their illness the actual physiology of their illness. What is actually happening in their bodies, because they tend to bring superstitious beliefs as well. They will tell you I am sick because some body did this to me. So you need to tell them what is actually happening in their bodies for example your blood is low and you need may be blood transfusion”

One nurse participant related what she would say when coaching the patient to trusting God;

“As a nurse I will tell the person that the doctor’s treatment that you have is only this world, the foundation of it all is in God. Even the power I have to talk to you is God’s will. So your trust must be in God who created you.

Linked to coaching was the person’s need for support. The participants perceived a need for support from the power higher than themselves. *“Spiritual care is where the person needs support from that power she or he believes in that is governing him or her”*. When participants were faced with difficult situations, they expressed a need for someone to give them emotional support. When they were extremely depressed, they needed someone to share their burdens with as stated in the example below;

“Then you take another extreme case like the patient who is absolutely reserved and might have emotional pain and they are always anxious, they panic, it’s because they are not getting moral support. The moral support could also include the minister the spiritual minister, it does not necessarily have to be the patient’s minister from home, you see sometimes that aspect can be left out, and also can include an important friend, it does not have to be part of the family, an important friend that has got a special relationship with the individual may be that support is not coming through”

The nurse was not perceived as the only person in giving support. there were other people like the spouse or a family member or other spiritual leaders who were perceived as the supporters of the patient.

“the main care giver, for example if the wife is being admitted and the husband is there readily supportive, like in this case the husband was the main care giver right there and one daughter they have is leaving in Cape Town but the two sons also arrived at the same time with their wives and that I know now this is a well cared for patient he is not neglected and the patient is not going to have an inner crying,...we assess quickly to be able to peak it up while the family is there and you converse with the family we do not only take the patient into conversation”

The nurse was perceived to be giving support by loving, caring and at times by just being there with the patient as this participant said;

“so you can see that the patient needs your support...She can accept and spiritually you must be there to support her by loving and caring by inspiring trust and support when the people need that support”

4.5.5 The Helping Role of a Nurse

The helping role of a nurse refers to the assistance the nurse is expected to give to the patient and to the family. Patients and families look to nurses for different kinds of help. Sometimes nurses themselves perceived their role as helpers or as a spiritual ministry. The nurses felt that they have an obligation to help in all aspects of life including spiritual and religious aspects as this participant said; *“make sure that spiritually and religiously, if they need to have religious help you would do that.”*

One nurse participant mentioned that one reason that patients look to nurses is because they are scared, they feel helpless and powerless. They look to nurses for help in their fears as they travel the rough death road.

“You do that to assist the patient, ... you have to prepare the patient because they are scared, they are going to leave the family behind with nothing, so may be spiritually is being troubled, what am I going to do what is my family going to do?”

One patient participant described the role of a nurse in helping the patient as like that of a servant as he said;

“The role of nurses with regards to spirituality is to be a servant. ..if you are a servant you can do anything. Even if you are to sweep the floors in God’s house, you are still a servant. That is what I believe in.”

Even though the nurse may perceive his or her role as a helping role, the patient or whoever is to receive help must also accept that he or she has a problem and that the nurse can work with him or her through that problem as this participant puts it;

“Spiritually, the person must accept that there is a problem, when she has accepted, then I can find people who can help the person spiritually who knows better about God. There are these people called spiritual healers. Then, I can find them to give help.”

Sometimes the participants referred to their helping role as either active or passive as they mentioned that sometimes they provide the patient with literature that will uplift them spiritually, and at times they were actively involved by reading the scripture to the patients. Whichever help the patient needed, the nurse was always perceived as the source of that help. The nurse would assess the patient’s readiness to receive help and then help the patient appropriately. The following nurse participant describes the nurses’ helping role this way;

“We have Bibles so that if the patients are for scripture we can give them or we can read to them because others they are old and they cannot see but they still need to hear about the word of God so you can just read the Bible to them.”

As the nurses may not do all the spiritual care work alone, there were times when the minister of religion or whoever was seen as the spiritual leader by the patient was called to give the type of spiritual care needed. Even in such situations nurses were readily available to find what or who the patient needed. This was facilitated by a list of religious leaders and their telephone numbers which was kept in the units.

“But we do have a list of the priests for different denominations and their phone numbers where if the need arises we can phone them to come in and see the patient.”

At times the patient express the type of help they need, for example they may ask for a prayer or minister of religion. Sometimes they are so sick they cannot even ask for help, so the nurse would be alert to recognize patients who are in need of help and should be able to provide the type of help needed as this nurse participant said;

“Well, I think there is a saying which says “most people pass through the hospitals than through the churches” people choose to go to church, but they don’t choose to get sick. So my feeling is that the nurses should have an idea, they should know if the patient says to you “please pray for me, I’m dying” A nurse should be able to pray with the patient, when she goes home after doing that she will feel that she did something, she took care of the patient physically, and she also took care of the spiritual part of the patient, because when the need arise, for her to pray, she could rise up to the occasion and pray with the patient at that particular time.”

This nurse participant continued to place her emphasis on the holistic helping role of a nurse by saying;

“So, I feel that we as nurses, must not just look at the patient as somebody that we are going to pump medications, the injections and tablets and say good bye go home, and when the patient needs some spiritual care we cannot help the patient in that respect. Not really saying that the nurses must all be Christians, it would be nice if they were, but they should be able to help the patient, because

now, when the patient comes to hospital, she or he entrusts us with the whole life.”

The nurses perceived their role as that of assisting the patient in whatever the patient expressed as a need as this participant said; *“We assist them in whatever they believe spiritually and we allow them to pray if they want to pray. We don’t educate them on spirituality as such.”*

Other forms of helping mentioned by the participants included acting as a comforter for the patient and family, encouraging and reassuring the patient and family, collaborating with other parties concerned and referring appropriately whenever it is necessary. Above all, the nurse was also perceived as the patient’s advocate. The patient and the family often needed the nurse to play a defense for them. They may not even be aware of their own rights to care and they may not even know their role. The nurse was perceived to be advocating for the patient to the health personnel. The nurse acted as a link between the patient and the medical physicians, para medicals as this nurse participant said;

“I explain the condition to the patient at first, then I explain to the doctor that the patient wants to be discharged. Under the circumstances we educate the patient about our treatment, but we do not prevent him or her from going because of his or her belief.”

The nurse’s advocacy role was not perceived as limited to the sick. The nurses played an advocacy role even after death as this nurse described her encounter with the funeral pallors. She was advocating for a person to be treated with dignity even after death.

“Ok, I was actually mad one day, a funeral parlour came to pick up a body. It was a black woman and for some reasons I was made to be mad, too upset at the way they treated her. I told the guys look, treat her with dignity, she is 70 or 80 years old, you don’t even know her. For all her life she has been treated with dignity and love in her family and you just come here and you just dump her

like that. And I said if you don't mind you are going to leave her. I said you are not going to take her anyway. Leave her here."

Linked to the helping role of a nurse is comforting the patient and the family. One nurse participant describing spiritual comfort said; *"Spiritual comfort means a patient is at peace emotionally. His spiritual needs have been met"* The presence of a nurse next to the patient and the support she gives to the patient and the families were also aspects mentioned to be contributing to the patient's comfort as this respondent said; *"To be readily available to make the patient comfortable, give them their dignity, hope, love, and give them all the support they need."*

In their comforting role the nurses were not only concerned about the patient, but also the family members as this respondent mentioned;

"we do not only take the patient into conversation because sometimes we make the patient comfortable and the family members are not comfortable they can have an interaction into the patient because you have not made them comfortable with what is happening to them."

Linked to comforting, advocating and helping is collaborating with other health care providers. The nurses sometimes help the patient by finding the appropriate person to assist the patient such as the social workers and the ministers of religion as the following participants report; *"that is why we have social workers here so that they can quickly relate the problem we do not leave it for the sun to go down."* They collaborate with the ministers of religion by telephone as this participant also reports;

"then we can phone the person to come in to meet that need of the patient at that particular time"

In the labor ward the helping role was facilitated in one setting by utilizing labor partners. The labor partners were described to be the person who would stay with the person during labor,

giving comfort and support to the laboring woman. These labor partners were perceived to be giving spiritual support to the person in labor.

“In here each patient has a labor partner if possible. Most of the time a labor partner is a person that can be able to cater for the patient’s spiritual needs. It will be like the mother, the husband, so they are allowed to stay in they will be able to pray with the patient.”

Sometimes a patient may be so sick that she or he cannot be in the position to even ask for the minister of religion. In such a case the nurses called a religious leader on their own discretion and the patients appreciated that as this respondent said;

“anyway nurses saw the need to call a Priest for me. And they did call the Priest I was on oxygen, everything” Another participant said; *“It’s very helpful in patients, if they want their own ministers, if they ask for a certain minister we call him. You can see during the visiting hours on Saturday”*

Referral was also mentioned as part of the collaborative helping role of a nurse. Participants mentioned several ways of referral. Some had a list of church ministers in the ward and their telephone numbers to facilitate referral. Often nurses reported that they were taught to refer the patient to appropriate spiritual leaders. *“We are often taught to refer the patient to the appropriate spiritual leader, a preacher or a priest”* There was one setting which had special spiritual care givers. The spiritual care providers were Sisters who were nuns. They visited the wards regularly and sometimes when they were called by the nurses for a particular patient. Some nurse participants tended to shift their role in spiritual care to this category of health care providers in this setting as this nurse participant reported;

“This is the part that one doesn’t really get herself involved. I think one is always pushing this to the Catechists, because we always say you talk as much as you can but if we see that a person still needs more explanation then we call the nuns.”

4.5.6 The presencing role of a nurse

The importance of being physically present by the patient's bedside was repeatedly mentioned by both nurse and patient participants. Being there by the patients sick bed was perceived as an integral part of spiritual caring as this respondent described spiritual care as follows;

“Spiritual care is meeting person at all levels, being very perceptive, and seeing that person as they are and staying with them where they are, to me that is spiritual care.”

Staying with the patient and being very perceptive in seeing the patient as he or she is, was demoted as an active engagement in the patient's affairs. Being with the patient does not only refer to the physical presence, but to being there with the patient in totality and actively involved with the patient. One respondent described the nurses' active involvement in this way; *“To be readily available to make the patient comfortable, give them their dignity, hope, love, and give them all the support they need”* At times the nurse participants indicated that there may not have much to do to help the patient spiritually or even physically or socially for that matter, but just by being there for the patient was perceived as sufficient to comfort the patient and reassure them that there is someone who is willing to walk with them on their hurting road.

Maybe spiritually, there is n't much that you can do, is only giving support to whatever they want, be there for the patient, be there for the patient.

The active presence of a nurse was repeatedly mentioned as an effective spiritual care function of a nurse. The following nurse participant described her presencing role this way;

“Mostly here, I am talking about here, most of our patients are dying they need you 100%, spiritually, emotionally and physically. So whatever we do, be there for the patient. You will be surprised that a nurse can stay by the patient's bedside do nothing, just stay there do nothing, hold their hand and just talk to them.

The above participant put an emphasis on being totally present by the patient's bedside, not only being there, but also using herself or himself as a therapeutic instrument in the healing process, not only physical healing, but spiritual healing as well as this participant said;

“You feel it in yourself, your conscious tells you, ok even if she does n't say anything I think I should be there. I can still give medications and should be there with this person”

The participants further stated that staying with the patient is not just a casual act, it must be organized and be purposeful and the patient should be involved. If for example the patient needs a certain nurse to be with her, one participant mentioned that, that should be provided giving a rationale for that as follows,

“If that patient feels ok, I think I need sister so and so to come and just sit with me. You can't assign somebody to go and sit with her. Do it, those few minutes may be the most golden time of her life, do it”

Another aspect of presencing which was mentioned in the previous sections was listening. Listening is an important tool of effective communication. When the nurse therefore sits by the patient's bedside, making herself or himself available for the patient is in a way giving the patient an opportunity to express his or her feelings. It was also perceived as the time to assess the patient's coping level with the illness or with death. The participant described this type of listening as sensitivity listening and at times they referred to listening between the lines. This describes an active form of listening. In short the presencing role of a nurse includes being readily available when needed by the patient or family, staying with the patient or the family, being there with them listening to what they say and listening with sensitivity and empathy.

4.5.7 The valuing role of a nurse

The valuing role of a nurse refers to the nurse's ability to recognize, accept, appreciate and respect the patient as a unique being capable of relating meaningfully to God and to other human beings and also able to make choices about his or her own relationships and destiny. The value of a

person is derived from the person's relationship with God and with other humans not from what the person has in terms of material wealth, but because of what a person is. What the person is worth originates from the person's spirituality and it is what God is worth. The participants repeatedly referred to value for human dignity as one of the objectives for spiritual caring. In other words the value the person has, cannot be measured by material wealth, but by his relationship to God Superior being. Therefore, the value of a person is determined by the worth God or the Supernatural Being gives to the person. Some participants saw the role of a nurse in spiritual caring as one of valuing the patient or promoting the worthiness in each person. Some participants used the concept of respect for human dignity while others directly used value. This participant emphatically said;

“Whatever you do, you must value the patient's dignity, her values or his values. That is where spirituality lies, So spirituality is valuing somebody's dignity, somebody 's beliefs

Not only was the nurse perceived to be able to value the patient's dignity, but also the nurse was to value the patient's choices of relationships, life style beliefs and values. The person was perceived to be worthy of respect whether in good health or whether in bad health, or facing death or, already dead as this participant said; *“they come to die in dignity, they come to be respected as human beings even if they are dead they are still human beings”* This nurse participant continued to say nurses ought to value the patient as he or she is.

“You have to value your patients and respect them as they are. But what we should do we should treat everybody with respect, with dignity. You don't know them, you don't know what they have been through throughout their life”

Along with valuing is understanding and being sensitive to the patient's needs as this participant said;

“I must be sensitive to the patient's needs and help her find whatever she believes in. All in all a nurse cannot provide spiritual care without understanding the patient. Yes, you have got to understand the patient's spiritual needs to be able to provide spiritual care”

Respecting the patient was perceived to be increasing the patient's sense of worth or self value which in a way would be able help the patient to cope with illness and death as this participant said;

“Respecting a person as a human being is very important, because much as she is ill..but she is a human being. This gives them a sense of value and you boost up their morale and they say “even though I am in this difficult situation, I am still myself, I ‘m still considered a human being”

Sometimes the nurses need to respect the patient's choices, even if they may not make sense to the nurse as this participant stated; *“So, we need to respect that although we know sometimes what is best for the patient”*

Respecting the patient was associated with increasing the patient's ability to exercise control over his or her situation. This increase in the patient's ability to control was labeled as “maximizing patient control” Maximizing patient control was noted when one participant reported that when a patient is approaching death, they allow that patient to do whatever he or she may want to do. This nurse participant put it this way;

“This is why we even stay here because the patient is in control and he is the boss. If he wants Savannah dry or alarm... at midnight you go and get it. That's the ideal. That's the ideal.

The idea in allowing the patient to do what he or she wants is to increase his or her sense of value or self worth. The patient must experience that he or she is accepted as he or she is, not because of conformity to some rules as indicated in the statement below.

“No, you can't say you are not allowed a champaign. No, you do what you like, you smoke, drink, you can do whatever you like until the day you die. That is the way it is. That is the difference between the hospital and the hospice. The hospice is different from the hospital, the hospice recognizes you as a person. That is a big difference”

Valuing the person was sometimes linked to the concept of “ubuntu.” Ubuntu has been defined before as referring to how a person relates to others within a group. It has to do with one’s love, concern and appreciation for the other. When nurses were showing kindness to others, that was perceived by some participants as “ubuntu.” In utilizing the principle of ubuntu the nurse demonstrates compassion for another human being as she is also a human being.

4.5.8 The intercessory role of a nurse

An intercessory role of a nurse refers to the nurses’ ability to communicate with God on behalf of the patient. Both the nurse participants and the patient participants expressed that nurses do intercede for their patients whenever they find a need for such. The participants reported that at times the nurses prayed for the patient even when the patient did not ask for prayer because a nurse saw the need to ask God to help the patient as this participant said;

“Sometimes if the patient continues going down...you can pray for that particular patient, even if he did not ask for a prayer, you can ask God to help this patient because some patients are struggling to death.”

Another nurse reported that when she observed her patient struggling with death and there was nothing she could do other than praying for the patient, she then prayed on behalf of the patient after which the patient died in peace. The nurse felt that she had done what was needed at the right time as she reported;

“You know sometime it was a terminal patient and I felt the only thing I could do was to pray and when I had done that and the patient died and that was the last thing he heard and I felt I did the right thing at the right time”

The respondent above mentioned that the only thing she felt she could do was to pray for the patient and when the patient died thereafter, she felt she did what was right. Sometimes the patients asked for prayer or scripture when they could but there were times when the patient could not say it out and the nurse had to decide for the patient. Other intercessory roles which were

repeatedly mentioned was a role of representing the priest or religious minister in baptizing the dying babies in obstetric units. If the mother and obviously the nurse believed that the baby needed to be baptized before death, the nurse would ask the mother if she or he could baptize the baby. Apparently in some settings nurses have been given the right to baptize the babies before death as this participant reported;

“Like in let’s say there is a baby that has been delivered may be the baby is having severe birth asphyxia, the baby we can see that the baby won’t make it, so the nurses to provide spiritual care, we as nurses we are allowed to baptize the baby, but we ask the permission from the parent the mother if we can baptize the baby, if we see that the baby won’t make it so the baby is sometimes baptized by the nurses”

Sometimes participants mentioned that they played an intercessory role by inspiring hope and faith to patients, and patients also reported that they need someone to give them hope and faith while struggling with their illness or with death. This participant includes both nurses and physicians as she commented;

“Is it just about nurses? Can I talk about doctors? I can talk about doctors. (Given a go ahead). Ok, some of the doctors they just give up hope on you. They don’t encourage you, they are not understanding as such because I had a doctor say to me, “you will die” and when I had that I became upset and I began to lose hope and I became sick, but then I realized, I had a lot to live for”

The following nurse participant reports how she encourages the patients to maintain their faith and hope even when it is dark.

“I say to the patient, please have hope, God will never leave you alone. If you have hope God will not disappoint you. You must say, “God do not leave me alone”

Another participant explained how she gave hope to her patients by communicating words of hope and faith as she said;

“You give a person hope by encouraging a person, tell the person to calm down, things are like this and that, God will give you what you need if you ask in faith and you are sincere, you do not doubt He will give you. Most of the times God gives you what you want.

The same participant goes on to say nurses should never cease giving hope to patient and she gives her rationale for giving hope as she explained;

“Yes you never stop giving hope, if a person loses hope begins to die. You don’t say to the patient your condition is hopeless, otherwise the patient will die because of that. You should always give hope and tell the patient that he/she must have hope, never despair. Despair leads to death. Never lose hope.

The above emphasis on giving hope does not necessarily mean that the nurses should be dishonest about the condition of the patient, but the emphasis is on hope in spite of the condition and hope that the one who the patient believes in has power over illness and power over death.

4.6 Spiritual care outcomes

The participants were asked to describe what they perceived to be the significance of spirituality. The answers given were quite informative and specific. Spirituality and spiritual care were perceived to be significant in coping with illness, death, child birth and child rearing and in accepting fatal diagnosis such as AIDS or cancer or accepting a severe physical defect of a new born baby. It was also reported to be significant in giving peace, hope, meaning and purpose for life in spite of unpleasant circumstances. Spiritual care was also perceived to be significant in teaching moral values to the children and the young adults at home.

These descriptions of the significance of spiritual care were thus labeled as “The Spiritual Care outcomes”. The spiritual care outcomes were then defined as the end results or the significance of a person’s spirituality or person’s relationship with God and with others. A positive relationship with God as understood by the person and with others was also perceived as essential in dealing with issues that threaten a person’s spiritual integrity. From the data it was unequivocally noted that, spirituality was very significant in determining patient care outcomes as this participant reported;

“I think it changes the whole perspective of how the outcome becomes you know, because if you give into the patients spiritual needs then all her needs are being met, even her emotional, spiritual and the physical, so the outcome will be more positive”

It was repeatedly reported that patients who were having a meaningful relationship with God and others were able to cope with pain, suffering and even death. These patients were more accepting. They had inner peace, hope, meaning and purpose in life. Sometimes participants reported incidences when the medical doctor has said the patient would not make it, but because of God’s intervention, the patient survived as this participant reported;

“The doctors had said they would do nothing for her, but God did something for her. We sang and prayed that night for her and in the very next morning she walked out of the hospital. God healed her. The doctors had said that they cannot help her. Even in the morning when the doctor came to see her he said only God could have saved her. The doctors could not do anything for her but God could”

Some participants reported that if the spiritual needs of patients were not met, it was difficult to handle such a patient as this participant reported;

“but if the needs are not met, the patient is gona behave differently and it becomes more difficult to handle the patient like that.

The nurse participant further reported that spirituality is also significant to nurses themselves.

“In my nursing, well, without it I would n’t be able to nurse my patients and understand them and have the patience about my job first, and also to treat people with dignity I would n’t have that aspect of me.”

Spiritual care does not only benefit patients, it also benefits nurses as the participant above also mentioned that, her own spirituality helps her to be understanding, patient, and also treating people with love and dignity. She said without spirituality she would not have that aspect of herself.

4.6.1 Coping as a spiritual care outcome

Coping with illness, pain, suffering, and death was cited by most participants as one of the most significant outcomes of spiritual care. Faith was mentioned as an important factor in coping as this participant said,

“My faith is what keeps me going I hope I will never lose faith so that I can be strong on the way, because without faith there is nothing else. When I go to church and meet with the fellow Christians and they give me counseling and doing all that, I hope that I will be all right, I will get used to what has happened.”

The above statement was given by a patient who had lost a three-year son and her husband at the same time. When a person has this type of faith, the person will be able to face any challenge in life. Spiritual care actually allays the anxiety and relieves anger, guilt, fear, deny shock and bargaining associated with the grieving phase of responding to triggers of spiritual integrity as this participant reported;

“Well, it actually eases off anger and allows the patient to be accepting and also give them completeness and dignity even to the end and peace of mind.”

Some patients were noted to be feeling at ease even when they were very sick and dying. One nurse participant reported that patients who have a good relationship with God and others wear a smile even at death as this nurse reported;

“There is this thing called terminal restlessness that you see when patients are dying. People want to run away from death because they are afraid. People who have peace with God don’t run away, especially Christians, they don’t run away, they have hope. Sometimes you can see someone dead in a smile showing that there was something nice, they went in a good way. Those who are afraid you find them with open eyes...”

Another nurse participant also reported a statement similar to the one above when she said;

“Some of them actually, feel at ease you know in their illness, it allays their anxiety... Yes, both ways (recovery and dying) It also helps, it helps them to die peacefully. It gives them peace, it removes that fear, the fear of the unknown. It does help to allay the anxiety.”

Another point related to the effectiveness of the spiritual care outcomes was the nurse’s belief. For a nurse to be able to provide effective spiritual care which will yield effective results she or he must also believe as this participant reported;

“But all in all, I think it helps because you can calm a patient down, if spiritually you also believe you can calm a patient.”

In a labor ward the women who had strong relationship with God as some nurse participants reported were very calm during labor;

“That person is so calm that you don’t even know they are in labor. You cannot believe it and when you check the progress you find that patient is progressing.”

To facilitate spiritual care outcomes, one setting had spiritual counselors who visited the patients regularly. After such a spiritual intervention the patient was able to relax as reported below;

“O! There is a lot (of changes that you see in patients as a result of caring for the patient’s spiritual aspect) because some people come in very aggressive and when you talk to her you find that she is touch me not, but with the longer stay with spiritual care practice you find that she is calming down, she is calming down and she is ok. It changes the behavior.”

Another aspect of coping mentioned by the participants was coping with death. Both nurses and patients participants reported that the spiritual care was very significant in helping terminal patients to cope with death. One nurse emphasized that the person’s spirituality determines the way that person dies as she said;

“It affects them very much because their spirituality will determine the way they die, the way they die, whether they die in peace or they die in anger? Whether they accept the death or not accepting death.”

Another participant reported how she felt after nurses had called for the Priest to pray for her as she was facing death.

“there after I felt so much better because I could see that death is near is coming and I was so much afraid, I was so much afraid, but after that I felt so calm. I was still not very well, I was still very sick but I said to myself at least now because I have seen the Priest, I have confessed, I have got the last ointment, if you want to take me God now you can take me.”

Spiritual care was also reported to be significant in dealing with grief. This responded explains how spiritual care has helped her to counsel mothers who have lost their newborn babies or those who had stillbirths or birth defects.

“Secondly it helps in grieving when we have stillbirths or abnormal babies, when you do the counseling spirituality also helps there and you find out that the patient accepts easier. Even when a patient has got an abnormal baby she starts after delivery when you show her and counsel that she has accepted it because she has psychologically and spiritually accepted everything.”

4.6.2 Acceptance as a spiritual care outcome

The spiritual care helps the person to accept her condition, diagnosis and even death because a person views whatever happens to him or her in terms of God’s will. Illness and death were also perceived as the will of God as this participant said;

“Maybe I can be cured according to God’ will or I cannot be cured according to God. So it is helpful because you nurse somebody who is more flexible than nursing a person who is not having this spirit”

Another participant said *“everything is provided by God whether is bad or good. We are not suppose to wait for the good only. The basis of everything is God.”*

4.6.3 Inner peace as a spiritual care outcome

One significance of spiritual care which was repeatedly mentioned is that, spiritual care gives inner peace to the person. Inner peace was not associated with being healthy or improved health status, but inner peace was experienced when a person had a meaningful relationship with God and with others as this participant said; *“If they are spiritually content, they die peacefully”*

Spiritual contentment came from knowing that there is one who is able to give peace in spite of death as this participant said;

“Spirituality involves inner peace and there is a need to get in contact with the higher Being that is God, so you have to get peace with God and knowing that you have somebody or something that you can rely upon”

4.6.4 Meaning and purpose for life as outcomes of spirituality

When there was belief in a meaningful relationship, the person was able to experience inner peace. Another significant outcome of spirituality mentioned by the participants was that spirituality also gives the will to live. Participants stated that their spirituality gave them the will power to live and a reason to live as this participant said;

“Without it (spirituality) I don’t think life is worth living, you have got to have that, you have to. I mean you got to have a will power, other wise you are going to end up a bagger or whatever, the life is not going to have any meaning, you are just going to live for today, you are not going to have a goal in life.”

Another example of the significance of spiritual care outcomes that was given by some participants was when dealing with patients with HIV/AIDS as this participant said;

“Well, the perfect example is that of AIDS somebody with AIDS you have to deal with their spirituality.”

Patients with HIV/AIDS need to have a sense of meaning and purpose for life as most of them seem to give up very easily. Even the women in maternity who were once considered healthy, as giving birth has often been considered a normal life process, participants mentioned that since mothers and babies are also victims of HIV/AIDS they need spiritual care to help them cope with the diagnosis and its final results as this participant said;

“...since we have this HIV/AIDS we no longer have healthy patients. In our patients in maternity is very vital also because there are babies involved. This is the part when we must show people that God is the miracle.”

4.6.5 Hope as the spiritual care outcome

One of the significant outcomes of spiritual care which was repeatedly mentioned was that spiritual care gives hope as reported below;

“Spiritual care is the care that is given to one who has already lost hope ..., and to strengthen those who already have faith and to promote that things should run smooth that people should know about spiritual care.”

The participants expressed the need for hope. Hope that was not found in getting better, but hope that even if the person was facing death, there was still a way through *“Their hope makes them to accept.”* Hope seemed to be related to what the person believed about death, illness and suffering. The persons who believed that death was a temporary sleep and that God has already conquered death were able to build their hope upon that blessed hope. Trusting in the power of God was giving hope in spite of as this participant reported;

“Yes you never stop giving hope, if a person loses hope begins to die. You don't say to the patient your condition is hopeless, otherwise the patient will die because of that. You should always give hope and tell the patient that he or she must have hope, never despair. Despair leads to death. Never lose hope.”

4.7 Summary and conclusion

This chapter gave a descriptive analysis of the concepts of spirituality and spiritual care in nursing from the perspective of 52 participants composed of nurses and patients. The relationships between concepts were also identified in order to develop a theory of spiritual care in nursing that is grounded in the data from the participants. There were five themes which developed from the data. The first theme was the description of the concept of spirituality. The concept of spirituality was described as an individual quest for a transcendent relationship. A quest for a transcendent relationship was described as a unique, dynamic and universal search for establishing and/or,

maintaining a relationship with God as understood by the person and with the significant others. The concepts which developed this theme were the concept of spirituality as an integrated whole, spirituality as a quest for a transcendent relationship and spirituality as a religious belief. Linked to spirituality as a religious belief the concepts of faith, trust hope, inner peace, meaning and purpose for life were also discovered.

The second theme that developed was called the trigger-response. From the data it appeared that the quest for a transcendent relationship was triggered by life's crisis such as emotional and physical pain associated with illness, difficult labor or delivery, birth defects, impending death or death of the loved ones, unemployment, poverty, crime, natural or man-made disasters. The life's crises triggered the responses which were classified into three categories. The first category was the grieving process whereby a person demonstrated deny, shock, anger, guilt, bargaining and fear. The second category of responses was the 'coming to terms' which was characterized by over dependency, acceptance and a search for meaning and purpose in suffering. The third category of responses was the search for a transcending relationship.

The third theme that developed from the data was the experience and expressions of spiritual needs. When the participants were searching for a transcendent relationship, they experienced and expressed spiritual needs. The spiritual needs were classified as self oriented needs, people centered needs and God centered needs.

The self oriented needs were identified as needs directed toward achieving peace with oneself. This involved a process of forgiving self, loving self and making peace within one self. People centered needs were classified as the need to establish and/or maintain a relationship with significant others. This step was characterized by making peace with others and searching for forgiveness from others. The third classification of needs was labeled the 'God centered needs'. The God centered spiritual needs were aiming at establishing and maintaining a relationship with God. This was characterized by searching for peace with God and receiving God's forgiveness.

The participants expressed their spiritual needs through communication with God and with others. They communicated through prayer, meditation, fasting, reading the Bible and other books, and

through participation in some spiritual rituals such as communion services and group fellowships.

The fourth theme that developed was labeled the spiritual care in nursing. This theme was built from the following concepts; (1) the definitions of spiritual care, (2) the principles of spiritual care. (3) The factors that influence spiritual care. (4) the nurses' role in spiritual care (5) the outcomes of spiritual care.

Spiritual care was defined as an act of assisting a person in establishing and/or, maintaining a dynamic relationship with God as understood by the person and with others. There were five principles identified as essential in spiritual care. These stated that spiritual care should be patient centered, it should be based on a trusting relationship, it should be driven by nurses' compassion for human suffering and pain, the nurse should demonstrate unconditional love for the patient and his or her family and lastly it should involve others including the patient, family and religious groups. The factors that were perceived to influence spiritual care were cited as the patient and the nurses' religious beliefs, cultural diversity, the patient's ability to express the spiritual needs and the nurse's ability to recognize the spiritual needs.

The nurses were perceived to be playing five major roles in spiritual care. The first role was the accompanying role whereby the nurse walked with the patient and the family to wherever they wanted to be. While accompanying the patient, the nurse was able to assess the patient and the family, facilitate the accomplishment of their goals and also coach them on their journey. The second role of a nurse was identified as the helping role whereby a nurse assisted the patient with whatever the patient needed. The patients needed emotional and physical comfort, encouragement and at times they needed other people. The nurse played a vital role in helping the patient. The third role was labeled the presencing role. When presencing the nurse was to be readily available for the patient, the nurse had to stay with the patient actively listening to the patient. The fourth role was the valuing role where a nurse demonstrated respect for the patient as an individual human being and acting on the basis of ubuntu. The fifth role was the role of being an intercessor for the patient. The nurse prayed for the patient and called the pastor or priest and also represented them in their absence.

The last concept which came from the theme of spiritual care in nursing was the spiritual care outcomes. Spiritual care outcomes were described as the perceived significance or end results of spiritual care interventions. The outcomes which were identified were the patient's ability to cope with life threatening events, accepting whatever state that one finds himself or herself in, finding inner peace, meaning and purpose for pain and suffering and also having hope that is not determined by the present circumstances.

CHAPTER FIVE: DISCUSSING THE RESULTS

5.1 Introduction

This chapter highlights the essential elements of the grounded theory of spiritual care in nursing. The research findings will be displayed in a theoretical scheme that has already been uncovered in the previous chapter. The researcher, interested in discovering the shared meaning of the phenomena of spirituality and spiritual care in nursing from the context of patients and nurses' in South Africa, analysed the concepts of spirituality and spiritual care in nursing in order to develop a substantive theory of spiritual care in nursing. In order to achieve the later, a basic social psychological process was identified.

According to Streubert and Carpenter (1995) the basic social psychological processes are core variables that illustrate social processes as they occur over a period of time regardless of varying conditions. The two authors further outlined six essential characteristics of a core variable. A core variable occurs frequently in the data. It links the various data together. It is central and therefore explains much of the variations in all the data. It has implications for a more general or formal theory. As it becomes more detailed the theory moves forward. Finally the core variable permits maximum variation and analysis (Streubert and Carpenter, 1995).

For this study a quest for a transcendent relationship was identified as an overriding basic psychological process in spiritual care as it stood central in all the interactions among nurses, patients and their significant others. There are five themes which have already been identified in the previous chapter. These themes have been cited as 1) the concept of spirituality 2) the spiritual trigger-response, 3) experiencing and perceiving spiritual needs, 4) the spiritual caring process and 5) the spiritual care outcomes. These themes form a basic foundation upon which the theory of spiritual care in nursing is built.

According to Chin and Jacobs (1983) a theory is defined as "a set of definitions, concepts and propositions that project a systematic view of the phenomena by designating specific interrelationships among concepts, for purposes of describing, explaining, predicting and

controlling phenomena.” Theories in general must have a goal or a purpose. This means that the theory is developed to meet specified goals. The second component is that theories have concepts which are often referred to as the building blocks of a theory. Concepts are complex mental formulations that are abstractions of objects, properties or events that are derived from people’s perceptual experiences (Chinn and Keamer, 1991).

The third component of a theory is that the concepts utilized should be clearly defined and should be explicated from the perceptions of those sharing their experiences and from literature. Fourthly, the theory should indicate the relationships between and among the concepts utilized in theory development. Linked to theoretical relationships is structural relationship which is the fifth component of a theory. Structural relationship refers to how the ideas are linked together as opposed to theoretical relationship which is concerned about how concepts are related. The sixth component says that the theory should have assumptions. Assumptions underline definitions, concepts and relationships. There are arguments whether the assumptions should come before a theory is developed or after. Chinn and Jacobs (1983) purport that assumptions may as well come at the end because they should develop from concept analysis.

The theory of spiritual care developed here meets the above criteria because its goals have been clearly stated, the concepts have been formulated, definitions given, relationships between concepts and ideas identified. This chapter will strengthen the relationship between concepts. This will be achieved by continued use of families of theoretical codes suggested by Wilson, 1985. Therefore, the researcher will display the theory by revisiting the 6 Cs of theoretical codes. These are the cause, the context, the contingencies, the covariance, the conditions and the consequences of the phenomena. To strengthen the theory, an extensive literature review will be conducted. In a grounded, theory literature review forms an essential part of the data (Wilson, 1985).

This chapter outlines the hypothesis developed through this grounded theory discovery and recommended for testing in future research. It also focuses on the relationship of the theory to existing nursing knowledge and the implications the theory has for further inquiry, nursing practice, and nursing education. (Cheniz and Swanson, 1985).

5.2 Describing the conceptual framework

This grounded theory research was directed at developing a theory, hence there was no attempt made in this study to give a theoretical framework. The theoretical framework was to be grounded in the data. Though no theory was utilized to collect data, the principles of symbolic interaction have been adhered with throughout the study. The meaning of the events was understood from the perspectives of the participants. How they defined their reality and how they act in relation to their beliefs were important considerations in data collection. The behavior of the participants was understood at the symbolic and behavioral levels. Secondly, meanings were derived through social interactions, hence the participants were interviewed and observed in their context (Chenitz and Swanson, 1985).

The conceptual framework that is going to be displayed in this study reflects on the premises of symbolic interaction. A conceptual framework is a structure comprised of concepts which are interrelated in one way or the other to form the whole. Often conceptual frame works are referred to as conceptual models or theoretical frameworks or models. Some authors use these concepts interchangeably. Generally, a conceptual framework implies that concepts are represented by words, whereas, conceptual model means that concepts are represented by objects, geometries, mathematical notations and words (Chinn and Jacobs, 1983).

Every profession develops a particular frame of reference which should guide professional practice. A commonly accepted conceptual framework unites the profession, explains its existence and acceptance in the society and implies its ideal goal for its service. Each profession explains the problem and hypothesizes the solutions in a way that reflects a specific orientation to the situation. Major discoveries or break through result from people's experiences and from the logical conclusions they come up with in regards to the new or different way of explaining a phenomenon. The result is that new knowledge is generated or added into the already existing epistemology. Sometimes new epistemology is upsetting and revolutionary and leads to discarding certain earlier explanations or practices. While the overall conceptual framework of the profession tends to unify its members, and to explain its service to the society, a specific framework held by

an individual member usually underlies the growth and the development of the professional knowledge.

The impact of a conceptual framework is felt in two major areas. The first of these is the essential knowledge of the profession. Knowledge is the basis of any learned profession. The conceptual framework around which the profession is developed suggests the appropriate areas for professional questioning, identity, the boundaries within which knowledge may be needed, and it clarifies the concepts upon which theories may be formulated. Research may then be done to build the body of knowledge about the professions appropriate concerns (Munhall, 1994).

A conceptual framework is the basis for professional practice. It is only when the professionals are free to practice, making judgement, choosing from alternatives, prioritizing amongst options, can they be appropriately described as practicing a profession. These activities require a clearly defined area of freedom to practice. The conceptual framework suggests which problems are appropriate for the professional to deal with and which are inappropriate and be referred to other professionals. Therefore the conceptual framework shapes practice and also influences the search for knowledge. The body of knowledge grows as the professionals turn their attention to unsolved problems and seek solution. A special body of knowledge develops as a result of answering questions differently from those others have asked, or from asking questions about different phenomena than others have studied. One profession may also use knowledge which another profession has discovered through its research, hence in this study a lot of theological language is utilized (Taylor, 1986).

A conceptual framework identifies the major concepts involved in a given body of knowledge. It serves as an important basis for theory development. Use of both inductive and deductive approaches clarify boundaries of the needed body of knowledge. A conceptual framework shapes daily professional practice because it reflects and influences the attitude of the professional and the client as well. The conceptual framework reflects values which guide in prioritizing professional actions. The practice of a profession takes place within relatively clear boundaries. Within these boundaries the professional is accountable to practice according to well established standards (Taylor, 1986).

The study of spirituality and spiritual care in nursing have added to the ontology and the epistemology of nursing and to be more exact to the holistic caring. A new paradigm has emerged and a call for paradigm shift is made. Often, matters of spirituality have been left for the clergy, yet while under the care of nurses, patients and their families expect nurses to intervene in their spiritual needs. Nursing therefore needs knowledge to base its actions within the context of holistic caring.

Knowledge comes from different sources and all these sources of knowledge are essential in realizing the truth about the reality. The following paragraphs will give an overview of the sources of knowledge in order to identify sources which have been utilized in developing this type of knowledge about spiritual care in nursing. Though these will be stated in a chronological order, it does not necessarily reflect on the importance of the source, rather on the importance of utilizing the source to build the profession (Munhall, 1994).

The first source is the revealed knowledge. The revealed knowledge comes from God. This accounts for the revelation of truth as found in the Bible or other inspired writings. In this study the inspired writings which were often referred to as valuable sources of knowledge by the participants were the Holy Bible, The Koran and other Hindu writings. The second source of knowledge is intuitive knowledge. Intuitive knowledge is knowledge within a person in the form of insight that becomes present in the person's subconsciousness as an idea or a thought produced by a long process of subconscious efforts. This method of discovery is nurtured through experience with the world. During data collection it became evident that nurses made the decisions about caring for the spiritual needs of patients and families based greatly on their intuition. Since there were no general guidelines as to how each nurse should provide spiritual care, nurses relied heavily on their intuition. Intuition is closely related to experience. The more experienced a nurse was, the better was the intuitive actions in spiritual caring.

The third form of knowledge is rational knowledge. Rational knowledge comes from exercise of reasoning and is exemplified by formal logic reasoning. The rational way of dealing with matters of spirituality noted from the participants was to leave this aspect of care to an individual's personal choices. Because of the diversity of religious belief systems and the sensitivity of the

topic of spirituality, participants' rational thought often made them to either ignore the topic of spirituality or dealt with it privately.

The fourth type of knowledge is empirical knowledge. Knowledge formed in accordance with observed facts. And is associated with scientific discovery of a theory that is grounded in the data as was done in this study. The fifth type of knowledge source is authoritative knowledge. Authoritative knowledge is knowledge that is accepted by faith because it is vouched by authorities in the field. This type of knowledge was not a prominent source for this study since no one claimed to be an expert in the field. The researcher and the participants had no authority to claim in the field of spirituality and spiritual care in nursing. The least attended to and the one holding much potential for nursing is intuitive knowledge. The repudiation of intuition as a source of knowledge was once one of the major themes when nursing moved towards establishing itself as a science. Intuition is considered unscientific, yet nurses greatly utilize this source of knowledge in their everyday practice particularly when a call for decision making is made (Taylor 1986).

Munhall (1994) further refers to five fundamental patterns of knowing which are considered to be the ways in which nursing identifies its epistemological interests. These patterns are explained by Munhall (1994) as the empirics, the aesthetics, the personal knowledge, the ethical knowledge and the "unknowing -knowing". The development of the theory of spiritual care in nursing has relied heavily on these patterns of knowing. The empirics refers to the science of nursing with its emphasis on the generation of a theory and of research that is systematic and controllable by factual evidence. Within this pattern of knowing there is a need for emphasis on knowledge about the empirical world. Knowledge that will be organized into general laws and theories, for the purpose of explaining describing phenomena of concern to nursing. Spiritual care has been of great concern to the nursing profession particularly over the past two decades. This theory therefore will add to the ontology and epistemology of nursing.

The esthetic pattern refers to the art of nursing. The emphasis is on expressiveness, subjective acquaintance, individual perceptions and empathy, rather than uniformity and general laws, there is a recognition of alternative modes of perceiving reality, which then clearly asks for a many

different ways in designing and practicing nursing care. Spiritual care in nursing is a call for a more artistic way of caring. The third pattern is personal knowledge. The emphasis here is on the importance of interpersonal processes and the therapeutic use of self, knowing self and knowing others and striving towards authentic personal relationships. A quest for a transcendent relationship appeals to the nurse's personal knowledge of herself as well as her patients. The fourth pattern is the ethics involved in the art of caring. In ethics, the emphasis is on matters of obligation, or what ought to be done. Knowledge within this domain requires understanding of ethical theories, conditions of society, conflicts between different value systems and ethical principles.

Though a quest for a transcendent relationship has been identified as a universal phenomenon, the diversity inherent in individual's beliefs and value systems requires understanding of ethical issues surrounding spiritual care. Munhall (1993) has suggested the fifth pattern of knowing which is referred to as the "Unknowing-Knowing". In contrast to "unknowing", "knowing" leads to a form of confidence that has a potential of a state of closure to alternatives and differences. Unknowing from an epistemological perspective is a condition of openness and seems essential to the understanding of inter-subjective perspectives. People tend to hear only what they want know. We can be limited by our own knowledge and our own belief systems. Often once we believe something or we think we know something, we cease further exploration and explanation. There has been an element of this type of "knowing-unknowing" in the area of spiritual care which has in one way or the other retarded the progress of generating the knowledge of spiritual care in nursing. All the above mentioned fundamental patterns of knowledge have and impact on the development of knowledge of spiritual caring in nursing, these patterns are interdependent. They are in no means mutually exclusive. There is intuition in the empirical world, our knowledge is grounded upon our ethical values and our philosophy about life.

5.3 A theoretical model of spiritual care in nursing

A theoretical model that emerged from this study is labeled "The spiritual care model". There has been a confusion in the definitions of a theory, conceptional model, conceptual framework, or paradigm. An in-depth study of theory shows that theories differ from conceptual models,

frameworks or paradigms. Theories consists of concepts organized in a systematic, logically connected manner to explain their relationship. Conceptual models, frameworks and paradigms serve as a link in theory development by being prototypes of a theory (Reihl-Sisca 1989). This is the reason that this researcher has decided to call this product a conceptual model.

Models are developed using related concepts which have not yet progressed towards theory. Models are therefore defined as structural designs consisting of organized and related concepts. Models are pictorial representations that show the simplified details of concepts considered relevant to measuring specific outcomes of a discipline. Models are developed to give some meaning to the relationships between concepts enabling the user to visualize diagrammatically how one concept logically or casually influences and connects with another (Fawcett, 1980). Statements expressing the relationships between concepts can be developed into propositions to be tested by research for truthfulness. These proportions are often referred to as conditional proportions because they state a particular conditions and a specific consequence. A conditional proposition contains the elements of an antecedent and a consequent (Reihl-Sisca, 1989).

5.3.1 The purpose of the spiritual care model

The spiritual care conceptual model is aimed at providing a guide for nurses on how to incorporate spiritual care in holistic caring. It will assist nurses in the process of planning, implementing and evaluating spiritual care for patients and families. This spiritual care model is also aimed at developing the ontology and the epistemology of nursing by adding spiritual care to the science of nursing. The model can be utilized in both clinical and class room settings to guide the practicing as well as the learning nurses.

5.3.2 Philosophical Base or basic assumptions of the Spiritual Care Model

Underlying all theoretical knowledge are the assumptions or philosophy about human beings and their relationship with their environment. The spiritual care conceptual model is based upon the following philosophical beliefs about a person, environment, health and spiritual health, illness and spiritual illness, nursing and spiritual care, and God.

5.3.2.1 Person

A person is an integrated whole consisting of physical, psycho-social, spiritual and moral aspects of the total being. A person or a human being is a valuable creature that is to reflect God's character of love to other fellow beings. A person is capable of making intelligent choices about his or her relationship with other human beings and with God. A person makes choices about his or her own health and how he or she can cope with life's threatening events such as pain, suffering and death. A person is also capable of establishing and maintaining a dynamic relationship with God as understood by the person and with one another.

5.3.2.2 God

God is the Supreme Being or power that is perceived by the person as the ultimate reality according to the individual's definition of ultimate reality. The people's perceptions about God vary and are relatively unique. They are influenced by family background, culture, religious affiliation and by a person's own way of perceiving phenomena. God is considered to be omnipotent, Omniscient and Omnipresent. Being omnipotent means that He is powerful, and is the Great of the Great (Unkulunkulu). Omniscient refers to God's unmeasurable wisdom or knowledge which includes the eschatological events and the destiny of this world and those who inhabit it. The concept of God as omnipresent refers to the acknowledgment of God as ever present and able to relate with humans in a continuous and meaningful way. God is perceived as the life giver and the sustainer of life. His plan for human beings is that they be fully restored to His original plan which is the life eternal, free of sorrows, pain suffering and death.

5.3.2.3 Environment

Environment refers to the context in which spiritual care occurs. It is the combination of external and internal factors which must interact within the individual. These factors are tangible and non-tangible realities which disturb the individual's spiritual integrity. The tangible or visual realities include the triggers of spiritual vulnerability such as illness, pain, physical and emotional suffering and death in this present world. The intangible variables include the ongoing controversy between

the spiritual engagement and disengagement, the evil and the good, the origin, destiny and the meaning of pain, suffering and death, the possibility of eternal life in a perfect environment and the possibility of eternal doom and judgement.

5.3.2.4 Health

Health is a state of positive well being which occurs in a continuum between relatively complete physical, emotional, social, spiritual and moral well-being in the upper level of the continuum and the pain, suffering and despair in the lowest level of the continuum. When the human beings strive to establish and, or, maintain a dynamic relationship with God and their fellow beings, the image of God is reflected in their lives and their health moves towards a positive upper pole of the continuum.

Spiritual health is also viewed as part of the total aspect of the person's health. On the highest level of the continuum of spiritual health is hope based upon the relationship of trust between the person and God. On the lowest level is "hopelessness" related to distrusting God. The degree of physical illness or even approaching death does not designate spiritual despair or spiritual illness. It may be at the point of severe physical illness or approaching death that the person's spiritual health is at its highest levels. The person's spiritual health depends upon the degree of the relationship between the person, significant others and God. The well established relationship helps a person to find meaning in human suffering and even in death. For such a person, every experience holds a new promise, every encounter carries new insights and every event brings new messages.

5.3.2.5 Illness

Illness is a disturbance in the person's total well-being causing a person to shift in the health continuum either upward or downwards depending on the individual's responses to what triggered illness. Illness may be physical, mental or spiritual in its origin and yet when it strikes, it affects the person as a whole. Though illness affects the person's total being, the physical, emotional and spiritual aspects are seldom at the same point of the health continuum at a given time. The lowest point of physical illness or even approaching death may be the highest spiritual level of the person. This is greatly influenced by the person's relationship with God, self and significant others.

Spiritual homeostasis

Comfortable zone

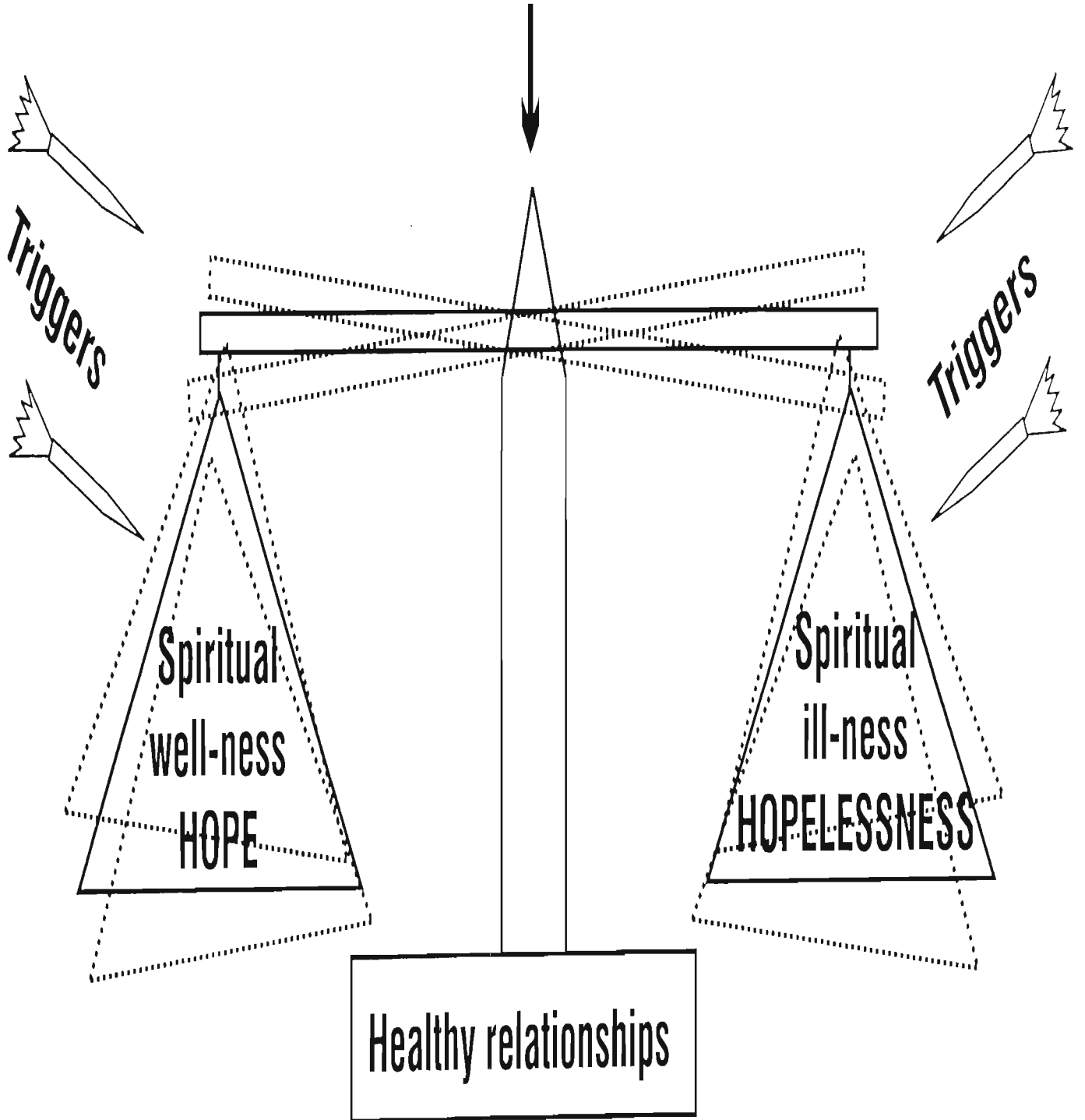


Figure 4 : Spiritual health / illness continuum

5.3.2.6 Nursing

Nursing is a scientific professional service that is based upon the principle of unconditional love towards other human beings, moved by compassion for human suffering and pain. It involves altruistic caring relationship between the nurse, the patients and their families in order to assist them to move towards the healthy point of the health continuum by promoting health and preventing illness at all levels. Nursing is aimed at improving the total well-being of the person by encouraging behaviors that will optimize the person's relationship with God, self and others.

5.3.2.7 Spiritual Caring

Spiritual caring is the scientific and deliberate art of caring that is aimed at assisting the person to develop and maintain a unique dynamic relationship with self, others and with God as understood by the person. Spiritual caring is embedded in the five major roles of a nurse which are the accompanying, helping, prencencing, valuing and intercessory roles. Spiritual caring is an integral part of total patient care which is inseparably interwoven in each and every nurse/patient encounter. Spiritual caring is based upon the belief that human being are capable of transcending above their present suffering and despair and that they are able to achieve hope in spite of suffering and even death because of their trusting relationship with God, self and others.

5.4 The concepts of the spiritual care model

The Spiritual Care Model has been developed through the use of a grounded theory method of inquiry. The major concepts that have emerged from data analysis include the concept of spirituality, the characteristics of spirituality, the consequences of spirituality, inner peace, hope finding meaning and purpose, religious belief, faith, trust and forgiveness.

5.4.1 The concept of spirituality

The concept of spirituality and its patterns reflects a phase of spiritual equilibrium or a comfortable zone in which the person's relationship with God and with the significant others

seemed to be in balance. The person has no reason to question this relationship because everything seems to be fitting well in its right place, there are no threats to one's spiritual integrity.

Spirituality in this model is defined as an individual quest for a transcendent relationship by establishing and or maintaining a dynamic relationship with God as understood by the person and with significant others. The concepts that were identified as antecedents to spirituality included religious beliefs, faith and trust. Religious belief, faith and trust are concepts which are often used interchangeable, but in this study a difference between them will be made. Religious belief refers to an acceptable idea that is recognized as true and is also put on to practice and it becomes part of the person's philosophy of life. Linked to religious beliefs is a concept of faith. Faith comes from the Greek word "Pistis" which incorporates belief as well as trust in its meaning. In our modern language, belief refers to a mere mental assent or an acknowledgment of facts and faith has also been used to refer to a belief in something for which there is insufficient evidence (Steed, 2000).

For Christians, the classic definition of faith comes from the Bible, Hebrews 11: 1 "Now faith is the substance of things hoped for, the evidence of things not seen". Faith is build upon evidence. It is not "leap in the dark" as some people believe (Maxwell, 1977). It does not even mean that the person who has faith gets precisely what he or she requires, but it does mean genuine trusting and confidence in one who is more powerful and wise in understanding what is best for each person. As Steed (2000) says "faith is the hand that lays hold of the boundless resources of omnipotence. Faith as trust is therefore not of any value if it is not anchored in the one who is trustworthy". Faith as trust includes complete commitment to a relationships with God irrespective of extrinsic rewards. It is being confident of and content with whatever state one finds himself or herself because of the trustworthiness of God.

The concepts of religious belief, faith and trust are identified as antecedents or conditions of establishing and, or, maintaining a transcendent relationship with God, self and others. Without these concepts in their right places, it will be impossible to establish and maintain a dynamic relationship with God and with others. Belief, faith and trust are based on a personal experience of God's love in a world filled with pain and suffering. One may not always be able to give a

rationale for pain, suffering and death, but trusting in God makes it easy to say “one day He will make plain those things that may not be fully understood today” as one participant said. Faith, belief and trust are always prerequisites for a transcendent relationship. Pierson (1974) said “we may with certainty trust Him where we cannot always trace Him” The exercise of faith is like that of a muscle it grows stronger with use. The more faith is exercised, the stronger it becomes (Knowles:1990).

5.4.2 Characteristics of Spirituality

Spirituality as a quest for establishing and or maintaining a transcendent relationship is characterized by the following important variables.

1. Spirituality is based upon the value of a person as a human being with human dignity that is derived from the link that human beings have with God and with one another. This may be termed a relational, value meaning that human value is based upon both horizontal and vertical relationships.
2. Spirituality is a unique human experience. Strange though it may be, the uniqueness of every being exceeds the commonalities among all humans. There is so much in common and yet so much unique. Every being has a different spiritual experience and thus a unique relationship with God and with others. The uniqueness of each person’s spirituality gives that individual his or her own identity. The person’s identity refers to the person’s unique being different from other beings. Identity includes one’s total being. Identity also involves one’s ownership. Who owns a person is reflected by his or her identity. The allegiance of a person goes to the one who is thought to be in charge or the one who owns that person. When a person recognizes God as his or her creator, then his or her allegiances go to God. He or she tries to identify with Him. This is one aspect that is often neglected by some people until a trigger comes in, and they begin to search for their true identity.
3. Spirituality is universal. The universality of spirituality stems from the fact that every human being is a spiritual being. Some people acknowledge their spiritual nature, while other people do

not. The fact that some people do not acknowledge their spiritual nature does not make them non-spiritual. Spirituality remains universal whether people universally recognize that or not.

4. Spirituality is dynamic. The dynamic spirituality refers to the power of a person has within himself or herself to grow and increase a relationship with God and with others. As mentioned in the previous chapter, spirituality grows and changes a person's experiences and perceptions of people, situations and even of his or her perception of God and himself or herself.

5.4.3 The consequences of spirituality

Consequences refer to the events or outcomes that occur as a result of the phenomena. These consequences will be analyzed in relation to the conditions or antecedents mentioned above. The consequences identified were hope, inner peace, finding meaning and purpose in life, pain and suffering and in death. Hope is the concept widely investigated in the field of health and health related disciplines. Hope is one of the most valuable spiritual resource. Hope is the consequence of a trusting relationship with God and significant others. Hope is sometimes defined as an anticipation of success with a feeling of uncertainty. Real hope goes beyond anticipated success to include hope when success is almost deemed impossible. (Miller, 1990).

One of the human being's most valued private and powerful resources is hope and trust (Carson, 1989). Hope is the concept that accompanies faith or belief. The basis of hope is faith. Hope is the negation of the worst possible outcome, an expectation greater than zero of achieving a goal. Everything humans do in life is based on some level of hope of which there are three levels of hope. The most elementary type is the superficial type which is based upon achieving simple things like a good day. When this level of hope is not actualized, little despair occurs and little psychic energy is spent (Miller, 1990).

The second level is hoping for relationships, self improvement and self accomplishments. When hope at this level is thwarted, the resultant level of despair is characterized by anxiety. The anxiety is relieved with new goal establishments. Psychic energy investment is greater than that spent at the first level. The third level of hope arises out of suffering personal trials or a state of captivity.

Deep despair or giving up occurs when according to the individual's evaluation, relief is not eminent. Total engulfment of psychic energy occurs at this point. It is in this situation tempered by despair that hope has its true meaning.

Maintaining hope despite a downward physical course is a challenge of **both** acute and chronic ill patients their families and nurses. Hope may be based upon God's promises and the assurance of His omnipresence. Regardless of the circumstances, this type of hope abides (Pereyra, 1993). Hope is an essential ingredient of human life. Pereyra (1993) refers to hope as a "magnificent rainbow after a devastating deluge". He further identifies six principles of what he calls the Biblical concept of hope. He says; (1) Hope is constantly longing for something to happen. (2) Hope means one has a future. (3) Hope identifies with trust, therefore, it is based on a trusting relationship. (4) The main object of hope is God. (5) Hope endures suffering, it gives perseverance and willingness to bear everything. (6) Hope makes a person to be open to change, even in desperate situations.

Individuals who have used religions beliefs and practices as coping mechanisms throughout their lives easily turn to God for hope when the uncontrollable nature of long term illness precipitates hopelessness. Trust is hope in a relationship. The **greatest of all bonds**, the one that provides the most hope is the bond with God. When individuals think poorly about themselves, they may feel unworthy of renewing their relationship with God. Hope is the radical refusal to set limits. When all in life looks grim-that is when what is happening is beyond the individual's influence, hopelessness is prevented by turning to God.

5.4.3.1 Inner peace

Arriving at inner peace with the human experience is the ultimate result of turning over the despair to God. Inner peace is one concept which is a clear consequence of a dynamic relationship with God. The Oxford English dictionary defines peace as a quiet tranquility, a mental calmness or serenity (Fowler and Fowler, 1990). This kind of peace does not come naturally, it only comes as a result of God's direct intervention in the affairs of humanity (Ammenta, 1997). This kind of peace originates from the author of peace and from one whose very nature is peace. It is peace

in the midst of the storms of life. Peace in pain and peace in death. The peace of God can calm the patient even during death. Nurses often refer to a peaceful death. This peace that God Himself offers. "Peace I leave with you, my peace I give unto you ; not as the world gives... let not your hearts be troubled, neither let it be afraid" (John 14:27).

A person who has faith in God will have hope and peace in spite of approaching death because of the confidence a person has in God. The person will also demonstrate a calm, relaxed state in whatever situation one finds himself or herself. Hope and peace go hand in hand with a sense of meaning and purpose for life.

5.4.3.2 Finding meaning and purpose in life, illness and in death

Finding meaning and purpose in life, illness and in death refers to a person's ability to make sense of his or her circumstances, to find a reason for living and even dying. An essential factor in finding meaning is the hope a person has. Hope gives courage and affirms meaning in whatever suffering a person is faced with. Finding meaning is another important variable that ties up with hope and peace. It is based upon a trusting relationship. Knowing that the one who is in control has the power to relieve suffering and the wisdom to know when suffering works for good. Those who trust in God find meaning in this text; "And we know that in all things God works for good to those who love him, who have been called according to his purpose" (Romans 8:28).

This means those who trust in God's unfailing love find meaning in all situation because of their faith in God. When a person finds meaning and purpose in life, illness and in death, that person remains calm and peaceful in whatever situation one is faced with. In the absence of a trusting relationship, meaning cannot be experienced. Without a trusting relationship with God, a state of meaninglessness exists. Finding meaning and purpose in life, and in suffering is an important variable in helping a person to cope with life's crises of illness, suffering and death.

5.5 The Spiritual Trigger Response

The second phase is a phase of disequilibrium. The Spiritual integrity is threatened. This concept is called the "trigger-response phase" the patterns which have emerged in this concept are (1) the

triggers (2) the responses. The spiritual triggers consists of factors or situations which disturb the spiritual equilibrium of an individual provoking a person to respond in one way or the other. The triggers identified in this model are called the physical, and the psycho-social life events that cause crises to a person or family member or members leading to a threat to one's spiritual integrity. Illness, pain, suffering and death were identified as the common spiritual triggers.

The response refer to the person's reactions to the presence of a trigger. When a person's spiritual integrity is threatened, a person is bound to respond. The responses vary from the grieving process characterized by fear, guilt, anger, shock, denial and bargaining to the level of coming to terms with what is going on in life, and going beyond the material realms. At this stage a person makes an active effort to find God and make peace with God and with others. The concepts that have developed from this pattern are :- grieving process, coming to terms, going beyond.

5.5.1 Grieving

Grieving consists of a number of interdependent components which include psychological, physical, social and spiritual reaction to a perceived spiritual trigger. Grief is a normal attempt of the whole person to bring life back into focus after a disturbed spiritual integrity. It is a healthy effort to regain spiritual equilibrium after a trigger has thrown a person off balance. Grief is a way of finding meaning after meaning has been shattered. Grief is not a pathological problem on its own unless it is left unattended. (Yeagley, 1984) There are no distinct lines of demarcation between the five stages of grief noted as spiritual responses to the triggers. The common emotions inherent in the grieving process have a spiritual component and a spiritual bearing.

5.5.1.1 Spiritual Fear

Spiritual fear is a response characterized by feeling of dread, or impending doom for one's self or loved ones based on a specific life threatening event. Spiritual fear is directed towards a disturbed relationship with God, significant others, self and in relation to one's future. Fear is expressed through anxiety and worry over God who is displeased about one's life. God is perceived as full of anger, ready to punish. Fear is accompanied by increased feeling of

inadequacy and a sense of worthlessness, helplessness, powerlessness and hopelessness. The uncertainty about future increases fear and feelings of being rejected by God and the significant others.

5.5.1.2 Spiritual Anger

Spiritual anger refers to feelings about the injustice of a situation directed at God. A person experiencing spiritual anger blames God, others or himself or herself about the undesirable situations. They may have out rage towards a transcendent source and also demonstrating negative criticism of institutionalized religion or those who represent it. Spiritual anger may progress into spiritual despair if a person continues to experience feelings that his or her hope to establish or maintain a transcendent relationship is no longer possible. Spiritual anger is accompanied by a feeling that life makes no sense and that it is not possible to make sense out of it or to find meaning and purpose in life (Labum, 1989).

5.5.1.3 Spiritual Guilt

Spiritual guilt is an expression of regret about the kind of life one has lived. An expression of feelings that suggest that one has failed to live up to an idealized value system. There is a wide discrepancy between "I" as perceived and "I" as lived. A person becomes overly concerned about his or her lifestyle and the values it has expressed. A guilty person condemns himself or herself. Guilt adds to the person's fears and increases anger towards self, or others and God. Guilt also contributes to a feeling of spiritual alienation whereby a person excludes himself or herself from a transcendent relationship because of feelings of being unworthy. Unrecognized and unattended guilt can be very destructive in relationships. Guilt may increase feelings of hopelessness and thus delay recovery or peaceful death.

5.5.1.4 Spiritual Bargaining

Spiritual bargaining refers to questioning God about the reason for allowing the crises to happen. During bargaining, God's power and ability to overrule in any situation is put on trial. A person

expresses bargaining by questions like why me? Why now? Where were you God? Are you still in control? Are you really what you claim to be ? These questions are an expression of disappointment and a temporary uncertainty about a transcendent relationship and about one's future. Bargaining result in an individual answering his or her own questions, when a person gives answers to his or her own questions, his or her relationship with God and others may either be strengthened or weakened. Bargaining can increase guilt, anger and fear. On the other hand if a person has got some spiritual resources such as faith, trust and hope to draw from, his or her relationship with God and others may be strengthened.

5.5.1.5 Spiritual Denial and Shock

Spiritual denial and shock are characterized by feelings of emptiness, confusion, disbelief and a sense of being eluded. In a state of denial a person cannot even approach God or others for help because he or she does not perceive a need for God's or others' intervention. If prolonged denial and shock may delay therapeutic progress to acceptance. When a person remains in a denial or shock state, it becomes difficult to intervene appropriately.

5.5.1.6 Spiritual Dependency

Dependency as a spiritual response to life threatening events refers to feelings of powerlessness and hopelessness to do anything for one's self including establishing a transcendent relationship with God. A person becomes dependent upon others to fulfil his or her spiritual needs. The closest person that patients often become dependent upon are nurses. At the point of dependency a nurse is perceived as capable of meeting the spiritual, physical, emotional and social needs of patients, while the patient perceive himself or herself as the vulnerable individual.

5.5.2 Coming to Terms

Coming to terms is a gradual realization that the unpleasant experience that the person is going through is real and that the person realizes that he or she cannot cope with the life threatening events without help from God or from others. Coming to terms is a phase characterized by

acceptance of illness or death as part of life. The person begins what is called peace process, whereby the person searches for forgiveness from self, others and from God. The major steps of the "coming to terms" phase are: acceptance, finding meaning and purpose in illness, pain and in death, peace making process and search for, forgiveness from self others and from God. When a person reaches the acceptance, he or she begins to accept that he or she is human and mortal, then he or she accepts the diagnosis, prognosis and the ultimate reality of death. The person finds meaning and purpose in suffering.

5.5.2.1 Forgiveness

Forgiveness is an integral part of acceptance and peace - making process. It is a form of realization. It does not deny, minimize or justify what others have done to us, and the pain that we have suffered because of what happened to us, or what we did to others. Forgiveness is an internal process that encourages a person to objectively look at the old wounds or scars to perceive them as they are and to bring inner healing in spite of the scars. Forgiving is dealing with the reality of the past and not suppressing it. The process of forgiving begins with one's self as Ross, 1998 say "we can find inner peace only when we realize that we must change ourselves rather than the people who have hurt us". Forgiveness brings inner peace. When a person forgives himself or herself, then that person will be able to accept forgiveness from others and from God or will also be able to forgive others.

Forgiveness is viewed in this conceptual model as a sign of a positive self esteem. When a person accepts forgiveness from God and from others, that person no longer identifies himself or herself by the past injuries and injustices. Forgiveness is letting go of the past though it does not erase what happened, but it does allow a person to reduce and finally eliminate the pain from the past experiences. The pain in the past no longer dictates how a person lives in the present, neither would it determine the future. Forgiveness is no longer wanting to punish those who hurt us and it is no longer fear of being punished because of what we did to others or to our selves. It is simple let go of the past and moving on with the present and facing future with courage.

Forgiveness is not forgetting. Often in our daily language we hear “forgive and forget.” At times this is repeatedly said from the church pulpits making those who have not forgotten their past hurts to feel guilty and on the other hand increasing their feelings of hopelessness. However, this is neither realist nor helpful. Forgive and forget simple increases a sense of guilt over the past because forgetting is impractical and unrealistic for a normal intelligent person. Ross (1998) says “It would be nice to be able to turn back the clock and erase the unpleasantness of our past. The real trick is not to forget the past, but to learn from the past and try use it to help ourselves and others in the present”.

Forgiveness is not condoning the unacceptable behavior. It does not minimize the past hurts but it does minimize the effects of that painful past on the present and future. Forgiveness is not a form of self-sacrifice. It is not pretending that everything is alright while a person is hurting. It is better to deal with inability to forgive than to pretend to have forgiven. Forgiveness is not a sign of weakness. This statement means that forgiving does not come because one has no other ways of dealing with the situation, but it comes when a person realizes that he or she does not need anger and hatred to protect himself or herself. Forgiveness does not come out of weakness towards the perpetrator but out of strength. Forgiveness is not a once for -all decision. It cannot be forced, it takes time and can only come from the inner part of the person who recognizes a need to forgive and to be forgiven.

Forgiveness is the core of any relationship. A healthy relationship is based upon the ability to forgive. The willingness of God to forgive lies at the foundation of a renewed relationship with Him. On the other hand the humans’ forgiving one another strengthens their relationship with one another and with God and it gives inner peace to the one who forgives. Ideally, our forgiveness should be inexhaustible.

Forgiveness is an essential component of coming to terms. It is also a spiritual need. When people are sick a need for forgiveness or to forgive others comes naturally and spontaneously. “Coming to terms with the reality of life leads to searching for a transcendent relationship, and going beyond the material realm.

5.5.3 Going beyond

Going beyond is the process that comes when the person has come to terms with the reality of life and has understood the fate of being human and the reality of pain and suffering inherent in humanness. It involves an active search for establishing a more meaningful and a deeper relationship with God, self and with other. During this phase a person experiences what is referred to as “a spiritual hunger or spiritual need”. Spiritual hunger is a human longing for spiritual fulfillment in a dynamic and unique relationship with God and with others. It is a quest for a transcendent relationship. A person finds ways of reaching out to God and to other fellow humans to fulfill his or her spirituality. This reaching out for spiritual fulfillment may be self oriented, people centered, and/ or God centered. When the spiritual hunger is God oriented, the person spends more time in communicating with God through prayer, meditation, reading scripture, repentance, confession, religious rituals and other forms of worshiping.

The people oriented person will cling to people, wanting their presence and company. Going beyond is a phase that is characterized by searching for a horizontal as well as vertical relationships. At the phase of being people oriented, the patient is mainly calling for help specifically from a nurse. It is at this point that the nurses’ sensitivity to the needs of patients is realized. The person finds inner peace, love and forgiveness in his or her relationships.

Sometimes when the patients move beyond they become self oriented. They want to be alone, quietly enjoying music, nature or a peaceful environment. They structure their lives and their environment to give them the situation which allows for their quest for a deeper understanding of life, death and themselves. This may involve talking to others, reading and meditation. Some enjoy to be taken out of the ward to view nature outside. When nurses are able to realize these needs, then a caring process will be started.

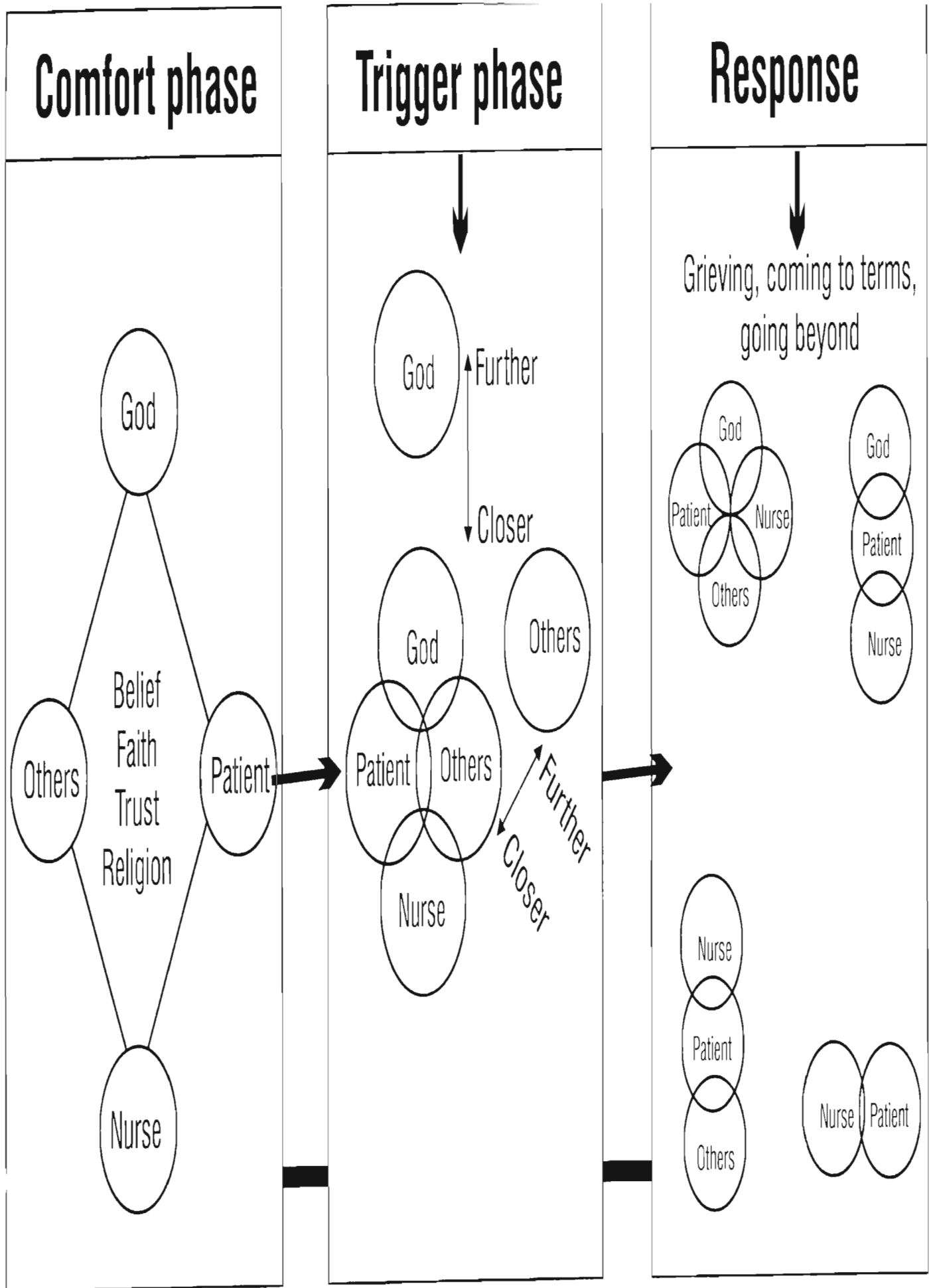


Figure 5 : Phases of Spiritual Experience

5.6 The Spiritual Caring Roles

5.6.1 Definition of spiritual caring roles

The spiritual caring roles refer to the interrelated nursing activities which are directed towards assisting a patient and his or her family in establishing and maintaining both the horizontal and vertical relationships with self, others and with God. Spiritual care roles are part of total patient care that is completely integrated in every nurse/patient encounter. These roles are fulfilled through accompanying, presencing, helping, valuing and interceding on the patient's behalf. Spiritual caring roles involve assisting a person to establish and maintain a unique, dynamic relationship with self, others or God as understood by the person.

5.6.2 Principles of Spiritual Care

1. Spiritual Care should be directed at the unique spiritual expression of the client and a nurse. Spiritual caring means that the nursing activities are directed towards meeting the patient's unique spiritual experiences by matching them with the unique spiritual expressions of the nurse. Because of the particularity inherent in spiritual experiences, nurses ought to give spiritual care that is directed towards the particular person's spiritual hunger. This type of care is based upon a trusting relationship between a nurse and a patient, which is built on compassion of the nurse and acceptance of the patient as a unique being. Meeting the unique spiritual expressions of the patient will take into consideration the patient's culture, religious beliefs, nationality, racial background and age. When the unique spiritual expressions of the patient are acknowledged and attended to, the patient, the family and the significant others will begin to move towards a more positive pole of the spiritual health continuum.

2. Spiritual Care is embedded in the unique roles of accompanying, helping, presencing, valuing and interceding which are driven by compassion for human suffering and pain. The care that is driven by compassion is characterized by sympathy, empathy, unconditional love and sensitivity to human pain and suffering. Sympathy expresses sorrow for the other person. In short sympathy

says, “I feel sorry for you”, on the other hand empathy gets inside the feelings and shows that the feelings are acceptable and understandable as real and that there is a way out of them. Empathy identifies with the feelings of the other and accepts them as real and accepts the person as genuine in the process. Empathy communicates acceptance of feelings while sympathy communicates recognition of feelings (Buchanan, 1985).

Compassion is a concept broader than both sympathy and empathy combined. It involves suffering with the person. Compassion says “I’m sorry, I recognize your feelings, I understand them, I accept them as real, I can identify with them and I will do something to help you feel better” (Folkenberg, 1998). A compassionate nurse walks a second mile to find whatever will make the patient feel better. Compassion is a concept closely related to unconditional love. Expressing compassion is a way of expressing unconditional love and acceptance of a person as a unique being.

Unconditional love can only be equated to God’s love for humans. This type of love knows no boundaries, it reaches out to all creatures great and small. It is not limited by race, culture, creed or nation. Unconditional love is the very nature of God. It embraces every duty we have to God and to those around us. If humans love God and other fellow humans, they will do nothing that will harm or hurt others. The human being’s natural tendency is to love on condition that a person meets certain human criteria for deserving love irrespective of the obligations incumbent upon them in relation to God and other fellow human beings. When patient care is based upon the principle of compassion and unconditional love, patients will sense this love and they will feel acceptable and loved. The love they experience will flow from the nurses to patients and their families.

3. Spiritual Care should be a communal activity. Communal involvement is the core of traditional African thinking about relationships between and among people. Communal refers to community involvement and participation in one another’s affairs. The nurse, patient, family, significant others and the community at large should be involved in providing spiritual care. This communal involvement is inherent in the principle of “ubuntu” which is the premise of communal involvement. African proverb says “umntu ngumntu ngabantu” which means a person is a person

because of others or “I am because we are and we are because you are”. This identifies a person with the community and on the other hand identifies the community with the people. Though the concept of “ubuntu” is an African terminology which cannot be easily translated to the Western language, its principles can be utilized in every community including the Western and the Eastern nations. With the increased AIDS epidemics and the need for community involvement in the care of patients and families, the principle of ‘Ubuntu’ will bring the solution to the crisis of home based care which has now become a trend in patient care. The capacity of care is every community member’s responsibility.

Based upon the principle of “ubuntu” spiritual care should include all interested parties. That is the patient, his or her own family and the significant others. Human beings are also social beings, therefore their spirituality cannot and should not be separated from their social life. Ubuntu recognizes this social aspect of being human, and puts an emphasis on the role played by other human beings in the development of a person as a whole.

5.6.3 Factors influencing spiritual care

Spiritual care is greatly influenced by the nurse and the patient’s religious beliefs, cultural diversity, the patient’s ability to express the spiritual needs and the nurse’s ability to recognize the needs and be able to intervene appropriately.

5.6.3.1 The influence of religious beliefs

Religious beliefs refer to what the person believes and to the way the person expresses his or her beliefs as expressed in a organized and recognized system. When a person’s belief is founded upon a credible authority and a trustworthy being, then a person will be able to find security in that being during the times of uncertainties of life. Religious beliefs are therefore springs that both nurses and patients can draw from to quench the spiritual thirst. It becomes important therefore for nurses to understand the patient’s religious beliefs in order to intervene appropriately. Religious beliefs provide a person with an interpretation of the situation. What illness and death means to people depend upon what they learn from their religious beliefs. If the person’s religious

belief gives an impression that illness and death are a punishment from God, then anger directed to God will be prolonged and the nurse will have to work with the patient to help him or her understand the God of love.

5.6.3.2 The influence of cultural diversity on spiritual care

Cultural diversity refers to the differences in the way of life, it includes differences in norms and values, in customs and traditional practices, in the way of worshipping God and in ways of relating to God as the Supreme being and in ways of relating to other human beings. How people relate to one another tends to influence how they relate to God. Cultural beliefs and practices tend to influence the person's expression of spirituality and therefore the delivery of spiritual care. Often the nurse and the patient may be from different cultural backgrounds and in that situation the patient's spiritual needs may not be understood and therefore not fulfilled. It is therefore very vital for a nurse to understand different cultures and to understand how patients express their spirituality within their cultural context.

5.6.3.3 Recognizing spiritual needs

The nurses' ability to recognize spiritual needs is also influenced by the nurses' exposure to different cultures, religious beliefs and to his or her own professional spiritual health. The ability to recognize spiritual expressions and to be able to give spiritual assistance also depends upon the nurses' level of spiritual education, intuitive abilities and personal experience with patients. The more experienced nurses were, the more they were able to recognize spiritual needs and there more they were able to provide spiritual intervention. Providing spiritual care was also influenced by the nurses' sensitivity to patient needs and by her compassionate nature. Sensitivity to patient's needs and compassion for human suffering and pain are skills that nurses need to learn. These skills do not come naturally, they are to be learned.

5.7 Nurse's Spiritual Care Roles

These are five major roles of a nurse that have been identified in this theoretical framework of spiritual caring. These roles are interrelated, and mutually inclusive. The activities directed towards meeting these roles may also be similar. These roles are cited as (1) Accompanying role, (2) Helping role, (3) Presencing role, (4) Valuing role, (5) Intercessory role.

5.7.1 The accompanying role of a nurse

The accompanying role of a nurse is the ability of a nurse to identify the spiritual needs of a patient and assess the patient's readiness for intervention and to walk with the patient from where the patient is to where the patient wants to be. Patients need company as they walk through the rough roads of life, pain, suffering and death. Walking with the patient gives an opportunity for a nurse to assess other spiritual needs of the patient. While walking with the patient the nurse also acts as a facilitator of patient's quests for bonding with the transcendent. While accompanying the patient, the nurse also gives guidance to the patient and his or her family. The nurse acts as a mentor for the patient and the family and also remembering that the nurse would not lead them faster than they would follow. When the nurse accompanies a patient, he or she walks with the patient where the patient leads not where the nurse wants to be.

When accompanying the patient and family, the nurse also educates and gives support to both the patient and his or her family. The company that a nurse give to the patient relieve spiritual fears and anxieties associated with illness and death. It is therefore hypothesized that accompanying a patient in the rough road of illness and death may increase his or her sense of self worth. The patient begins to perceive himself or herself as valuable. The principle of communal responsibility is clearly revealed in the accompanying role of a nurse. A person is a person because of others. Therefore others are needed throughout the life cycle.

5.7.2 The Helping Role of a Nurse

The helping role of a nurse refers to the nurse's ability to give whatever assistance the patient and his or her family needs. The nurse may not always be able to give the help needed per se, but she or he may find another person to provide that particular need. The forms of help mentioned as part of the helping role of a nurse include giving comfort, encouraging, reassuring, advocating for the patient and family collaborating and referring appropriately.

5.7.3 Presencing Role of a Nurse

The presencing role of a nurse refers to the nurse's ability to be readily available to the patient and his or her family by being physically present by the patient's bedside. Being with the patient and his or her own family in their pain and suffering and in death is an indispensable role of a nurse. Presencing involves being physically and emotionally with the patient and his or her family. Just being there next to the patient's bed is one way of expressing one's compassion for human pain and suffering. While being there, the nurse is engaged in active listening to whatever the patient or family want to say. Active listening involves being every perceptive of statements that the patient, family make, listening with sensitivity and listening between the lines in order to catch and note the patient and the family's concerns

5.7.4 The valuing role of a nurse

The value is the worth assigned to something or someone, therefore, the valuing role of a nurse refers to the nurse's ability to care for the patient as a unique and a precious being bearing human dignity (Taylor, 1986). The link with God in every human being is what determines human value. When valuing a person, a nurse will accept the patient and respect the person as a human being. A nurse gives value to the patient and respect his or her dignity including the patient's choices of relationships, life style, beliefs and values.

When a nurse cares for the patient as a valuable being, that increases a patient's sense of self worth and the ability to cope with illness and with death. Valuing a patient maximizes patient's

control and reduces nurses' control over the situation. The patient become in charge of his or her own illness and prognoses. Valuing the patient is recognizing a patient as a person and in terms of "Ubuntu". Umuntu is the concept unique to the African languages it reflects the communal responsibility of one person to another. "Umuntu ngu mntu ngabantu" (I am because you are, you are because we are) "Ubuntu" is expressed in human relationships through expressions of love and compassion for one another (Flale, 1999).

5.7.4.1 Love and Compassion as expressions of human value

These two concepts are so closely linked that none would exist without the other. A loving person is a compassionate person and visa-versa.. Love compels a person to do something for the other without expecting a reward in return. This is referred to as the unconditional love. The concept of compassion comes from the Latin word which means "to suffer with". Compassion challenges a nurse to go where it hurts, to enter where there is pain, to share brokenness, fear and anguish, to cry with those in misery, to mourn with those who mourn, to identify with the weak, the vulnerable and the powerless. This form of compassion is more than being kind and respectful.

Compassion is not a spontaneous natural feeling. It requires a genuine conversion of the mind and a conscious effort on the part of the nurse. What comes natural to humans is to have love and compassion to those we think they are deserving our love and compassion. This type of compassion is not compassion at all. If we love the lovable and give compassion to the deserving, we are simply rewarding those for their "good" behavior.

Folkenberg,(1995) states that "we often prefer to be selective with our compassion. We have compassion for people with AIDS- as long as they got the disease from blood transfusion. We have compassion for people whose houses burn down as long as they did not start the fire by smoking in bed. We have compassion for people who've lost their jobs - as long as it wasn't their fault". He concludes by saying "we need a personal relationship with God to understand and practice compassion."The compassion God gives can so fill our lives that it will spill over to all around us" (Folkenberg, 1995). Compassion goes beyond sympathy, to include empathy,

sensitivity to human; suffering, non-condemning love, willingness to walk as a second mile and accepting and giving one's self.

5.7.5 The Intercessory Role of a nurse

The intercessory role of a nurse refers to the nurse's ability to plead with God on behalf of her patients and their families. Moved by compassion for human suffering and pain, nurses often communicate their concerns and their petitions for patients and families to God. Nurses intercede for patients and families through intercessory prayers, through giving and nurturing faith and hope. Sometimes, when the need arise, nurses act as representatives of religious priests and pastors in their absence.

5.7.5.1 The intercessory prayer

Prayer is communicating with God openly expressing one's feelings as one would do to a very close friend. Prayer is an expression of trust. When a person prays sincerely, that person has confidence that what he or she says to God will be treated as confidential, and an answer will be given. Patients and families believe in prayer and prayer seems to have a calming effect on their anxieties and fears. Sometimes patients and families ask a nurse to pray for them. If the nurse knows how to pray. She or he would not have a problem. If she or she does not know, then a trusting relationship between them may be hampered.

Intercessory prayers originate from the Bible. Abraham bargained with God on behalf of Sodom and Gomorrah's wicked people (Genesis 18: 16-19). Moses pleaded with God on behalf of the rebellious nations of Israel (Exodus, 32:31). Daniel and Paul also pleaded with God on behalf of sinful nations (Daniel 9:18), Romans 9:1-4). Intercessory prayers are still used today. Parents pray for their children, family members pray for one another, friends also pray for one another, people pray for one another and also pray for their nation. People pray for whatever is of concern to them. If so, then patient and their families are of great concern to the nurses. They need intercessory prayers.

5.7.5.2 Nurturing Hope and Trust

Nurturing hope and faith are essential elements of intercession. Nurses give hope and faith in various ways. They may just stay with the patient and simply listen to what the patient says. Being there next to the patient's bedside and listening. Sometimes the nurse reads the encouraging statement from any book available to him or her. The nurse should make a conscious effort to communicate hope and faith to the patients and their families. Hope says there is a way out of pain and suffering, there is someone who understands the pain. Hope communicates the feelings of being secured in spite of uncertainties. Hope may utilize past encounter with life crises to bring positive future. How one coped with previous crises may be an encouragement that the present situation will also be overcome in similar manner. Hope is also based upon a trusting relationship with God. When a person trusts God even when the person is faced with death, that person will never lose hope in trusting in God, because God is in control of the past, present and future.

5.8 The spiritual Care Outcomes

Patient and families who receive spiritual care, demonstrate the following results. These results are referred to as "Spiritual Care Outcomes. Spiritual care outcomes are defined as the end results or the significance of spiritual care. Establishing and maintaining a dynamic personal relationship with God helps people to cope with pain of illness, suffering and death. When a person is closely connected with God, the attributes of God are reflected in that person. God is the prince of peace, so those connected with Him have peace.

Hope is another important outcome of spiritual care. Hope transcends the possible disappointments because of securing that is found in God who is the source of hope. Hope that is based upon the fulfilment of certain expectations according to one's defined timetable often subjects an individual to despair when his or her deadlines are not met. The healthy hope is based upon God's wisdom in dealing with whatever situation one finds himself or herself. This type of hope transcends imaginations and goes beyond circumstances (Miller, 1990). This type of hope prevents patients, families and even nurses from clinging to what they have. It frees them to move

away from what they think is the safe place and to enter into the unknown and the fearful territory of death (Fly, 1993).

Hope and trusting are the essential factors in the realization of spiritual care outcomes. Both nurses and patients must have this trust in God so they may communicate peace, love and hope. Those who trust in God, uphold His promises as true. God Himself is the hope of glory. Those who trust in Him wait for that blessed hope the glorious appearing of our great God and Savior” (Titus 2:13). Another motivation for hope lies in accepting the promise of the resurrection of the dead and the coming of God particularly for the Christians. “For the Lord himself will come down from heaven with a loud command, with the voice of the archangel and with the trumpet call of God, and the dead in Christ will rise first. After that we who are still alive ... will be caught up together with them in the cloud to meet the Lord in the air. And we will be with Lord forever” (1 Thessalonians 4:16, 17). Verse 18, further states that “Therefore encourage each other with these words”.

When nurses understand the faith of their patients they may be able give them appropriate words of encouragement. From such encouraging words, a person may find meaning and purpose in illness pain, suffering and death. Finding meaning is an essential factor in coping with triggers of spiritual integrity and contribute to effective outcomes.

Another important outcome of spiritual caring is development of unconditional love and acceptance. Those connected with God through their personal relationship with Him, will show love for themselves and love for others. Love is God’s nature. “God is Love” (John 4:7;8). When a person is connected with God, he or she can accept those not easily accepted.

The spiritual care outcomes may be summarized as follows:

- * Spiritual care gives inner peace in the midst of turmoil and storms of life.
- * Spiritual care gives hope in spite of present uncertainties.
- * Spiritual care, assist a person in finding meaning and purpose for life, illness, suffering and even death.
- * Spiritual care brings acceptance and love for oneself, others and God.
- * Spiritual care gives a person ability to cope with all challenges of life by increasing one’s faith and trust in God.

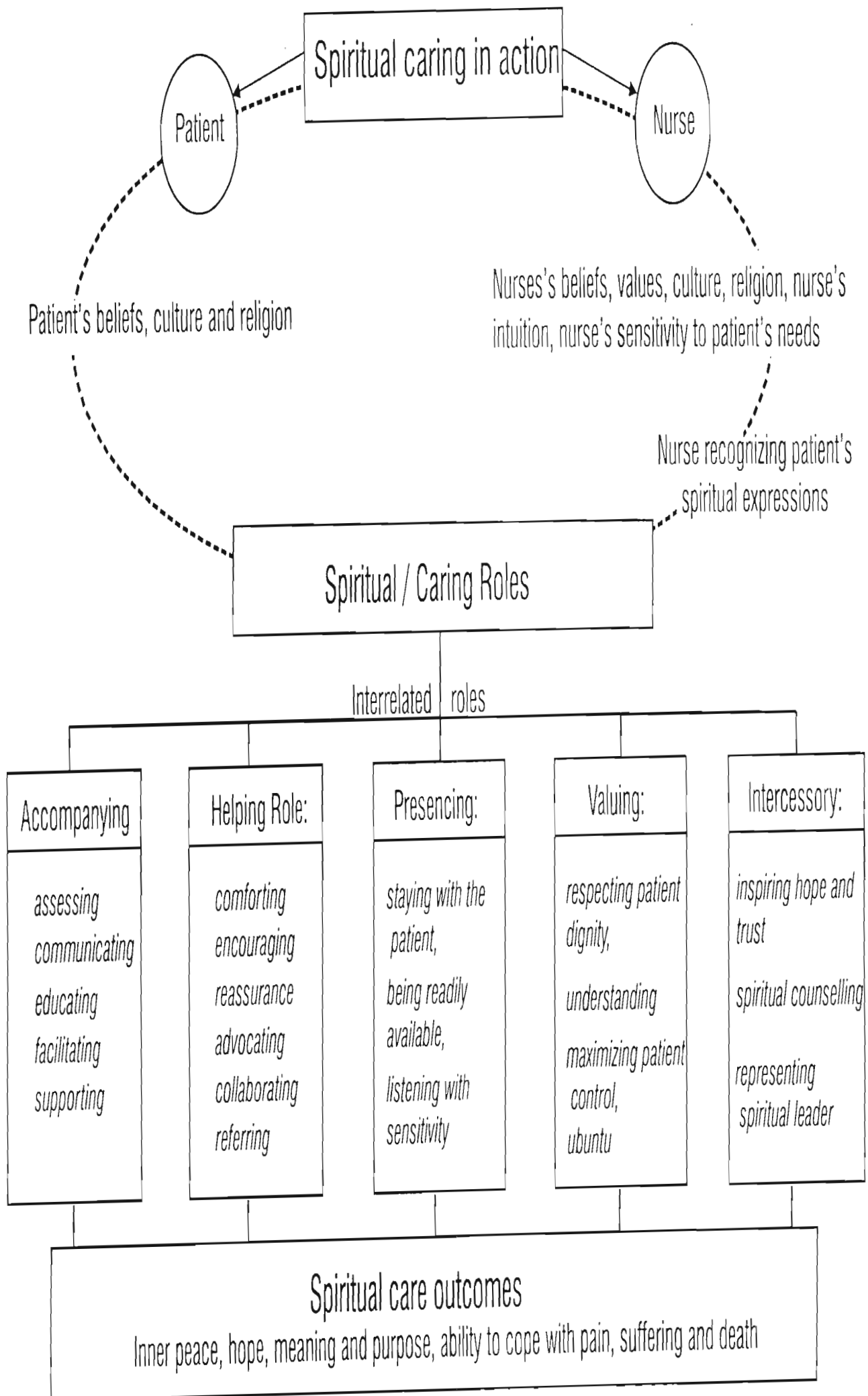


Figure 6 : Spiritual Care

5.9 Discussion in relation to the literature.

5.9.1 Contrasting definitions of spirituality and spiritual care

The purpose of this study was to find a relevant definition of the phenomena of spirituality and spiritual care from the perspectives of both patients and nurses, with an aim of discovering a shared meaning of the concepts from a South African context. The concept of spirituality was conceptualized as a unique, dynamic quest for a transcendent relationship. A quest for a transcendent relationship was manifest in an individual's desire to establish and/ or maintain a dynamic relationship with God, self and significant others.

This definition of spirituality agrees with several definitions found in literature such as the definitions given by Shelly & Fish (1988), Carson (1989), Golberg, (1998) Newshan (1998) and others. These authors agree on the fact that spirituality has to do with one's natural inclination towards transcending relationships. Human beings are also social and spiritual being, they need to relate meaningfully to themselves, to others and to God as they understand Him.

The definition given by Kretzshmar (1995) in his discussion on prerequisite for reconstruction of South Africa shows how vital the spirituality of individuals is to the development and reconstruction of South Africa. Kretzshmar (1995) says, "a holistic spirituality seeks to integrate rather than separate the various dimensions of human existence. We are created to be in relationship with the rest of the created order, each other and God". Spirituality within a South African context with her diversity of culture, religious beliefs and nationality, needs to adopt a more holistic approach. Kretzchmar (1995) quoting Thayer (1985) says "In the most generous sense spirituality has to do with how we experience ourselves in relation to what we designate as the source of ultimate power and meaning in life, and how we live out this relationship".

Spirituality is not merely an inner feeling, it has to do with the integration and coherence of ourselves as experiencing and interacting persons. Therefore spirituality from a South African perspective is the integration of our experiences of God into ourselves and the effect that this

ongoing experience has on the way in which we act within all spheres of reality. The essence of spirituality is inescapably linked to the pursuit of a closer walk with God (Kretzschmar, 1995).

Spirituality is also defined as the dimension of a person that is concerned with ultimate end and values. Spirituality is that aspect of a person which inspires a desire to transcend the realms of the material (O'Brien, 1999). Defining spirituality as a relationship has been used by other authors such as Carson (1989), Simsen (1985), Piles (1990), Ross (1994) and Mc Conochie (1994). Spirituality is also identified in literature as closely related to an individual's faith (Rasi, 1993). In this study faith was identified as an essential factor in realizing the transcendent relationship. Sometimes spirituality is said to be characterized by unfolding mystery related to one's attempts to understand the meaning and purpose of life (Ross, 1994).

Nolan and Crawford (1997) in their discussion of spirituality in relation to mental health state that spirituality must be viewed in four different levels. The first level may be viewed as how a person relates to himself or herself. The essence of a healthy relationship with one's self is related to the authenticity of the person to herself or himself. Accepting what the person really is, accepting one's self and reject the pretense of being someone else is an integral aspect of a healthy spirituality. The second level is concerned with how a person relates to others. A healthy relationship with others brings inner peace and also contributes to self acceptance. The third level of spirituality is concerned with relationships between and within groups. Personal growth and self awareness are achieved through others. This statement agrees with the concept of "ubuntu" that was identified as one of the important principles of providing spiritual care in this study. There is a need for social awareness and communal involvement in realizing spirituality.

The fourth level is the relationship that a person has with the transcendent or with the power a person considers to be the ultimate reality. For most people transcendent relationship is realized through religion, while for others it is realized in terms they use to think about life and death. On every level spiritual aspirations are mediated through the social structures such as education, religion, trades union, social organizations and health services (Nolan and Crawford, 1997).

5.9.2 Conceptual frameworks of spiritual care in literature

Several authors have attempted to analyze the concepts of spirituality and spiritual care in nursing and have developed different conceptual frameworks. These conceptual frameworks mainly utilize the pathological model of viewing the phenomena. These models differ in their approach to the phenomena and yet they basically use similar terminology. Most nursing authors have attempted to conceptualize the phenomena of spirituality and spiritual care from a Christian perspective. For example Shirley & Fish (1988) view a person as created by God in His image and able to relate meaningfully to Him. Shirley & Fish (1988) also identified three types of relationships which are essential for human existence. They refer to these relationships as the self, others and God relatedness.

From these three types of relatedness Shirley & Fish(1988) also identified three types of needs associated with relationships namely: love, forgiveness, meaning and purpose. Their model is based on spiritual needs and the nursing process. Their approach to spiritual care is also based upon the steps of the nursing process with therapeutic use of self by listening, empathy, humility, and commitment to patient care. They state that prayer, scripture, referral to clergy are the important means of spiritual intervention. They also put a great emphasis on the nurses' vulnerability to spiritual needs. The nurse's own spirituality is another important issue in Shelly & Fish (1988) model of spiritual caring. Though their model is not research based, it is gratifying to note that authors are giving attention to systematizing this type of care.

The conceptual model of spiritual care developed in this study has also depicted spirituality as a unique quest for a transcendent relationship with self, others and God. The difference between the conceptual models found in literature and this model developed in this study lies in the way of explaining the relationships between concepts.

In this study spirituality cannot be placed in compartments, it is part of being a person. This relationship of the person's spirituality to the person's total being can be likened to the person as a cultural being. The person cannot be separated from his or her culture. In a similar manner, a person cannot be separated from his or her spirituality. This author therefore purports that the

aspect of spirituality that can be assessed in a formal, organized systematic process is only a fraction of the person's spirituality. The predetermined nursing interventions to meet spiritual needs may only be drawn as a guide for the novice nurse with an understanding that each patient expresses spirituality differently.

Carson (1989) also utilizes a pathological approach from a Christian point of view. Writing on the spiritual dimensions of a person Carson (1989) says "The person's spirit is Imago Dei (image of God) within every person, making one a thinking, feeling, creative being, able to relate meaningfully to God (as defined by the person) self and others". Carson (1989) views spirituality as a human drive for bonding with the transcendent, an animating, intangible principle that gives life to the person. For Carson (1989) spirituality integrates and transcends all other dimensions of the person. Sometimes she refers to it as the breath of life, the real person, the part that nobody can see the inside you, the part that does not die and the part that provides the person with God consciousness, however God is defined by the person. Carson (1989) further states that, "spirituality is the core of one's being; a sense of personhood; what one is and is becoming".

Carson (1989) views spirituality as an aspect of the being that is in a way more powerful than other aspects of the total being. This view again contradicts the idea of holism. Holism is based upon the premise that the sum is greater than its parts. Therefore, the total being is definitely greater than the spirit or the physical. Those who subscribe to the holistic view of caring will in no way segment the spiritual from the rest of the personhood. The "inside you" that Carson (1989) refers to in her definition of the spirit is what some participants referred to in this study as one's identity as they say "spirituality is you as a person". Spirituality therefore, is not what is inside you, it is you as a person. Spirituality is one's total being.

According to Carson (1989) spirituality is concerned with bringing meaning and purpose to one's existence. It is also concerned with what, or who one ought to live for. It is an intangible motivation and commitment directed toward ultimate values of love, meaning, hope, beauty and truth based on a trusting relationship with the transcendent. Carson (1989) conceptual model has three dimensions of human nature that is (1) the biological aspect with five senses which give a person physical consciousness, (2) the psycho-social aspect which is composed of the soul, self

conscious and self identity, (3) the spirit which gives a person God-conscious and relatedness to deity. With these dimensions, Carson(1989) purports that the spiritual dimension is the essence of personhood. This contrasts the grounded theory of spiritual care developed in this study which sees the spiritual dimension of a person as an inseparable part of the total being, occupying neither the center nor the periphery. In the theoretical model of spiritual care in nursing, a person is an integrated whole consisting of inseparable spiritual, physical, psycho-social and moral aspects. The person is able to relate meaningfully to God as understood by the person, self and others. An integrated whole does not have the aspects or dimensions that can be identified and be allocated space within the person. In the grounded theory of spiritual caring, all aspects of being a human form the whole, they cannot be separated even for research or for nursing care purposes.

Another aspect that Carson (1989) brings in her model of spiritual care is the health-illness continuum. This health continuum is composed of five levels namely: the person in the center relating to self, others, God and environment. In Carson(1989) model the person's relationships are grounded in expressions of love, forgiveness, and trust that result in meaning and purpose in life. The person's well-being is often threatened by stressors of life throughout the developmental stages. Carson(1989) conceptual model of the health continuum depicts stressors of life directly affecting the person's spiritual being, causing spiritual distress. In this approach the nurse is able to intervene in the patient's life by utilizing the nursing process to provide spiritual care to relieve spiritual distress.

In the spiritual care model developed in this study, an effort has been made not to extract the spiritual aspect from the whole in this manner. In this study spiritual health is viewed as a part of the total aspect of the person's health. The continuum has three parts namely; the person in the center moving between the highest optimum level of health and the lowest levels of health. On the highest level of the continuum of spiritual health, is hope based upon a relationship of trust between self, others and God. On the lowest level, is hopelessness related to feelings of being alienated from God and from others.

In this mode the physical illness and the approaching death do not necessarily project spiritual distress. The person's movement within the spiritual health continuum may be influenced by the

relationship the person has with himself or herself, others and with God or whoever the person perceives as the ultimate reality. The lowest point of physical illness or even approaching death may be the highest spiritual level of the person. The relationship between the physical, the psychosocial and the spiritual health and illness is not clear in literature.

Carson (1989), Shelly & Fish (1988) and O'Brien (1999) tend to focus on spiritual distress. They do not clarify the relationships between the concepts used in their models of spiritual caring. The concepts used by both Carson(1989) and Shirley & Fish (1988) have also been utilized in the conceptual model of spiritual caring developed in this study. The spiritual distress that Carson (1989) and Shirley & Fish(1988) refer to reflect on their pathological approach to health and spirituality.

O'Brien (1999)also utilizes the approach similar to Carson (1989) and Shirley & Fish(1988). She calls her model a nursing theology of caring. The theology of caring is composed of the concept of being, listening and touching. O'Brien (1999) argues that the nursing theology of caring is supported by a Christian parable of the good Samaritan which is based on the Biblical principle recorded in Luke 10:30- 34.

O'Brien(1999) views spirituality as related to holistic nursing. According to O'Brien (1999) spirituality encompasses values, meaning and purpose, morality which includes human traits of honesty, love, caring, wisdom, imagination, compassion and recognition of higher authority that guides the person in a mystical manner. Spirituality is also viewed as a human need that is concerned with ultimate ends and values. It is the part that inspires a person to quest, to transcend the realms of the material. O'Brien(1999) further states that many individuals that are Christians, Islamic, Judaism view the concept of spirituality in relation to transcendent which incorporate belief in God. O' Brien's(1999) views of spirituality and spiritual care are similar to views of Carson(1988) and Shirley & Fish (1989).

O'Brien(1999) views about the theology of caring is based upon the view of nursing as a ministry concerned about the person's total being. "The process of spiritual caring includes being with the sick without judgement for meaning to emerge and for the holy to be revealed". Her concepts of

caring include listening and touching. She further refers to spiritual caring as including prayer, pastoral care, scripture, religious rituals, devotional articles and sacred music. Her perspective of spiritual caring utilizes concepts similar to those used in the spiritual care model developed in this study, even though her emphasis is on theological caring. The difference between O'Brien (1999) model and the spiritual care model developed in this study is that O'Brien's model is also a need approach. It emphasizes meeting specific spiritual needs. The approach utilized in this study, puts an emphasis on the integration of the person's spirituality with the total being by saying, all nursing care activities should take into consideration the fact that the patient and the nurse are both spiritual beings.

When providing care, a nurse, patient and family come together as unique spiritual beings. Spiritual care therefore, is a result of the natural coming together of the patient, family and the nurses' spirituality as the nurse accompanies the patient and family through their journey of life and uncertainties of death. Spiritual caring therefore means being myself as a nurse who is a spiritual being and being sensitive to the patient's expressions of his or her own spirituality. For example, giving a patient a bed bath may meet the physical as well as the spiritual needs. On the other hand praying for the patient may also be a spiritual as well as a physical intervention. Touching a patient is not sometimes a physical, sometimes a psycho-social and sometimes a spiritual intervention. It is always all three.

O'Brien (1999) further makes a specific reference to specific spiritual needs during specific stages of development throughout the life span and she further identifies spiritual needs associated with acute and chronic illnesses during these stages of development. The analysis of the concept of spirituality has often taken a Christian perspective and as a result it has not appealed to nurses and patients with religious affiliations different from Christianity. Widerquist & Davidhizar (1994) argues that nursing has its roots in Christian concepts, therefore the pastoral caring and nursing caring have distinct similarities.

They are both concerned about providing comfort, meaning to pain and suffering, hope, facilitating expressions of feeling and promoting actions aimed at seeking forgiveness. Widerquist & Davidhizar (1994) also argue that nursing is a ministry which originates from the Christian

roots. True though that may be, the claim of nursing being Christian in its origin should not limit the profession to Christianity. Holistic caring is not necessarily tied up to Christianity, just as spirituality is not exclusive to Christians.

Sibley (1997) writing about the role of a nurse in caring for the dying Buddhists states that the nurse caring for the Buddhist patient should be sensitive to the Buddhist principle of moral conduct which are placed upon individuals as their responsibility. The nurse should also be sensitive to meditation and development of wisdom that is based upon an individual's experiences of one's self. Caring for a Buddhist may require that the Christian nurse gets into the life of the sick and dying patient by accepting the patient and facilitating the patient's spirituality. Nurses of different religious backgrounds can still provide spiritual care to patients and families of different religions by simply playing the five major roles of accompanying, helping, presencing, valuing and interceding.

Stanworth (1997) views spiritual caring as an art of giving and receiving that goes on between and among humans. It cannot be limited to the vocabulary of religion and a single way of perceiving God. Stanworth (1997) argues that in a secular society such as ours, (referring to the British society) very few patients use religious language to express their ultimate concerns.

She argues that most patients in a secular world use symbols and metaphors to reveal what she calls "the silent side of the boundaries at which they stand". Talking, about the spiritual aspect of palliative care, Stanworth (1997) further states that "if we are to hear patient's spiritual concerns, we have to be prepared to risk uncertainty and to travel with them places where there is no expert vocabulary to protect us" This statement emphasizes that spiritual care may be limited by language particularly if nurses are dealing with patients whose religious beliefs and values differ from theirs. Those patients may not use the common vocabulary of religion to express their spiritual feelings. They may not even talk about God because God may not be in their everyday language. Nurses therefore, ought to listen with sensitivity and listen between the lines to patient's unique expressions of spirituality of who they are and what they see as important.

Burkhardt(1989) states that spirituality has been described as the process and a sacred journey, the essence of life principle of a person, the experience of the radical truth of things, a belief that relates a person to the world giving meaning to existence, a personal quest to find meaning and purpose in life and a relationship, or a sense of connection with higher power, God or universe.

From the discussion presented about the usage of the concept of spirituality in literature, it became evident that the different terms used overlap in meaning, and that their approaches to the concept of spirituality in the context of the holistic view of a person vary. It is recognized that the concept of spirituality does not lend itself to a natural science approach to research, nor can it be limited to medical model forms of assessment. It is important to note that the effective assessment of the person's spirituality occurs within the relationship between a nurse and a client. This relationship develops when the nurse is truly present in the life of a patient and his or her family.

Burkhardt (1989) refers to a relationship with self, others and God as harmonious interconnectedness, which means a person experiences harmony with self and thus demonstrate self acceptance and self esteem. The person has a sense of belonging in the world with family, friends, social groups, church and other self fulfilling groups. The person demonstrates love of self and others and engages in reconciliation with others. The second relationship is the interconnectedness with others, family, friends and social groups. The person tries to reconcile with others. Thirdly, a person's interconnectedness is with divinity, universe, or higher power. This type of connection helps a person to find meaning, joy, support in chosen religious practices.

The fourth concept is environment interconnectedness, whereby a person experiences connection with all of life and nature and is aware of the effect of the environment on one's life and well being (Burkhardt, 1989). In contrast to the grounded theory of spiritual caring, Burkhardt (1989) approaches the phenomena of spirituality and spiritual care from a humanistic existential perspective whereas the grounded theory has endeavored to be more eclectic in its approach to the topic. Burkhardt (1989) concludes by saying that her analysis suggests that nursing practice, related to spiritual care needs to be based on the broad understanding of the concept of spirituality and spiritual care. Interconnectedness emerged as a significant aspect of spirituality that needs to be addressed by nurses and clients.

The idea of spirituality as a process of coming into relationship with reality has been recognized by Stuart, Deckro, Mandle (1989). They make a clinical application of the usage of the concept and they suggest a clinical program that integrates the body, mind and spirit to health and healing. The focus of their program was the cardiovascular therapy. This program could easily be adapted to other illnesses. A positive attitude towards life achieved through nurturing of hope and faith decreased the blood pressure of most patients that were on the program. By opening the mind of the patients to the possibilities that exist, they were able to change their lifestyle which were detrimental to their health. Therefore, understanding the patient's spirituality can be an effective therapy (Flemming, 1997).

The concept of spirituality in nursing was also explored by Goldberg (1998). She labeled her study as "connection". She explored the meaning of spirituality in relation to nursing care using the concept of synthesis. The concepts that emerged from her study of literature around spirituality are meaning, presencing, empathy/compassion, giving hope, love, religion, transcendence, touch and healing. According to Goldberg (1998) the concepts that emerged from her synthesis all appeared to be the product of a relationship, physical, emotional, meaning, hope, love and religion. Some of these concepts appeared to fit in all categories which is the reason she calls her model connection. Her emphasis of spiritual caring is based upon assisting a person to find meaning in life, illness and in death.

She also uses the concept of presencing to refer to the nurse being truly present to the other, demonstrating empathy/compassion, giving hope and love by use of touch. The concepts used by Golberg (1998) agree with the findings of this study. These concepts were unequivocally expressed by the participants as the essential elements of spiritual caring.

5.9.3 Factors influencing spiritual caring in literature

Ross (1995) also tried to conceptualize the spiritual care with regards to the nurse's role and she identifies those factors which affect spiritual care. In her research study, her aim was to discover how nurses perceived spiritual care and how they described giving spiritual care in practice and what factors appeared to influence giving spiritual care to patients. She found that spirituality was

described in terms of needs experienced by patients. The need that was commonly identified was a need for bonding with the transcendent. These were needs for belief and faith, peace and comfort, giving and receiving love and forgiveness, meaning, purpose and fulfilment, hope and creativity. Spiritual care was perceived to be influenced by factors relating to both nurses and patients. These factors included perception of spiritual needs and spiritual care, life experiences, belief, willingness to give of self and sensitivity to patient's needs, environmental factors, lack of time, lack of quietness and privacy, problems of communication on the part of patients associated with hearing loss, dementia and coma.

The factors that were discovered to be influencing spiritual care in the grounded theory of spiritual caring were related to both patients and nurses' religious beliefs, cultural diversity, patient's ability to express their spirituality, nurse's experiences in recognizing patient's spiritual expressions and the nurse's sensitivity and compassion to patient's suffering and pain. The diversity of religious beliefs and cultural practices that are part of the South African nation were related by participants particularly nurses as important factors that influenced their provision of spiritual care. Nurses reported that they were mainly challenged by cultural practices related to African ancestor worship and those related to specific religions such as refusal to receive blood transfusion. Therefore when the South African nurses consider realizing spirituality as an integral part of their nursing care, they will be sensitive to patient's cultural and religious beliefs.

As South Africa is a rainbow nation which indicates the unity in diversity so should be the nurses' consideration in providing spiritual care. Among other principles mentioned in this study is that spiritual care should be based upon the value of a person as a unique spiritual being with unique spiritual expressions.

In contrast to Ross (1995) discovery of communication factors influencing provision of spiritual care, this researcher in the grounded theory of spiritual caring found that the major communicating factor was the patient's inability to express their spirituality. Participants reported that most patients and nurses were embarrassed about openly communicating their spiritual problems. This made it difficult for nurses to provide spiritual care. Other factors which were found to be influencing spiritual caring in this spiritual caring model were nurses' experiences and expertise

in recognizing patient's spiritual expressions. Junior nurses were reported to be lacking intuitive abilities to recognize and attend to patients' spirituality. In Ross(1995) study, senior nurses were more sensitive to patients needs compared to junior nurses and the type of ward where the nurse worked influenced their understanding of spiritual care. These findings agree with the findings reported in this study. Narayanasamy (1993) also found that the majority of nurses viewed spirituality as a religious matter and they rarely offered spiritual support. Therefore nurses had a desire for further education to improve their knowledge and confidence to attend to the spiritual needs of patients. In this Study, nurses also expressed their desire for more knowledge regarding spiritual care. They felt that their lack of education on spiritual matters contributed to their neglect of the patient's spiritual expressions.

Spirituality, religious belief and culture seem to be the variables which are closely linked to each other. Research has revealed that religion has played an important role in helping patients and relatives to cope with both physical and mental illness. Foskett (1999) studies show that personal faith and organized religion were important resources in helping patients and their families cope with mental health problems. Parents of autistic children reported use prayer to cope with their children's challenges of autism (Coulthard, & Fitzgerald 1999). Religious beliefs were also perceived to be playing a major role in coping with anxiety and depression (Peeifer & Waelty, 1999).

Authors writing from a non religious connotation such as Labun (1988), Goddard (1995), and Cawley (1997) purport that spirituality does not necessarily have to include a religious component, although religion may be one method by which patients can perceive meaning to their lives. For example, when patients were asked what contributed to meaning and hope in their life, the patients' responses indicated that the presence of the nurse and the care given by that nurse were the most significant factors. On the other hand, factors which did not contribute to meaning were identified as nurses who were too busy or who were incompetent, who did not spend time in interpersonal relationships with patients. For these patients the presence of a nurse was a major factor in giving meaning and a sense of value (Hams, 1997).

5.9.4 The nurses' responsibilities in spiritual caring

According to Ross (1994) nurse's responsibilities in spiritual caring included recognizing spiritual needs of the patients, facilitating participation in religious rituals, communicating by listening and talking to the patient and the family, by being with the patient, caring, supporting and showing empathy and by promoting a sense of well being. Ross (1994) purports that spiritual care can be provided through the use of the nursing process. In this study spiritual care is provided through five major roles; that is accompanying, helping, presencing, valuing and intercessory roles. Every nursing activity should integrate the spiritual aspect. The nursing process can only be utilized for a limited portion of the patient's spirituality. Spiritual care is therefore an important aspect of each and every nurse/ patient encounter.

Literature on spiritual care in nursing as reported by Cawley (1997) reports the studies of spirituality from a religious connotation such as those studies one by Reed (1986, 1987) whereby the hospitalized patients manifested personal religiousness to a significantly greater degree than healthy adults. The results of the study supported the hypothesis that terminally ill patients have a greater spiritual perspective compared to non terminally ill adult patients. Sodestrom and Martinson (1987) reported by Cawley (1997) discovered from their exploratory study of the spiritual coping strategies of hospitalized cancer patients that 96 per cent of the patients who appeared to cope well had religious affiliation and 88 percent found meaning and purpose in their life through a belief in God.

The use of prayer was the most commonly utilized coping strategy for those patients who believed in prayer. Similar to the findings in the grounded theory of spiritual caring, patients and nurses utilized their religious beliefs in coping with pain and suffering. The commonly used expressions of spirituality found in this study were prayer, meditation, fasting, Bible reading or reading other spiritual books. These were reported to be able to relieve anxiety, anger, guilt and other forms of grief. In addition to the above coping strategies both patients and nurses utilized other people to help them cope with the pain of suffering and death (Benner, 1984).

The people whose presence was found most comforting were the nurses, family, friends, religious ministers and church groups. Even the presence of the researcher was found to be very comforting as one patient participant said "It is so nice that you are here and talking to us. We are very lonely here, we need people to come and talk to us and nurses seem to be very busy".

The presence of other people was reported to be an essential comfort and a coping strategy in the grounded theory of spiritual caring. Presence may mean just being there next to the patient and being silent, listening to the patient's expressions of himself or herself as a spiritual being. On the other hand presence may be part of performing a procedure embracing silence as well as speaking. The importance of being present next to the patient's bedside was reported in literature as an essential role of a nurse (Burkhardt, 1989).

Other authors like Goddard (1995) suggest defining spirituality as an integrative energy in which different aspects of a person are brought together interlinked and harmonized. This energy may be depleted or maximized by an individual during illness. Goddard (1995) definition also incorporates the idea of being connected to others which again may be manifested through communication. Communication is a fundamental act in promoting spiritual caring. Boutell and Bozett (1990) reported by Cawley (1997) indicated that nurses used communication through listening as an important indicator for assessing patient's spirituality. The information obtained through listening was reported to be 91 per cent, the information received through observation of patients was 75 per cent and 50 per cent through asking the patients. This indicates that spiritual caring is mainly based on nurse/patient interaction through listening and presencing of a nurse and sensitivity to patient's unique expressions of spirituality.

In the grounded theory study of spiritual caring, listening was repeatedly mentioned by the participants as an important factor in nurse/patient interaction. The participants repeatedly mentioned the need for the nurse to listen with sensitivity in order to identify the clues of spirituality in patients. Therefore presencing involves staying with the patient, being readily available and listening with sensitivity. Other spiritual caring roles which have been identified in the grounded theory of spiritual caring which are interlinked to presencing were accompanying, helping, valuing and intercessory roles.

The accompanying role of a nurse includes, communicating, educating, facilitating and supporting the patient in his or her unique spiritual expressions. The helping role of a nurse involves comforting, encouraging, re-assuring, advocating, collaborating and referring. The helping role is an indispensable role in spiritual caring. It is linked to other roles that have already been mentioned.

5.9.5 Antecedents and Consequences of spirituality

Burkhardt (1989) states that the concept of spirituality has no antecedent because it is a thing on its own, it cannot be explained by something not spiritual, it is irreducible, it can be conditioned by something without being caused by it. She further lists some consequences of the concept of spirituality which are; inner peace, joy, making life giving choices, drawing on inner strength and health. Inner strength manifests joy, peace and self awareness, it gives ability to grow within, to touch into one's well being, it manifests hope and has ability to see beyond the present realities and is able to live with ambiguity and uncertainty.

Cawley (1997) also commenting on antecedents and consequences of spirituality says that spirituality is a broad concept and it may be difficult to identify the antecedents and consequences because these will present differently in each person and they are very personal and individualistic. In contrast to the above statement by Cawley (1997) and Burkhardt (1989), the theory of spiritual caring has identified faith, trust, and a commitment to a personal relationship with self, others and with God as the antecedents of spirituality. On the other hand, hope, inner peace, finding meaning and purpose in life have been identified as the consequences of spirituality. Hope has been largely investigated and has been proven to be effective in caring for patients with chronic illnesses such as cancer. What nurses need is to learn how to increase patient's hope and trust so that patients may find meaning in life, illness and in death.

The significance of hope in cancer patients is well documented. The challenge now lies in making nurses to be more aware of the importance of promoting hope in their patients (Rostoen, 1998). This researcher argues that the spiritual expressions are learned from social interaction, so it

cannot be stated that there are no antecedents and no consequences. Perhaps, this is an area that needs further investigation.

McGrath (1998) also views illness as the problem of meaning. Her emphasis is on the influence of culture to the individual's spirituality. She argues that culture is a template that outlines the possibilities, so culture is learned through social interaction and therefore spiritual expressions are also learned through social interaction. The meaning people have for their illness is derived from their social integration or culture. The way the persons express their spirituality is greatly influenced by their cultural background.

From literature it is evident that nurses ought to nurture faith and support patient's religious beliefs because these have been discovered to be valuable coping skills (Foskett, 1999). In the grounded theory of spiritual caring, nurturing faith, inspiring hope and trust were classified as the nursing activities which form the intercessory role of a nurse. Authors like O'Brien (1999), Lister (1997) view nursing as a theology of caring. In this study nurses act as nurses whether they perform pastoral work. When they give spiritual counseling, they do it in the capacity of a nurse, not in the capacity of a religious minister. Spirituality was found to be a universal phenomenon, though it is experienced in a unique manner.

Therefore, playing an intercessory role involves nurturing of faith by recognizing the unique manner which the patients use to express their faith. Rasi (1993) argues that faith is found in the stories we tell to bring coherence to what happens to us in life. It is this faith that has the power to sustain us in an imperfect world. Faith is nurtured through a relationship with a person or persons that are worthy of trust. Faith is knowing that God is both near and concerned, but also above and beyond (Rasi, 1993). As spirituality has a vertical and a horizontal dimension, so is faith. Faith has a vertical and a horizontal dimension. It connects each individual with God and with fellow human beings. It reveals itself in actions motivated by the decisions to fulfill the wishes to the trustworthy person.

A dynamic faith is key to spiritual victory for both the nurse, the patient and family. In the grounded theory of spiritual caring participants reported that faith was the major factor in keeping

them going. Faith helped the patients to go through pain and suffering, it gave them ability to cope with the vicissitudes of life. It was through faith that the participants were able to grieve, come to terms with the reality of pain, and death and to finally go beyond.

Patients experiencing physical pain associated with cancer or other chronic illnesses also drew meaning for their pain and suffering from their religious faith (Kappeli, 2000). In the study conducted by Mtalane (1989) on the experiences of death and dying of the Zulu patients, their families and care-givers, religious belief was an important factor in coping with death and dying.

Though no studies have been reported in South Africa on the concepts of spirituality and spiritual care in nursing, South African nurses have speculated the concepts related to spiritual caring such as the concept of ubuntu in relationship to the nurses' compassion about human suffering and pain. The concept of "ubuntu" is the concept that is a part and parcel of being a person. The word ubuntu is the South African Constitution, yet its principles are not limited to the South Africans. Ubuntu is a universal phenomenon of just being a human (Haegert, 2000). Those who possess this virtue of ubuntu are noted by their compassion for human suffering. Ubuntu concept puts an emphasis on the realization that a person is a person through others.

Haegert (2000) purports that an African ethics for nurses is based on the principle of ubuntu. In this study the concept of ubuntu was identified as one of the principles of spiritual caring. Ubuntu was based on the value of a person as a human being. The nurses guided by the principle of ubuntu will demonstrate respect for human dignity, accepting and understanding the patient as really is and maximizing the power of the patient to control his or her own care.

Other studies related to the concept of spirituality are those reported from the Eastern part of the world. The consequences of spirituality found among the rural Thai elderly patients tally well with those reported in this study. Consequences of belief among the rural Thai elders were found to be their ability to cope with vicissitudes of life, being hopeful and having a peace of mind (Tongprateep, 2000). Hams (1997) also speculated the concept of trust as an important factor in caring for patients with coronary disorders. The concept of trust has also been found to be essential in spiritual caring.

Spiritual caring relies heavily on the patient and the nurse's belief systems. Using faith in helping the patients to cope with dying in hospice care is an awareness of a sense of sensitivity to other cultures (Lister, 1997). Nurses therefore need to nurture in one way or the other their own spirituality so that they can be able to accept and understand patients' spirituality (Cornette, 1997).

Sometimes the nurses' attitudes and beliefs regarding spiritual care affected their ability to provide spiritual care (Taylor, Highfield and Amenta, 1994). These authors viewed spiritual care as associated with promoting well-being within a holistic caring, respecting and supporting patient's beliefs, providing emotional care for the suffering, promoting or offering transcendent qualities, sharing the self by being present and facilitating relationships.

There are quite a number of similarities in the concepts used in literature and in the concepts used in this study. The main differences are found in the way each individual author approaches the topic. Each author approaches the topic from his or her own philosophical point of view about reality. That is perhaps one reason that this researcher concludes by saying spiritual caring must be understood from both the patient and the nurses' point of view as they are all unique spiritual beings subject to their own spiritual beliefs and values.

5.10 Recommendations.

Several hypotheses have been developed in this study needing further investigation and testing. The theory of spiritual caring needs to be tested for its practicality in clinical practice and in education. The concepts that have been developed in this study also need further analysis, definitions and testing from a different setting within the South African context. A larger sample may be appropriate in the subsequent studies to strengthen the validity and the reliability of the findings utilizing the quantitative research methods to find out from both nurses and patients their opinion about spirituality and spiritual care in nursing and the factors which influence how they give spiritual care and receive such care.

Quantitative research will be appropriate in testing and measuring specific areas of spirituality such as measuring hope and trust and also finding the relationships between specific variables.

The antecedents and the consequences of spirituality also need further investigation. There are some aspects of spirituality which cannot be measured by quantitative methods. Therefore, this researcher recommends that more qualitative studies should be done to strengthen the grounded theory that has been developed in this study.

Most nurses during the interview reported that they were never taught how to provide spiritual care during their educational programs. They reported that only when they were in actual practice did they realize that they needed to care for the patient and families; spiritual aspects too. Spirituality was reported to have been mentioned only when educators defined a person. After that introduction nothing was mentioned regarding the care of the person as a spiritual being. There is therefore a need to incorporate the spiritual aspect of care in nursing education. Nursing students need to be taught how to recognize spiritual quests and how to deal with them. Spiritual care should be an integral part of the nursing education curricula.

Qualified nurses should also be provided with in-service and continuing education courses on the topic of spirituality and spiritual care. For clinical practice, the increased AIDS epidemic calls for a real paradigm shift to patient care. Spirituality is not going to be just another option to patient care, but it is going to be the real thing. There is a greater need for spiritual care with palliative care. Nurses in the clinical practice need to implement spiritual care in their care.

This research has vital implications for the clinical practice as well as the education of nurses. If nurses are to continue to claim that they are providing total patient care, the spiritual component of their patients will be an integral part of their practice. On the other hand, if nurses educators are to develop nursing curricula that are based upon the concept of holism, spiritual care will form part of their education. Spirituality will move from the intuitive level of knowing to the scientific level.

5.11. Conclusion and summary

This chapter has outlined the conceptual framework of the grounded theory analysis of the phenomena of spirituality and spiritual care in nursing. A conceptual framework is defined as the

set of interrelated concepts that explain, predicts the relationships between the concepts. Conceptual framework serve as guides to the practice of a profession. The model that has been developed in this study is called the “spiritual care model”. The spiritual care model has been developed through the use of a grounded theory method of inquiry. The conceptual model of spiritual care is aimed at adding to the ontology and the epistemology of nursing through scientific modes of discovery. It is assumed that added knowledge to the nursing profession will improve the quality of patient care.

The conceptual definitions used in the conceptual framework originated from the participants. The major concepts that were developed were basically related to the participants’ understanding of spirituality and spiritual caring. Spirituality was defined as an individual quest for establishing and or, maintaining a dynamic relationship with self, others and with God as understood by the person. The antecedents for spirituality were identified as faith, trust and hope. The consequences of spirituality were also identified as the inner peace, finding meaning and purpose for life, illness and death and hope that goes beyond the material realm. Spiritual homeostasis was found to be threatened by life’s crises of illness, suffering and death. These spiritual threats were labeled as “triggers”. The triggers aroused responses which were classified as grieving, coming to terms and going beyond.

“Going beyond” marked the period of spiritual experience characterized by a quest for a closer relationship with self, others and/or God. Spiritual care was defined as part of all care rooted upon the principles of being considerate to the unique needs of the patient and his or her family; being compassionate and loving and being part of the community guided by communal principle of “ubuntu”. The nurses’ intervention was described in terms of five major roles, rather than in discrete actions. These roles were identified as accompanying, helping, presencing, valuing and intercessory roles. The spiritual care was marked by the following outcomes; inner peace, hope, trust, finding meaning and purpose in life.

The descriptive words of the concept of spirituality have been explicated from the perspective of those experiencing the phenomena. The similarities and the differences in the meaning of the concepts used in spiritual caring have also been discovered. Therefore, it is time to get the spiritual component out of the private world to the open for scientific discovery so that the quality of total patient care can be improved.

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ANNEXURE A:

Permission for research (regional)

23 February, 2000.

The KwaZulu-Natal
Department of Health
Private Bag 9051
Pietermaritzburg.
3200.

Dear *Sri Madam*,

REQUEST FOR A PERMISSION TO CONDUCT A NURSING RESEARCH STUDY.

My name is Sarah Mahlangu, currently studying at the above mentioned university towards a doctoral degree in nursing. My research interest is on total patient care and how the aspect of spirituality is, or can be incorporated in nursing. The concept of spirituality in this study is used to refer to the aspect of every being which gives purpose to life and a will to live, a sense of value and meaning in spite of suffering and illness. a philosophy of life to live by and to be understood. Research reveals that crisis such as illness or impending death tends to increase one's sensitivity to matters of spirituality.

My research title is; **Spiritual Care In Nursing: A Grounded Theory Analysis**. The purpose of this study is to analyse the concepts of spirituality and spiritual care from the perspectives of both nurses and patients/ clients in order to discover a shared meaning of the concepts in question. Secondly this study is aiming at generating a middle range theory of spiritual care in nursing that is grounded upon the patients/clients and the nurses's perspectives of the process of providing spiritual care.

This researcher trusts that this study will increase the ontology and the epistemology of nursing, and thus improving total patient care by incorporating patients' values of spirituality in nursing

care. On the other hand the development of a middle range theory of spiritual care will assist nurses by providing guidelines for spiritual care.

This researcher therefore, requests a permission to collect the data on one to one interviews with patients/clients and nurses. Other methods of data collection will be focus groups discussions with nurses and also observations of clues of spiritual care in the nurse/patient interaction. The hospital of choice is Addington Hospital medical surgical units and a postnatal unit. I would also like to conduct an introductory and a break away focus groups with professional nurses working in these units. The criteria for inclusion in the study is outlined on the short proposal.

Enclosed is the research proposal summary and the interview guide for both nurses and patients participants. I will appreciate your assistance in helping me to achieve my research objectives.

Yours' Faithfully,

Sarah, N. Mahlangu.

NATALIA
350 LONGMARKET STREET
PIETERMARITZBURG

Telephone : 033 3952111
Fax :
E-mail :

Fax : 033-3948868
E-mail :
E-mail :

Private Bag : X 9051
Isibhama Seposi : Pietermaritzburg
Frisanatak : 3206

Reference: HRD Research
Enquiries: Dr L.L. Nkonzo-Mtembu
Extension: 2275

Date: 17 April 2006

Ms Sarah N. Mahlangu
University of Natal
Faculty of Community & Development Disciplines
School of Nursing
DURBAN
4041

PERMISSION TO CONDUCT A NURSING RESEARCH STUDY
TOPIC :- SPIRITUAL CARE IN NURSING : A GROUNDED THEORY ANALYSIS

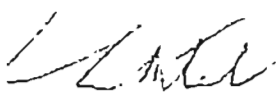
Thank you for identifying Addington Hospital as a facility from which to conduct the proposed research.

Given the probing nature of the chosen study you are required to:-

- submit written approval from the University Ethical Committee;
- seek permission to use the facility from the institutional management.

Permission to conduct the research is granted provided you adhere to the instruction in paragraph two.

You are expected to acknowledge the Department of Health in the completed thesis and supply a copy of the thesis.



DIRECTOR : HRD

Permit_permission (2)

PROVINCE OF KWAZULU-NATAL
DEPARTMENT OF HEALTH

ISIFUNDAZWE SEKWAZULU-NATALI
UMNYANISO WEZEMPILO

PRIVATE BAG X54318
DURBAN
4000

TEL: (031) 3374392
FAX: (031) 3322576



DURBAN ILEMBE REGION (F)

Enquiries: Ms B. Pillay
Reference:

Date: 20 March 2000

Ms S N Mahlungulu
Faculty of Com. & Dev. Studies
University of Natal
Durban

Dear Ms Mahlungulu

PERMISSION TO CONDUCT NURSING RESEARCH

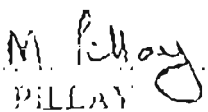
I have pleasure in granting you permission to conduct the interviews at Addington Hospital

Please ensure that the proposal is also forwarded to Dr J. Hursi, Chief Medical Superintendent - Addington Hospital as a record of your utilizing the hospital staff for the interviews

You also need to liaise with the Nursing Services Manager to acknowledge specific times for the interviews so that service delivery is not interrupted

Please forward a copy of your results and the final outcome of your studies to the Durban-Ilembe Regional Office (031) 3322576. Wishing you every success in your studies.

Yours sincerely


M PILLAY
REGIONAL DEPUTY DIRECTOR
B63/3

ANNEXURE B:

Permission for research (local)

05/ May/2000

The Chief Nursing Manager
Addington Hospital
Durban.
4000.

Dear Sr/ Madam,

REQUEST FOR A PERMISSION TO CONDUCT A NURSING RESEARCH STUDY.

My name is Sarah Mahlangu, currently studying at the above mentioned university towards a doctoral degree in nursing. My research interest is on total patient care and how the aspect of spirituality is, or can be incorporated in nursing. The concept of spirituality in this study is used to refer to the aspect of every being which gives purpose to life and a will to live, a sense of value and meaning in spite of suffering and illness. a philosophy of life to live by and to be understood. Research reveals that crisis such as illness or impending death tends to increase one's sensitivity to matters of spirituality.

My research title is; **Spiritual Care In Nursing: A Grounded Theory Analysis.** The purpose of this study is to analyse the concepts of spirituality and spiritual care from the perspectives of both nurses and patients/ clients in order to discover a shared meaning of the concepts in question. Secondly this study is aiming at generating a middle range theory of spiritual care in nursing that is grounded upon the patients/clients and the nurses's perspectives of the process of providing spiritual care.

This researcher trusts that this study will increase the ontology and the epistemology of nursing, and thus improving total patient care by incorporating patients' values of spirituality in nursing


care. On the other hand the development of a middle range theory of spiritual care will assist nurses by providing guidelines for spiritual care.

This researcher therefore, requests a permission to collect the data on one to one interviews with patients/clients and nurses. Other methods of data collection will be focus groups discussions with nurses and also observations of clues of spiritual care in the nurse/patient interaction. The hospital of choice is Addington Hospital medical surgical units and a postnatal unit. I would also like to conduct an introductory and a break away focus groups with professional nurses working in these units. The criteria for inclusion in the study is outlined on the short proposal.

Enclosed is the research proposal summary, the interview guide for both nurses and patients participants, the two copies of letters of permission from the Province of KWAZULU-NATAL Department of Health Regional Director and HRD Research. Enclosed also is the written approval from the University Research Committee.

I trust that you will kindly assist me to achieve my research objectives.

Yours' Faithfully,


Sarah, N. Mahlangu.

Province of KwaZulu-Natal
Isifundazwe SaKwaZulu-Natali
Provinsie KwaZulu-Natal

Health Services

Ezempilo

Gesondheidsdienste

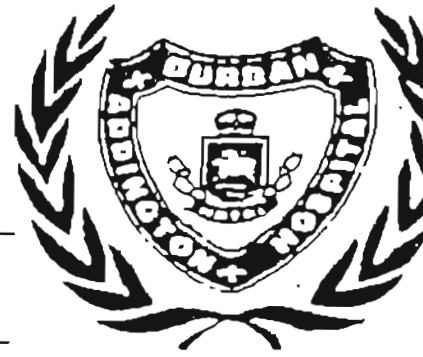
Office of the Deputy Director: Nursing

Your Reference

Our Reference

Tel: (031) 3272000

Fax: (031) 3272387



P.O. Box 977

DURBAN

4000

12 July 2000

Ms S Mahlangu
BY HAND

Dear Ms Mahlangu,

RE: PRACTICALS : RESEARCH IN NURSING

Your letter dated 05 May 2000 refers.

Permission is hereby granted for you to conduct a Nursing Research Study on 31 July 2000.

Please report to Matrons Office (1st Floor) on your first day of commencement to complete an Indemnity Form.

Yours faithfully


DEPUTY DIRECTOR -- NURSING

For Chief Medical Superintendent
PA/kp





School of Nursing
Decentralised Programmes

Durban 4041 South Africa
Telephone +27 (0)31 260 3122
Facsimile +27 (0)31 260 1543

February 22, 2000.

The Nursing Service Manager,
Saint Mary's Hospital,
Private Bag X16 Ashwood.
3605.

Dear Sr/ Madam,

REQUEST FOR A PERMISSION TO CONDUCT A NURSING RESEARCH STUDY.

My name is Sarah Mahlangu, currently studying at the above mentioned university towards a doctoral degree in nursing. My research interest is on total patient care and how the aspect of spirituality is, or can be incorporated in nursing. The concept of spirituality in this study is used to refer to the aspect of every being which gives purpose to life and a will to live, a sense of value and meaning in spite of suffering and illness. a philosophy of life to live by and to be understood. Research reveals that crisis such as illness or impending death tends to increase one's sensitivity to matters of spirituality.

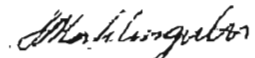
My research title is; **Spiritual Care In Nursing: A Grounded Theory Analysis**. The purpose of this study is to analyse the concepts of spirituality and spiritual care from the perspectives of both nurses and patients/ clients in order to discover a shared meaning of the concepts in question. Secondly this study is aiming at generating a middle range theory of spiritual care in nursing that is grounded upon the patients/clients and the nurses's perspectives of the process of providing spiritual care.

This researcher trusts that this study will increase the ontology and the epistemology of nursing, and thus improving total patient care by incorporating patients' values of spirituality in nursing care. On the other hand the development of a middle range theory of spiritual care will assist nurses by providing guidelines for spiritual care.

This researcher therefore, requests a permission to collect the data on one to one interviews with patients/clients and nurses. Other methods of data collection will be focus groups discussions with nurses and also observations of clues of spiritual care in the nurse/patient interaction. This researcher would like to interview patients in the surgical, medical and postnatal units and the nurses who care for these patients. The criteria for inclusion in the study is outlined in the short proposal.

Enclosed is the research proposal summary and the interview guide for both nurses and patients participants. I will appreciate your assistance in helping me to achieve my research objectives. Data collection will begin as soon as I receive your approval.

Yours' Faithfully,



Sarah, N. MahJungulu.



ST MARY'S HOSPITAL

MARINE

Phone 800 X10
Fax 800 200
St. Mary's

FAX MESSAGE

TO: *Sarah N. Madhugula, Faculty of Community
Development Discipline,
School of Nursing, W. Virginia State*
TEL: *260 1542*

DATE: *22 03 2000*

FROM: *MRS M Madhugula, St. Mary's Hospital*

REQUEST FOR PERMISSION TO CONDUCT
NURSING RESEARCH

your letter re the above refers

*We agree to your request in principle
but will require to inspect the
proposed project*

*Kindly call my Secretary, MRS KERR
in order to make an appointment
for our discussion*

With thanks and regards

[Signature]
MRS M Madhugula

23 Feb. 2000

The Nursing Service Manager
Highway Hospice,
PO Box 28,
Westville, 3630.

Dear Sr/ Madam,

REQUEST FOR A PERMISSION TO CONDUCT A NURSING RESEARCH STUDY.

My name is Sarah Mahlangu, currently studying at the above mentioned university towards a doctoral degree in nursing. My research interest is on total patient care and how the aspect of spirituality is, or can be incorporated in nursing. The concept of spirituality in this study is used to refer to the aspect of every being which gives purpose to life and a will to live, a sense of value and meaning in spite of suffering and illness. a philosophy of life to live by and to be understood. Research reveals that crisis such as illness or impending death tends to increase one's sensitivity to matters of spirituality.

My research title is; **Spiritual Care In Nursing: A Grounded Theory Analysis.** The purpose of this study is to analyse the concepts of spirituality and spiritual care from the perspectives of both nurses and patients/ clients in order to discover a shared meaning of the concepts in question. Secondly this study is aiming at generating a middle range theory of spiritual care in nursing that is grounded upon the patients/clients and the nurses's perspectives of the process of providing spiritual care.

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and thus improving total patient care by incorporating patients' values of spirituality in nursing care. On the other hand the development of a middle range theory of spiritual care will assist nurses by providing guidelines for spiritual care.

This researcher therefore, requests a permission to collect the data on one to one interviews with patients/clients and nurses. Other methods of data collection will be focus groups discussions with nurses and also observations of clues of spiritual care in the nurse/patient interaction. This researcher would also like to conduct an introductory and a break away focus groups with professional nurses working with terminal ill patients in your hospice. The criteria for inclusion in the study is outlined on the short proposal.

Enclosed is the research proposal summary and the interview guide for both nurses and patients participants. I will appreciate your assistance in helping me to achieve my research objectives.

Yours Faithfully,

A handwritten signature in black ink, appearing to read 'S. Mahlunqulu', written over a horizontal dashed line.

Sarah, N. Mahlunqulu.



THE HIGHWAY HOSPICE ASSOCIATION

59 Locksley Drive, Sherwood 4091 ☎ 2086110 Fax: 2082945 ✉ 28, Westville 3630
E-mail: highhosp@dbn.lia.net Internet: www.hospice.co.za

16th March 2000

Ms Sarah N. Mahlangu
Faculty of Community Development Disciplines
School of Nursing
University of Natal
Durban
4001

Fax No: 260-1543

Dear Sarah,

RE: REQUEST FOR PERMISSION TO CONDUCT A NURSING RESEARCH STUDY

I am pleased to inform you that permission is given to use Highway Hospice as a site for your research and we look forward to meeting you for further discussion.

Yours sincerely

**Karen Hinton (Mrs)
Head of Education**

February 22, 2000

To All Potential Research Participants

Dear Sir/ Madam,

My name is Sarah Mahlangu, currently studying at the above mentioned university towards a doctoral degree in nursing. My research title is; **Spiritual Care In Nursing: A Grounded Theory Analysis**. The purpose of the study is to analyse the concepts of spirituality and spiritual care in nursing from the perspectives of patients/ clients and nurses. The ultimate aim is to generate a middle range theory of spiritual care in nursing that is grounded upon the patients/ clients and nurses' views of these concepts.

You are therefore, kindly requested to participate in an interview that will be conducted on one to one basis. Each interview will not last for more than 15-20 minutes at a given time. The information shared with the researcher will be kept confidentially. An audio tape will be used during the interview to record the conversation between the researcher and the interviewee. This will be done to facilitate recording. To ensure confidentiality, the researcher will assign numbers to each participant so that the information given is recorded in numbers not in the name of the participant.

Participation in this study is purely voluntarily and essential though not compulsory. Participants are free to discontinue their participation at any time during the study if for any reason they feel they cannot continue with the study. The researcher trusts that the information received will add to the nursing knowledge of total patient care by incorporating aspects of spirituality to patient care.

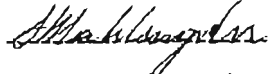
Though participation is not compulsory, it will be a great privilege for you to be part of this new development in nursing. If you will participate please indicate by a mark next to Yes if you will not participate, please mark No on the space below

I will participate on the research study on spiritual care in nursing; a grounded theory analysis.

Yes----- No-----.

Thanking you in advance,

Yours Truly,


S. N. Mahlungulu.

22 March 2000

Kulabo abangaba yingxenyeyocwanningo(research participants).

Mnumzane/ Nkosikazi/ Nkosazane,

Igama lami ngingu Sarah Mahlangu, ngifunda kule University engentla, ngenza iziqu zobudokotela ebuhle ngakazini. Ngenza uphando ngokunakekelwa komphumlo ebuhle ngakazini **“Spiritual Care in Nursing: A Grounded Theory Analysis”** Uyacelwa ngokuzithoba okukhulu ukuba ube yingxenyeyolulucwanningo lapho kuyo xoxiswana nawe ngale sisihloko, ubuzwe imibuzo (interview). Le mibuzo angekhe ithathe ngaphezulu kwamizuzu angamashumi amabili. Okuxoxwe nawe kogcinwa kuyimfihlo. Igama lakho ngekhe lisetshenziswe, kepha, uyonikezwa inombolo eyosetshenziswa esikhundleni segama lakho. Ingxoxo iyoqoshwa kwisi qophamazwi (tape recorder).

Ukuba yingxenyeyalolucwanningo akuphoqiwe, uba yingxenyeyalo kuphela uma uvumile. Uma uvumile ukungena kulolucwanningo ukhululekile ukushiya uma usufisa ukuyeka. Umphathi walolucwanningo uyathemba ukuthi imiphumela iyosiza kakhulu ukwandisa ekuhlengweni kweziguli ngokuphelele.

Yize noma ungaphoqelekile ukuba yingxenyeyalolucwanningo, kepha, kungaba kuhle kakhulu nakuwe ukuthi ebenegalelo ekuthuthukiseni ulwazi lobuhle ngakazi. Uma uvuma ukuba yingxenyeyalolucwanningo yenza uphawu olunje “X” eduze kokuvuma (Yes) noba eduze kokunqaba (No) uma ungekhe uphumelele ukuba yingxenyey.

Mina ngiyavuma ukuba yingxenye yalolucwaningo; Yebo (Yes) ----- Qha (No) -----

Ngiyabonga kakhulu!

Yimina ozithobileyo

Sarah Mahlangu

A handwritten signature in black ink, appearing to read 'Sarah Mahlangu', with a long, sweeping flourish extending downwards and to the right.

ANNEXURE C:

Guidelines for interviews

RESEARCH INTERVIEW GUIDE

SECTION ONE.

SPIRITUAL CARE IN NURSING: PATIENT/CLIENT INTERVIEW GUIDE

The purpose of this interview is to gather information about the concepts of spirituality and spiritual care as you understand and experience them in your every day encounter with life's experiences of happiness, illness pain and suffering. The ultimate goal is to develop a general understanding of the concepts in order to improve nursing care by incorporating aspects of spirituality as desired by the patients/clients.

There are no right and wrong answers to the questions. The idea is to find your honest opinion and experiences that you would classify as spiritual encounters.

CONCEPT OF ONES' SPIRITUALITY

1. What do you understand by the term "spirituality"?
2. Which personal experiences would you describe as spiritual experiences?
3. What significance does spirituality have in your life?
4. How does your spirituality affect your responses to life's crisis such as illness, pain and separation from loved ones?
5. How does your spirituality influence your moments of joy, peace and happiness in your life?
6. Which activities would you classify as directed towards meeting your spiritual needs?

7. What is the role played by spirituality in your life?

Spiritual care in nursing.

1. What do you need for spiritual satisfaction?

2. Which life experiences increase your spiritual needs?

3. How does your spirituality affect your present illness, or how does your present illness affect your spirituality?.

4. During the course of your illness and hospitalization which spiritual needs have you experienced?

5. Which role do you think nurses should play in meeting your spiritual needs?

6. What are your spiritual values that you would like to see respected while in the hospital or continuing with treatment outside the hospital?

SECTION TWO

SPIRITUAL CARE IN NURSING: AN INTERVIEW GUIDE FOR NURSES.

1. What do you understand by the concept of spirituality?

2. What role does spirituality play in total patient care?

3. How do patients express their spirituality?

4. What is the significance of spirituality in providing patient care.
5. What are the spiritual clues you have observed on patients?
6. What role is played by spirituality in patients who are faced with terminal or major illnesses?
7. How have you responded on patient's spiritual needs?
8. How can you describe spiritual care?
9. Which nursing activities would you classify as meeting the patient's spiritual needs?

FOCUS GROUP INTERVIEW WITH NURSES.

The purpose of this focus group is to introduce the topic of my study.

Introduction.

Nurses aspire to provide total patient care which includes the physical, psychosocial and spiritual aspects of all patients. How do we as nurses reach our aspirations? For the physical we clean our patients give treatment as prescribed, making sure that the patient is as comfortable as possible. What about spiritual? What is the spiritual aspect of a person? What is the significance of spirituality in nursing? How does spirituality affect our patients and their responses to nursing care?

In the next fifteen minutes we shall look at these questions and try to answer them as the

answers come to our minds. Remember there are no right and wrong answers. We shall simply be brainstorming on what we think about spirituality and spiritual care in nursing. Thank you for your participation in this focus group discussion. I trust that as we continue to search for answers in spiritual aspect of nursing care, we shall finally find the ways in which we can improve our patient care.

Thank you.

ANNEXURE D:

Table of codes

TABLE 1

REPORT ON CODING OF DEFINITIONS OF SPIRITUALITY FROM ALL DOCUMENTS

Numbers	Nodes	Paragraphs Coded	Documents Coded	Passages Coded
1.	Spirituality as belief	23	11	26
2.	Spirituality as religion	3	2	3
3.	Spirituality as faith	5	4	6
4.	Spirituality gives hope	6	5	7
5	Spirituality as inner peace	8	5	7
6.	Spirituality gives meaning	2	1	2
7.	Spirituality gives purpose	2	1	1
8.	Spirituality as an entire being	2	2	2
9.	Spirituality as emotion	3	3	3
10.	Spirituality as the soul	4	3	3

11.	Spirituality as energy force	2	2	2
12.	Spirituality as inner part	9	6	7
13.	Spirituality as a relationship	9	7	9
14.	Spirituality as ubuntu	4	3	5
15.	Spirituality as value	2	2	2
16.	Spirituality is unique	4	3	4
17.	Spirituality is universal	6	4	6
18.	Spirituality is dynamic	1	1	1
19.	Spirituality as identity	11	5	11
20.	Spirituality as morals	9	4	7