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Spiritual Care Perspectives of Danish Registered Nurses

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A Gadamerian hermeneutic phenomenological methodology was selected to explicate the essence of spiritual care with six registered nurses working within hospital settings. Findings revealed that deep knowing of the patient was essential before registered nurses would engage in spiritual care. Furthermore, spirituality was understood as a private matter, with chaplains being seen as the most appropriate providers of such care. These findings suggest that within the culture of Danish nursing, a mandate to incorporate spiritual care into everyday nursing practice may be somewhat problematic.

Keywords: *caring; nursing care; nursing interventions; nursing role; patients; spiritual care*

Literature clearly raises some interesting dialectical tensions regarding the phenomenon of spiritual care provision by registered nurses (RNs). On one hand, spiritual care is claimed to be a fundamental dimension of RN practice (Carroll, 2001; Carson, 1989; Kociszewski, 2003). Within this literature, it is implied that nurses, who purport to give holistic care, are responsible for providing spiritual interventions for their patients as needed.

On the other hand, international studies have shown that there is a lack of knowledge and general confusion regarding nurses' perceptions and interventions related to spiritual care (McSherry & Draper, 1997; Narayanasamy & Owens, 2001; Schärfe, 1988; Sievers, 2003; Strang, Strang, & Ternestedt, 2002). It is claimed that whereas "sexuality is recognized as an important area of concern for nursing, spirituality is approached by many nurses with embarrassment and hesitation" (Dyson, Cobb, & Forman, 1997, p. 1183). These polarized views give some indication of the complexity of defining and understanding the phenomenon of RN provision of spiritual care.

Adding to the complexity of this discussion, national and international codes of nursing ethics state that the nurse is responsible for the provision of care, which respects patients' values, religions, customs, and spiritual beliefs (Dansk Sygeplegeråd [DSR], 2004; International Council of Nurses [ICN], 2000). Implicit in these mandates is a suggestion that there are different approaches to philosophies or frameworks of life, which might result in different perceptions of the phenomenon of spirituality and spiritual care. Furthermore, values, customs, religion, and spirituality are interrelated phenomena as a person's belief and religion influences and in many cases determines the person's values. In addition, the terms *spirituality, religion,* and *religiosity* are often used synonymously, and this tendency has led to a lack of conceptual clarity.

This discussion, albeit brief, highlights some complex issues related to the provision of spiritual care and provides some insights into the impetus for the current study, which explored the practice of spiritual care within the context of Danish nursing as seen through the eyes of six practicing clinical nurses.

Literature Review

According to Carson (1989) spiritual care is a part of holistic nursing. Carson suggested that nurses must not only observe the patient's nonverbal and verbal behavior, their interpersonal relationships, and their environment but must also undertake observations that indicate a patient has spiritual or existential needs. Examples of such observations include if patients pray during the day, if their attitude conveys a sense of loneliness, if they complain out of proportion to their illness, or have religious artifacts to keep up

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their spirit. Carson recommended that nurses work with patients helping them to identify their concept of *God,* source of hope and strength, and possible religious practices, undertaking tailored nursing interventions in the light of patients' unique needs.

Concerning the nature of spirituality and spiritual care, a study using a phenomenological heuristic approach and semistructured interviews of 15 hospice nurses was conducted by Carroll (2001). In this study, it was claimed that hospice nurses demonstrated an awareness of the existential, religious, and universal nature of spirituality. The findings indicated that hospice nurses perceived spiritual care as a part of holistic care and further suggested that the spiritual dimension was revealed through development of a trusting relationship between the patient and nurse. The nature of spiritual care was defined as recognizing and assessing spiritual needs, demonstrating empathy and developing a trusting relationship, seeking help, recognizing when to let the patient go, and fostering the search for meaning. Moreover, the findings suggested that providing spiritual care required a team approach to care. It is important to note that the participants of this study received education in spirituality. Therefore, it is reasonable to assume that this influenced the study findings. Furthermore, hospice philosophy supports a holistic approach to nursing care, and it is reasonable to question whether the dimensions of spiritual care identified were aspects of spirituality or aspects of a palliative care philosophy.

Kociszewski (2003) conducted a phenomenological pilot study with three nurses about their provision of spiritual care. The findings identified seven themes of spiritual care: the spiritual nurse, capturing the elusive and abstract nature of spirituality, the nurse–patient journey, opening the doors for the spiritual journey, choosing to be silent, the nurses as a role model of spiritual behaviors, and reaping the benefits of spiritual care. Taken together, these themes described the essence of providing spiritual care. It was reported that participants believed being spiritual themselves was a first step to providing spiritual care, described as a complex phenomenon, a connection between the inner and the outer self, and sometimes a connection with a higher power or God. The findings underscored the importance of being silent with the patient as an aspect of spiritual care, and being immersed in a deep relationship with the patient and family. Moreover, it was believed that nurses could teach the family how to touch the patient with love or support them in the final good-byes, when needed. The findings of this study highlight a number of important elements of spiritual care that nurses could consider. However, they should be used with caution as they are based on a very small number of participants.

Despite studies that assert spiritual care as a role function of RNs, others have shown that there is a lack of knowledge and confusion regarding nurses' perception and intervention related to spiritual care. For instance, Narayanasamy (1999) asserted that spirituality ought to be framed within a holistic view of the person, which holds the notion that a person is the inseparable integration of body, mind, and spirit. However, Narayanasamy identified that despite the fact that many nurses believe in holistic care, their interpretation of *spirituality* seems to be deeply entrenched within their understanding of Christianity. This raises a question about whether spiritual needs of patients will be recognized and put into practice only in the context of Christian patients.

A study conducted by Strang et al. (2002) in Swedish health care stressed that holistic care is often not put into practice. The main thrust of this study was to describe the term *spiritual care* and to identify groups of patients for whom spiritual needs might be important. The findings identified that RNs' knowledge about definitions of *spirituality* was limited, although they were willing to pay attention to spiritual needs. However, despite this willingness, they had difficulty defining what such care should include, believing that attributes of spiritual care were being a good listener, respecting and meeting the patients at their level without imposing beliefs, and facilitating the creation of contemplative surroundings. Although these attributes are wholesome, it could be argued that they are normal aspects of the nursing role and not unique to the provision of spiritual care.

McSherry and Draper (1997) suggested a definition of *spirituality* that is universal in its approach, taking into account the uniqueness of individuals and the relevance of this phenomenon to clinical practice. They argued that the knowledge of spirituality for many years has been based on nurses' personal and intuitive opinions of the phenomenon and cautioned that the phenomenon of *spirituality* is too important to be limited by the nurse's subjectivity. This is an important point to acknowledge indicating that further education regarding this elusive concept may be needed.

Although not providing a comprehensive overview of issues related to spirituality or spiritual care, this brief literature review highlights that RN provision of spiritual care is a complex area that warrants further consideration.

Conceptual Framework of the Study

As mentioned previously, the current phenomenological study embraced the philosophy of understanding elucidated by Hans Georg Gadamer (1994). Most particularly the concepts of *Bildung*, *prejudice*, *horizon*, and *fusion of horizons* were utilized in the conduct of the current study, as explained below.

Gadamer contributed to the explanation of understanding by asking how understanding might be possible and in so doing, laid a claim for a hermeneutic form of interpretation. One of Gadamer's key concepts of understanding was *Bildung*, or being open to meaning. Gadamer contended that maintaining an attitude of Bildung enabled one to be open to what is other and to more universal points of view. Furthermore, Gadamer claimed that to understand another, it is important to consciously acknowledge one's personal judgments to be open to the standpoint of another (Gadamer, 1994). Hence when Bildung is embraced, this leads to being open to meaning (Turner, 2003), an essential characteristic that was used within the current study.

According to Gadamer (1994), important to the concept of *understanding* is the utilization of prejudices. Prejudices constitute our historical reality; thus, when an objective is to understand, it is important to embrace prejudices, for they assist understanding (Turner, 2003). According to Gadamer, understanding involves discriminating among prejudices, not eliminating them, while moving beyond our understanding to allow fresh meanings to emerge (Fleming, Gaidys, & Robb, 2002).

Gadamer (1994) explained that things that are a part of our own understanding constitute our horizon. Our horizons are constantly in the process of being formed and cannot be shaped without an understanding of our past. Understanding occurs through a process in which our horizons fuse with those of another, creating historical consciousness (Turner, 2003).

In conclusion, Gadamerian hermeneutic phenomenology was selected as a philosophical basis to explore the phenomenon of how nurses understand spiritual care and how this understanding influenced their practice. Using this methodology assisted the researchers to gain a deeper understanding of this phenomenon, while being aware of and acknowledging their own positions regarding the phenomenon being explored.

Study Design

In-depth audiotaped individual interviews were used to explore the phenomenon of RN provision of spiritual care. In-depth interviews enabled the research participants to freely express their own unique ideas about the phenomenon under investigation, while the researcher maintained the interview focus (Kvale, 1996; Lillibridge, 2002).

Ethical Considerations

Ethical approval was obtained by the university and institutional ethics committees of the data collection site. Participants gave voluntary, informed noncoerced written consent to participate. All participants were advised they were free to withdraw from the study at any time, and should this occur, any data collected up to that time would be omitted from the study findings (Heggen, 1995; Kvale, 1996).

Recalling practice situations and views on how a patient's spiritual care needs were met could be perceived as an invasion of privacy; however, given the participants' voluntary and informed involvement, this was not an issue. It was not expected that recall of a past situation would cause undue distress; however, plans were made to temporarily discontinue the interview until such time as the stress response was resolved. In the unlikely event the issue was not resolved; it was planned that participants would be referred to a chaplain for follow-up care. However, despite these considered plans, they did not need to be activated.

The true identity of each participant was known only by the researchers, and their names were kept separate from the transcribed data, which used the participants' pseudonym. Throughout this research, while not in use, data was stored in a locked cabinet to which only the researchers had access. Furthermore, computer data were stored under password, known only by the researchers. On completion of the study, secured data storage was affected.

Participants

The participants were six RNs who were recruited from a hospital located in Holstebro, Denmark. It is widely acknowledged within qualitative research designs that a sample size from six to eight participants will yield sufficient data to explore the phenomenon of *concern* (Grbich, 1999; Roberts & Taylor, 1998). Furthermore, as the findings of a qualitative study are not intended to be generalized, issues related to the power of the sample to answer the research questions are not relevant or meaningful. The participants were all RNs who were employed from 4 to 26 years in surgery, neurology, and dialysis settings. All were married

women with children, who were between age 28 and 48 years, with an average age of 40 years. All were educated within a hospital-based education program. Three participants had previously been employed in primary health care, one had worked as a psychiatric nurse, and one was a deaconess. Only one participant had completed postgraduate studies.

Data Collection

To recruit participants' notices regarding the study were distributed to all wards of the hospital through the internal postal system. In addition, some posters were placed in the canteen, an area that nursing staff regularly visited. These notices invited RNs who were interested to directly contact the first author; hence the recruitment strategy encouraged RNs who were interested in the study topic to self-select to be involved. The notice explained the purpose of the study and advised that participation involved an audiotaped interview of approximately 1 hr, which would focus on a past nursing situation concerning a patient who had spiritual needs. Potential participants were assured that all discussions would be kept confidential, with only the researchers having access to the information obtained at interview. In total, six RNs volunteered to take part in the current study.

The first author met each participant at a mutually convenient time and place to answer questions related to the study and to obtain written consent. At interview, each nurse was asked to think about a situation with a patient that included spiritual, existential, or religious questions or needs, where the nurse tried to help the patient or family to meet their questions or needs. Recall of this situation was used to commence the interview, which took place in a location that was free from distractions. Some sample questions or exploratory probes that were asked were "When and how did you recognize that the patient had spiritual, existential, or religious questions or needs? At the time, what did you think the patient's spiritual needs were, and what led you to think this? Describe what you did to help the patient to meet his or her spiritual needs. Are there other situations or times when you believe you provided spiritual care to your patient(s) and if so describe what happened?" Subsequent to the interviews, they were transcribed verbatim to create the text for analysis.

Data Analysis

The method of analysis used was developed by Turner (2003) and is congruent with Gadamerian hermeneutic phenomenology. The analysis involved the interviewer and participants in the process of developing a mutual understanding of the phenomenon being explored. Each interview was read and listened to over and over again to identify meanings that were embedded in the dialogue (Kvale, 1996; Lillibridge, 2002; Turner & Emden, 1999). During this process fore-projection, prejudices, and horizons were formed and reformed, while understandings, beliefs, and perceptions were constantly questioned. Throughout, the researchers were prepared for the phenomenon being explored to reveal fresh and new insights. In summary, the analysis had three steps, (a) identifying early ideas that emerged (fore-projections) as the wholeness of what the participants understood as spiritual care was contemplated, (b) revealing prejudices that emerged throughout the analytical process, and (c) explicating the understanding of spiritual care as a fusion of horizons between the researchers and the participants (Turner, 2003).

Credibility and Legitimacy Issues

The methodology that guided the current study and the interpretation of the data was transparent, and an audit trail was developed. The findings were verbally shared with the participants in an individual follow-up meeting with each participant, which was arranged by the first author at a time that was mutually convenient. At this meeting each participant verified that the findings authentically expressed her horizons of spiritual care. During the process of analysis the researchers questioned their own understanding, beliefs, and perceptions of spiritual care and maintained a reflexive attitude throughout the research (Malterud, 2001). Moreover, credibility was demonstrated by using quotations from the interviews (Kvale, 1996; Malterud, 2001; Turner & Emden, 1999).

Findings

To be congruent with the methodological approach selected for the current study, the findings are conveyed using not only Gadamer's philosophy of understanding but also the language that Gadamer used to explain how understanding takes place, from an existential, ontological perspective. The following section reveals the participants' fused horizons, or expectations and inherent positions that they shared concerning their provision of spiritual care. These four fused horizons, when taken together, explicate the phenomenon of spiritual care provision as seen through the

participants' eyes. The horizons that are shared more fully in the following are *deep knowing is required for spiritual care, giving spiritual care is challenging, spirituality is the patient's private area,* and *the chaplain is the provider of spiritual care.*

Deep Knowing Is Required for Spiritual Care

The participants of this research expressed that deeply knowing the patient was prerequisite to giving spiritual care. This required the nurse to consciously build up a relationship of trust. As Participant 5 expressed

> I talk with them, listen to them, ask and try to find out what ideas they have . . . and especially I am open to them so they have the opportunity to bring forth their thoughts, because it requires a relationship of trust. It requires that you stay with them, that you have enough time. . . . And I try to catch the small comments that appear . . . "If I am going to have it this way, you may as well shoot me." How is this going to be interpreted? It is said in a funny way. You can easily slide over it. . . . But it is also a cry about—"help me I am scared." . . . Or is this ever going to be better?"(Participant 5)

Most participants believed that giving physical care paved the way for the provision of spiritual care. For instance, a participant indicated that she liked having a concrete role in providing care for the patient, as this naturally paved the way for spiritually loaded questions. However, it required the nurse to consciously use this situation and through this intimacy show the patient that they were aware of their nonphysical needs. As was expressed:

> I believe that you can offer something concrete like helping them with a shower . . . then a relationship of trust, that you later can benefit from, is established. I believe that . . . it underscores that here I am, and you can use me for what you need. (Participant 1)

> I need to feel that the patient feels secure with me. . . . It is through the physical care that I first will come closer, because this is part of all we are obliged to provide. . . . But if you attend the patient with ideas about more than washing and cloth, then I believe you are understood in a positive way. (Participant 2)

Some participants highlighted that getting to know the patient and their family was essential to providing spiritual care.

> Patients are not just patients . . . they are special and unique . . . and it influences me that he was very good playing the drums, that he played together with his wife, and that they actually appeared together—such bits of pieces of their life until the accident happened. It helps me to see him . . . as a person. . . . So I try to meet them . . . so that I can picture the person I face. What did you do together? How have you been together? and What has he done? So I get a picture of . . . the context that I right now am listening to. Then we have a shared foundation. (Participant 3)

Giving Spiritual Care is Challenging

The participants generally agreed that the provision of spiritual care was complex and hard work.

> But I sometimes feel that we let them down, either we dare not or they do not put it (spiritual needs) up and nonetheless you feel in some way or another when the end is coming, then they have the need, but cannot open up for it . . . and we don't either. It's not good enough anyway. (Participant 5)

> It might be difficult to get started with—that is if they do not themselves put it up. However it is not something that you take up from day one. You need to have a relationship with them or to have known them or have had a course with them. (Participant 4)

Lack of time was, on the other hand, recognized as a legitimate reason to forget or to give a lower priority to the provision of spiritual care, and this was exemplified through the following dialogue: "thus if you are very busy—it is really too bad—then you do not do it, because you really need to have good time to listen to, what they have [to say]" (Participant 6).

However, others felt challenged and obligated to take the initiative to provide spiritual care as a part of nursing, as reflected by the following two participants.

> It is a very exiting area, but I think it is difficult . . . it is so important to embrace the human as a whole being. You need to be more courageous instead of thinking on beforehand to be afraid—and then they just have to back out. (Participant 6)

> Spiritual care is to put it in words, to dare to ask, to dare to sit down and listen, also if uninvited. It is to communicate a sort of peace and confidence. (Participant 1)

Spirituality Is the Patient's Private Area

Spirituality was viewed as a private matter. It was believed that to discuss spiritual matters required a

close relationship of confidence, with a view being expressed that not even a husband and wife or relatives in general discussed mutual spiritual concerns.

> Spiritual care, it is a bit too much—you are really close to the patient, when you discuss spiritual matters. I really feel you need to know them very well before you even might permit yourself to come that far. . . . However it is all over a sensitive area—not only in this system—not really taboo . . . but a very private area that I think not even many discuss with their relatives. As long as they [the patients] have been healthy it has not filled their daily life—so I believe many might feel it embarrassing to discuss. (Participant 5)

The participants expressed that they sometimes kept spiritual care and spiritual interventions as a sort of secret between the patient and the nurse.

> But if they have something confidential they want to tell me, then I keep it between us. . . . There are some spiritual matters, that stay between the patient and me . . . there needs to a confidentiality that is not passed on. (Participant 2)

The Chaplain Is the Provider of Spiritual Care

Referral to the chaplain was a significant intervention used by the participants, who expressed concern that they might impose their own beliefs on the patient. The chaplain was seen as a natural collaborator; however, it was not always clear who might want to see the chaplain, and the participants were sometimes caught by surprise when patients asked for chaplain assistance.

> They might concretely mention that they need to talk with a clergyman. Sometimes we offer them to talk with the chaplain . . . to talk with a chaplain, you did not beforehand think they were interested in that. So we experience that those whom you did not think were interested, nevertheless wanted it. (Participant 4)

> For me, if they signal that they have hard thoughts and so on. Then I mention the chaplain. Also because she is good to talk with, not only about death, but all over about the thoughts they might have in their current situation . . . and this is not only the Christian interpretation. (Participant 5)

Implications of the Findings

The findings of this study provide valuable insights into the provision of spiritual care within a Danish nursing context, although it is acknowledged that the findings cannot be generalized. The participants clearly articulated that spiritual care was important, but there were many stipulations that needed to be met for such care to be initiated. These stipulations, such as deeply knowing the patient before spiritual care, is offered and having sufficient time for spiritual care within a busy working day must be challenged and ultimately overcome, particularly within a fast-paced, rapid turn-over health care delivery system. A study by Greasley, Chiu, and Gartland (2001) indicated that patients had widely varying expectations regarding their spiritual needs, such as a desire to have their sense of meaning and purpose in life acknowledged. Burkhardt (1989) contends that the nurse must be prepared for a variety of expressions from patients and underscores that spiritual care implies an intentional way of being with the patient, being aware of questions such as: "What is sacred to the person?; What brings joy or causes fear in the person's life?; Where and with whom does the person feel a sense of connectedness?; and How does the person understand God or an Ultimate other?" (p. 75). There is a level of intimacy implied in these questions, which we suggest would be difficult for these participants to initiate, particularly given their acknowledgment of spirituality as a private matter. Furthermore, it is difficult to reconcile a belief that providing spiritual care is essential whilst simultaneously holding the belief that spirituality is a private matter.

A significant finding of this study was that the participant's, although being very committed to providing spiritual care to their patients, nevertheless found it difficult. One possible interpretation of this may be rooted in shyness or embarrassment. Another possible explanation may be that the participants were hesitant to expose themselves to their patients, or that they wanted to be very careful not to impose their own beliefs on the patient. These ideas are supported within some Scandinavian investigations (Schärfe, 1988; Sievers, 2003; Strang et al., 2002) and may be rooted in the secularized and pluralistic view of spirituality and religion in Scandinavia, as stressed by Gundelach (2002), resulting in a feeling of uncertainty regarding patients beliefs and the meanings that they ascribe to their spirituality.

It is timely to consider how important spiritual care is, for the patient, and for the nurse, as well as what skills are required to enable nurses to provide spiritual care. The question of whether patients expected spiritual care from nurses was investigated by Taylor and Mamier (2005), who concluded that while some

clients welcome spiritual care from nurses, others do not. The findings suggested that the most preferred interventions were using humor, helping patients to have quiet time, and nurses' private prayer. The least desired therapeutics were psychological approaches like writing and drawing about their spirituality, helping patients to think about their dreams and offering to talk with patients about the difficulties of praying when sick. These findings seem to imply that having the competence and the confidence to offer spiritual care is a matter that requires our utmost consideration. Perhaps it is timely to recommend that we focus on structuring education programs to enhance registered nurse capabilities in initiating and providing spiritual care at both undergraduate and postgraduate levels. This might translate into designing curricula and units of study that specifically focus on enabling registered nurses to gain skills in spiritual care provision. Or it might translate into the mounting of in-service education programs that are designed to enhance registered nurses' understanding of their own spirituality and how this influences their ability to give spiritual care (van Leeuwen & Cusveller, 2004). We suggest that strengthening education programs and placing emphasis on spiritual care content may promote nurses' ability to deepen and expand their own understanding of spirituality and spiritual care, which may result in the creation of spiritual environments for patients. Furthermore, education might pave the way for the understanding of spiritual care as an accepted part of holistic care within the nursing paradigm, prompting nurses to care for the spiritual needs of their patients equally to the patient's other needs. According to Carson (1989) and Stifoss-Hansen and Kallenberg (1999) nurses must reflect on their own spiritual beliefs, as nurses, who are unaware of their own views, might tend to withdraw from patients who have spiritual needs, or they might only come to terms with their own spirituality in the light of their patient's spiritually loaded questions.

In conclusion, we submit that it may be timely for Danish nurses and perhaps nurses from other areas of the world, to consider what can be done at professional and personal levels to enable registered nurses to draw closer to becoming competent in providing spiritual care.

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Christensen and Turner's (2008) study delves into the challenging topic of spirituality and spiritual care as viewed from the perspectives of six Danish nurses. The investigators employed a phenomenologic approach based on Gadamer's (1975) philosophy of science. They confront readers early on with the contradiction inherent in nursing: On one hand, spiritual care is fundamental to nursing practice, whereas on the other hand, nurses continue to lack personal, practice, and empirical knowledge about the nursing science of spirituality. Nevertheless, the concepts of spirituality and spiritual care—like holism, holistic care, or palliative care—offer scope and depth of meanings that are useful in defining the very essence of our discipline. Phrases basic to nursing ontology such as "trusting relationship between the patient and nurse," "nurse-patient journey," "uniqueness of individuals," and "integration of body, mind, and spirit" surface in reviews of studies of spirituality.

The investigators' conceptual framework as based on Gadamerian philosophy is quite fitting for the study of spirituality, in which personal bias and cultural differences influence understandings acquired through research as well as through other intersubjective practices. The data in Christensen and Turner's (2008) study were generated by nurse respondents who were asked to not only reflect on a patient they judged as expressing spiritually related needs but to report on what nursing behaviors the nurse respondents thought facilitated the patient's spiritual processes. Gadamerian analysis strives to reveal and incorporate historical and situational perspectives to inform researchers' interpretations of data. Spirituality is an area of study laden with and in fact defined by bias and belief, personal values and history, situational crises and tradition—all of which Gadamer embraced in his approach to understanding human beings and their world.

We know from the 60-year-old Gadamer wisdom expressed in his magnum opus *Truth and Method* that really there can be no such thing as a Gadamerian "method" if by *method* we mean a strategy of science that bypasses interpretation to generate a representative and stable form of knowledge. Instead, a Gadamerian approach to understanding patients' experiences navigates somewhere between the unwavering reality of objectivism and the disregard for any truth of subjectivism. Thoughtful application of Gadamer's philosophy in spirituality research may eliminate need for the paradoxical practice of apologizing for the elusive nature of spirituality while at the same time attempting to distinguish between the *spiritual* and the *religious*. Regardless of our efforts to methodically pin down definitions, spirituality simply won't be constrained by methods. It must be informed in part by the context of our nursing practice.

Systematic study of spirituality can provide specific insights into this basic human experience for nursing practice. As a result of their research, the investigators identified dominant themes, not so much of patients' spirituality but more of spiritual nursing care: deep knowing through physical and emotional care; the challenge of nurturing a relationship that reveals the whole being of each person and that exposes some of each person's most intimate dimensions; and recognition of the significance of the chaplain as well as other care providers in the interdisciplinary nature of spiritual care. With further study, these spiritual care themes may be confidently interpreted as essential nursing characteristics and behaviors.

What is abundantly clear from the authors' results and interpretations of these themes is that spiritual

care requires personal and practice-based knowledge beyond the forms of knowledge typically promoted in evidence-based practice. Spirituality is not a detached or circumscribed area of knowledge that is then applied to nursing care. Instead, spirituality is already inherently a process of nursing—of relating, trusting, connecting, listening, supporting, respecting, and transcending the immediate situation by engaging one's potential for growth and healing. Continued study of spirituality and spiritual care, like that of Christensen and Turner (2008), grounded in philosophies compatible with the nursing perspective, can help enhance our nursing processes through reflective research and practice.

References

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