Nursing Students' Experiences in Personal Spiritual Formation and in Provision of Spiritual Care to Patients

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Andrews University
School of Education

NURSING STUDENTS' EXPERIENCES IN PERSONAL SPIRITUAL FORMATION AND IN PROVISION OF SPIRITUAL CARE TO PATIENTS

A Dissertation
Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

by
Beverly Jane Cobb
July 2004
ABSTRACT

NURSING STUDENTS' EXPERIENCES IN PERSONAL SPIRITUAL FORMATION AND IN PROVISION OF SPIRITUAL CARE TO PATIENTS

by

Beverly Jane Cobb

Chair: Shirley Freed
ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University
School of Education

Title: NURSING STUDENTS’ EXPERIENCES IN PERSONAL SPIRITUAL FORMATION AND IN PROVISION OF SPIRITUAL CARE TO PATIENTS

Name of researcher: Beverly J. Cobb

Name and degree of faculty chair: Shirley A. Freed, Ph.D.

Date completed: July 2004

Problem

Nursing professionals acknowledge that (a) spiritual care is part of holistic care, and (b) nursing education about spiritual care of patients is inadequate. Evidence points to the importance of personal faith and spirituality in order for the nurse to more effectively render spiritual care to patients. Enhancing knowledge about how nursing students learn spiritual care can benefit nursing education and, ultimately, patient care. This study explored how students with high faith maturity provided spiritual nursing care to patients.

Method

This study engaged phenomenological methods with a study population selected from two faith-based educational institutions. A total of 187 nursing students within
three semesters of graduating completed a brief demographic survey and a 12-item faith maturity scale. From this sample, 62 students who had experienced an intentional spiritual encounter with a patient volunteered to participate in semi-structured interviews. The sample was further refined to those who claimed commitment to Christian faith and scored high on the faith maturity scale, resulting in an interview sample of 16 students from Liberal Arts University and 11 students from Health Sciences College. Data from the interviews were triangulated with written documents describing the schools and their curricula, and with faculty interviews.

Results

Four themes emerged from exploring how life experiences influenced personal spiritual formation in nursing students: Personal spiritual disciplines, relationships, an environment of Christian teaching and growth, and struggle and/or loss. Three patterns of care were evident in the stories the students recounted of how they provided care to patients: Holism, presence, and witness. As the students considered how to become prepared to provide spiritual care to their patients, two areas of enabling were personal faith and preparation.

Conclusions

Twenty-seven Christian nursing students of high faith maturity recounted descriptive experiences of providing spiritual care to their patients. Results of the study showed that their personal faith was the key influence enabling them to give holistic spiritual care. To equip students to provide spiritual care, nursing educators are offered
specific ways to help grow students’ personal faith, as well as preparations educators can use to instruct students about specific aspects of spiritual care provision.
NURSING STUDENTS' EXPERIENCES IN PERSONAL SPIRITUAL FORMATION AND IN PROVISION OF SPIRITUAL CARE TO PATIENTS

A dissertation presented in partial fulfillment of the requirements for the degree Doctor of Philosophy

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Beverly Jane Cobb

APPROVAL BY THE COMMITTEE:

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Date approved
July 6, 2004
To

Jesus, my Savior and Lord

Dan, my forever optimist and life-time love;
Janelle, who uniquely opens a beautiful window to my inner self;
Jeremy, for sharing music and sensibility;
Jonathon, who reminds me daily of God’s providence;
My parents, models of spiritual strength and loving generosity.

My coach, who inspires possibility thinking and positive action;
My faithful friends, sources of comfort and incredible happiness;
My colleagues, from whom I learn so much;
The nursing student participants, who were my teachers.
# TABLE OF CONTENTS

LIST OF TABLES.................................................................................................................... viii

ACKNOWLEDGMENTS ............................................................................................................... ix

Chapter

I. **INTRODUCTION** ........................................................................................................ 1
   
   Foreword......................................................................................................................... 1
   Background of the Problem ....................................................................................... 3
   Statement of the Problem .......................................................................................... 5
   Purpose of the Study .................................................................................................. 6
   Assumptions................................................................................................................ 6
   Research Questions .................................................................................................... 7
   Theoretical Framework ............................................................................................... 7
   Significance of the Study ........................................................................................... 9
   General Methodology .................................................................................................. 9
   Limitations and Delimitations .................................................................................... 11
       Limitations ................................................................................................................ 11
       Delimitations ........................................................................................................... 12
   Definitions of Terms .................................................................................................. 12
   Summary ..................................................................................................................... 13
   Organization of the Study ........................................................................................... 13

II. **THEORETICAL FRAMEWORK AND LITERATURE REVIEW** .......... 14
   
   Theoretical Framework ............................................................................................... 14
   Fowler’s Stages of Faith ............................................................................................... 14
   DeWitt-Weaver’s Social Process of “Becoming Ready” ........................................... 18
   Nouwen’s “Wounded Healer” Metaphor ................................................................... 21
   Literature Review........................................................................................................ 23
   Spirituality Defined ..................................................................................................... 23
   Spiritual Formation ..................................................................................................... 28
       Research in Faith Development/Spiritual Formation Theories .................................. 29
       Spiritual Formation Practices ................................................................................... 35
   Spirituality and Nursing Education ............................................................................ 40
   Nursing Theories .......................................................................................................... 50
III. METHODOLOGY ................................................................. 55

Introduction............................................................................... 55
General Methods......................................................................... 55
Sampling.................................................................................. 56
Data Collection.......................................................................... 59
  Observations........................................................................... 59
  Interviews With Faculty.......................................................... 61
  Interviews With Students......................................................... 62
  Documents Obtained................................................................ 64
Data Analysis.............................................................................. 64
Researcher as Instrument......................................................... 68
Validity and Reliability............................................................. 69
Generalizability.......................................................................... 70
Summary................................................................................. 71

IV. LIBERAL ARTS UNIVERSITY ............................................... 72

Introduction............................................................................. 72
Demographic Data Findings....................................................... 72
Liberal Arts University............................................................... 74
  Liberal Arts University’s Nursing Program.............................. 75
    Godly living........................................................................ 75
    Care.................................................................................. 76
  Liberal Arts University’s Interview Sample.............................. 79
Research Question 1: Personal Spiritual Formation Themes ....... 81
  Personal Spiritual Disciplines.................................................. 82
  Relationships......................................................................... 85
  Environment of Christian Teaching and Growth....................... 87
  Struggle and/or Loss.............................................................. 90
Summary................................................................................. 92
Research Question 2................................................................ 93
  Providing Spiritual Care......................................................... 93
    Holism............................................................................. 93
    Presence........................................................................... 95
    Witness............................................................................ 98
  Enabling Spiritual Care......................................................... 110
    Personal Faith................................................................. 110
    Preparation....................................................................... 117
Summary.................................................................................. 124

V. HEALTH SCIENCES COLLEGE ............................................. 126

Introduction............................................................................ 126

v

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Health Sciences College..................................................126
Health Sciences College’s Nursing Program......................127
Health Sciences College’s Interview Sample.....................132
Research Question 1: Personal Spiritual Formation Themes ....134
  Personal Spiritual Disciplines........................................134
  Relationships.............................................................136
  An Environment of Christian Teaching and Growth..............138
  Struggle and/or Loss...................................................139
Research Question 2.........................................................142
  Providing Spiritual Care...............................................142
    Holism.....................................................................142
    Presence.................................................................144
    Witness..................................................................149
  Enabling Spiritual Care................................................153
    Personal Faith.........................................................154
    Preparation............................................................157
Summary........................................................................164

VI. THE DATA COMPARED ..................................................166

Introduction.......................................................................166
Cross-Case Analysis: The Interview Samples......................166
Research Question 1.........................................................169
Research Question 2.........................................................173
  Providing Spiritual Care...............................................173
    Holism.....................................................................173
    Presence.................................................................178
    Witness..................................................................181
  Enabling Spiritual Care................................................183
    Personal Faith.........................................................184
    Preparation............................................................186
Theoretical Integration......................................................188
Summary........................................................................193

VII. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS........194

Introduction.......................................................................194
Summary of Data Findings...............................................195
Research Question 1.........................................................195
Research Question 2.........................................................195
Conclusions..................................................................197
Recommendations for Nursing Educators.........................198
  Forming Personal Faith...............................................199
  Preparation for Spiritual Care Provision........................201
Recommendations for Future Research..............................204
Summary........................................................................204

vi
Appendix

1. MY PERSONAL REFLECTIONS ................................................................. 207

2. DEMOGRAPHIC QUESTIONNAIRE AND FAITH MATURITY SCALE .......................................................... 217

3. INTERVIEW PROTOCOL AND QUESTIONS AND CONSENT FORMS .......................................................... 220

4. LIST OF DOCUMENTS REVIEWED .............................................................................................................. 225

5. EXAMPLE OF DATA ANALYSIS GRID .......................................................................................................... 228

REFERENCE LIST ................................................................................................................................. 230

VITA ....................................................................................................................................................... 238
LIST OF TABLES

1. Piaget and Vygotsky Compared..............................................................................34

2. Comparison of Demographic Frequencies Between Total Sample and Interview Sample.................................................................................................................73

3. Comparison of Demographic Frequencies Between Two Interview Samples .......167
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CHAPTER ONE
INTRODUCTION

Foreword

The profession of nursing has long been a proponent of holistic patient care, care which emphasizes the integration of the mind, body, and soul. Nurses caring for patients must concern themselves with physical, mental, psychosocial, and spiritual functioning if they hope to genuinely provide care of the “whole person.” Nurses are undergoing a period of re-discovery of spiritual care in nursing. Moving from the historical roots of nursing where Florence Nightingale (1992) advanced nursing as a deeply embedded, God-centered calling, nursing has experienced a period of secularization and humanism (McSherry & Draper, 1998). Yet recently, even within this secular, humanistic context, exploration of spiritual care as a topic of study and focus in nursing is undeniably advancing, as evidenced by over 1,600 references to spirituality and nursing within the CINAHL database in the past 10 years. The editor of IMAGE: Journal of Nursing Scholarship boldly asserted the value of the spiritual in nursing, against the secular tide, in a 1995 editorial (Henry, 1995):

Moral reformation is needed in our civilization, in our society and in nursing. There is moral disorder and narcissism that comes from the loss of spiritual thought nearly everywhere. There is the grotesque imagery in the media of sex and violence. There is abdication of personal and public responsibility.

Some nurses tell me it is not their place to make judgements, to decide with and for patients what is right or wrong. For too many of my students anything goes in the name of multiculturalism and moral relativism.
Yet in a democracy, professionals are expected to exercise moral judgement and this is nowhere more so than when it comes to nurse professionals judging what is best for people's health—their physical, intellectual, and emotional health, but also their spiritual well-being.

There must be a capable core in nursing insisting on higher standards of understanding and action concerning the spiritual factor in people—its nature and how it manifests. There must be those in the profession who can point out the connection between the incessant affronts to human decency and civility, morality and spirituality. Our understanding of the transcendent force in the universe is in the Nightingale tradition of virtue in nursing. (p. 86)

Nursing education within religious educational institutions has valued holistic care and has more readily recognized the importance of spirituality in nursing, perhaps because the concepts of spirituality and religion have been intertwined for many years. Some colleges and universities with strong Judeo-Christian heritage reflect their beliefs about the whole person in their mission and values, even asserting that their Judeo-Christian perspectives contribute something uniquely valuable to students who are learning the healing arts, such as understandings about the value of humankind, morality and ethics, hope and meaning in life (Scriven, 2002/2003).

The profession of nursing is both an art and a science, with the goal of promoting health and assisting individuals through their life span to attain the highest level of health possible (Donahue, 1985). Nurses are privileged to assist clients through episodes of great vulnerability and need, providing support during acute, chronic, and terminal illnesses, during emotional tumult, and even assisting some clients to experience dignified death. In an exploratory investigation into nurses' conceptions of and practices in the spiritual dimensions of nursing, nurses perceived that more spiritual concerns were expressed by patients who were dying, acutely ailing, or aging (Dettmore, 1986). Attending to these concerns, particularly during times of vulnerability, is requisite to the goals of nursing. Holistic nursing care, therefore, includes the spiritual component.
Nurses who provide spiritual care assist individuals to establish and/or maintain an authentic, fulfilling relationship with a transcendent God and with persons significant to their lives.

Nursing education acknowledges the need to educate students to provide spiritual care to patients. In a nursing education study, Lemmer (2002) surveyed baccalaureate nursing programs in the United States to explore how the spiritual dimension of nursing care was being taught. She affirmed that nursing faculty regarded the teaching of spiritual care important to the preparation of students for nursing practice, yet she also found a lack of common definitions of spirituality or spiritual nursing care even within individual nursing programs. Considerable variation also existed in both the content and methods for teaching spiritual care, and little research has been conducted to inform nursing educators of how nursing students learn and develop skill in providing spiritual care.

**Background of the Problem**

A few qualitative research studies have explored nurse preparation to provide spiritual care. A study of 63 registered nurses revealed several interesting points relevant to this study (Dettmore, 1986). Nursing educational preparation for dealing with spiritual care of patients was minimal, if any; however, life experiences were found to be important for learning spiritual care. Role modeling of instructors and valuable non-nursing courses in the curriculum were also factors in nurses' preparation for spiritual care (pp. 110-116).

Using grounded theory research methods with registered nursing participants, Schnorr (1988) identified spiritual care factors within the context of the nursing process.
and proposed key concepts to include in spiritual care instruction. Various strategies for learning spiritual care, including role modeling, personal experiences of the nurse, and religious education were consistent with Dettmore’s findings. Schnorr cited two obstacles to educating students in spiritual nursing care, including (a) the nurse’s personal discomfort with spirituality, and (b) forces within society that de-emphasize religion and spirituality (p. 141).

A grounded theory study in the area of nurse preparation to provide spiritual care was conducted by DeWitt-Weaver (2001). Her theory involved the social process of “becoming ready” to provide spiritual care and was comprised of three sequential stages: Learning faith, thinking it through, and trying it out (pp. 66-82). DeWitt-Weaver’s unverified theory will be discussed more fully in the theoretical framework section of chapter 2.

A qualitative study of 11 nurses’ experiences with spirituality and end-of-life issues confirmed the lack of education about spirituality within basic nursing programs (Brown, 2000). In addition, as in Dettmore’s study, life and professional experiences contributed to the nurses’ abilities to provide spiritual care. The nurses relayed how their own spirituality enabled them to facilitate good death experiences for patients and their families and contributed to their own personal renewal as they cared for patients at end of life. Brown makes the case that “nurse educators also have a responsibility to help students create within their own lives a sense of spirituality that will grow with their experiences in nursing and life” (p. 122).
Statement of the Problem

Holistic care is the integration of physical, mental, emotional, and spiritual concerns of patients. The nursing profession espouses holistic care, accepting it as part of their nursing role. Health care accrediting agencies, such as the Joint Commission on Accreditation for Healthcare Organizations (2003), have mandated that health care facilities provide spiritual assessment and care for patients and their families, thus further emphasizing the importance of spiritual care in the health care arena. It is logical, therefore, that nurses be educated and trained for their spiritual care role. Many researchers have suggested that nurses’ own personal spiritual formation enhances their attitudes and skills as providers of spiritual care (Brown, 2000; Dettmore, 1986; Getzlaf, 1996; Harris, 1994; Kemp, 1998; Vander Werf, 1999). Yet, nursing research indicates that practicing nurses do not believe they received adequate education and personal development to provide spiritual care to patients (Bath, 1992; Berry, 1997; Brown, 2000; Grotbo, 2000).

Limited research exists in the area of spiritual care and nursing education. Some research suggests the importance of nursing students learning methods to cultivate spiritual awareness, learning how to recognize spiritual encounters, and how to reflect on this aspect of nursing practice (Conco, 1993; Getzlaf, 1996). Other research proposes curricular ideas for teaching spiritual care and/or enhancing students’ attitudes about spiritual care provision (Carson, Winkelstein, Soeken, & Brunins, 1986; Schnorr, 1988; Shih, Gau, Mao, Chen, & Lo, 2001). One research study by DeWitt-Weaver (2001) proposed a theory to explain the processes involved in student nurses feeling prepared to provide spiritual care (p. 11). DeWitt-Weaver’s research is directly relevant to the purposes of this study, yet her theory has not been verified. There is no other research to
demonstrate how nursing students enhance their own personal spiritual formation and become ready to meet the spiritual needs of patients. This study provides further research into how nursing students become ready to provide spiritual care.

**Purpose of the Study**

This research explored nursing students' perceptions of their own personal spiritual formation, and the life and curricular experiences that influence how they provide spiritual care to patients. The guiding research question was: How do students with a high faith maturity provide spiritual nursing care to patients? The populations for this study came from two undergraduate nursing programs in private, religiously affiliated institutions of higher education located in the Midwestern region of the United States. Nursing students within three semesters of graduation were invited to complete a 12-item faith maturity index. From this sample, nursing students selected for phenomenological interviews scored high on faith maturity within the population sample, professed Christian faith, and had had an experience of providing spiritual care to patients.

**Assumptions**

1. Faith development, also known as spiritual formation, is the means by which individuals grow to higher levels of faith maturity.

2. Faith maturity can be objectively measured.

3. Individuals with high levels of faith maturity can provide more effective spiritual care to others than individuals who are not mature in their faith.
4. Educational experiences can influence students’ faith development and their understandings about spiritual care.

5. Students are aware of and can articulate the phenomenon of their faith experience and its relationship to their spiritual care of patients.

**Research Questions**

The research questions which focused this study were:

1. How do life experiences influence personal spiritual formation in nursing students?

2. In what ways do these life experiences described by nursing students and students’ experiences within the nursing curriculum influence how they provide spiritual care?

**Theoretical Framework**

The work of three individuals provided the theoretical underpinnings of the proposed research: James Fowler’s (1981) classic research explicating the stages of faith development, Diann DeWitt-Weaver’s (2001) recent grounded theory research about nursing students “becoming ready” to provide spiritual care to patients, and theologian Henry Nouwen’s (1979) well-known metaphor of the “wounded healer.” Each of these frameworks is described in greater detail in chapter 2.

Fowler’s stages of faith development are relevant to research question 1. He regards faith as

our way of finding coherence in and giving meaning to the multiple forces and relations that make up our lives. Faith is a person’s way of seeing him- or herself in relation to others against a background of shared meaning and purpose. (Fowler, 1981, p. 4)
As a “universal human concern,” irrespective of one’s religious experience, Fowler believes that faith and religion are “reciprocal,” impacted, changed, and invigorated through interaction with each other (pp. 9-10). In Wilfred Cantwell Smith’s words, “Faith is meant to be religious” (as cited in Fowler, 1981, p. 10). “But in fact, faith struggles to be formed and maintained in many persons today who feel they have no usable access to any viable cumulative religious tradition” (p. 10). Fowler’s theory was heavily influenced by several well-researched developmental theorists: Piaget, Erikson, and Kohlberg (p. 39).

DeWitt-Weaver (2001) theorized three growth stages of becoming ready to provide spiritual care to patients. Using a concept map, the basic social process of becoming ready to provide spiritual care emerged in the sequential stages of “learning faith,” “thinking it through,” and “trying it out” (p. 46). This theory was selected because of its direct relevance to nursing education. The research questions for this study related harmoniously to the intended outcomes of each stage of becoming ready and the data that emerged were analyzed in light of this theory.

Lastly, Nouwen’s (1979) image of those who minister to others as “wounded healers” fits with the findings of several researchers that nurses must be in touch with and nurture their own spiritual needs and well-being to more effectively render care to others (Brittain & Boozer, 1987; Getzlaf, 1996; Grotbo, 2000; Harris, 1994; Nagai-Jacobson & Burkhardt, 1989).
Significance of the Study

A study of nursing students' perceptions about their own spiritual formation and their provision of spiritual care to patients is important for several reasons. First, for at least 25 years contemporary nursing practice has recognized its historical roots as holistic care givers. Yet in spite of the recognition of the importance of spiritual care for patients, the explicit role of the nurse and the education of nursing students to provide spiritual care have not been well developed (Brittain & Boozer, 1987; Groer, O'Conner, & Droppleman, 1996; Piles, 1990). The need for spiritual care by the care givers who most often frequent the patient's bedside is unquestioned, even if the care is limited to appropriate assessment and referral. Literature demonstrates that teaching basic nursing students about spiritual care is important, yet few studies have been conducted to learn how students emerge with beginning skills as spiritual care givers. This study was undertaken to help fill this knowledge gap.

Second, DeWitt-Weaver's (2001) theory of nursing students becoming ready offers an opening understanding, but this theory has not yet been verified. This study may provide useful data to aid in theory verification.

The primary value of the study has been to provide information to improve nursing educators' abilities to teach spiritual care to undergraduate students. Enhancing knowledge about how nursing students provide spiritual care can benefit nursing education and, ultimately, patient care.

General Methodology

Qualitative phenomenological methods are the appropriate research methodology for exploring the lived experiences of participants. "The defining characteristic of
phenomenological research is its focus on describing the 'essence' of a phenomenon from the perspectives of those who have experienced it" (Merriam, 2002, p. 93). The data collection process was threefold:

1. Information about the educational institutions in general and, more specifically, the curricular instruction, was obtained from the participating institutions through faculty interviews and review of documents from the educational institutions and from the nursing programs.

2. A spiritual maturity scale was completed by each participant. This quantitative instrument assessed the participants' spiritual maturity as viewed from a Judeo-Christian perspective.

3. Face-to-face interviews using open-ended, semi-structured questions pertinent to the research purposes were conducted with participants who scored high on faith maturity.

Data from these interviews were then reduced and analyzed for major themes common to participants from each educational institutional and the themes common to all participants. The findings were discussed in light of the theoretical constructs chosen to guide the study, as well as relevant literature.

The population for this study came from two undergraduate nursing programs in private, religiously affiliated institutions of higher education in the Midwestern region of the United States. Sample selection used purposive sampling techniques. "Purposeful sampling is based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned"
The following criteria were used in selecting the interview participants:

1. Enrollment in an associate or baccalaureate nursing program
2. Class standing within three semesters of graduation
3. Nursing students who have the highest faith maturity scores within the population sample
4. Profession of Christian faith
5. Awareness of having experienced at least one intentional spiritual encounter with a patient.

The sample numbered 27 participants, 16 participants from Liberal Arts University and 11 participants from Health Sciences College. The sample reached saturation, a primary criterion in determining the sample size for a qualitative study (Merriam, 2001, p. 64).

Limitations and Delimitations

Limitations

One challenge of phenomenological research is the ability of the researcher to engage the research subjects in conversations that “focus on concrete examples and feelings rather than on abstract speculations” (Eisner, 1998, p. 183). The extent to which subjects described their lived experience in sufficient detail and depth determined the meaningfulness of the information gleaned. Additionally, sampling strategies in phenomenological research are more limited than other types of qualitative research because the subjects must have previously experienced the phenomenon (Creswell, 1998, p. 118).
Delimitations

Students used for this study were situated within two Midwest Christian institutions of higher education, thereby narrowing the scope of study. The two nursing programs in which the students were enrolled profess and teach from a Christian world view. Views of and experiences with spirituality for these students were from the Christian perspective, rather than a universal perspective. Additionally, only students within three or fewer semesters of graduation were invited to participate.

Definitions of Terms

Nursing. O’Brien’s (1999) definition of nursing was selected for this study. O’Brien states,

Nursing is a sacred ministry of health care or health promotion provided to persons both sick and well, who require caregiving, support, or education to assist them in achieving, regaining, or maintaining a state of wholeness, including wellness of body, mind and spirit. The nurse also serves those in need of comfort and care to strengthen them in coping with the trajectory of a chronic or terminal illness, or with experiencing the dying process. (p. 6)

Spirituality. Spirituality is essentially relationship—a relationship of the whole person to a personal God and to other people. It is personal, not an impersonal energy force, giving inspiration to deep moral and ethical principles (Shelly & Miller, 1999, p. 82). Spirituality cultivates a meaningful purpose to one’s life and develops when nurtured.

Spiritual formation. “Spiritual formation is a process of being conformed to the image of God for the sake of others” (Mulholland, 1993, p. 12).

Spiritual care. Spiritual care is an integral component of holistic nursing care. Its focus is to assist individuals to establish and/or maintain an authentic, fulfilling relationship with a transcendent God and with persons significant to one’s life.
Summary

Chapter 1 presented an introduction of the topic, background for the study, poses the research problem, purposes, and assumptions, and defines the research questions. Theoretical frameworks were introduced and the significance of the study elucidated. General methods, limitations, delimitations, and definition of key terms concluded this chapter.

Organization of the Study

Chapter 2 describes the theoretical context of this research topic and situates it within other relevant research. Chapter 3 describes the methodology of qualitative research. Additionally, sampling parameters, issues of validity and reliability, human subjects review committee approvals, participants’ consent, interviewing, and data collection and analysis are described in depth. Chapters 4 and 5 present the data specific to each educational institution. Chapter 6 compares and contrasts the data from the institutions, and discusses research findings in relationship to the theoretical frameworks and other relevant literature. Lastly, chapter 7 summarizes the study and the findings, provides implications for nursing education, and recommends future research.
CHAPTER TWO

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Theoretical Framework

The theoretical underpinnings of this study are guided by the concepts found in Fowler's (1981) stages of faith development, DeWitt-Weaver's (2001) stages of becoming ready to provide spiritual care, and the wounded healer metaphor advanced by Nouwen (1979), and are described in the pages that follow.

Fowler’s Stages of Faith

This section summarizes the stages of faith advanced by James Fowler (1981). Faith development has relevance to spirituality because of the intertwining of terminology and themes used to define both concepts. Spirituality has been studied by nurses and others for over 30 years without even consensus about its definition. When asked to discuss or define spirituality, a full understanding of its meaning eludes many nurses (Brown, 2000; Dunajski, 1994; Taylor, 2002). Similarly, Fowler (1981) describes the concept of faith as “inexhaustibly mysterious.” Like spirituality, faith is unique and variable for each person and universal to humanity. It is relational, interactional, imaginative, capable of growth, and influenced by community, ritual, and language. Faith conveys meaning, purpose, and commitment larger than our individual selves. It provides context and coherence to life and helps to unify our life, allowing us to answer the question, “For whom or what will you give your one and only life?” It shapes our
initiatives and aspirations according to what one recognizes as ultimate value and power (pp. 3-31, 93).

Fowler, a theologian and psychologist, re-introduces the work of comparative religionist Wilfred Cantwell Smith with his description of faith:

Faith, then, is a quality of human living. At its best it has taken the form of serenity and courage and loyalty and service: a quiet confidence and joy which enable one to feel at home in the universe, and to find meaning in the world and in one’s own life, a meaning that is profound and ultimate, and is stable not matter what my happen to oneself at the level of immediate event. Men and women of this kind of faith face catastrophe and confusion, affluence and sorrow, unperturbed; face opportunity with conviction and drive; and face others with cheerful charity. (as cited in Fowler, 1981, p. 11)

“Faith involves an alignment of the heart or will, a commitment of loyalty and trust” (Fowler, 1981 p. 11).

Fowler’s faith stages are classic in religious literature and are also cited in literature reviews in nursing studies related to spirituality (Dunajski, 1994; Getzlaf, 1996; Hitchens, 1988; Schnorr, 1988). Schnorr stated that Fowler’s theory was particularly applicable to nurses who understand holistic nursing concepts (p. 165). Hitchens (1988) used Fowler’s conceptual framework for analyzing spiritual care within the student nurse-patient relationship and found it to be a useful model for teaching and researching about spiritual care. Fowler draws from and acknowledges the immense influence of well-known structural-developmental theories of Piaget (cognitive development) and Kohlberg (moral development) in his study of faith development, particularly to help him “study the structuring activity of faith” (Fowler, 1981, p. 109). Yet Fowler departs from his colleagues by including emotion and imagination, as well as cognition, in his faith stages (pp. 101-103). His work draws more heavily from the work of Erik Erikson, whose contribution to understanding emotional developmental stages has been significant.
in nursing. Fowler used Erikson’s work to develop the functional aspects of faith, enabling him to couple existential issues with the life cycle. Even more importantly, Erikson’s work enormously contributed to Fowler’s mind-set for his research (p. 110). What follows is a discussion of Fowler’s stages of faith development. Fowler describes stages as

the characteristic patterns of knowing, reasoning and adapting in ways that describe general features of human growth, applicable to all of us, despite the vast differences we recognize in our unique experiences and the contents and details of our particular life stories. (pp. 89-90)

Alternative names for each faith stage, suggested by Astley (1992), are included in parentheses because they better describe the faith stage than the technical terms used by Fowler.

Stage zero, primal faith (nursed faith, foundation faith), begins undifferentiated during infancy. While it is impossible to empirically research this period, Fowler believes that it sets the stage for important faith development issues that will arise later in life, such as trust, hope, courage, and love.

Stage one, intuitive-proj ective faith (impressionistic faith, imaginative faith, unordered faith), begins in early childhood and uses symbols, words, and imitation as tools. Knowledge and meanings emerge through stories. Imagination is unrestrained and can evoke intense feelings. Fear of death is common. Awareness of death, sex, and parental taboos exists. Primary awareness is of family, and God is undifferentiated from the self.

Stage two, mythic-literal faith (ordering faith, narrative faith), emerges during the school years. Imagination is strong, as are concrete thinking and literal symbolism. Meanings still come from stories, yet the child is enmeshed in the story, without the
ability to reflect from a distance. Fairness and reciprocity constitute the approach to moral judgment. Relationships extend to those who are similar.

Stage three, synthetic-conventional faith (conforming faith), gives rise during adolescence. Characteristically of adolescence, interpersonal relationships and peer loyalties hold prominence, and fear of failure arising from desire for others’ approval can exist. Beliefs are tacitly, yet very deeply held. Cognitive patterns are non-analytical. Images of God evoke someone companionable, supportive, and a personal guide. This stage of faith seeks personal acceptance, affirmation, and confirmation. Authority is external to one’s self. Symbols, rituals, and reality are intertwined and inseparable. It is possible for individuals to maintain a synthetic-conventional style of faith indefinitely, sometimes for one’s remaining years. Interestingly, stage three is the normative faith stage in North American churches and synagogues.

Stage four, individuative-reflective faith (choosing faith, either/or faith), generally becomes evident no earlier than young adulthood. During this stage objectivity and critical reflection emerge and individuals begin to distance themselves from their previous value system. Knowledge and meanings are reduced, flattened, and made explicit, through analytical thought patterns. High confidence levels join with a capacity for critical reflection of one’s world view. Faith meanings become separated from their symbols. Faith can become one’s own as beliefs are deliberately chosen.

Stage five, conjunctive faith (balanced faith, inclusive faith, both/and faith), occurs during mid-life and beyond, if at all. It is represented by complexity, paradoxes, and an ability to experience interrelatedness and interdependence within one’s world. One is open to interfaith conversations and to conversion. Contemplative, meditative
reflection provides a useful tool for examination of faith complexities. Symbols and their conceptual meanings are reunited, enabling the past to be reworked and reclaimed so that a “deeper self” emerges. Healing images of God prevail.

Stage six, universalizing faith (selfless faith), rarely occurs, but when it does, the impact is extraordinary, as evidence in the lives of individuals such as Mahatma Gandhi of India and Mother Teresa of Calcutta. Individuals at stage six possess an enormous and intentional commitment to justice and love. They are guided by a vision, born of identification with those down-trodden. Feelings of love, freedom, and generosity which are characteristic during this stage are accompanied by a readiness to sacrifice one’s self. God, imaged as compassionate, transcendent, and generous, becomes mirrored in the faith experience which is generous, transforming, and redeeming. One’s world view is pluralistic and diverse, with no attachment to power.

In summary, drawing from Erik Erikson’s functional stages of emotional development, Fowler identifies six stages of faith development which incorporate existential faith issues with the human life cycle. Most individuals in North America stop their faith development at stage three. Only extraordinary individuals ever reach faith stage six. Faith development is progressive, and greater development of faith enables people to weather life crises more effectively.

DeWitt-Weaver’s Social Process of “Becoming Ready”

Next, we turn to DeWitt-Weaver’s grounded theory (2001) research which describes the processes at work that contribute to nursing students feeling prepared to provide spiritual care (p. 42). Twelve senior baccalaureate nursing students from schools that included spiritual care content in the curriculum constituted the sample. Nine of the
12 participants attended religiously affiliated schools; the remaining 3 participants attended state universities. Clinical experiences were reported to have been in primarily religiously affiliated hospitals.

Data analysis yielded the core concern of the study: The concept of “becoming ready” to provide spiritual care. The process of becoming ready involves three apparently sequential stages: Learning faith, thinking it through, and trying it out (p. 46).

Personal spiritual development of the participants influenced the stage of “learning faith.” Experiencing one’s self as a spiritual being, receptivity to spiritual matters, and the influence of family role models contributed to the participants’ spiritual formation. Groups, such as churches or spiritually focused “small groups,” also provided instruction and influence.

In the second stage of becoming ready, called “thinking it through,” the participants identified influences that facilitated their professional and spiritual integration. Envisioning themselves as spiritual care providers was aided by learning information about the spiritual care role, content such as understanding concepts of holistic care in nursing, nursing diagnoses related to spiritual distress, therapeutic communication, and culturally specific care. Other sources of information cited by participants were nursing journal articles and conferences related to spiritual care. Environmental influences (i.e. open and encouraging attitudes about including spiritual care within the professional nursing role,) role models, and small group discussions during the college experience, gave the students permission to integrate spirituality into the professional role.
In the third stage of becoming ready to provide spiritual care, “trying it out,” students had opportunity to incorporate spiritual care in actual nursing practice. In order to be prepared to even recognize opportunities for trying out spiritual care, nursing students identified the need for a relevant knowledge base. Additionally psychomotor skills played a role, either sufficient confidence in psychomotor skills in order to be able to focus on holistic care, or a care setting where psychomotor skills were not prominent. Having the motivation to be sensitive to patients’ spiritual needs and a degree of confidence in the nursing role were also important. Once prepared to recognize opportunities for providing spiritual care, the student nurses then described a variety of cues from patients which indicated readiness for spiritual care, verbal, non-verbal, and environmental cues. Environmental support was experienced through the mission focus of the agency, a sense of unhurriedness, and one-on-one patient encounters. When the pre-cursors to care, opportunity, and then a supportive environment occurred, students reported providing spiritual care. Confidence levels and motivation to provide spiritual care were enhanced through doing it.

DeWitt-Weaver’s study demonstrated careful understanding of methodological planning. Techniques such as prolonged engagement, comparison of data, memos and journals of the researcher, peer debriefing, and an audit trail enhanced the credibility and confirmability of the study. Sufficient description was used throughout the study to illustrate the themes and coding conclusions. The researcher generously evidenced literature support for the concept map and the basic social process of becoming ready which she proposed.
Additionally, several study limitations are also apparent, including a lack of saturation “due to the small number of participants, lack of follow-up interviews, some lack of in-depth description by participants, and time constraints combined with a novice grounded theory researcher” (p. 40). However, as a doctoral student, her background in grounded theory data collection and analysis had been enhanced through additional exposure at an institute for spiritual care research. I also did not see evidence of piloting the research questions.

In summary, DeWitt-Weaver’s research generates new substantive theory about how students “become ready” to render spiritual care to patients. This theory encompasses three sequential stages of this social process: “Learning faith,” “thinking it through,” and “trying it out.”

Nouwen’s “Wounded Healer” Metaphor

The third framework I propose for this study is not a theory and it has not been empirically tested. However, I believe Nouwen’s (1979) metaphor of the “wounded healer” is relevant to the conversations with nursing students about their perceptions of personal spiritual formation and provision of spiritual care to patients. As a theologian, Nouwen addressed his book, *The Wounded Healer*, to ministers who seek relevance and effectiveness in their healing role. It is not a stretch to conceive of nursing as a call to healing ministry. Consider Grotho’s (2000) statement:

Nursing comes from the very essence of the human spirit striving for meaning in a world where strife, hunger, and pain exist. Just as art, music, and ritual are spiritual, so nursing itself is a spiritual expression. Ask any young person of any religious background or culture wishing to enter this profession why and they will probably answer that they want to help people be well. (p. 11)
So while Nouwen’s wounded healer metaphor was written with the ministerial calling in mind, its application to those who experience calling as a nurse can also be meaningful.

Nouwen (1979) draws his metaphor from Talmudic identification of the promised Messiah who “sits among the poor binding his wounds one at a time so that he can be ready to help someone else when needed” (p. 82). Nouwen suggests an analogy of Jesus’ own broken body as the means by which Christians draw healing and life—Jesus’ own wounds become the source of healing power for humanity. Nouwen invites readers to consider that we are all wounded, with a universal wound called loneliness. He elaborates on ways loneliness is experienced and maintains that people often live with the fantasy that their world will be complete, if only.

Nouwen (1979) challenges caregivers to embrace their woundedness as a reflection of “the depth of the human condition which all men share” (p. 88). When healers embrace their own woundedness, they can more effectively facilitate the healing of others. The healing task, oddly defined with the concept of hospitality, is a process that calls for the healer to help another feel comfortable, free, and fearless. Nouwen believes this process can be accomplished by attending to and genuinely listening to the wounded, giving them freedom to come to their own place of healing. Nouwen maintains that healing is not given to another person, but rather the healer creates conditions whereby the wounded can examine their own wounds and feel challenged to see a better future. O’Brien (1999) applies the wounded healer metaphor to the nursing role:

The nurse, as any person who undertakes ministry, brings into the interaction personal and unique wounds. Rather than hindering the therapeutic process, the caregiver’s wounds, when not unbound all at once, can become a source of strength, understanding, and empathy when addressing the suffering of others. The nurse as a wounded healer caring for a wounded patient can relate his or her own painful
experiences to those of the ill person, thus providing a common ground of experience on which to base the initiation of spiritual care. (O'Brien, 1999, pp. 11-12)

In summary, Nouwen advances the importance of being in touch with and learning from one’s own “woundedness.” Then, one’s personal “wounding” can serve as a platform for more effective care giving to others.

With these three conceptual models as backdrop, their relevance to this particular research study will be explored with the data analysis.

**Literature Review**

The three general areas of study comprising the literature review include (a) a survey of research and literature defining spirituality, (b) literature pertaining to spiritual formation, and (c) studies exploring the area of spirituality and nursing education. Nursing theories related to spirituality will be very briefly explored. Several databases, ERIC, CINAHL, Dissertation Abstracts, ATLA Religion, First Search OCLC and Academic Search Elite, were accessed and reviewed, using combinations of these key words: “Christian,” “spirituality,” “nursing care,” “education,” “spiritual formation,” “faith development,” and “health care.”

**Spirituality Defined**

A brief review of the nursing literature pertaining to spirituality illuminates one of the phenomenon perceived to be problematic in the study of this subject: There is no commonly accepted unifying definition of the term spirituality (Groer et al., 1996; McSherry, 2000; McSherry & Draper, 1998; Stoll, 1989; Taylor, 2002). Some nursing authors believe that a standard definition of spirituality is impossible because the concept is inherently subject to individual interpretation (Cawley, 1997; Grotbo, 2000). This
view is supported by such religious writers as O’Gorman, who states “By its nature spirituality is not definable” (2001, Summer, p. 351). Individuals holding a monotheistic world view (belief in a personal God as creator and ruler of the universe) will naturally view spiritual matters differently from a polytheist or an atheist. Following her dissertation defense, Carson (1993) reflected on the issue of one’s world view and spirituality. She stated,

There indeed could be different expressions of spirituality—a Christian spirituality; a generic spirituality which contains no clear reference to spirit but focuses on a humanistic quest for transcendence and meaning in life; a Jewish spirituality characterized by a belief in the God of the Old Testament and an expectation for a Messiah; a pantheistic spirituality which infuses Eastern philosophies and the New Age movement. (p. 25)

Studies continue to try to define spirituality as viewed by practicing nurses. For example, using phenomenological methods to research spirituality and end-of-life issues, Brown (2000) reported that the small, purposive sample of 11 nurses indicated spirituality was difficult to define, but they described it as “a belief, a relationship, a connectedness with everything, and a higher power . . . truth and honesty in our relationships with others” (pp. 74-75). Grotbo (2000) used qualitative methods to explore spirituality within the clinical setting. Set against a biblical illustration of Mary and Martha, friends of Jesus described in the Gospels, she asked the question, “How do nurses recognize when it is appropriate to act as Mary in relating to patient needs versus Martha?” (p. 6). Participants, all of whom were reared in the Roman Catholic religion, used these phrases to define spirituality: “Need for meaning and purpose,” “meaningful relationships with others or a higher being,” “transcendence above everyday life,” “individual and personal,” “a search for answers to illness, death or life,” and “part of religion, but separate and different from” (p. 34). Yet Grotbo herself seems to
acknowledge the difficulty of achieving a universally accepted definition of spirituality because she states,

As much as some nursing theorists wish to view spiritual caring from a Judeo-Christian background or to find a universality to define spirituality, the reality may be that there is no way to unify the concept and the approach would be to switch the thinking from uni-spirituality to multi-spirituality. . . . Perhaps education in the varied religions and spiritual beliefs strongly grounded in a nurse's own spirituality are the main ingredients required to provide spiritual care along with empathy, respect, and knowing the patient. (pp. 14, 65)

McSherry and Draper (1998) believe that the nursing profession is still in the early phases of concept and theory development with regard to spirituality and advocate the importance of finding a universal definition of spirituality in order to help further research into this aspect of care. Using concept analysis, Emblen (1992) attempted to explicate spirituality, as distinguished from religion, through a review of nursing literature published between 1963 to 1989. This review determined that spirituality is a broader term than religion, citing the words that appeared most frequently in literature definitions of spirituality—personal, life, principle, animator, being, God, quality, relationship, and transcendent. Words used to describe religion included system, beliefs, organized, person, worship, and practices (p. 41). However, Dunajski (1994) concluded that spirituality was not “distinct from and broader than institutionalized religion” and that it is also not “distinct from and broader than the psychological dimension” (pp. 192-193). The nursing subjects in her phenomenological study perceived spirituality to be a universally unifying theme requiring relationships with others in order to grow and nurture one’s spirituality. She concluded that “spirituality is an umbrella concept under which caring operates and that spirituality and caring are best expressed through relatedness” (pp. 196-197).
A study by Golberg (1998) has contributed another conceptual perspective to the subject of spirituality in nursing care. Golberg used both literary and qualitative approaches to synthesize the concept of spirituality in order to create a new insight about its meaning. From reading a variety of literary works about spirituality, she distilled two categories of phenomena identified as products of a relationship—a physical relationship (presencing, touch, and healing) and an emotional relationship (meaning, empathy/compassion, hope, love, and religion/transcendence) (p. 840). Moving from these categories, Golberg then selected the concept “connection” to represent the essence of spirituality in nursing care. She validated this conclusion through conversations with nurses and through a return to the literature to determine the adequacy of the concept.

Similarly, Lickteig (2003) studied spirituality from a theoretical perspective, incorporating existential theories of Martin Buber and Rosemarie Rizzo Parse's nursing theory. Her goal was “to conceptualize spirituality in a way that brings it into everyday life” (p. 27). The key word she uses for spirituality is “connection” of people with themselves, each other, and their world. The experience of connection is important to nurses being able to genuinely care and convey compassion for their patients. However, an encounter with God or with the divine was not necessary to experience connection or transcendence.

With all the various definitions of spirituality evident in the nursing literature, I selected Shelly and Miller’s definition (1999) because I believed that it would encompass the world view of many students enrolled in the religious institutions from where my study sample would be selected. Nevertheless I struggled with this definition. Undeniably, individuals from all societies, cultures, and eras have been, are, and will be
face to face with the hard-to-define experience of "spirituality." Existential questions surrounding the meaning of joy, suffering, and hope, the purposes for which one lives, and the values for which one would give everything slip into the consciousness of maturing humanity, no matter the culture. I asked myself, "Is there a 'right' and 'wrong' spirituality?" Some assert, yes, the claims of Jesus cannot be disregarded in the matters of spirit (Shelly & Miller, 1999). However, answers to this question were not apparent in nursing research literature; I believe they are rooted and grounded in one's world view, with all its variations and individuality. For example, an evangelical Christian chaplain who has mentored many college students provides a simple and concise definition of spirituality drawn from his understanding of the writings of the Apostle Paul.

"Spirituality is learning to pay attention to the presence of God in everything" (Anderson, 2002, p. 67). In another example, nursing author Verna Carson (1993) reflects her Christian world view about spirituality in her analogy of a prism to an individual's spirituality.

A prism bends or refracts light as it passes through. Some prisms refract white light so that all the colors of the spectrum are visible. To me, this is analogous to Christian spirituality—a belief in Jesus reflects all truth. However, other beliefs refract or bend spirituality so that some colors, but not all, are visible. Anyone who seeks to be spiritual will share some common ground, regardless of their world view. (p. 25)

It is beyond the scope of this inquiry to debate the merits of differing world views. But it does appear that spirituality encompasses a uniquely human quality of the human race. Other life beings on this earth share what we know as physical, emotional, and intellectual qualities. But what other life forms share spirituality, vague and ill-defined as the concept may be? As Taylor (2002) suggests, "Spirituality is an innate, universal
aspect of being human. Everyone has a spiritual dimension. This dimension integrates, motivates, energizes, and influences every aspect of a person’s life” (pp. 4-5).

This section of the review of literature explored the definition of spirituality, primarily from nursing literature. In conclusion, I cite a description of spirituality from Stoll (1989). This description depicts spirituality with vibrancy, enthusiasm, and passion—qualities often found when reading spirituality literature and research, perhaps because this topic represents the writings of those for whom spirituality is real and personal. Stoll wrote,

Spirituality is my being; my inner person. It is who I am—unique and alive. It is me expressed through my body, my thinking, my feelings, my judgments, and my creativity. My spirituality motivates me to choose meaningful relationships and pursuits. Through my spirituality I give and receive love; I respond to and appreciate God, other people, a sunset, a symphony, and spring. I am driven forward, sometimes because of pain, sometimes in spite of pain. Spirituality allows me to reflect on myself. I am a person because of my spirituality—motivated and enabled to value, to worship, and to communicate with the holy, the transcendent. (p. 6)

Spiritual Formation

In this section, the literature pertaining to spiritual formation is reviewed. For the purposes of this literature review, the terms *spiritual formation* and *faith development* were considered essentially similar concepts, with the process of spiritual formation ideally leading to maturity in one’s faith. A number of researchers have explored faith development as a process in which stages of maturity are identified. Researchers and religious scholars have also written extensively about the means, practices, and disciplines which position an individual to be receptive to God’s formative power. This section will explore both of these dimensions of spiritual formation.
Research in Faith Development/Spiritual Formation Theories

Well-known researchers in the area of developmental theory include Jean Piaget, Erik Erikson, Robert Kegan, Carol Gilligan, and Lawrence Kohlberg. The work of such theorists provides an important backdrop to understanding the dynamics of faith, particularly for the foremost faith development researcher, James Fowler. Fowler’s work in the area of faith development is regarded as the most comprehensive and effective in relating faith to development theories (Parks, 1986). Because his original work in the stages of faith has been previously discussed in the theoretical framework section, it will not be explored here.

Fowler’s own publications about faith development have continued to evolve (Fowler, 1984, 1992, Autumn, 2001; Fowler & Nipkow, 1991) and his work has spurred a significant amount of reflection, study, and research by others throughout the world. Two texts have been devoted solely to further exploring Fowler’s faith development theory. In the book, Faith Development and Fowler, editors Dykstra and Parks (1986) evaluate Fowler’s theory from a variety of perspectives, promote ways of enhancing the theory, and make ministry applications. Astley and Francis (1992) also compiled a significant amount of thoughtful evaluation, critique, and application of Fowler’s stages of faith. Undeniably, Fowler’s theory is very appealing because it speaks to experiences that are familiar to the reader. Because his understandings of the concept of faith are central to exploring faith stages, it is natural that the primary discussion, clarification, and critique of Fowler reside in the definition of “faith.” Yet to reach a definition of faith acceptable to evaluators has been as elusive as defining spirituality. The second most
frequent criticism of Fowler’s faith stages pertains to the adequacy and appropriateness of the methodology used for determining his sixth stage of faith.

Situating her research within Fowler’s faith stages, Sharon Parks (1986), another important researcher in the field of faith development, explores the faith experiences of young adults and the role of higher education. She proposes a transitional stage between Fowler’s stage three (synthetic-conventional faith, or conforming faith) and stage four (individuative-reflective faith, or choosing faith). This stage is characterized by a probing commitment, fragile inner dependence, and a mentoring community which helps to ground the young adult’s faith. Parks (1986) borrows a metaphor of “shipwreck” from one of her professors to describe threats to one’s faith precipitated by disequilibrium and life events which create the potential for transformation and growth. With transformation comes gladness, for “we typically would not wish to return to not knowing that which we have come to see on the other side of shipwreck” (p. 24). Parks also introduces the important role of professors in higher education as mentors and in a later book explores this responsibility and privilege in greater depth (2000).

Fowler’s work has also been the springboard for numerous dissertation research studies. Some of these studies have analyzed the structure and developments of Fowler’s theory (Cristiano, 1986; Oikarinen, 1993). Others compared aspects of Fowler’s theory with other faith development theories (Hancock, 1992; Thomas, 1990). Drewek’s study (1996) tested Fowler’s model in an Eastern cross-cultural environment and found cultural biases in defining stages three and four. Four studies used Fowler’s theory to explore different aspects of faith in higher education: Creel (2000) investigated predictors of college student coping and found that spirituality was the only significant predictor that
explained the variances in coping resources. Hiebert (1993) explored the effects of liberal arts, professional, and religious post-secondary education on faith development and discovered that students in liberal arts education tended to display more existential open-mindedness than displayed by students in professional or religious education.

Bolen (1994) found Fowler’s research theory useful in his exploration of faith development with college students, except that it did not explain the students’ perceptions of their parents and how these perceptions affected their interpretation of life issues.

Lastly, Houghton (1994) studied how faith development theories were applied as practice models in Christian colleges’ student affairs programming. She concluded that there was little evidence of faith development theory being used in these higher education settings, except in three institutions.

Whereas Fowler’s faith development is cast from a universal faith perspective, Fortosis (1992) presents an evangelical approach to spiritual formation stages. His early work in stages of spiritual growth was later followed by research into the theological foundations of this model (Fortosis, 2001, Winter). Fortosis describes three stages of Christian formation. First, formative integration begins at the time of religious conversion. Individuals in stage one possess less biblical knowledge or discernment. They tend toward dogmatism, without differentiating areas of faith where there is room to differ. Feelings easily surface, serving as fertile ground for spiritual doubts. Enthusiasm is genuine, yet motives and attitudes are extrinsically influenced. Approval-seeking behavior is common. Second, responsible consistency emerges. Christians in this stage grow in biblical knowledge and can discerningly apply it to daily life situations. They demonstrate concern and sensitivity for others and give themselves faithfully in service.
Love becomes less conditional and motivations purer. Convictions are strong, with less theological dogmatism. Third, self-transcendent wholeness develops. Intimacy with God is deep, consistent, and unwavering. Coherence exists between the private and public life. Faith, strong and unwavering, sustains individuals even during crises. Strong biblical knowledge, secure theology, and compassionate love help the believer be flexible, adaptable, and redemptive with others. Life is lived for the sake of others and a sense of social justice prevails. Fortosis describes the Christian growth process in this manner (1992, pp. 294-295):

1. The growth model is similar whether converted as a child, adolescent, or adult.
2. Gender differences are not a significant factor.
3. The Holy Spirit supernaturally influences the process.
4. Pure motives are the true measure of spiritual growth.
5. Christian formation is God-seeking, not self-centered.
6. The rate and quality of growth cannot be forced.
7. Crisis, or dissonance, provides points of decision, which can result in more intense spiritual growth.
8. Spiritual regression is possible, especially during early stages of Christian growth.
9. Growth areas are not uniform.

Ratcliff (1993) attempts to re-introduce some early pioneering work in spiritual development by Harold Darling (1969). He proposes Darling’s stages as a synthesis of Wesleyan and Reformed views, which may help those in evangelical theology to find common ground in the study of faith development. The Wesleyan position believes two
crisis experiences are central to spiritual development: First, salvation—the beginning of
spiritual life, and then Christian perfection—"a moment of cleanings of the carnal nature
and perfecting love for others" (Ratcliff, 1993, p. 74). The second point of crisis is
particularly controversial with those of the Reformed view, who believe that perfection is
unattainable in this life; however, even traditional Wesleyan theology has been shifting
slowly away from the sinless perfection model. Darling's (1969) stages of spiritual
growth incorporate physical and emotional development, beginning with the first stage of
birth. Next comes spiritual childhood, spiritual adolescence, and finally adult spiritual
maturity. A time of spiritual turbulence seems normative during spiritual adolescence
and resolution can occur in either dysfunctional or healthy ways. Dysfunctional
resolution includes spiritual neurosis (abnormal concern about the spiritual condition),
spiritual psychosis (elevation of doctrine and fanaticism), re-enslavement (defeat and
retreat to the pre-salvation existence), regression to spiritual childhood, and fixation
(perpetual turmoil and faultfinding). The healthy resolution is surrender to the Holy
Spirit and strongly embracing faith. In this model, spiritual growth is discontinuous. The
ideal is for spiritual growth to continuously increase, but the reality of human failing
creates times of pause and reversal.

In 2002 the conceptual framework used to study spiritual formation took a much
different approach than the structural developmental process effectively advocated by
Fowler. Lev S. Vygotsky's developmental theory, which has had significant impact on
contemporary approaches to education, is beginning to be explored for its application to
spiritual formation (Estep, 2002). "The fundamental premise of Vygotsky's concept of
development is that the formation of the mind or cognition is dependent on the social
context in which an individual lives" (Estep, 2002, p. 145). Estep summarized the primary differences between Vygotsky and Piaget theories, as seen in Table 1. (As previously stated, Piaget’s and Erikson’s theories heavily influenced Fowler’s approach to faith development.)

Table 1

*Piaget and Vygotsky Compared*

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Although Vygotsky’s theory did not address spiritual formation or spirituality, applications of his theory bring new insights to the study of spiritual formation. Estep describes six such implications. Quoting from Estep,

1. *Spiritual formation begins outside the individual.*
2. *Spiritual formation and its ecology are holistic.*
3. *Spiritual formation is not a linear or unidirectional process.*
4. *The community of faith is an essential element for spiritual formation.*
5. *Spiritual formation occurs when faith is mediated between individuals.*
6. *Teachers and deliberate instruction are essential for spiritual formation.* (pp. 160-162)

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One final model of spiritual formation I wish to present was compiled by Keith Anderson (2002) from his understandings of the Apostle Paul’s teachings. These principles guided Anderson’s work in developing a planning and assessment process for spiritual formation on college campuses affiliated with the Council for Christian Colleges and Universities. Anderson writes,

1. Spiritual development requires community with others.
2. Spiritual mentors are needed.
3. God causes the spiritual growth in our lives.
4. Spiritual disciplines provide a place, or the classroom, to learn spiritual truths.
5. Spiritual development occurs in the everyday of life work and relationships.
6. Spiritual development is rooted in understanding the person of Jesus Christ.
7. Christian maturity is about paying attention and responding to the activity of God in our lives (p. 69).

**Spiritual Formation Practices**

Not surprisingly, research studies that explore practices and conditions for enhancing spiritual growth are often situated within faith-based institutions. Seventh-day Adventist education extensively explored the effectiveness of its educational and congregational programs for youth in Grades 6 through 12. Rice and Gillespie (1992) reported on this landmark study involving nearly 11,000 students and 2,300 parents, teachers, and pastors. The Faith Maturity Scale served as a survey instrument, with one in five Adventist youth displaying mature faith, just under the high of 28% reported by the U. S. Southern Baptist Convention in studies of faith maturity in other denominations.
Fourty-one effectiveness factors were isolated in youth who displayed greater faith maturity. The strongest of these factors included the quality of family worship, a church climate that emphasizes "learning, discussion, question-asking, and independent thinking," and the "quality of the school religious education program" (p. 59).

A second, more comprehensive Valuegenesis study was conducted 10 years after the 1989 Valuegenesis\(^1\) (Rice & Gillespie, 1992) study. Its population sample numbered almost 25,000 students in Seventh-day Adventist schools and enabled a comparison of Seventh-day Adventist youth to Valuegenesis\(^1\), as well as provided a picture of the values, commitments, and choices of the millennial generation (Valuegenesis\(^2\), 2001). An increased number of students in Valuegenesis\(^2\) displayed high faith maturity (40%) and saw themselves as religious (96%) compared to the previous Valuegenesis\(^1\) study. Personal devotional practices, such as prayer, Bible and other religious reading, and participating in religious programming, were important predictors of mature faith. Over 50% of boys and girls held intrinsic religious attitudes, a very positive indicator of faith. Similar to Valuegenesis\(^1\), the family religious formation played a crucial role in the faith development of youth, especially the comfort levels of parents in discussing personal faith. Family worship continued to be important, as did an open church climate that encouraged questions and new ideas.

Several faith development studies from the field of higher education explored ways to impact spiritual formation in students. Using qualitative methods, Newman (1998) explored the faith experiences of first-year traditional college students on a faith-related campus. She found seven factors contributing to faith development including, (a) significant background events in students' lives, (b) a campus setting that promotes faith,
(c) conscious choices of students to participate in campus programming, (d) strong ties with parents, peers, and significant others, (e) faith instilled by parents, (f) faith in God during challenging times, and (g) personal involvement in the process of sorting out their own individual beliefs.

Next, a study of personal spiritual formation within seminary education conducted by Tasker (2002) explored how pastors in training were impacted by a 10-week required class in spiritual formation. Using a qualitative case study approach, several different data collection methods enabled excellent corroboration of the data; reading reports, journals, retreat survey, final reflection paper, focus groups, metaphors, interviews, participant observation notes, and surveys were used. The beginning sample at the start of the research was 116, with 62 students completing the 1-year-later survey. This study provided rich results from the large variety and quantity of data, including analyses of the effectiveness of the retreat and the various class assignments, the impact of the required spiritual disciplines, small group connections, the importance of mentoring by a teacher/facilitator, and 1-year-later changes in the students' lives created by engaging in this class experience. A suggestion to shift the phrase “spiritual disciplines” to “relationship enhancers” may create a more preferable image in the mind of students, as would the phase “spiritual journey” rather than “spiritual formation.” Tasker concludes, 

Spirituality cannot be legislated or manufactured, since it has more to do with recognizing who God is and allowing Him to be God in all aspects of our lives, than it has to do with human endeavor. Yet without intentionally planning personal time for God, the busyness of everyday life is likely to crowd out activities that could enhance relationship building initiatives. Spiritual formation is not a program to be implemented, but a life to be lived in the presence of God for the sake of others and is something which God desires for all people. Thus, peoples' spiritual lives seem to benefit from help with the forming of daily habits and practices through the spiritual disciplines. (p. 341)
Tasker continues her discussion of spiritual formation with a vivid definition.

Spiritual formation is the process of learning to live life as it was always meant to be—living in the presence of God, with God at the center of our lives, so that who we are with ourselves and with others and the world depends on who we are with God. Appreciating and enjoying God becomes the greatest treasure, and open, honest, and authentic relationships, without mask or pretension, become the valued by-product. Thus spiritual formation initiatives commencing with those charged with the responsibility of nurturing spirituality in others is an important place to begin modeling the process of personally knowing God. (p. 350)

A third study by Barber (1999) explored the changes in the spiritual lives of students from Oakland City University through use of a spiritual formation curriculum. The curriculum includes (a) theological and historical overview of spiritual formation with encouragement to students to experiment with various spiritual disciplines, (b) use of Myers-Briggs Type Indicator to match students’ personality temperaments to the disciplines, and (c) a weekly one-to-one accountability group session, plus two accountability conferences with the instructor. Using pre- and post-testing inventories with this small research sample of 14 students, the results of the study found that a spiritual formation curriculum had a positive influence on students’ spiritual practices and on their attitudes toward the significance of using spiritual disciplines. Students also demonstrated measurable progress in identifying their calling into service to others. However, scores on three of the six subscales of the Spiritual Life Inventory were lower, perhaps as students became more in touch with their spiritual progress through the introspective and reflective activities.

Using a church population in India, researcher Srinivasan (1996) investigated how a mentoring model could be adapted to helping an individual contribute to the faith development of another individual. The model was developed using Daniel Levinson’s concept of mentoring and Fowler’s faith development theory. Goals, content, and

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methods suitable to the mentoring process and faith development were suggested. Lastly, a feminist approach to spiritual formation has been proposed by Paik (1999) after her narrative research into women’s spiritual growth.

Some of the richest, most helpful literature pertaining to the subject of spiritual formation practices comes from theological investigation and reflection by thought leaders in the discipline of theology. While not based in formal research, any discussion of spiritual formation would be incomplete without mentioning the incredible heritage to the Christian faith that such authors have provided. Kenneth Boa (2001) annotates a number of classic authors in his excellent and comprehensive text, *Conformed to His Image: Biblical and Practical Approaches to Spiritual Formation*. Boa also attempts to explicate the immensely elusive concept of spirituality by discussing 12 different facets of spirituality to “reflect the various dimensions of biblical truth as they relate to practical experience on a personal and corporate level” (p. 21).

Hidden Life in God (1998) contribute a rich tapestry to an understanding of Christian spiritual formation.

This section above explored the literature related to two aspects of spiritual formation, first the theories of spiritual formation, and second the means by which spiritual formation occurs.

Spirituality and Nursing Education

Next the research pertaining to spirituality and nursing education is examined. Numerous research exploring spirituality among patients and/or nurses has concluded that educating students for spiritual care is an appropriate responsibility of nursing education; some studies also suggest concepts and methods for teaching spirituality and spiritual care (Brown, 2000; Conco, 1993; Dettmore, 1986; Getzlaf, 1996; Grotbo, 2000; Harris, 1994; Piles, 1990). Additionally, non-research literature also tackles the “whys” and “hows” of teaching spirituality in the nursing curriculum (Brittain & Boozer, 1987; Carson & Gerardi, 1985; Forshee & Wiebe, 1984; Pesut, 2003; Piles, 1989). However, this section of the literature review is confined to a review of the most relevant research studies dealing with spirituality and the nursing curriculum, students, and/or faculty. Where appropriate, incidental findings related to spirituality and nursing education are also cited.

The study with the most relevance to my research topic is the grounded theory study by DeWitt-Weaver (2001). This study explored the experience of Christian student nurses becoming ready to provide spiritual care and was analyzed in detail earlier under the theoretical framework.
A quantitative study by Bath (1992) explored the challenges which nurses and students perceived as they engaged in spiritual care to their patients. Bath found time, uncertainty about personal spiritual beliefs, and a lack of knowledge about spiritual care as hindering factors to spiritual care provision. Bath’s research was undertaken in an institution with religious affiliation and did not include faculty perspectives. Meyer (2002) extended Bath’s study 10 years later in a quantitative study which explored factors contributing to students’ perceived ability to provide spiritual care, as well as the changes occurring in students’ perception of spirituality during their nursing education program. With a sample size of 280 students and 111 faculty members, Meyer used a one-time convenience sample from baccalaureate programs, broadening it to include six in public institutions and six in private schools with religious affiliation. The tools used included two student surveys, a 28-item Spirituality Assessment Scale, and a 10-item Student Survey of Spiritual Care, which included items informed by Bath’s results. Faculty also completed a four-item survey developed for this study. The findings from Meyer’s study showed “decreased religious commitment of students in public programs, less program emphasis as rated by faculty and students and a decreased perception of ability to provide spiritual care” (p. 97). Students believed attention to spirituality was essential for holistic care, but they did not feel adequately prepared to provide spiritual care. Those in public schools believed that spirituality was too private a matter to be discussed with patients. More than 60% of the students also believed their views about spiritual care had positively changed since entering the nursing program. The time dedicated to teaching spiritual care within the curriculum did not significantly differ between public and private
programs, and totaled less than 6% of classroom instruction and less than 10% of clinical discussions.

Peterson (1997) investigated differences in spiritual care of patients between collegiate schools of nursing that used the Neuman Systems Model and schools that did not. A quantitative study, using a stratified sample, explored nursing students and faculty self-evaluated issues of spiritual care using a 19-item Spiritual Care Questionnaire and a 10-item Spiritual Needs Questionnaire. Peterson’s study found increased curricular time spent on spiritual care in schools which used the Neuman Systems Model. Unlike Meyer’s (2002) study, Peterson found that those schools with religious foundations reported more time spent in teaching spiritual care than in non-religious schools. She also found that using Neuman’s Systems Model helps to highlight the importance of spiritual care provision.

An early study by Banks (1980) surveyed present and future experts in the field of health education using a modification of the Delphi Technique to determine experts’ perceptions of whether spirituality should be included in professional education. Three rounds of data collection were used, the first sample being six health education experts’ views about the spiritual dimension. Next a sample of 56 current experts, graduate teaching assistants, and retired experts ranked the relative importance of each of 27 items produced from the first data collection round. The third round of data collection was then used to develop majority and minority opinions from the results of round two. One positive aspect of this type of study is its ability to regard futuristic questions, for example, identifying the perceived significance of the spiritual dimension in the next 25 years (p. 199). A possible methodological limitation may have occurred because the
second and third data collection processes discussed only what was generated in the first round from the small panel of experts. The study ranked the components of the spiritual dimension, resulting in a definition of the spiritual dimension of health care. According to Banks, spirituality involves (a) a unifying force to one's life, (b) meaning and purpose in life, (c) selflessness and giving to others, and (d) individual ethics to live by (pp. 199 & 201). Suggestions of effective ways to teach spirituality included recognition of diversity in backgrounds and in spiritual experiences of students and patients, respect for one's personal spiritual and religious beliefs, recognition of different levels of importance in the spiritual dimension to one's life, and regard for separation of church and state. Clearer reporting of the study results could have improved readability and understanding of the results and would have assisted the reader to more easily identify the study conclusions.

Two studies reported student reactions to teaching spirituality within the nursing education experience. Carson et al. (1986) evaluated the effect of didactic teaching about spiritual care. Educators administered pre- and post-tests using a tool entitled the Religious Belief Questionnaire; this tool assessed the spiritual attitudes of 176 junior-level baccalaureate nursing students. Students were randomly assigned to one of 7 elective nursing courses. A course exploring spirituality and nursing was one of the options, while the other elective courses acted as control groups. Reliability and validity of the instrument had been verified and appropriate provisions were made for subject anonymity during the questionnaire distribution, collection, and coding. Study findings indicated no significant demographic differences between groups. There were also no differences in students' self-perceptions of their own religiosity among the students in the
various elective courses. Using an analysis of covariance for each subscale in the
questionnaire, changes in four of the pre- and post-test subscales occurred with students
who took the spirituality course. The four subscales indicative of positive attitude
changes were God, the Bible, religious practices, and organized religion. The attitudes of
students in the other electives remained unchanged. Sample items for each subscale
provided additional understanding of the subscale.

A second study, an international exploration of spiritual care in Taiwan, also
evaluated the effectiveness of a teaching course on spiritual care with master’s degree
nursing students (Shih et al., 2001). Seventy-seven percent of the 22 subjects reported
no previous experience in providing spiritual care to patients. In this course, taught by
Christian faculty members, a universal definition of spirituality was used, rather than one
bound by religious connotation. A methodological triangulation research design was
employed, comprised of three phases: Didactic course work for 18 weeks, field methods
where the students practiced providing spiritual care to a client, and narrative descriptions
of their experiences using case-study methods. The authors included full description of
the course content, rich examples of the various teaching strategies, and detailed analysis
of the case study results. The study results indicated the course in spiritual care achieved
its intended outcome by assisting the students to clarify the theoretical concepts of
spiritual care, provide “culturally bonded” spiritual care planning, self-disclosure of the
nurse’s own spiritual needs and values, and understanding the meanings and impact of
religious rituals in the patient experience (p. 341). Several study limitations are identified
in the sampling and methods. There was no teaching about spiritual care related to
psychiatric disorders, as well as some religious practices to which students were exposed.
in the clinical portion of the study. The clinical experiences were student generated and not supervised, so the evaluation of this experience is limited to the students' perspectives. Because the course was elective in nature, student sampling bias may have also occurred. The results of this study and the previous study by Brittain and Boozer (1987) give evidence to the belief that “spiritual care can be taught and attitudes enhanced through education” (Shih et al., 2001, p. 345).

From interviews with 17 nurse educators, Miklancie (2001) found five themes which describe the impact of these nurse educators’ personal spirituality on their teaching practice:

1. Relationship with God, with self and with others;
2. Ways of being spiritual;
3. Finding meaning and purpose in and beyond earthly life;
4. Risk-taking/role-modeling because of a spiritual “boldness”; and
5. A call to serve others spiritually. (Miklancie, 2001, p. 147)

She concluded from the study findings that spirituality needs to be integrated into nursing education settings and there is value in including spiritual assessment skills and formal courses about spirituality into the curriculum.

Using descriptive research methods, Denham (1990) examined spiritual care in nursing education from the viewpoint of nursing faculty members. A wide variety of issues were explored: Faculty members’ perceived ability to teach spiritual care, attitudes and roles in educating students about spiritual care, faculty members’ religious views and education, the nursing programs’ philosophy, theoretical framework, and curricular content. Questionnaires were mailed to 64 nursing schools in the state of Ohio. All types of nursing programs preparing for registered nurse licensure were included in the survey—diploma, associate degree, and baccalaureate. Each program director was
requested to select two faculty members to complete the survey—one faculty member who was perceived to be biased toward spiritual care and the other who was perceived as unbiased. The sample population totaled 128 nursing faculty, with a return rate of 70.3%. The self-administered data instrument had been slightly modified from two other instruments with construct validity, and the revised instrument was not tested for validity and reliability. There was also no evidence of relating the study results to either of the two theoretical models selected to frame the study.

Key results of Denham’s study were these:

1. A large percentage (98.9) of nursing faculty support spiritual care as part of a holistic model for nursing care.

2. Faculty noted greater skill and comfort, as well as allotted time, to teaching interventions identified as caring behavior and psychosocial support than interventions more specific to spiritual care. Other research findings correlating to Denham’s research are an often-referenced study by Highfield and Cason (1983) which found that nurses identified many spiritual problems as psychosocial in nature, rather than spiritual. Nurses professing spirituality in Dunajski’s study (1994) also identified spiritual needs when expressed in the context of God and/or religion. Other needs were interpreted as psychological.

3. Faculty who rated their religious views as important perceived themselves as views as important.

4. The school’s theoretical framework impacted the inclusion of spiritual care in the nursing curriculum.
5. The philosophy was related to threading spiritual care content through the curricula, but not to offering a focus area in spiritual care or a spiritual care elective.

6. Religious schools had a greater tendency to include spiritual care as part of the curriculum, either by curricula threads or course elective.

7. Many faculty, 70.8%, perceived a lack of time as the most significant obstacle to teaching students about spiritual care.

Two more recent qualitative studies reached conclusions about the issue of time, yet from a different angle. Conco (1993) studied spiritual care from the recipients’ perspective and wrote,

Finding from this study indicate that in most instances spiritual care was not time consuming nor did it require extensive knowledge of different religions and philosophies. Brief comments about a supreme being’s care, an encouraging word, or touch, and visits of five to ten minutes were all remembered as significant spiritual care. (p. 66)

Grotbo’s (2000) registered nursing participants acknowledged the reality of time limitations, but recognized how to address spiritual needs while caring for physical needs. The following description captures a clear and realistic picture of how to make effective use of valuable, precious time nurses have in caring for their patients.

So how do you train nurses to optimize their time? Again, it is not so much duration as it is repetition. If every time you go into the room you sit down with the patient, you may not spend more time in that room than you did before, but you are on a different level, because you are looking at the patient and the patient sees that you are willing to make eye contact. I have seen guests and visiting ministers come in and decline a seat. Well that means they are scared to death or they are in a hurry. It is a whole lot more effective than puttering or fidgeting or rearranging. I try to teach my students that, but they find it hard to see. I try to incorporate that into their med/surg area, so when we are doing units on IVs and ‘piggyback’ and ‘pushes’. You have push? [sic] What a great time! You are going to learn something about the patient. No, you are not there to put that med into them. Your job was to determine if that was the right med, adverse reactions, compatibility before you went into the room. Your job now is to sit down and get to know that patient while you administer that medication. (p. 40)
Schnorr's (1988) study used grounded theory methodology to explore spiritual nursing care. The strength of this study was the research design. The volunteer sample, comprised of 46 registered nurses with interest and skill in spiritual care, came from a variety of nursing education backgrounds, health care settings, and practice/specialty areas. Nurse participants had been recommended by other nurses for their expertise in spiritual care. After familiarizing herself with the interview guidelines by doing practice interviews, Schnorr then engaged participants in unstructured interviews. She reached sample saturation and reported her results with thick, rich description, further enhancing the credibility and confirmability of the study. The literature review lacked analysis or synthesis of the literature and it was difficult to determine which of the works cited were research-based.

Five primary concepts defining spirituality emerged from Schnorr's study: Individuality, security, purpose, feelings, and total person. In addition, her findings indicate that spirituality is perceived to be related to, but distinct from, religion and psychosocial concepts (p. 56). Respondents thought that spirituality involved a relationship to a higher power, but was not tied to specific religious beliefs or formalized religion. Her study noted that spirituality was similar to psychosocial aspects, but different, deeper, involving a belief in a higher power and transcendence (pp. 62-63).

Schnorr's depiction of the practice of spiritual nursing care was embedded in the steps of the nursing process. The assessment step identified religious and emotional cues from the patient, as well as guides to help conduct the spiritual assessment. The heart of the spiritual nursing care model encompassed the planning and intervention steps of the nursing process and was summarized by the CIRCLE model, a mnemonic device with
each letter representing one of the categories of planning and intervention. These
categories represented caring, intuition, respect for religious beliefs and practices,
caution, listening, and emotional support (p. 116).

Schnorr’s study also explored how spiritual care was learned by the nurse
participants. Methods cited included religious education, role modeling, personal
experience, experiences of patients, reading, and nursing classes. She also offered a
variety of suggestions for educating students in spiritual care, noting ideas for curriculum
integration, specific courses on spiritual care, key concepts to teach, and continuing
education options. This study emphasized, as have so many, the opportunity to improve
spiritual care education through increasing the nurse’s personal comfort with spirituality.

Lickteig (2003) endeavored to influence a new pedagogy of spirituality through
envisioning spiritual connectedness. In this connectedness, both the nurse/patient and/or
the teacher/nurse experience transformation of “living and teaching in the everyday
world” (p. 26). To accomplish the spiritual journey, she highlights several themes she
believes are essential for connecting on a spiritual level. Discomfort energizes spiritual
movement. Quietude provides the time and space for reflection about life and its
meanings. Contemplation enables one to be present to the moment. Surrender allows us
to experience spirituality, rather than attempt to “own” and master it. For a teacher to
enable this journey of connectedness, the teacher must embark on finding “their own path
toward connection” (p. 168). Lickteig also provides suggestions to teachers who wish to
facilitate spiritual awareness in the lives of their students. In order to create relationships,
she recommends that teachers model connecting in dialogue with others, as well as
experiencing connection through inanimate others, such as music, poems, or stories that

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tap the inner soul. She advocates embracing discomfort because it can have a regenerative effect. Paradox is to be valued. Lickteig recommends that teachers surrender certainty and authority, giving others the opportunity to create their own realities and meanings. Faculty must also leave time for connecting with others, including with students, and give space for contemplative experiences.

The above section reviewed the literature pertaining specifically to spirituality and nursing education.

Nursing Theories

The literature review would be incomplete without referencing nursing theories which highlight spiritual aspects of care. Martsolf and Mickley (1998) created a thoughtful analysis of modern nursing theorists’ reviews of spirituality as evidenced in the nursing theories. They divided the nursing theories into two world views: The reciprocal interaction world view and the simultaneous action world view. The reciprocal interaction world view sees humans are part of a whole, interacting with other humans and their environments. Change happens only in response to threats. The simultaneous action world view identifies patterns in humans which interact with the environment. Change continuously occurs as “humans move towards more complex organization” (p. 295).

The authors also evaluated the extent of focus given to the concept of spirituality, with only four theorists holding spirituality as central enough to change the theory if spirituality were omitted. Betty Neuman’s systems model does not promote Christian faith, but it does not preclude a Christian world view. Other theorists, Margaret Newman’s theory of health, Rosemary Parse’s theory of human becoming, and Jean
Watson’s theory of human caring, do not approach spirituality from a Christian perspective. Using the world views described by Martsolf and Mickley (1998), reciprocal interaction or simultaneous action, the type of world view does not seem to influence whether the theories regard spirituality as major concepts. Neuman’s and Watson’s theories hold a reciprocal interaction world view, while Newman’s and Parse’s theories have a simultaneous action world view. A number of other nursing theorists embedded spirituality within their models, but if the phenomenon of spirituality were to be removed, the theory would not substantially change.

This section briefly explored nursing theories in regard to spirituality and spiritual aspects of nursing care.

Summary

Chapter 2 discussed the theoretical frameworks used in this study, specifically those of James Fowler (1981), Diann DeWitt-Weaver (2001), and Henri Nouwen (1979), and presented literature about spirituality, spiritual formation, and spirituality and nursing education. Nursing theories which include spirituality as a major concept were mentioned.

Fowler’s classic work in faith development incorporated existential faith issues with the human life cycle to achieve his six stages of faith development. The stages of faith most relevant to this study are stages three, synthetic-conventional faith (conforming faith) and individuative-reflective faith (choosing faith, either/or faith).

DeWitt-Weaver’s research developed a grounded theory describing how student nurses become ready to provide spiritual care. She identified three sequential stages of becoming ready: Learning faith, thinking it through, and trying it out. Her research
advanced new ideas in the knowledge of students’ professional development as spiritual care providers.

The last theoretical framework used in this study is Nouwen’s metaphor of “wounded healer,” applicable to those in healing professions. Nouwen believes it is important for healers to come in touch with their own woundedness and learn from it, in order to use it as platform for serving others.

The literature review also encompassed the challenge of defining the term spirituality. There is no commonly accepted unifying definition of the term spirituality (Brown, 2000; Dunajski, 1994; Groer et al., 1996; McSherry, 2000; McSherry & Draper, 1998; Stoll, 1989; Taylor, 2002). Definitions of spirituality from nursing literature are impacted by the world view of the writer. Some nursing professionals believe it is important to achieve a common definition of spirituality in order to advance research, education, and practice (McSherry & Draper, 1998); others believe it is not possible to achieve a consensus about the definition because it is inextricably tied to one’s world view (Grotbo, 2000).

The study of spiritual formation has not been undertaken in any significant way in the field of nursing. For research in the area of spiritual formation/faith development theories, I turned to James Fowler, the foremost faith development researcher (Fowler, 1981; 1984, 1992, Autumn, 2001; Fowler & Nipkow, 1991). Sharon Parks (1986) used Fowler’s research to launch her own study into the faith development of young adults. From this research she proposed a transitional stage of faith development appropriate to the experiences of young adults and occurring between Fowler’s stages three and four. She also advances the importance of mentoring by faculty to assist students at this critical
juncture of life (Parks, 2000). Fowler’s research also spawned a number of other studies further exploring and/or applying his faith stages (Bolen, 1994; Creel, 2000; Cristiano, 1986; Drewek, 1996; Hancock, 1992; Hiebert, 1993; Houghton, 1994; Oikarinen, 1993; Thomas, 1990).

Faith development theories of several other researchers were also examined. Fortosis (1992), exploring faith development from an evangelical perspective, found three stages of spiritual formation: Formative integration, responsible consistency, and self-transcendent wholeness. Ratcliff (1993) proposed stages of spiritual growth in this manner: Birth, spiritual childhood, spiritual adolescence, and finally spiritual maturity. He explained how times of spiritual turbulence can be resolved in both healthy and unhealthy ways.

Using Vygotsky’s developmental theory, Estep (2002) contributed some new insights into the study of spiritual formations. Similarly, Anderson (2002) shared some helpful principles of spiritual formation which he gleaned from the writings of the Apostle Paul.

Next, spiritual formation practices were explored. Studies from Seventh-day Adventist education were introduced which pointed to the importance of family religious formation to the faith development of youth (Rice & Gillespie, 1992; Valuegenesis 2, 2001). Other studies taken from higher education found that courses in spiritual formation had a positive impact in the spiritual development of the students enrolled (Barber, 1999; Tasker, 2002). Newman (1998) studied faith development of first-year traditional college students on a faith-based campus and found seven influences to faith
development. Many non-research-based references from classic religious literature were listed to provide a reference for spiritual formation within the Christian context.

The literature pertaining to spirituality and nursing education explored the appropriate role of educating students to provide spiritual care (Brown, 2000; Conco, 1993; Dettimore, 1986; Getzlaf, 1996; Grotbo, 2000; Harris, 1994; Piles, 1990). Three studies (Brittain & Boozer, 1987; Carson et al., 1986; Shih et al., 2001) evaluated the effectiveness of didactic teaching about spiritual care and found positive effects in students' knowledge and attitudes. Meyer (2002) and Peterson (1997) combined the perspectives of both students and faculty in their studies of spiritual care, including the curricular time spent in school with and without religious affiliation. Additional studies addressed spirituality and spiritual care from the vantage point of faculty members (Denham, 1990; Lickleig, 2003; Miklancie, 2001), recipients of spiritual care (Conco, 1993), and practicing nurses (Bath, 1992; Grotbo, 2000; Schnorr, 1988) which provided insights into spiritual care issues that need to be considered within the nursing curriculum. These issues included the nature of spiritual care, the importance of theoretical frameworks in the nursing curriculum, addressing perceived obstacles, such as time, the relationship of psychological and spiritual concerns, the nurses' own personal comfort with spirituality, and ways to encourage connectedness with others as the essence of spirituality.

Lastly, nursing theories by Betty Neuman, Margaret Newman, Rosemary Parse, and Jean Watson were mentioned by Martsof and Mickley (1998) as theories which embed spirituality centrally within their theory.
CHAPTER THREE

METHODOLOGY

Introduction

Chapter 3 describes the research method selected for this study, with supportive rationale. A description of the population, the sampling procedures, instruments and data collection procedures, as well as a discussion of pilot studies and data analysis, is presented. An exploration of issues relevant to validity, reliability, and generalizability in qualitative research concludes the chapter.

General Methods

This section explains the qualitative methods used in this research, including the sampling and the data collection procedures, the data analysis, and validity, reliability, and generalizability.

The nature of the research questions informs the type of research method to be selected. In this explorative study of nursing students’ perceptions about their personal spiritual formation and their provision of spiritual care to patients, qualitative methods were appropriate. Creswell (1998) defines qualitative research in this way,

Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting. (p. 15)
Specifically, phenomenological methods were employed. Phenomenological methods emerged in the 20th century, with methods advanced by Edmund Husserl (Parse, 2001). Sometimes confused with phenomenology and qualitative research, in general, Merriam (2002) clarifies the phenomenological research approach by saying, “Although all qualitative research is phenomenological in the sense that there is a focus on people’s experience, a phenomenological study seeks to understand the essence or structure of a phenomenon” (p. 93). Prior to data collection, using phenomenological methods refined by Husserl, I “bracketed” my personal biases about the phenomenon of study by describing and explaining my own views so as not to impose these preconceptions into the study (Creswell, 1998; Merriam, 2002). See Appendix 1.

Approval from Andrews University human subjects review committee and from the institutions where the research was to be conducted was requested and received prior to commencing data collection.

Sampling

The sampling process used in this study is now described. The study population was selected from nursing students in private, religiously affiliated basic nursing programs located in the Midwestern region of the United States. The following criteria were used in selecting the interview participants:

1. Enrollment in an associate or baccalaureate nursing program
2. Class standing within three semesters of graduation
3. Nursing students who have high faith maturity scores within the population sample
4. Profession of Christian faith
5. Awareness of having experienced at least one intentional spiritual encounter with a patient.

These criteria were selected because the experiences were thought to enable participants to respond to the research question with sufficient description.

Sample selection was achieved using purposive sampling (Merriam, 2001). Two strategies were used in sampling selection. First, I received permission to visit the classrooms with students from the eligible population. I explained the research and invited students to complete a 12-item faith maturity index. In addition, they completed a demographic data form which enabled me to identify students who profess Christian faith and have had a spiritual encounter with a patient. (See Appendix 2.) The students also noted if they were interested in participating in the interviews. Second, interested students who met the sampling criteria and who had the highest faith maturity index scores were contacted to affirm their willingness to participate in the interviews. I arranged for a mutually convenient time and location for the face-to-face interviews on the respective campuses, and completed 28 interviews. One participant's data were removed from the study because sampling criterion were not entirely met, resulting in a sample size of 27 students, 16 from Liberal Arts University and 11 from Health Sciences College.

The sample size was sufficient to reach saturation. I expected to interview approximately 15 students, but the primary importance to determining the sample size was the achievement of redundancy (Merriam, 2001, p. 64). I knew redundancy had been achieved when I began to identify themes as I listened to the students' stories and when successive interviews provided no new data. Students from Liberal Arts University
eagerly volunteered to interview and quickly committed to an interview time. I found that I had more interviews than necessary for the purpose of saturation, but completed the interviews that I had already scheduled. In contrast, while I had equally as many students from Health Sciences College who volunteered to interview, they were slower in responding to my request to arrange an interview time. Because of this fact, I asked a faculty member from Health Sciences College to encourage some of the students to contact me and was finally able to achieve saturation.

The Faith Maturity Scale used for this study was originally developed as a broadly based interdenominational measure from a Judeo-Christian perspective and contained 38 items (Benson, Donahue, & Erickson, 1993). The scale measures eight core dimensions of faith maturity by two subscales. One scale emphasizes the relationship between self and transcendent reality, the other focuses on how the individual relates to humanity. A short 12-item form of the scale was refined from the original scale, with a resulting reliability of .88 for adult respondents, comparable to the original scale, using Cronbach’s alpha. Correlation between the 12-item and 38-item scales is .94, appropriate in this case because the 12-item scale is a subset of the 38-item scale (Benson et al., 1993, p. 22). The current scale contains additional modifications of the available responses and the question format from the original scales to further refine the tool. Validity of the data, whether respondents are telling the truth, was enhanced by forming the questions in the same manner used by the United States government in tracking drug usage by high school seniors. “The distribution of responses observed – how many high, how many low – are consistent with what one would expect in a denominational educational system” (Donahue, 2002, Sept. 9, p. 5). There was no “sampling error” because the
Valuegenesis survey was done as a census, rather than a sample. The Cronbach’s alpha reliability coefficient used determined for my study sample was .887.

Data Collection

A multi-faceted data collection process was used for this study and is described in detail in the pages that follow.

Observations

As I gathered the sample of students who completed the demographic questionnaire and the faith maturity scale, I noticed that each educational institution had its own “flavor.” The commonality was the student participation in the first phase of the data collection; it was almost 100% in every classroom I visited. Yet there were differences, as described below.

I first attended classes at Health Sciences College during the fall semester in 2003, the week prior to final exams. Psychiatric-mental health nursing was the first of three classes I visited. The prior period the students had completed a unit test and were now preparing for classroom instruction. A faculty member named Carlene introduced me and briefly explained my purpose in coming to the class. I gave more specific detail about the study, how students could be useful, and invited student participation. Carlene commented about the wonderful opportunities for spiritual care that the students had experienced in their clinical rotations during the semester. She said she knew there were several students in the class who had rich spiritual care experiences and hoped they would volunteer to be interviewed. She also affirmed the growth the students had made during the semester. A total of 16 students out of 33 students attending the class that day volunteered to interview.
I visited two additional classes at Health Sciences College to solicit the sample. The students chatted freely with each other and with the faculty. Each faculty member allowed me to introduce myself and my research project, and expressed support for the endeavor. In one of the classes the faculty member left the room temporarily and asked me to distribute the course evaluations for her after I obtained the research data. After the data collection, one of the students asked to make an announcement about a donation she was spearheading for a fellow nursing student who had recently experienced significant family concerns and financial problems; students voiced their support for the project and expressed concern for their classmate’s well-being. The students were attentive and helpful, it was also evident they were absorbed with end-of-semester academic issues. In the end, 18 interview volunteers came from two classes of students totaling 70 in number.

During the third and fourth weeks into the start of spring semester 2004, I attended two classes at Liberal Arts University to gather data. Each classroom was full of students, over 40 in each class; the atmosphere was friendly and warm. The senior class was the first class I visited, hosted by the program chair who was teaching that day. She began the class by suggesting that they sing some praise songs together and invited students to select the song. The students seemed hesitant, yet there was easy banter between the program chair and the students. She said, “If you don’t choose something, then you know we’ll sing the song I always like.” The students laughed, and they sang her selection together. She then offered prayer and invited the students to share recent spiritual care opportunities they had been having in their clinical experiences. One-by-one the students shared several stories. After each student’s story, the program chair
offered an affirming statement about the experience and related it to something the students had previously learned in class. When there was a pause in the discussion, the program chair then introduced me and asked me to tell something about myself so that the students could become acquainted with me as a person. I recounted my background as a nurse, my current roles as college administrator and doctoral researcher, and affirmed my experience with Liberal Arts University where my son was also currently a student. I then explained the purpose of my research and invited their participation. The program chair urged students to participate, saying, “I want at least 20 of you to volunteer.” She also affirmed the importance of the study to nursing education. A total of 20 students volunteered to interview.

The second class at Liberal Arts University was junior level students. The faculty member warmly talked with students as the class was assembling. She then introduced me; she asked me to tell something about myself and explain my purpose. I shared similarly to what I had with the senior level students, and invited the students’ participation in the study. The faculty member encouraged students to participate; she also affirmed the potential value of the study and the important professional role of students to participate in research. A total of 12 students volunteered to interview.

**Interviews With Faculty**

I told the program chairs from each educational institution that I would like to interview with individuals who were knowledgeable about the spiritual care aspects of the curriculum. The program chair from Liberal Arts University referred me to Janette, a long-term faculty member who had worked at the University since the inception of the nursing program, and who had authored at least one article about spiritual care education.

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An additional faculty member was a secondary suggestion if I had more questions after interviewing Janette. The program chair from Health Sciences College found faculty members to interview by asking her faculty which of them felt particularly knowledgeable about spiritual care; three faculty members volunteered.

Using the faculty interview protocol to guide the interviews, I was able to obtain sufficient information about the Liberal Arts University from Janette, the faculty member. I felt that I did not need to interview the second faculty member. The three faculty members from Health Sciences College wanted to interview together, so we arranged a time. One of the faculty members was ill the day of the interview; however, I confirmed the written data with her and solicited additional information. She said the curriculum information had been adequately represented.

The faculty interviews were audiotaped and then transcribed by an independent transcriptionist.

**Interviews With Students**

The primary data collection method was face-to-face interviews, conducted using open-ended, semi-structured questions pertinent to the research purposes. Through the interview process, I sought to enter into the student's perspective (Patton 1990, as cited in Merriam, 2001, p. 15). Prior to interviewing, the questions and interviewing process were reviewed by several nurses experienced in providing spiritual care and by the research committee in order to clarify any confusing questions. This review resulted in substantial rewording of the interview questions, as well as further refinement of the research questions, before conducting interviews with actual participants. An interview protocol (Creswell, 1998) was developed, a consent form with an explanation of the
study and confidentiality protocols, and finally, interview questions and probes. See Appendix 3. The questions and probes served to guide the semi-structured interview. Before each interview began, the participants signed a consent form. During the data collection process it became evident that I had not acquired a signed consent from one student prior to the interview. I conveyed the situation to the student via e-mail and the student eagerly provided me the consent to use his interview.

All interviews were audiotaped. Interviews at Liberal Arts University were all conducted in a private conference room adjacent to the nursing department during the period of time from January 30 to February 16, 2004. Interviews at Health Sciences College were conducted in one of two private offices from January 14 to February 19, 2004. The interviews ranged in length from 30 minutes to 75 minutes, with an average interview length of approximately 40 minutes. After the tapes were transcribed by an independent transcriptionist, I listened to the audiotapes, following the transcript, word for word, line for line, in order to correct errors and fill in any blanks or difficult-to-understand passages (Merriam, 2001). A total of 221 pages of single-spaced transcription resulted. Confidentiality of the data and audit trail occurred by retaining appropriate security measures at my home where the data were transcribed and analyzed. Anonymity of the participants was ensured by assigning a number to each participant and coding participant responses using their assigned number. Each participant was given a pseudonym for presenting the data results. The audiotapes will be destroyed when the dissertation is approved.

The interview protocols used for the faculty and the student interviews are available in Appendix 3.
Documents Obtained

Information was also gleaned from each educational institution to provide an additional means to understand the context of the educational environment and the contributions of the schools to the students’ learning about spiritual care. The documents that I reviewed included the follow:

1. Academic bulletins for information such as a description of the institution and its spiritual mission
2. Admissions application forms and policies
3. Nursing department mission, philosophy, purpose, and/or conceptual framework
4. End of program objectives
5. Other curriculum documents giving evidence to the mapping or threading of the spiritual components, such as grids, curriculum organizers
6. Examples of course descriptions
7. Examples of course and clinical evaluation tools
8. Examples of class outlines for spiritual care instruction
9. Examples of course assignments pertaining to spiritual care
10. Textbooks used for spiritual care.

See Appendix 4 for a complete listing of documents from each educational institution that I reviewed for this study.

Data Analysis

In the pages that follow, I describe the data analysis used for this study.

Customary data management processes for analyzing qualitative and phenomenological
data included tools such as word processing and Microsoft Excel spreadsheets, in addition to manual methods. After checking the transcriptions, I read the interview data a second time, highlighting key phrases and making notations. I formulated preliminary ideas about themes during this review and then read the data a third time in order to perform a gross tally of themes. Before further developing the themes, I stepped back to once again relate the research questions to the interview questions, and to the emerging themes I was discovering. While some research themes were beginning to form, they felt very tentative and needed deeper scrutiny and verification. Using Excel spreadsheets, my next step was to create data grids listing the individual participants and the key themes represented in their narratives. As I read the data yet another time, I entered “X” marks on the grids, made notes, and added some key descriptors under the themes. Exploring the data using this degree of detail enabled me to continue to refine and collapse the themes. In order for a theme to be reported as a theme, a majority of the students in the study must have conveyed the theme in some fashion as I reviewed the student narratives. I retained field notes of the data analysis process with each iteration of the theme development process, and occasionally referenced these notes as I went back and forth during the process to ensure that the rationale for theme selection and inclusion was solid and defensible.

Next I selected narrative exemplars from each theme, while at the same time continuing to tweak and refine the data analysis. In a circular, “loopy” process I moved back and forth between the research data detail and the larger research questions. Rereading the theoretical constructs then enabled me to see the data in light of the theories I had chosen to guide the study. Curricular data were also used to help
contextualize the themes that emerged from the interviews. After the process described above was completed, I explored the quantitative frequencies from the demographic data, the age means, and the means from the total faith maturity scale data to see if there were patterns or relationships with the qualitative data.

This process of data analysis relates to that described in the literature about qualitative methods. Creswell (1998) identifies three data analysis strategies common to all types of qualitative research. The first step is a general review of all data, in this case the transcription and field notes. The researcher then begins to react with and sort out the data by writing notes in margins, making memos and reflective notes. Next, one starts the data reduction process by working with words, playing with metaphors, concepts and analogies. Data continue to be reduced through processes such as comparisons and contrasts, visual representations, diagrams, and patterns. Codes and categories are created, and with the development of themes and patterns, unnecessary data can then be eliminated. Creswell recommends developing no more than 25-30 categories of information in order to be able to eventually reduce them to no more than 5 or 6 needed for the narrative process. (p. 142). Creswell further describes specific steps appropriate to the analysis of phenomenological research:

1. A full description of the researcher's own experience with the phenomenon begins the descriptive process.

2. Data are classified through a process called horizontalization, where the researcher finds significant interview statements about how the participants experienced the phenomenon.
3. These statements are then grouped into a list of non-repetitive, non-overlapping statements.

4. Interpretation of the data is developed through creation of textural descriptions (what happened), and structural descriptions (how the phenomenon was experienced), in order to formulate an overall description of the experience, the “essence.”

5. The essence of the phenomenon is then represented through words, figures, or other means (pp. 147-150).

Paterson and Zderad (as cited in Munhall & Oiler Boyd, 1993) suggested similar methods for conceptualizing nursing phenomenon, as follows:

1. In order to intuitively grasp the phenomenon, the researcher must be open to the phenomenon. Techniques for achieving openness include awareness of one’s own views, identification of and setting aside a priori beliefs, intentionally exploring different ways of looking at the phenomenon, being immersed in the phenomenon, and observing from within the phenomenon.

2. Next, an analytic examination is achieved by considering various aspects of the phenomenon. Techniques include comparison and contrast, identification of common themes, determining how elements are interrelated, and distinguishing from and relating to similar phenomenon.

3. Description and synthesis occur through definition, description, and construction of a concept central to the phenomenon. Techniques include classification, negation, use of metaphor, use of analogy, and isolation of central characteristics (p. 121).
The data analysis processes described by the qualitative researchers referenced above resembled the processes that I used in this study. Next, I explore my qualifications as qualitative researcher.

Researcher as Instrument

In qualitative research, the primary instrument for data gathering and analysis is the researcher (Merriam, 2001). Merriam describes three qualities of an effective qualitative researcher: Tolerance for ambiguity, sensitivity and intuitiveness, and a good communicator, both interpersonally and in writing. My educational experience as a psychiatric nurse and my professional experiences as an administrator have contributed to the development of the three qualities Merriam cites. Additionally, leadership experiences in my church and the doctoral educational process have improved my skills of reflection and analysis.

For the past 10 years the topic of spirituality and spiritual formation has been of great interest to me. I have explored many books on the topic, in an effort to understand my own spiritual beliefs and to nourish a joy-filled Christian experience. Some of these beliefs are found in Appendix 1 of this research, where I reflected about my personal faith stages, spirituality, and spiritual care. While I have been educated through the master's degree in nursing, I shifted professions 9 years ago to the field of higher education administration. As I have studied spiritual care and nursing literature I have been reminded that the care of the spirit, for which nurses have remarkable opportunities to explore with their patients, captures the heart of what I have loved most about nursing.
Validity and Reliability

Next, I turn to a discussion of the concepts of validity and reliability. In order “to produce valid and reliable knowledge in an ethical manner” (Merriam, 2002, p. 22), first, my biases, world view, and theoretical orientation were clarified prior to data collection. Second, after the interviews were transcribed, I sent copies of the coded transcriptions to each participant for verification. One student responded with a request to make a minor spelling edit. All the other students who responded affirmed the accuracy of the transcription. Third, I periodically reviewed some of the raw data with two colleagues to assess whether the findings were plausible. Fourth, in-depth immersion in the data to the point of redundancy of data constituted data saturation. Fifth, rich, thick description was used by many participants, enabling the reader to make decisions about transferability of the research findings. Sixth, triangulation of the data occurred through use of multiple data sources, specifically, interviews, a quantifiable faith maturity scale rating for each participant, an overview of each educational institution, and an analysis of the curricular instruction related to spiritual care. At the end of the research, I wanted readers to conclude that the research results “rang true” (Creswell, 1998; Merriam, 2002).

Internal validity is appropriate for qualitative research and is evidenced when there is structural coherence or structural corroboration within the study itself. Every attempt has been made for the results of this research to achieve consistency and coherence in the presentation of the data.

Reliability, the extent to which research findings can be replicated, presents itself somewhat differently in qualitative research.

Replication of a qualitative study will not yield the same results, but this does not discredit the results of any particular study; there can be numerous interpretations of
the same data. The more important question for qualitative researchers is \textit{whether the results are consistent with the data collected}. (Merriam, 2002, p. 27)

In this study, the colleague examination and the audit trail of reduction process by use of data grids were two methods used to address reliability. An example of one of the data grids is in Appendix 5. The audit trail of the reduction process was preserved, which describes in detail "how the data were collected, how categories were derived, and how decisions were made throughout the inquiry" (Merriam, 2002, p. 27).

In summary, multiple methods, including triangulation of data from each educational institution, the nursing curricula, the faculty, and the students were used to ensure the results were trustworthy.

\textbf{Generalizability}

Lastly, I discuss the concept of external validity, or generalizability, in qualitative research. Eisner (1998) states that "the process of generalization is inherent in all learning" (p. 211). He views skills, images, and ideas as those elements which generalize. And qualitative research in particular has the capacity to generate images through its vivid descriptions and ideas shared through theories and concepts. As the reader reviews the research results, it is the reader's responsibility to determine the meaning of the results and whether the results have application to another situation. Merriam (2002) describes a concept called concrete universals in discussing generalization in qualitative research. "The general lies in the particular; that is, what we learn in a particular situation we can transfer or generalize to similar situations subsequently encountered" (p. 210).

Eisner indicates that generalization helps us make sense of, or see new light in, what has past, the retrospective view. And he also discusses how generalization can help
us look to the future. "The idea or concept functions as a guide through which experience that might otherwise not be achieved can, in fact, be secured. Like a guidebook, the generalization sensitizes readers to what is likely to be found, if they know where and how to look" (p. 207). In responding to critiques about the limited ability of qualitative research to contribute to the accumulation of knowledge, Eisner asserts that qualitative research accumulates knowledge horizontally rather than vertically, thus building "paradigm plurality" (p. 211).

Research studies, even in related areas in the same field, create their own interpretive universe. Connections have to be built by readers, who must also make generalizations by analogy and extrapolation, not by a watertight logic applied to a common language. Problems in the social sciences are more complex than putting the pieces of a puzzle together to create a single, unified picture. Given the diversity of methods, concepts, and theories, it's more a matter of seeing what works, what appears right for particular settings, and creating different perspectives from which the situation can be construed. (p. 211)

Generalizability is an important consideration in qualitative research, with the final determinate being the reader.

Summary

Chapter 3 described the research methods used in the proposed study. A description of the population, sampling processes, pilot studies, and data collection procedures set the stage for the research methods. Discussion of the researcher as instrument, participant consent and confidentiality, and a review of data analysis methods used in general qualitative research and phenomenological research were presented. Techniques for addressing validity, reliability, and generalizability in qualitative research concluded the presentation of methodology.
CHAPTER FOUR

LIBERAL ARTS UNIVERSITY

Introduction

How did students with a high faith maturity provide spiritual nursing care to patients? What themes emerged from the data? With these questions in mind, the data will be explored in chapters 4 and 5. First, an overview of the demographic sample is presented.

Demographic Data Findings

Before exploring the data specific to Liberal Arts University, I wish to present the demographic findings relative to the entire sample. Table 2 summarizes the demographic frequencies between the total sample and the interview sample. The total sample population from which the interviewees were selected numbered 187 students. Sixty-two students, or 33%, were willing to interview. Twenty-eight students (15%) participated in the face-to-face interviews; however, one interview was eliminated from the qualitative analysis because the participant did not meet the sample criteria. Scores from the faith maturity scale (FMS) differed between the total population and those who were interviewed. Out of the highest score of 60, the FMS mean of those interviewed was 54.67 compared with 49.27 for those who were not interviewed.
Table 2

Comparison of Demographic Frequencies Between Total Sample and Interview Sample

<table>
<thead>
<tr>
<th></th>
<th>Total Population Sample</th>
<th>Interview Sample</th>
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<tr>
<td></td>
<td>N = 187</td>
<td>Percentage</td>
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<td><strong>Gender</strong></td>
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<td>8.0</td>
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<td>2.7</td>
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<tr>
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<td>0.0</td>
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<tr>
<td>African-American or Black</td>
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<td>3.2</td>
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<tr>
<td>Caucasian</td>
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<td>90.9</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>4</td>
<td>2.1</td>
</tr>
<tr>
<td>Native American</td>
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<td>1.6</td>
</tr>
<tr>
<td>Indian</td>
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<td><strong>Faith Experience</strong></td>
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<td>83.4</td>
</tr>
<tr>
<td>Other</td>
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<td>Health Sciences College</td>
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<tr>
<td>Dec. 2004</td>
<td>31</td>
<td>16.6</td>
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<tr>
<td>May 2005</td>
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<td><strong>Spiritual Care</strong></td>
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<td>Provided spiritual care</td>
<td>156</td>
<td>83.4</td>
</tr>
<tr>
<td>Did not provide spiritual care</td>
<td>31</td>
<td>16.6</td>
</tr>
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</table>

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Liberal Arts University

The sections that follow will introduce the reader to Liberal Arts University and its nursing program. Liberal Arts University is a private university of arts and sciences located in a small Midwest town. It is primarily a residential campus, with a student body that is largely of traditional age, single, and a balance of male and female gender. The university holds a Christian, theistic world view within the Baptist tradition, presents a strong, unapologetic Christian mission in its published materials, and authentically supports the stated mission in its actual day-to-day practices. Faculty of the university must be committed to the faith tradition espoused by the university and actively promote its mission. The institution requires applicants to describe their faith experience. It also seeks information about the applicants’ agreement with the university doctrinal statement, and expects enrolled students to conform to a published lifestyle commitment, both on and off campus. All curricular and co-curricular activities are intended to support and help fulfill the university’s spiritual mission. Students graduate with a minor in Biblical Studies, taking a required group of courses which include Spiritual Formation, Christian Life and Thought, Old Testament Literature, New Testament Literature, Christian Worldview Development, and Christian Worldview Integration. They attend daily chapel services and weekly church services within their communities, as well as volunteer for a variety of local and worldwide ministries. The student body tends to be homogeneous in its faith expression. The university takes seriously its responsibility to help disciple and grow students in their Christian faith.
Liberal Arts University's Nursing Program

This section describes the nursing program at Liberal Arts University, including curricular information and faculty perspectives about teaching spiritual care.

The nursing program educates students at the baccalaureate level. It mirrors the university's Christian, theistic world view in its nursing education and practice. The department’s vision statement reads,

We, the Department of Nursing at Liberal Arts University, are called to educate nursing students who fulfill God's purpose for their lives in local communities and throughout the world. Through the power of the Holy Spirit we are leaders in promoting the health of people in a variety of settings. We are devoted to God's service through the ministry of nursing. 2 Pet 1:3-8.

The curriculum model features four curricular organizers—Godly living, care, culture, and information management. The objectives for each course are mapped through to these four end-of-program objectives, which are also incorporated into the student evaluation tool. The two end-of-program objectives specific to spiritual care include Godly living and care.

Godly living

Nursing students are expected to articulate a biblical world view including its relationship to nursing practice. They are to value each person as uniquely created in the image of God. Students are taught to synthesize a position on ethical issues in nursing using the Bible as a framework for analysis. Lastly, students are taught the importance of tapping into a source of strength and direction for one's life and are expected to be growing in Christian character, as defined by 2 Pet 1:5-9.

One example of an assignment given to senior level students to help move them toward this objective is the “Growth in Brotherly Kindness Assignment.” Students
complete a concept map of the biblical term “brotherly kindness” using the Bible, concordances, and reference tools to help them understand the Greek root for the phrase. They formulate five sentences to illustrate this phrase and another five sentences to illustrate what brotherly kindness is not. Additionally, they apply the idea of brotherly kindness to their life and nursing practice, with a specific action plan, self-evaluation methods, and journal. The assignment states, “The goal is to grow in Biblical character, which means that there will be a change in what you are currently thinking, saying, or doing.” Likewise, in an ethical analysis assignment, students also apply a biblical model to making ethical decisions in a case situation, and cite biblical passages to support their position. Faculty member Janette said,

Some of our objectives are not necessarily spiritual care as such. They are godly-principle directed care for how we work with people, how we as Christian nurses look at ethical issues differently from other nurses, and how we grow in our own personal godliness.

Care

Holistic nursing care is provided to individuals, families, and communities across five interrelated, multi-dimensional aspects of care: Physical, intellectual, emotional, social, and spiritual.

The intended outcomes reflecting this concept of care include (a) delivering care based on knowledge from the Bible, the art and science of nursing, the biological and behavioral sciences, and the humanities; (b) taking actions to enhance resources and diminish demands to promote health balance in and across the five dimensions; (c) demonstrating empathetic concern when providing care of individuals, families and communities; and (d) coordinating components of the health care system in delivering nursing care. (Conway, 2001, Spring, pp. 22-23)

Spiritual care is integrated throughout the curriculum beginning with the first didactic nursing course which students enter during their first semester of college. At this
first level, students are introduced to spiritual care as part of the five-dimensional aspects of nursing care. They also have a beginning understanding of the relationship between spiritual care and ministry. As Janette said, student nurses are taught to “provide an answer for what lies within us.”

Students enter clinical practice during the junior year. Faculty teach them about prayer as a health promotion activity. They also teach spiritual care and needs within the nursing process, using references such as Nursing Diagnoses: Definition and Classification (North American Nursing Diagnosis Association, 1996), Nursing Interventions Classification (NIC) (Iowa Intervention Project, 2000), and Nursing Outcomes Classification (NOC) (Iowa Outcomes Project, 2000). As students progress through the 2-year clinical curriculum, they learn about spiritual care across the nursing spectrum in maternity, mental health, public health, pediatric, geriatric, and culturally diverse environments. They explore spiritual aspects of crisis, suffering, end-of-life care, ethical issues, alternative therapies, and nursing leadership. Discussions about nursing theory compare and contrast between the secular, generalist approach to theory and Christian nursing. Two additional spiritual care references have helped to shape the faculty’s teaching about spiritual care: Spiritual Care: The Nurse’s Role (Shelly & Fish, 1988) and Called to Care: A Christian Theology of Nursing (Shelly & Miller, 1999).

Clinical experiences are concentrated during the last 2 years of college, with a nursing leadership clinical course at the end of the senior year. Particularly in the clinical setting, faculty encourage students to be sensitive to spiritual care. They begin pre-conferences with prayer and look for ways to reaffirm the “five-dimensions” model, including the spiritual dimension. Students are expected to evaluate spiritual needs and
provide care as appropriate. Faculty actively encourage students to offer to pray for and with their patients, and sometimes they collectively pray in post-conferences for patients who have special needs. They instruct students to look for environmental cues that could suggest a spiritual dimension to a patient’s life. The faculty also want students to understand that some patients will not be receptive to spiritual care. Janette acknowledged that the students experience a dichotomy. She said, “On one hand, we’re supposed to be evangelizing and on the other hand, we have to be careful in the clinical setting to not offend.” She believes that providing the opportunity for patients to receive spiritual care is still important. “If they choose not to take it, it’s like any of the other four dimensions. If we ignore it, then we are not dealing with it at all,” said Janette. Often times when patients learn that the student is from Liberal Arts University, the reputation of the school will open a door to talk about spiritual care.

Janette told me a story about a student one evening who was concerned about caring for an AIDS patient. Janette said to the student, “Well, you don’t have to care for the patient, but the patient’s care must be given. So if you are not going to do it, who is going to do it?” The student was in a clinical experience where she was in a leadership role and decided the next morning that she was ready to care for this patient. Janette recounted that as soon as the student went in to care for the patient, his first question to her was, “Well, why do you want to take care of me?” Through the student nurse being willing to touch him, listen to his story, and care for his needs, the patient’s attitude changed. The next day the patient gave the student an opportunity to witness about her faith when he said to her, “Well, you’ve heard all about me. Now tell me about you and what makes you different.”
Janette cited three reasons that make it difficult for students to be skilled spiritual care givers. Students (a) do not like to invade people’s privacy, (b) feel they do not have time, and (c) do not see staff giving spiritual care, so it is not reinforced in the clinical setting. She believed that Liberal Arts University students know how to give spiritual care, but they sometimes feel uncomfortable if they think spiritual care means only evangelizing. She said the most important action a student can do to enhance their ability to give spiritual care is to make it as much a priority as physical care. “If you make it a priority, the opportunities will present themselves.”

In summary, the instruction provided by faculty to students at Liberal Arts University is intentional and focused. Attention is given to learning how to give spiritual care to patients and families. Additionally, growing personal faith in the lives of their students is a core value for both the nursing department and the entire university.

Liberal Arts University’s Interview Sample

The paragraphs below provide a picture of Liberal Arts University’s interview sample by highlighting demographic frequencies and sharing stories of how past experiences influenced some students’ decisions to enter nursing.

Sixteen students from Liberal Arts University participated in the interview phase of this research. All 16 interviewees were single, Caucasian adults. Three were males and 13 were females. Eleven of the 16 intended to graduate in May 2004, and the remaining 5 were scheduled to graduate in May 2005. The mean age was 21.13, with SD = .72. The faith maturity scores ranged from a low of 51 to a high of 60, with a mean score of 55.50 and SD of 3.08.
Some of the Liberal Arts University nursing students shared interesting stories about previous experiences which had influenced their desire to become nurses. Some had always wanted to be nurses or to work in health care. For example, Shelley said, "Nursing is the only thing ever I wanted to do. I really can't explain it other than I think God planted that desire in my heart." She remembered as a young child playing hospital with her dolls and stuffed animals; later in elementary school she wrote papers about nursing pioneers, Florence Nightingale and Clara Barton. Like Shelley, Christy also always wanted to be a nurse, "It's the one thing I always wanted to do." She was additionally inspired to become a nurse from an aunt who was a neonatal nurse. Lauren wanted to be a nurse since the age of 7. Living on a farm, she developed an early curiosity about life processes and also enjoyed the experience of seeing her siblings born at home. As she grew older, she prayed about her nursing interest and felt God confirming her direction to become a nurse. Linda, Rick, Susan, and Sophia first wanted to become physicians, but for various reasons entered nursing. Each student discovered great satisfaction with nursing, particularly the holistic view within nursing and the opportunity to relate on a personal level with their patients more than medicine seemed to provide.

A couple of students became acquainted with nursing in deeply personal ways. Sara remembered wanting to be a nurse since "the age of walking and talking." At Sara's request, her grandparents read her bedtime stories from a medical encyclopedia. "When I had chicken pox, I asked my grandparents, 'Read to me about chicken pox.' When I had strep throat, I said, 'Read to me about strep throat.'" But later as a sixth-grader, she saw real nursing care close up when her father was diagnosed with cancer. As her father's
condition deteriorated and Hospice nurses came to care for him, Sara was fascinated by all the different equipment, the butterfly catheters, and morphine infusions. “Nursing has been a calling all of my life. I have just always known. There was never anything else I’ve wanted to do,” she said.

Joe’s situation involved caring for his younger sister, whose brain was destroyed when his mother contracted cytomegalovirus (CMV) when she was pregnant. Joe explains,

My third sister was born without most of her brain. The whole family had to learn how to care for her together, and we’ve been taking care of her 24/7 for sixteen years. The discipline, the self sacrifice, and the endurance that I’ve learned because of taking care of her have directed me toward wanting to use nursing as a way of life.

Amy’s older sister was diagnosed with leukemia, providing Amy with a lot of exposure to children’s hospital. She knew she wanted to be a nurse, specifically a pediatric nurse.

The demographic frequencies listed above reflect a rather homogeneous composition to the Liberal Arts University interview sample. Their stories show the deep desire of a number of the students to pursue a nursing career. In the next section I share themes that emerged from the interviews as they relate to the specific research questions.

**Research Question 1: Personal Spiritual Formation Themes**

How do life experiences influence personal spiritual formation in nursing students? Four themes emerged regarding the spiritual formation of students. They include (a) personal spiritual disciplines, (b) relationships, (c) an environment of Christian teaching and growth, and (d) struggle and loss. These themes are described and illustrated below.
Personal Spiritual Disciplines

Liberal Arts University nursing students identified regular participation in
spiritual disciplines as important to their spiritual growth and nurture. Boa (2001)
underscores that spiritual disciplines are “merely tools to help us grow. . . . Some will be
more essential for you at one time, and some will serve you better at other times” (p. 82).
Willard (1988) used a twofold typology to classify spiritual disciplines: Disciplines of
abstinence (solitude, silence, fasting, frugality, chastity, secrecy, and sacrifice) and
disciplines of engagement (study, worship, celebration, service, prayer, fellowship,
confession, and submission). The most frequent spiritual disciplines identified by
participants from Liberal Arts University were prayer and Bible/devotional reading.
Meditation, journaling, and service were also mentioned. Using Willard’s typology,
many participants used the disciplines of engagement.

Students described an intentional, deliberate approach to Bible reading and study.
For example, Debra uses a 365-day Bible plan to read through the Bible in a year. She
begins her study by asking God to open her to learning something new from His Word.
Then she will think about what she has read and try to apply it in some way to her life, or
use the passage as a meditation experience through the day. She adds,

I think one of the things that I’ve learned over the years is the necessity of spending
time every day, quieting myself before God, asking him to teach me, to make me
moldable and flexible and very adaptable to what he wants to do that day. I ask him
to make me open to the needs of other people, so that I can see them and learn how to
respond.

Joe, Amy, and Christy also described a process of intentional Bible study. In
addition, Christy leads a Bible study group of women from campus in which they are
currently studying the life of Paul. She adds Scripture memorizing to her Bible study,
saying, “When I get to a situation where I need wisdom, instead of fumbling around for
it, it is right there because the Bible says the Word of God is living, active, and sharper than a two-edged sword.” Another student, Jane, has kept a spiritual journal since high school because she believes she can express herself better on paper than out loud. She makes journal entries several times a week and uses her journal for self-accountability and for tracking her spiritual journey. She stated,

One of the biggest things I notice as I look back in my journal is that I struggle with the same things in different ways. It’s always the same issues, and I am constantly learning about it and refining it. We all have our besetting sins and the things that we struggle with. There are some things that I would just never dream of struggling with. But the other ones, they get me every time. I think it is going to be a life long thing, which is frustrating in some ways, because I’m a perfectionist. Ultimately, it causes me to look forward to when we’ll all be changed in the image of Christ.

Sophia loves to study the Bible, especially hard texts. She likes to be challenged to learn and grow spiritually. “I don’t like being comfortable. I firmly believe you should always be wrestling with something and if you are not, it’s very dangerous.”

Personal prayer was also a spiritual discipline which influenced the spiritual formation of students. Most students mentioned it only briefly. However, a few students described their prayer experiences in more detail. Debra enjoys an ongoing conversation with God throughout the day. “Walking to class is a wonderful time for prayer. In the biting cold, you can walk and pray. It doesn’t have to be structured.” Sara has been afraid to pray out loud in public or in groups because “I’m afraid I won’t have the right words to say.” As she has increased her private, personal prayer experiences, she is now more comfortable praying with other people. “The more I pray daily, even one sentence prayers, I find that my spiritual life has slowly matured, a steady growing process because of the time that I spent.” Robin said that she keeps a prayer journal about the prayers she offers on behalf of others.
Students like Amy, Sara, and Robin talked about the importance of consistency in their private devotional life. Amy was not raised learning spiritual disciplines in her early life, so it has been a struggle for her to keep consistent with prayer and Bible study. She commented about the time demands of college life and the challenge of finding space for private time with God. Amy said she notices when she does not read her Bible. She stated,

I can see evidence in the decisions that I make or the way I act toward others, or just the general hunger and thirst that I have for spiritual knowledge and for God’s teaching and His wisdom. It’s there, and I can feel it almost like you feel hunger pains, and so I recognize it when it’s missing.

Robin said she feels empty on the days when she does not spend time with the Lord. And if several weeks go by without personal devotions, she feels distant from God and unable to give herself fully to ministry. “When I follow through on my commitment to personal devotions, I have a peace and joy that only God can give.” Sara also remarked about the differences she notices in her life when she slacks off from her time with God. She said,

When I’m in the habit of spending that time with God, and then I don’t, I feel like I have missed out on being with my friend. Just like my best friend who lives next door, if I don’t see her at least one time during the day I feel like so depressed. It’s the same thing.

Rick is likewise intentional about his spiritual goals. He described himself as a new Christian seeking to live like Christ did. For him, living as Christ did means rejecting the secular world’s message to “do what feels good” and replace it with loving behaviors toward others. He acknowledged that it has been hard to “unravel 21 years of secular living.” He said he attempts to be mindful about the things he thinks about. He stated,

I guess for me it’s disciplining my mind, focusing on my faith in God. And I try to do the normal things like read the Bible, go to church, and be constantly in prayer.
But it's a gradual shift of focus from the stuff the world says is important to what God says is important.

Students from Liberal Arts University vividly expressed the role of personal spiritual disciplines in their spiritual growth and nurture. Overall, their comments reflected a purposeful and thoughtful approach to spiritual discipline practices.

Relationships

Relationships were also a key aspect in the spiritual growth and nurturing of participants from Liberal Arts University. These relationships were evidenced in various areas of life, such as home, church, Christian friends, discipling groups, and spiritual mentors, and reflected a progressive growth experience.

For some students, like Christy and Robin, the home environment provided the early spark for faith nurturing. Both students, from pastors' families, were exposed to Christian faith at a very early age. By their examples, Christy's parents were a big influence to Christy developing integrity and a moral compass. Robin's parents instilled daily spiritual practices that helped her develop habits which she would one day adopt as her own. Debra also grew up with influential Christian parents who gauged her readiness for spiritual growth. She said, "They didn't push me too fast, but rather came along side and supported me." Susan described accepting Christian faith as a fourth-grader and attending church weekly. As she entered the high-school years, she decided to embrace her faith more fully by involving herself in the life of the church, and thus developed a support system of Christian friends. Susan said,

You realize you are not alone. You grow in love for each other and for the Lord. We help each other to keep pursuing Him. We spur one another on. It helps you get into the Word. I look back on high school as a tremendous time of growth.
People within the community of faith greatly impacted the lives of students. Jill was involved in a youth group during her high-school years. "I had a youth pastor who was very influential, who was very good about keeping us accountable to people." She has continued these accountability practices by participating in a discipleship group in her dormitory hall once a week. "We pray for each other and pray for the other girls in the hall. We can really see how God is working in each of our lives. It's important to be there for each other and encourage one another." Linda found friends who would lovingly point out areas of immaturity in her faith and challenge her to become more mature, while at the same time praying for her and encouraging her. She particularly valued the examples of older, more mature Christians, such as women from her discipleship group and nursing faculty from the university, who reached out to her. Linda stated,

They want to know everything about you, such as who your friends are, whom you are dating, and what new things God's been teaching you. How they live their lives has been an influence to me. I want to live the kind of life they do, the kind of life that people notice.

Ranelle also grew in faith through the examples of others, beginning with her mother. A church go-er since fourth grade, she also found her church family to be a major influence in her relationship with God. Ranelle said that seeing people live "different from culture" has "encouraged, challenged, and strengthened me in ways that I never thought would be possible."

Lauren believed that the times she has grown the most involved interaction with people in some new way. The summer after high school she accompanied a couple who were teachers in Uganda, Africa, for 6 weeks. The experiences were entirely new and varied as they went from village to village. She watched the couple work with the
villagers to set up churches, and start a school and a literacy program. Their passion for God’s work impressed her. She began to contribute a little by leading music, sharing her testimony, and playing with the children. One day she and Sharon, the teacher, found themselves conducting a seminar just for women at which time they answered questions about topics the women would not talk about in the men’s presence. Lauren stated,

For the first time I started to look for variations in life processes and wonder, “How do they get to that situation?” and “What’s the solution?” This experience really had a big impact on me spiritually because it formed a lot of my world view and how I saw my role in life, not so much what I want to do in life, but instead, “What’s my role in God’s plan first?” I began to understand that it doesn’t matter what I want to do, it just matters how open I am to having God use me with whatever I’ve brought to the situation, or that He’s given me to accomplish.

The experiences of these young adults give evidence to the reality that Christian faith is to be lived in community. As Christy said, “Time with other Christians is big because life is not easy. Having ‘the body’ as a support is just awesome.” The students’ faith took root and grew through the influences of others.

Environment of Christian Teaching and Growth

An environment of Christian teaching and growth contributed to the spiritual formation of Liberal Arts University students. In this environment, students were taught Christian faith and exposed to Christian influences. They also experienced the freedom to question and try out faith for themselves.

Sometimes the teaching or the growth environment came from home or church. Joe came from a church who discipled its children through Sunday School and Awana, a program for children that combines Scripture memorization, games, and social activities. Joe’s faith was also ignited during the annual Christian summer camp experience.
Shelley grew up in a Christian home. She also regularly attended church, Sunday School, Awana, and the church youth group. “I learned faith by osmosis. They just keep teaching you the truth, week after week.”

Sometimes the growth environment came from the college experience. Liberal Arts University students specifically identified their college experience as helpful to their spiritual growth, through Bible classes, chapels, study groups, and the opportunity to make faith their own as they made the transition to adulthood. For example, Amy thought she was a very mature Christian when she compared herself to non-Christians or other Christians in her high school. However, coming to Liberal Arts University, she found herself in a “completely different ball game” when she was around people who were more advanced spiritually. Jane is another student who expressed how the University has nurtured her faith. She said she cannot think of a single thing at the University that has not influenced her faith in positive ways. “All of the things I have learned through chapel, classes, ministries, and through conversations with friends here in my church, have all shaped what I’ve become now.” Shelley cited the sound biblical teaching, the discipleship programs, and Christian ministry opportunities as helping her to know the Lord. According to Debra, Liberal Arts University emphasizes the importance of prayer and Bible study to Christian growth. “But we have to make it a personal thing. You can’t do it because they tell you to do it. It needs to come from a heart that is willing to be used of God.” She also underscored the chapel speakers, saying they “have just been incredible in providing that extra nudge to ‘go for it’ and become all you can be.” Amy loves the chapel worship experience, as she expressed below:

I love to worship God in song and praise in chapel. I live on it. Different people get more out of some things. I love the opportunity to praise my God in chapel. I’ll have
hymns or spirituals or praise songs stuck in my head and I’ll sing those throughout the day, so there is always a constant awareness that God is around, that He’s near, and that I need to be aware of Him.

Jill found her experience at Liberal Arts University vastly different from the secular high school she attended. Although the schools were approximately the same size, the lifestyle differences were enormous. In her high school of over 2,000 students, only 20 of them were involved in the weekly Christian club. To come to a university where faculty, staff, and students are united in faith has been “awesome.” Even Jill’s daily routines were different at this Christian university. Jill said,

Any time we want, we are able to sit down and read our Bible. It’s not like a lot of secular places where you get looked down upon because you’re sitting at the table eating dinner and reading your Bible. This morning in chapel, 2500-3000 people stood singing and praising God. It was just amazing to hear that many voices. A lot of the professors take prayer requests and open class with prayer. At meals and in late night discussions we talk about Biblical topics and what I believe compared to the way someone else thinks. This transition alone was a growing experience. And there has been even more growing since I’ve been reflecting on what I really believe and what faith is all about.

Fowler (1981) describes stage four, individuative-reflective faith, as a choice point when individuals begin to distance themselves from their previous value system and engage in a critical reflection of one’s world view. It is at this point that faith can become one’s own as beliefs are deliberately chosen. Several students briefly described how they came to claim faith as their own and the importance of having an environment where this exploration could occur. One student, Robin, said that although she was raised in a strong Christian home, since coming to Liberal Arts University, she has had to choose her own faith practices and has questioned her doctrinal beliefs. Through this process and with the influence of her local church, her faith has become more real to her, more her “own.” And consequently, she has become more vocal about her faith. Casey

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is another student who learned faith at an early age, but he was “saved” later in life. He said,

When I was first saved, I had to re-evaluate from a new perspective everything I had been taught [as a young child]. I learned about faith, and then I obtained it. I did struggle with it at that point, and then I understood it. I had an expanded understanding of the faith that I initially accepted. It was an understanding of the implications [of my faith], of what it is to live to that faith, what it is to be a Christian.

Other students described a maturational process during which they came to their own personal understanding of faith within the normal environments of home and college. Susan attended a week-long church conference in ninth grade and for several summers. She also did a missions trip and gradually decided that she needed to embrace her Christian faith more fully. It was at this point that her Christian friends and disciplines such as Bible reading began to have an impact in growing her faith. Robin has grown by regularly going to church and through involvement in her church’s youth ministry. “I get fed there.”

Struggle and/or Loss

Some students from Liberal Arts University conveyed experiences which evidenced principles from Nouwen’s (1979) “wounded healer” metaphor. Looking back upon their experience with woundedness, participants found personal spiritual growth.

Rick stated he became a Christian only a year ago, since coming to the University.

Though students are required to make a faith statement as part of their application and admission process, Rick, the son of missionary parents, “faked it.” He came to the University to escape the drug scene that he was a part of, but he managed to find other friends who used drugs. He was suspended from school once, “kicked out” of the
nursing program once, and out of the university twice. He also developed heart problems due to the drug usage. He recounts,

One night we were doing drugs in Detroit and something happened. I just realized exactly what was going on with my life and what would happen if I didn’t stop. It takes me 80 times to really learn a lesson sometimes. I have to hit rock bottom a lot of times before I really realize. That kind of put me where I am today, wiser.

Looking back, Rick said that he sees God’s hand in shaping his life, in teaching him about trust. Rick said that “as far as nursing goes, [my experiences] have taught me real compassion. There are many people with issues that they need someone to talk to, especially when in a hospital.”

Amy’s parents divorced when she was 9, creating a “huge, life-changing point.” She sees her life as different from most students at Liberal Arts University because of the anger she felt from being used as a “foothold” in the divorce and from the hardships of living in a single-parent home. Her mother’s remarriage added to the conflict in her home. “So, all the dysfunction in my family drove me closer to the Lord.” With a strong faith in the Lord who supported her through the difficulties of her family life, she sees herself as mature in some aspects of her faith, but paradoxically, she feels she is just beginning to learn the basics of Christian faith. If it were not for her relationship with God, she believes her life could have easily gone another way. Amy said,

I can’t explain it. I don’t know what the difference is, other than the Lord had a grip on my life. He didn’t let me go out of His grip. Yes, I’ve made some wrong decisions, but for the most part, I’ve followed the straight and narrow path. I haven’t gone and rebelled against things that I know to be true. I can only attribute it to the grace of God.

Sara was raised in a Christian home. Tragedy came when her father died and her mother went into a deep depression following his death. Though very close to her mother, Sara strived to be the “perfect child” to spare her mother from any further grief.
“I would not do anything that would make her ashamed of me or disappointed in me.”

Part of becoming a perfectionist meant that Sara always had to be in control. God was pushed to the background. “My life said, ‘God, I can handle this better than you. Just leave me for a while. I can run my life.” All this time, Sara was going through the motions of being a Christian, leading the youth group praise and worship team, serving as one of the leaders in the youth group, and giving Bible studies. Sara stated,

No one knew the difference. Yet those were probably the darkest days of my life. I was so depressed and lonely. Somewhere in the spring of my senior year, I fell on my knees and said, “God, I’ve made a total mess of my life. I can’t do anything on my own. I can’t do it without you.” So I re-dedicated my life that night on my knees next to the bed.

Sara said she still struggles with perfectionistic tendencies, especially with her academic studies, out of fear that she will disappoint someone. But her life is now headed in a different direction than before.

Sophia began to question whether God was a loving God when one of her closest friends in high school caused the accidental death of her friend’s younger brother. How could a loving God allow this to happen to an innocent 9-year-old child? Though she never understood the reasons, she chose to continue her belief in God and He confirmed and strengthened her faith.

Jane grew up in a strong Christian family, yet her brother was not a Christian until recently. Dealing with some things her brother went through helped to strengthen her faith “because I realized it’s not a family thing. It’s an individual thing.”

Summary

Students from Liberal Arts University grew their personal faith through practicing personal spiritual disciplines, through relationships in the home, church, or school,
Research Question 2

In what ways do these life experiences described by nursing students and students' experiences within the nursing curriculum influence how they provide spiritual care? The themes pertaining to this research question are now described.

Providing Spiritual Care

The spiritual care offered by the Liberal Arts University student nurses to patients and their families encompassed three key patterns of care. The themes are (a) holism, (b) presence, and (c) witness.

Holism

Holism means caring for the multidimensional needs of patients, including spiritual needs, based on a sensitive assessment of needs made by the nurse. Students who address the whole needs of patients willingly meet whatever needs their patients present. Liberal Arts University students referenced the curriculum instruction they received about the “five dimensions” of nursing care, meaning the physical, emotional, intellectual, social, and spiritual aspects of patient health. For example, Sara and Linda talked about meeting the multiple aspects of patients’ needs. “It’s a holistic approach, five dimensions of care.” Rick recognized the holistic approach as counter-intuitive to typical health care methods. He said,

The attitude is so much on bio-medical these days, so much focus on procedures. We’re brought up in this environment to look at evidence, look at labs, and take the results. But the spiritual, just because you can’t see it, doesn’t mean it’s not there.
Several descriptive stories of spiritual care from Liberal Arts University's nursing students give evidence to how they cared holistically when providing spiritual care to their patients. Two stories are described here. Casey explained how he cared for an elderly woman in the nursing home who was depressed. Noticing that she had two rosaries around her neck and a calendar of priests and nuns, he told her that he was going to go home and pray for her. As he cared for her in subsequent days, he noticed that her rosary tended to slip down underneath her back. The crucifix would dig into her back, leaving a big imprint. He cared for her skin by protecting it from a potential pressure ulcer, and also introduced a spiritual topic for discussion. This elderly, sometimes confused woman was of French origin. So Casey would say to her, “Tell me how ‘Our Father’ goes in French.” She had lived in America long enough that she struggled when speaking French, except when she said the Lord’s Prayer. Saying the Lord’s Prayer would draw her back to memories of her family and at times helped to clear some of the confusion. There were also occasions when she could not finish the prayer because of her confusion, giving Casey an opportunity to assess her mental status.

Sophia cared for an Alzheimer’s patient who used to be a secretary for many years at a Baptist church that Sophia attended. This patient’s behavior was unpredictable; her speech was jumbled and often difficult to understand. She was incontinent and required considerable care. Taking time to sit with her and talk one day, Sophia assessed that her patient struggled with suicidal depression when her patient said, “I need someone to take my hand and put poison in it so it can go through me.” Sophia reminded her, “Betty, we have the Lord!” Immediately the patient brightened and said, “That’s right!” They continued walking hand in hand and began singing hymns together. Sophia felt that
the patient provided spiritual care to her. “It’s so neat to see a strong Christian woman at the end of her life have Jesus in her long-term memory, so that she could still say, ‘I believe He’s our Lord.’”

The students brought up the curriculum “five-dimensions of care” as something important they had learned in the nursing program to impact their thinking about spiritual care. However, many of their stories of spiritual care more clearly illustrated the theme of witness.

Presence

The theme of presence manifests itself by the nurse being available to the patient to listen non-judgmentally, by offering the gift of time and silence to encourage the patient to talk, and by using touch to convey acceptance and caring.

Christy offered presence to a young woman having an anxiety attack who was very frightened. She and a classmate helped the woman to breathe more slowly, then stayed with her, held her hands, and offered prayer. Later when the students were preparing to leave the unit, the patient asked to speak with them. She said,

I just wanted to tell you that what you did meant so much to me. When my mom was terminally ill in the hospital, no one touched her. All the time she was there, she was never touched. When you guys touched me, and held my hand, and prayed for me, it meant so much to me. That’s more than any medicine, any procedure, anything you could have done. That’s the best nursing care I’ve ever had.

Linda believes being willing to listen is providing spiritual care. Being willing to say, “I understand that you are having some struggles. What can I do to help you? Can I talk with you about it? Can I just listen?” helps patients, especially those who do not have family members who visit. As Linda said, “Sometimes the nurses are the only
people there. Someone who is just willing to go the extra mile, I think that is the biggest thing.” Another student, Lauren, said,

If I start realizing that I am talking a whole lot, then communication is going to shut down pretty soon. I need to know exactly what this person’s needs are. Also, if they can arrive at solutions that are their own, that sticks with them a lot better than you saying, “There’s the way to do it.”

Casey offered an insight about listening to patients. He said,

Whatever people talk to you about is what is important to them. So if you go into a room and the patient keeps bringing up something, you might want to explore it a little because you’ll probably build up their spirits, either because they need to get it out of their system because it’s bothering them, or just because they love it and it’s going to make them happy. You need to listen to what people are talking about because then you know what they value. I need to develop rapport. I need to show that I am interested and I need to know who they are as a person.

Casey also described learning to know one of his Alzheimer patients who had previously been a waitress. He helped her to find activities that were fulfilling to her, such as wiping the tables, even in her confused state. “You’re remembering that they are human. An issue of spirituality is that the patient never ceases to be human.”

Sara recounted an experience with a 15-year-old patient who was recovering from a drug overdose suicide attempt. The nursing staff had asked her to talk with the patient because she was really depressed. Sara said,

I didn’t know what to expect. But I walked in and just kind of started talking to her. I pulled up a chair next to her and said, “Hey, I just came in. I thought maybe we could chat; maybe you might want to talk to someone.” So we started talking. We made small talk for a while. About a half hour went by and I asked her, “Do you want to tell me what happened? Why are you here?” I remember having about a good hour just talking with her, trying to win her trust.

Jill emphasized the importance of having a loving spirit while giving presence.

She said,

Patience, tolerance, having a good attitude through everything. Not getting upset with your patient because they need for the fiftieth time that day. Just being able to
keep your attitude maintained in the right direction and demonstrate Christ’s love though the whole shift helps the nurse be effective.

It is reasonable that the students would feel comfortable giving presence to their patients because engaging in interpersonal relationships with patients was a key motivator for these nursing students to be in the nursing profession. They recognized and valued the opportunity nursing affords to interact with patients on a deep interpersonal level. Several students, such as Jane, Shelley, and Rick, stated simply that patient contact gives them great enjoyment and pleasure. Sara reflected, “Every day I come home from work, there has been something that has touched my life, whether it is something the patient has said, or a way I could have encouraged a patient.” Christy commented, “I’m a big interactor. In nursing, I love how you can get involved with the family and the patient and offer them care, not just physical care.” Ranelle stated she likes to get to know patients so that she can know best how to serve them, how to make them comfortable and happy. Linda echoed this in saying she wanted to take time with her patients so that she could go the extra mile in ways other caregivers may not have been able. Susan talked about getting to know her patients by hearing their stories. “I just love listening to older men tell stories of where they used to work, what kind of family they have, what they are going through, and how they came through difficult experiences in their lives.” Lauren said she enjoys working with patients who have things all under control. But she finds herself drawn to patients who are struggling emotionally or spiritually. “I tend to naturally seek out that point [of struggle], and once I find it, I enjoy that.”
Why are interpersonal relationships important to these students? Perhaps as O'Brien (2001) says, "It is in human interaction that we make living the treasure of Jesus in our hearts and in our lives" (p. 87).

**Witness**

The theme of witness was evidenced by every student from Liberal Arts University. Witness is described by (a) verbal witness, (b) discussing religious beliefs and practices, (c) nonverbal expressions of personal faith, and (d) inviting to faith or affirming faith.

**Verbal witness**

Many students envisioned spiritual care as a verbal witness of their own faith through avenues such as personal testimony and/or prayer for patients and their families. For example, Robin cared for a patient who was being kept alive by a ventilator. She felt the Lord prompting her to pray with his family, but there was no opportunity before going to post-conference. At post-conference, she prayed, "Lord, if the family is still there, I am going to go in and pray with them." She did not know what to say to a family who needed to make the decision about removing life support. But she went in anyway and offered, "I just want you to know that I care about your situation. I wondered if I could pray with you." At first, the family members did not know what to say or do, but then they agreed. Robin took the patient's hand; the family members held hands while Robin asked God to comfort them, to show them that He cared, and to help them with the adjustments they had to make. When she was done with the prayer, through their tears, the family expressed appreciation to the student for her prayer. Robin said, "They
seemed relived. You can tell when someone appreciates something, otherwise it’s awkward.”

Linda witnessed when an elderly female patient initiated discussion about her spiritual concerns. The patient said, “My life isn’t right; it’s not what it should be. If I get out of this hospital, I’m going to go back to church with my kids and my family.” After talking with her about these concerns, Linda offered to pray for her. “I prayed with her about her illness, that she’d be able to get out of the hospital and go back to church with her family, and be able to come to know God, or grow closer to Him if she had fallen away.” Before Linda left that night, the patient said, “Make sure you pray for me.”

As Linda returned to care for the patient the next morning, the patient inquired, “Did you pray for me last night?” Linda had and she continued to talk with her patient throughout the day. Later, as Linda transferred her patient to a new unit, the woman requested again, “Before you leave, please pray for me.” So once again, Linda prayed with her and was comforted to see that her patient’s roommate had a Bible out and had heard their prayer. She said, “It was encouraging to me to know that what I had started was hopefully going to be continued.”

Jill entered into a spiritual discussion with a patient who asked to know more about the student nurse’s faith. The patient said she was looking for a new church where she would feel accepted and encouraged in her faith. She posed some doctrinal questions and asked the student where she attended church. The student told her and a few weeks later, she saw this woman at the church she attends. The patient has continued attending the same church for over a year and a half.
Several students used music as a means of witnessing about their faith to patients with spiritual needs. Lauren described how she sang hymns with a stroke patient whose speech had been affected by the stroke. Despite her patient’s fumbling speech, Lauren learned that her patient liked to listen to hymns on a particular Sunday morning broadcast. She said to her patient,

“Oh, do you like hymns? Why don’t we sing something?” As soon as we started singing that hymn, she could say every word. She didn’t have to stop and think; it just flowed freely. She lit up. She was so happy and so excited. She finally felt like she wasn’t miscommunicating and that she wasn’t frustrating anybody. And I just loved it.

Sara encouraged a Christian family who had lost one of their two daughters in a car accident. The parents came to the ICU to visit their remaining daughter, a 9-year-old. Taking cues from a Christian T-shirt the father was wearing, the student inquired about various Christian recording artists, saying, “Did you ever hear of Jeremy Camp?” The father replied that he had and that someone had suggested he listen to one of Camp’s songs. Sara told the father that for some reason she just happened to have this particular CD in her book bag and offered to play it for the family. She found the CD and played a song that Jeremy Camp had written an hour after his wife died of cancer. The lyrics conveyed the message, “God, I still believe that you are in control and you are number one in my life.” With the family in tears, Sara prayed with them. She then leaned over to the little girl and whispered in her ear,

“Do you know you are going to see your sister again in heaven?” She nodded and I said, “OK, I just want to make sure because I can’t wait to meet her, too.” She just burst into tears. During that same day another nurse who came into the room heard the music and liked it. So the family and I both started to witness to this nurse that I’m working with. The family, even in their grief, was trying to share their testimony to her. It was amazing.
Discussing religious beliefs and practices

The second way witness was demonstrated was by discussing particular religious beliefs and practices. Ranelle cared for a male patient who was depressed and struggling with auditory and visual hallucinations. “He asked me flat out if I believed in demon possession. That is a very touchy subject for Christians, let alone anybody.” Ranelle felt very hesitant to know how to respond and silently prayed, “Oh no, please help me God.” After this brief prayer, the words seemed to flow and her patient seemed to understand what she was saying. In another example, Lauren was caring for a new mother and posed a question to her about how things were going to change when she returned home from the hospital. This new mom expressed a desire to take her three children to be baptized in a local church they had just begun attending because she felt it was important for children to grow up in the faith. This statement opened the door for Lauren to explore what faith meant to her. Through discussion together, Lauren introduced the idea of faith as “trusting in God’s control of our lives.” Lauren’s patient decided she did not want to force her beliefs on her children, but rather she would set an example of faith for her children to see. Another student, Rick, talked with the family of an elderly man who was dying. The family shared their Catholic beliefs about what would happen when their loved one died. Rick said, “It can be comfortable if you want it to. It was all very natural.”

Casey found unique ways to engage patients in spiritual discussions. Working as a nurse aid in a long-term care setting, he knew his patients well and endeavored to provide them spiritual care that met their specific needs. One patient Casey cared for was a quadriplegic multiple sclerosis patient whom he described as a very intelligent man.
This resident, a hardened atheist, liked to have Casey challenge his atheism. Casey described,

He wanted to engage. He wanted the discussion. He came from a Roman Catholic background and thought that all Christianity was Roman Catholicism. I would come out straight with something from my Reformed Baptist belief system; and that would bring his spirits up because it gave him something to think about. He would sit with his little mouthpiece typing for hours on end, writing his memoirs. Every now and then my conversations with him showed up in the memoirs. He didn’t always agree with me. But it gave him something to think about, something to make use of his time. He was an intelligent man trapped in a little room because of his immobility.

Non-verbal expressions of personal faith

A third sub-theme of witness was non-verbal expressions of personal faith, through intentional acts of love, compassion, patience, and in joyful attitudes. When Ranelle had clinical experiences on the psychiatric units, she learned that “compassion and patience are very, very big. You need to exaggerate those qualities with people who are hurting so badly, who are seeking and have failed so much.” Linda said she believes that Christian nurses caring for patients should do so with a cheerful, willing spirit, even when doing “the most awful job in the world.” She said they should also be willing to go the extra mile for the patient, and “regardless of how long, how tough, how difficult, how disgusting the task, think totally about that person above yourself.”

How student nurses act, talk, and care for patients can be spiritually encouraging to a patient, without sharing the gospel. As Jill stated,

If there is the most terrible patient pushing a call light every five minutes, you will demonstrate Christ’s love when you go in the room with a good attitude and a willingness to answer the patient’s questions. Just by your actions, the patient can see that you are different. I think there is a definite difference that you can tell between the people who are there to care for the people, and the people who are there just to get the job done.
Amy also talked about having a joyful attitude and “letting the Lord shine through me.” She asserted that a smile goes far in giving spiritual care to a patient who may not know God. Susan said she believes that “really loving people” is a “huge thing,” even without speaking about faith or praying with patients.

It is not surprising that the narratives of the theme of “witness” by students from Liberal Arts University were so rich and descriptive. They often expressed their motivations for being a nurse with the words “ministry” or “calling,” as evident in the paragraphs that follow.

Ranelle, Debra, and Susan were introduced to nursing through the work of their nurse mothers. Their interest in nursing grew with more exposure to the profession through activities like mission trips and visits to nursing homes. However, seeing how nursing would enable them to serve others was the key element for choosing nursing. As Ranelle said, “I was thinking about the best way to serve God and serve people at the same time. I decided that nursing would be the best way.” Jane also said she wanted her life to be a ministry, and found nursing as a “fit” for serving.

Sophia liked the reputation of the profession as one of care and compassion. “It’s an awesome opportunity to express those innermost feelings for fellow mankind, which is what Christ did.” Amy and Robin discussed how their ideas of nursing had changed since entering Liberal Arts University. Where nursing had once been a professional career, it was now a tool for ministry. Thinking of nursing as ministry changed the students’ mind-set as they approach the daily clinical arena; it has also given students like Amy a different life focus. Amy said, “Now my horizons are broadened to going overseas as a missionary nurse and working in the orphanages to improve the quality of
health care for orphans.” Christy embodied the idea of nursing as ministry when she said,

At the end of the day, I want my patients to have seen Christ, to have seen something in me which shows I care about them as an individual. I want to be able to say, ‘My patient is better because God worked through me today. I was used.”

Jill sees herself making a difference through teaching her pediatric patients. “I want to be able to instruct them, give them another step, and guide them in another direction.” Lauren likes to promote independence in people. “When people have control of things I step back to enable them to do more. There is a fine line when you recognize this person doesn’t have control right now. That is when I step up my help.” Similarly, Joe said, “I like to put my expertise into someone so that they could say, ‘Why you helped me a lot. I couldn’t have done it without you.’ I want to help people get back on their feet again.”

Some students just like to see the difference their support can make to a person’s emotional well-being. Debra said, “The days I feel most satisfied are the days I feel I’ve made an impact, when I see who they are as an individual and look for ways to support and encourage them.” Susan recounted, “The part of nursing I love is making people feel better, with a smile, with medicine, or nursing techniques. My favorite part of nursing is seeing the person progress.”

Some students feel called to make a difference even in the most despairing situations. Sara described caring for an abused, 3-month-old girl who had skull fractures, femur fractures, and retinal hemorrhages. “They couldn’t tell the difference between grey and white matter on her MRI.” Sara said that her heart broke as she cared for this baby, yet she gave the child love, tenderness, and attention. “It didn’t seem right to
leave, and at the same time, I walked away saying, 'I gave the best possible care I could today.' That's encouraging to me.”

Inviting to faith or affirming faith

The fourth and final manifestation of witness was demonstrated by students who actively invited patients to accept faith or to affirm and encourage their existing Christian faith.

Students with strong evangelistic desires, such as those at Liberal Arts University, sometimes experienced tension between their sense of responsibility or obligation as Christian believers to share the gospel with their patients, and the need for demonstrating sensitivity and respect for the patient. Interestingly, four students made the distinction of how spiritual care is provided differently to “believers” versus “non-believers.” One of those students, Jane, said she finds it easy to offer a word of encouragement from Scripture, to pray, to talk about spiritual growth and things God is teaching through the experiences of life with believers. But she finds it harder to “connect” with non-believers, harder to know when to “cross the line of offending people.” She acknowledged that there is a point where people “shut off” from discussion. “You don’t want to do that. And you don’t want to cause people to think badly of Christ or Christianity.” Jane thought that maybe the answer was to help patients focus on something other than their circumstances. She wants that focus to be Jesus Christ, but knows that is not always possible. Hear the conflict in her statement, as Jane said,

I think as Christians we are called to be ambassadors of God. He wants us to help people whether or not they are believers, whether or not we can actually share the gospel with them. I hate it when people say, “I just want to love them, and share Christ with them by the way I live.” Well, that’s true, but it’s the gospel that matters. You can be nice all you want. Many Mormons and Muslim people are very nice, but
what do they have to back that up? I think it is very important to get the gospel in there, but more than that, God calls us only to give Him glory with our lives and that’s all I want to do, ultimately. I’d like people to know that I do represent the Lord and through that offer them encouragement, offer them comfort, offer them a temporary hope, if not eternal.

Some students leaned toward “telling” patients about their beliefs, with less emphasis on following the patient’s lead in the conversation. For example, in discussing how to give a personal witness, Jill said, “It doesn’t really matter what other people think of me because they can do whatever they want with whatever I tell them.” For Joe, spiritual care is never devoid of God. Caring for patients’ spiritual needs without God in the picture “is more like pacifying them emotionally, rather than meeting an inner spiritual need.” Joe said,

I like to talk to people about where they are spiritually and if they give me the right and let me open the door, I tell them what I believe. I like giving them whatever they’ll take. I’m not going to force any Bibles or scripture tracts on them. But I know that Christianity is a religion of good news, of joy and hope, and of a promise of life beyond the pain they may be currently in.

Later in the interview Joe expressed concern that he may have seemed a little intolerant. He said,

I do want to emphasize that it is also very important that you show the utmost respect because this is the most important topic for having respect on. If your patient does not agree with you, that is totally OK. On the flip side, there is truth. Everything can’t be true. But if you lay your claim to the utmost in spiritual care and they reject it, then you have done your best to care for them. Sometimes stopping the conversation may be better for them than trying to finish what you thought is the very best plan of care.

Ranelle also expressed a desire to not force her religion on her patients, but she also feels called to share the gospel with everyone. She said,

It’s a hard balance because you can go through a ton of patients and realize that they can die without Christ if I don’t share it with them. But if they are not going to accept it, forcing it on them might just push them the other way. There’s a point of readiness that has to be considered.
While the issue of sensitivity to patients and not wanting to compel patients to accept a particular belief was articulated by students, the occasional story implies there is room for continued learning and growth in understanding how to approach and offer spiritual care that considers the issue of readiness. Admittedly, it is difficult through narratives to assess the "tone" of the conversation, the body language, and relationship that was established between the student and the patient. There was also no objective measure for determining effectiveness of the nurse-patient interaction, other than the student's own reporting about the experience. The first example was expressed by Shelley who accompanied a female patient to the radiology department for testing.

Shelley described,

We were just waiting and so I was talking to her about my life in general. In turn we began talking about religious beliefs. She was Catholic. She said that she didn't believe there was such a thing as hell. I was trying to provide her with Bible verses that say to the contrary. She was nodding her head "yes" to everything I was saying. It was an interesting conversation. I'm glad I could have it with her. I don't know where she ended up because afterwards she said that she would think about it.

The next example is shared by Susan who cared for a 50-year-old man who had just been told he had inoperable lung cancer. The man's wife and 13-year-old son were in the room and the family was "on edge." Susan felt compelled to share the gospel with him. She recounted,

I had a chance to go in when nobody else was there. I said, "I'm sorry about this news and I just want to know if you know what happens to you when you die." I shared with him about Jesus and how it doesn't have to be the end, how it seems like such devastating news, but in some ways it can be a new beginning. It's never too late to accept Christ. What a hope that is. He was very open. He said, "Thank you" and I was just able to say, "I'll be praying for you."

One of the staff nurses with whom Susan was working asked where she had been. Susan replied, "Well, this guy's going to go home. I'm a believer and just had to share with
them. Honestly I don’t always feel like I need to go in and share. I’m never going to see the guy again and he may not live six more months.” Susan believed it was a matter of whether her patient would go to heaven or to hell. She said that the situation opened up spiritual conversations with the nurse who was also a believer. The nurse told Susan, “I know I want to be living a little bit better.” Susan did express concern about having sensitivity in discussing spiritual things with patients. She added,

I pray that God will guide me who to talk to and who not to. I want to be careful. I never want to go in and seem like, “I have to convert this person.” Just going in and loving them is a huge thing, even if the words don’t always come, just being able to love, to really love people.

If she were a patient, Susan said she would want a nurse to be attentive to where she was spiritually, rather than “someone coming in and trying to convert me.”

Other students have considered this responsibility for sharing the gospel, and approached their patients from a point of perceived need. Debra is a student who finds some difficulty giving spiritual care because she wants everyone to “come to a saving knowledge of Christ.” But she said the reality of giving spiritual care is different, as she described,

I think spiritual care is showing people who I am in Christ and not being ashamed of that, but at the same time, being willing to assist them in nurturing their spirit and their own faith. I may not necessarily agree with it, but it is still my job to work with them in nurturing their spirit, and hopefully to show them who I am in Christ in the process.

Lauren sees the ideal spiritual care as leading a person to salvation if they do not know Christ. “However,” she said, “that doesn’t really take into account the fact that the person might be very happy and content with the religious ideas that they already have.” Instead of seeing spiritual care as “spreading the gospel,” she sees it as “the portion of care where I can talk to them about their spiritual beliefs—where they currently are, what
they used to think, how that has changed now.” Lauren did not come to this belief easily. She said she has thought about it considerably and talked with others. Because she sees salvation as a “process” where “sometimes you come in the beginning, the middle, or the end” of a person’s experience, she said that it may not be God’s will to see a person come to Christ. Lauren said,

You have to be open enough and totally in tune with the Holy Spirit at that moment to say, “However God is working in this person’s life right now, I know that the Holy Spirit will help me to recognize and interact in whatever way God is trying to grow the person spiritually, however He is drawing the person to Him.”

Sophia said she finds an immediate common bond giving spiritual care to “believers.” Like Debra, Sophia sometimes feels discouraged when she does not present the gospel to someone who does not know Christ. She has had to reconcile this within herself. She reflected,

The Lord has probably given them some kind of opportunity in their lives and I am not personally accountable for the choices they have made. Whether they choose to follow Christ or not is not on my shoulders. It’s not a matter of saying, “That’s not my problem.” It’s more a freedom that the decision is with them.

Sophia said she believes her role in giving spiritual care is to observe and listen to where a person is, rather than trying to bring them to the point of changing them. She said,

Even if I don’t agree with their faith, I can still respect it and give care to them. Sometimes Christian nurses have a tendency to write people off that they can’t change. I think it’s very important to observe where they’re at, not to change them, but just to meet them where they are and encourage them.

Casey held the same view. “Sometimes I need to honor the beliefs of another and strengthen them spiritually in that way, even if it is different from my beliefs.” Casey reasoned that Christian faith has no place for forcing anything on another person. “It’s about love, and love does not abuse.” He advised that nurses need to approach others with Christian love and with respect for the patient’s beliefs.
In summary, Liberal Arts University students demonstrated the theme of witness in their beliefs about spiritual care and in the provision of spiritual care to the patients. No identifiable differences in their understandings of verbal witness, discussion of religious beliefs or practice of the patient, and non-verbal expressions of personal faith were evidenced. However, how students approached the issue of inviting patients to accept faith differed among these students. Liberal Arts University students were motivated as nurses by a calling to nursing and saw nursing as their avenue for ministry to others.

Enabling Spiritual Care

What factors enable nursing students to be effective spiritual care providers? The analysis of the experiences and perceptions of Liberal Arts University nursing students showed that giving spiritual care is enabled by students’ growth in (a) personal faith, and (b) preparation. These themes are discussed and illustrated below.

Personal Faith

Liberal Arts University students believed personal faith was an essential attribute for providing spiritual care. It is characterized by (a) spiritual mindedness, (b) a sense of God’s leading, and (c) experience and practice, which further enhance one’s spiritual care abilities. The Christian students I interviewed could not envision providing spiritual care to a patient without their personal faith. Their faith was the initial preparation to give spiritual care. Additionally, some students believed having stronger, bolder faith would help them be better prepared as spiritual care providers. The three facets of personal faith discovered in this research are now discussed in greater detail.
Spiritual mindedness

Being mindful, confident, and unselfconscious about their own faith enabled students to use themselves as a vehicle for offering spiritual care to their patients. These students’ comments illustrate the mindfulness about spiritual matters that they believed was important to providing spiritual care. Rick reflected on his years as a non-Christian as he thought about what enabled him to give spiritual care. “I wouldn’t have been able to give spiritual care before and felt legitimate about it just because I didn’t really have any beliefs. Previously I didn’t take it seriously because I didn’t see any need.” Joe spoke about the importance of awareness of his own spiritual state and consciousness of spiritual care needs, adding “Know the Word of God and be able to articulate the hope that is in Christ.” Joe also believed that the nurse himself is the instrument to offer spiritual care. “You can’t use a pair of scissors or gauze or tape to heal spiritual needs. You use yourself. And to be a good spiritual care giver, you must yourself be a sharp tool.” Sara believed that it would be very difficult for a non-Christian nurse to offer hope to someone without it themselves. “They need to have a value and a hope themselves in order to give hope.” Debra said, “There’s no way to speak into somebody’s life if you are not right with God. It’s vital to have that dynamic relationship with Him and not allow myself to get caught up in the busyness of the day.” Robin stated it this way: “You need to find your spiritual oneness. Without it, wholeness is nothing. If God isn’t at the center, there’s no hope at all.” Christy saw her faith in Jesus Christ as the reason why she cares for people. “Having a strong faith in Christ drives my action.” Likewise, Susan said, “My faith is my motive for serving. I feel prepared to give spiritual care when I stay in the Word.”
Confidence and maturity in one’s faith also influence spiritual care, according to several of the students interviewed. Jill commented, “I think a lot of it is becoming confident in what I really believe and being able to show that to other people.” Another student, Ranelle, put it this way:

If you aren’t spiritually mature enough, then it doesn’t matter how much preparation or how much teaching you’ve had. You still are not going to be able to provide spiritual care. Student nurses need to have confidence, to know this is part of care.

The significance Debra gives to spiritual matters makes having confidence more consequential. Debra said, “It takes a lot of courage to talk with a patient about spiritual things, more so than other things. Because spirituality is the most important thing to me, I get the most scared about it.” She added, “But it’s about just loving yourself and being open to being used of God.” Sara believed Christian nurses need confidence to take advantage of opportunities for giving spiritual care. She said,

Christian nurses need guts. Giving spiritual care takes that. For whatever reason each of us gets that stumbling block, “What do I say?” Deep down, it’s “God, I know you want me to say this right and talk to them, but I can’t.” I think the biggest thing is to get over whatever fear we have and make the most of every opportunity that God has provided.

Joe said, “A greater boldness on my own part to approach the subject of spiritual care would help. I may seem confident in some situation, but when I approach a subject that I fear may be uncomfortable for someone, I have some trepidation in that.” Amy also said that it is easy to “cower away from being bold about your faith.” She strengthens her confidence by saying to God, “This day is your day and I’m here to serve you. Just lead me.” Jane said she recognizes many opportunities to share the gospel with patients and when she sees such an occasion, she says to herself, “Yeah, go for it!”
Casey approached the idea of spiritual mindedness from a different perspective than his classmates. He thought that having an awareness of his own beliefs would help him not let them get in the way while providing spiritual care. He also advocated coming to know and understand one’s own spiritual beliefs by being around non-Christians. “It doesn’t happen by separating yourself from others. You need to see what others are thinking and believing because that will help you understand what you believe.” He said he believes that Christians must keep searching for faith to understand it more fully. Yet, he admits, “You’ll never fully understand the faith. If your faith cannot change, you have a faith in self alone, the assumption that ‘I know all,’ or ‘the omniscience of self.’”

Spiritual mindedness additionally means being unselfconscious about issues of personal faith. Sophia said, “I think a big thing about spiritual care is being comfortable with me.” Lauren described growing up as the only Christian, non-Mormon, in her class for many years. She found that her friends were usually interested in talking about faith if it came into normal conversation. Lauren said,

My comfort in talking about spiritual things and actually enjoying it came from growing up with a lot of opportunity to talk about God. A lot of people don’t like it. It’s not really any different even if you are surrounded by a hundred of your classmates who are Christians. They tend not to talk about spiritual things anyway. But I guess I felt more of a drive to, or more ready to, because I knew that those people weren’t saved.

Shelley believes it helps to be comfortable talking to people, offering to pray with them, and being ready to give an answer for the hope that is within. “Other than that, it’s an ‘as you go’ type of thing. The most important thing is a personal relationship with Christ.”
A sense of God’s leading

Many students describe a spiritual care-giving process that is intentional and purposeful, either in recognizing their need for God’s direction as they begin their clinical day or as they approach a point of helplessness in knowing how to proceed in meeting a patient’s need. To initiate that leading, Sara believed, “The biggest thing I can do to prepare to give spiritual care is to pray. I pray before I go to work every day.” Ranelle echoed this thought. She said, “If you are praying that day for a specific opportunity to share the gospel, God answers prayer abundantly. I usually pray to, ‘Be what you want me to be today or do what you want me to do today, God.’” Amy said she notices a difference in the days that she prays in the car while driving to the hospital. She said,

I ask the Lord to go before me and prepare the patients that I might come in contact with. I pray for an opportunity to share my beliefs, to encourage others in their faith, or to share salvation with them, that the Lord would make it evident to me.

She believes that the key to spiritual care is having a mind-set of wanting to be used of God that day in whatever way He opens for her. Likewise, Susan said, “Praying that the Holy Spirit will guide whom to speak to and what to speak about is such a key thing. And then be open to that.” Jane commented about praying to the Lord for occasions to serve. “I’m always on the lookout for opportunities to provide spiritual care because I feel it’s my most important calling.”

Lauren told how she was reminded to pray daily as she went to her clinical assignments. One day she found herself performing tasks, such as turning her patient and doing hemodynamic and vital sign checks, for a patient who was completed sedated and on a ventilator. “I thought to myself,” she said, “What am I doing here? I’m just wasting time, busying myself.” So as she looked at her patient’s breathing, she began to
pray for her patient. In recounting this experience to her father, she wondered why she had not previously thought to pray. He said, “Every day the doctor, the lab people, and your nursing professors have things they want done. But what does God want you to do for these patients today?” Her father advised her to pray every morning, “Today I’m going to interact with these people, God. I want to know what you want me to do for them. What is the care I should give them from your point of view?” Now she prays every day on her way to clinical assignments that God would prepare her patients’ hearts to whatever way she can minister, “and let me go at it with grace and kindness.”

Debra described the unrest she feels when experiencing a prompting from the Holy Spirit to do or say something. She said,

I usually know when I’m supposed to pray with a person because I feel a tightness inside. I can’t really explain it, but I definitely know I need to do something. I’m praying, “God, am I really supposed to do this?” “Yes, you’re supposed to do this!” And sometimes it’s difficult and I have ignored it at times.

Ranelle and Amy felt God’s leading while in the process of giving spiritual care. Ranelle’s patient asked her about demon possession. She attempted to answer him and realized she was stumbling and fumbling for words. “I just quickly prayed, ‘Please, help me God.’ Then it just seemed to flow and he seemed to understand more what I was saying. And I could understand what I was saying. It made sense.” Amy has had times when she did not know what she said to patients, but she knew that the Lord placed words in her mind to speak to a person because she said exactly what the patient needed.

Finally, one student named Shelley questioned how much a student could even prepare to give spiritual care. Shelley stated,

I don’t know if you can conscientiously prepare for giving spiritual care, other than reading the Bible and praying that God would help you be ready. A lot of it is really based on the Holy Spirit’s leading. . . . It has to be a Spirit-led thing because there are
things that are going on with persons that you know nothing about. You can’t know all that’s going on in their heart, or who else has talked to them, or what the last few hours or the last few days have brought. You have to trust God that he’s going to get his message to them, if that’s what he wants. It’s his choice. He’s sovereign. Either he can use you or he can choose not to use you.

Experience and practice

Students recognized that the more experience they have in giving spiritual care, the more effective they will become. Joe wants to gain more experience in giving spiritual care by practicing so that he can bring up spiritual issues more comfortably in various situations he finds himself. Jill suggested it could be helpful to have a time in the educational program where students are given practice in sharing personal faith. She also thought students could practice spiritual care with patients using different case situations. Jill said, “Sometimes it’s harder to do with your friends than with somebody you may never see again.” Debra also wished for a chance to practice giving spiritual care in a classroom setting. She said,

Sometimes it becomes too easy in lectures, “Well, you do this and you do this and you can use these verses.” But it’s not always that easy. When patients are going through crisis situations, it’s up to the Lord to lead you in that.

In a sense, Debra was saying that situations will always be new and that no one can always know exactly how to give spiritual care. Robin said she found her experience in summer camp as she worked with youth and encouraged them to have a personal relationship with God. She said, “Spiritual care is kind of like evangelizing. God really used that summer to teach me how to be vocal about my faith and to be concerned about people’s spiritual care.”

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Preparation

Preparation played a key role in enabling students to provide spiritual care. Students also suggested ways they could have been even better prepared. The theme of preparation includes (a) instruction and discussion, (b) handling perceived societal boundaries regarding spiritual issues, (c) modeling and encouragement by faculty and nurses, and (d) other data.

Instruction and discussion

Students from Liberal Arts University believed the education they received at the University helped prepare them to be spiritual care providers. Gaining a mind-set about spiritual needs of patients and feeling a sense of permission from faculty to give spiritual care helped students begin to see themselves as spiritual care providers. Robin emphasized the value of teaching that spiritual care is just as important as physical care. Amy said the classes at Liberal Arts University emphasized being open to spiritual care as the student enters the hospital room. She felt the faculty helped students relate the spiritual needs of patients to different disease processes. “I’ve always felt that what I’ve learned here was more than adequate to prepare me.” Linda also thought the nursing department talked a lot about what it means to provide spiritual care. “Our school has made a point of saying, ‘You are a Christian and nursing is a service to other people. It’s your way of ministering to them. It’s OK to talk to patients about God. It’s OK to pray with them if they look like they are hurting.’” As mentioned previously in the section entitled “Holism,” the faculty members at Liberal Arts University use a curriculum model which identifies five dimensions of people—the physical, intellectual, emotional, social, and spiritual dimensions. Students were very familiar with the model and spoke easily
about “the five dimensions.” Additionally, Sara spoke about the clinical worksheet that helped her pose questions to her patients, such as “Do you believe in God?” “What gives you hope?” “What do you value?” Robin stated she found help in learning how to be a good listener and learning more about how to communicate effectively with patients.

The requirement for a minor degree in Biblical Studies has been a benefit to Linda, Jill, Amy, Sara, Rick, and Robin. Jill remarked that the Bible classes gave her the background and content needed to develop her understanding of the Bible so that she could talk about faith in a way that another person would understand. Sara said the Bible classes also gave her opportunities for witnessing.

Some students expressed a desired to have more opportunity to discuss the spiritual aspects of care. Lauren said she would like to have more time to talk with her classmates about spiritual care situations. She felt that classmates were not always comfortable with providing spiritual care and did not keep it in the forefront of their thinking. “Sometimes it seems like we talk about ideal situations, and then assume that everybody knows how to share the gospel.” Yet she felt that spiritual care was not about “getting people saved.”

That’s a very Christian thing to do, but not a very nursing thing to do for providing spiritual care. I don’t want to be relativistic. I want to leave them with salvation, but in a way that hits them where they are at, and not just throw it at them. I don’t feel we talk about that aspect enough. I think it should be a part of post-conferences.

Casey also expressed a desire to have more opportunities to discuss spiritual care with faculty and fellow students. He thought that hearing how others approach spiritual care would be very useful, to discuss what has worked and what has not worked. “There are a lot more variations for spiritual care since you are dealing with different people.” To go from practice to discussion to practice to discussion is a learning model Casey would
support. In addition, he felt it would be useful to expand the discussion about giving spiritual care to “people who believe differently from me.” He thought he could glean some wonderful ideas about spiritual care from “hearing how a non-Christian gives spiritual care to a Christian, or how a non-Christian gives spiritual care to a non-Christian of a different type. I would love to have an interaction like that just because of the difference in perspective.”

Several students suggested some specific areas of spiritual care instruction they perceived would be helpful. Rick said that a lot of spiritual care is to “go with the flow,” but he felt he needed more preparation to handle end-of-life issues.

I’m just an average Joe off the street when it comes to end-of-life spiritual care. . . . It’s one thing to talk about it. It’s another to go in there and see a man who’s wasting away and tell him what you think as a healthy, vibrant twenty-one-year-old, you know? Maybe it would help to get a mind-set ahead of time if you suspect someone might have that kind of issue.

Lauren believed it would be helpful for nursing students to better understand different beliefs and world views, even though it would not be possible to understand them all. She added,

The amazing thing about God’s plan of salvation for the world is that God can use any Christian nurse to provide spiritual care. It doesn’t take a genius to spread the good news. However, you can more effectively guide others to that truth if you are aware of the background they are coming from, their spiritual beliefs, and how can the gospel fit right in with some of what they are believing. Then it’s not really that mysterious after all and you can really do something powerful.

One student commented about the encouragement she has received from her patients as she endeavored to be more effective in spiritual care. Susan said,

Patients have been able to give me spiritual care in some ways. It’s been a therapeutic thing both ways. One guy had a disease where his skin tightened as stiff as can be. I’ve never seen anyone like it. He can’t smile or anything, but he was telling me about his hope in the Lord and how the Lord is so faithful to him. What an encouragement that his faith has stood the trial.
Handling perceived societal boundaries regarding spiritual issues

What is permissible to say and do when giving spiritual care? Some students were unclear about what was allowable, not just individually with a given patient, but within the environments they were in. Robin remarked, “Sometimes in situations, I am not sure how much freedom I have in the hospital to offer spiritual care. I’m not sure of the rules, so I don’t know if I can just initiate [prayer.]” Joe said, “I don’t know if there’s a rule against giving things to people. I find that if I have a bit of scripture that I could say, ‘Would you like this?’ it tends to help conversations get started. A tract can sometimes communicate better than I can.” Rick thought that most nurses were afraid to broach the subject of spiritual care with their patients because of legality and fear of law suits or pushing themselves on people. He said he has figured out how to handle “the line” of appropriateness. Rick said,

I am not really afraid of that because I know exactly where the line is drawn and I am not going to go over it. I ask for permission and I am very careful. Like I said, I don’t push it on them. I’m not going to force my opinion on them. I’m not even going to give my opinion. They either ask me, or I ask if I can share it.

Debra also wondered about the legality. “I’m still stuck on the fact that we’re not really allowed to do this in the hospital. I know we are, but it seems almost unreal because I know praying isn’t allowed in schools anymore.” Jill and Jane expressed concern about possibly offending someone as they offered spiritual care. This concern caused Jill to feel intimidated about talking about spiritual things. “I wasn’t sure exactly what I was going to say because you don’t want to offend somebody.” She found being a student from Liberal Arts University an opening to talk about spiritual care because some of her patients would begin the discussion by talking about the University.
Modeling and encouragement

The impact of faculty and others who are experienced in providing spiritual care is significant to enabling students to become spiritual care providers. Devotionals before clinical experiences are an important venue for modeling and encouragement. Sara explained how her clinical instructors began the clinical pre-conference with prayer for opportunities to witness and for the students as they cared for their patients. She said,

So now I think, “God, just be with me as I’m working with these people. I don’t know what I am going to come against today. I don’t know if I’m going to be really stressed out. I don’t want to make any mistakes that could cost anyone’s life or do anything wrong. But at the same time, provide me with opportunities to share.” The faculty are very good role models.

Susan was inspired and touched by one instructor’s example of providing spiritual care to her classmate. Susan’s classmate described how, at the end of a clinical day, she did not remember what to chart about her patient’s care or what she was supposed to do. Susan empathized with her classmate knowing that all students have “those kinds of days.” Susan shared,

But what really hit was our instructor came up along side of her, pulled a little Bible out of her pocket and said, “OK, we’re going to look at this.” And she opened up and read in Philippians, “I can do all things through Christ who strengthens me.” It’s not us doing it. It is Christ doing it through us. That was so encouraging because we’re not perfect nurses by any means. It’s a huge thing with spiritual care, recognizing it’s not me, but Christ is doing it. That’s a freeing thought.

Linda worked with a nurse preceptor in home health care who led and modeled spiritual care for her. “She really focused on knowing her patients individually, knowing their ins and outs.” Her nurse preceptor gave an example of how to focus on providing comfort to her patients, rather than simply doing tasks.

Seeing spiritual care given or being exposed to more real-life situations was important to students. Christy would like to have more live stories from people who have
done spiritual care, not examples from nursing practice, but from students in school. She said,

It would be like, “OK, this is real. This is how you really do it.” Sometimes at first it’s hard to keep track of all the things student nurses must do and then offer spiritual care, too. Seeing how people really do both would help.

Christy applauded how nursing faculty modeled holistic care in the ways they related to nursing students. She reflected,

We have support here in the professors who invite us to their homes, who care about us as people. They care about us as individuals, and we go and care for others. It’s been modeled throughout my life, through my parents, then the youth group, then growing up and coming to school. It’s been the same.

Lastly, Debra described a way that she would have liked to have been encouraged. “Knowing that somebody was praying for me while I was giving spiritual care would have definitely boosted my confidence a little. To get support from even one of my fellow peers would have encouraged me.”

Other data

Most of the students were the initiators of spiritual care with their patients. Patient-initiated spiritual discussions generally arose from patients’ inquiry about Liberal Arts University’s reputation as a Christian university. Jill and Linda’s intimidation about talking about spiritual things was less when her patients initiated a discussion about the university. But as Linda said, “When I go home, back to Maryland, nobody has ever heard of this university. At home, what am I going to say?” Linda and other students wanted to learn more ways to recognize opportunities and start conversations with their patients. Environmental cues were important, but insufficient. The students’ clinical
assignments which require them to ask questions helped to initiate conversations.

However, Debra felt,

It’s definitely the “getting started” that is hard. It’s been so helpful to hear faculty and staff experiences about the way they initiated those conversations and the ways that God directed them. Even the verses they have used at times for comfort. I know that a lot of it is the Spirit’s leading, but there is also a certain amount of preparation that we can do to have the tools ready.

Jane also spoke about having more tools to seize the opportunities. She would like to have suggested things to say and do when starting spiritual care. Jane said,

What we learn in our nursing classes is very general, things that we already know. And maybe that’s all we need, just a reminder. I’ve learned about the five dimensions and that’s been helpful. But as far as making it practical, I don’t feel like I have learned that much. It’s been just by experience.

Linda stressed that having a patient focus would improve spiritual care provision. She said,

Just be willing to be cheerful about what you’re doing; put aside the things in your life that you are dealing with at home and your social life in order to totally focus on your patient. Think completely about what is best for your patient. Regardless of how much time it is going to take you, regardless of how long, how tough, how difficult, how disgusting the task, you must be willing to think totally and solely about that person above yourself.

Summer work in a nursing home also made it easier for Linda to broach such subjects as spiritual care because she had sufficient time to build relationships over time.

Casey believed rapport is very important to providing spiritual care. “If my patients do not like me or perceive for some reason that I do not like them, I won’t be able to provide them with spiritual care. It will create a tension that runs directly contrary to the Spirit.” Consequently, Casey attempts to show his patients that he will do his best to serve them and to know them as persons.
Lauren, Susan, and Christy spoke about skill development and nursing care. They felt it was easier to provide spiritual care when they were not as focused on learning new psychomotor skills. Lauren stated,

For the first couple of years of clinical experience, I was so focused on looking at monitors, skin color and all those things you need to do for patient assessment because it was so new to me. It’s just been in the past couple of months that I finally felt like I have it under my belt enough now so that is like second nature. Now I can finally get a focus on the patient’s spiritual aspect. Before it was an idea we talked about, but now it’s finally something that I am able to focus on. It’s more of a process than an idea.

Christy had a “life lesson” when she was affirmed by a patient to whom she had provided spiritual care. The patient’s appreciation said to her, “Don’t forget. Touch your patient; pray for your patient; show that you care about them.” She learned that “even as a new grad, as a new nurse, as a nursing student, it is so easy to get mixed up in all the technicalities, procedures, and everything that you forget you are dealing with a person.”

This section discussed two themes of enabling spiritual care—personal faith and preparation.

**Summary**

Chapter 4 introduced the statistical data findings from the entire sample before presenting data analysis from Liberal Arts University. A description of Liberal Arts University was followed by curricular information about Liberal Arts University’s nursing program and a description of the interview sample from Liberal Arts University.

The two key research questions explored provided the foundation for the themes that were discovered in the data. In response to question 1 the spiritual formation of Liberal Arts University nursing students was influenced by (a) personal spiritual
disciplines, (b) relationships, (c) an environment of Christian teaching and growth, and (d) struggle and/or loss.

The second research question explored how the experiences of nursing students in life and in the nursing curriculum influenced their provision of spiritual care to their patients. The spiritual care provided by students to their patients encompassed patterns of (a) holism, (b) presence, and (c) witness. The ways that spiritual care is enabled, according to these students, is through development of personal faith, and through preparations, specifically instruction and discussion, handling perceived society boundaries, and modeling and encouragement.
CHAPTER FIVE

HEALTH SCIENCES COLLEGE

Introduction

This chapter begins with a description of Health Sciences College and its nursing program. The interview sample from this college is then described and the data presented for each of the two research questions.

Health Sciences College

Health Sciences College and its nursing program are now described. A private, religiously affiliated, Christian health care educational institution, Health Sciences College is located in a suburb of a mid-sized Midwestern city. Its student body is predominantly female (70%), and diverse in martial status and age; the mean age of the student body is 27. Most students live in the community; however, about 90 students reside on-campus. The College offers certificate, associate, and baccalaureate degree programs in nursing and the allied health sciences. Four themes, relationship with God through Jesus, character formation, service to others, and a whole person view, guide the college’s spiritual understandings and inform the spiritual outcomes desired for its graduates. The first three themes reflect beliefs common to most Christians. The interpretation of the fourth theme, a whole person view, is specific to the college’s Seventh-day Adventist denominational affiliation. The college communicates its spiritual

126
identity in the college web site, in publications, and in academic and campus life. Students who enroll at the college must agree to abide by the conservative standards of conduct while on campus. They also participate in various activities designed to augment the faith experiences of the academic community, such as monthly chapel attendance. The college core curriculum requires each student to complete a course called *Introduction to Christian Healthcare*, as well as four additional semester hours of religion. Opportunities exist for ministry activities and mission experiences for which a minority of students volunteer. Unlike Liberal Arts University, no faith commitment is required of students enrolling at Health Sciences College. Eighty-five percent of the student body espouse some type of Christian faith, and there is a noticeably wide variation of faith development among students who attend this religiously heterogeneous campus.

**Health Sciences College’s Nursing Program**

This section presents information about the nursing program, its mission and philosophy, its curriculum relevant to spiritual care, and faculty perspectives.

The mission of Health Sciences College’s associate degree nursing program is to provide quality nursing education within a distinctly Christian learning environment. Faculty teach students concepts of whole-person care, integrate the art and science of nursing, and develop professionalism for the benefit of the community. Students may choose to pursue a baccalaureate nursing degree upon completion of the associate in science program. The associate degree prepares students to provide whole-person health care to individuals and families in settings characterized by established policies and protocols.
Spiritual underpinnings clearly exist within the curriculum, beginning with the
philosophy and continuing through the conceptual framework, curriculum organizing
themes, within courses and clinical evaluation tools, and the students’ assignments.
Beginning with the nursing philosophy, portions of which are cited below, spiritual
elements are included in the department’s view of people, health, and nursing:

Humans are viewed as having received life as a gift from God and therefore are in a
dynamic relationship with their Creator in order to become whole. Through His
nurturing acceptance, God allows humans to exercise free will in making choices
throughout the life span. Inherent to free will is being responsible and accountable
for one’s own choices.

Levels of health constantly change, ranging from wellness to illness. Wellness is
achieved when the spiritual, physical, psychosocial aspects of a person’s life are
effectively integrated. The faculty believes that a close relationship with God permits
individuals to experience life and wellness to the fullest potential. . . . Health is a
dynamic process that is impacted by interactive spiritual, physical, and psychosocial
dimensions.

The art of nursing encompasses compassion, flexibility, and sound judgment
consistent with the ethical principles exemplified by Christ. . . . Christian caring is the
context for the provision of nursing care, enhancing movement toward health
maintenance, promotion, and restoration. In response to having received God’s
unconditional love through faith, the nurse honors God by providing whole-person
care for self and others through nurturing acceptance and compassionate service. . . .
Essential to Christian professionalism is openness to guidance provided through an
ongoing relationship with God.

The program’s conceptual framework extends the philosophy. Concepts specifically
relevant to spiritual goals include the Christian context of nursing practice, the whole-
person view of human beings, and a dynamic health process, including the spiritual
dimension of health.

The six organizing themes threaded through the curriculum are (a) Christian
caring, (b) safe, effective care, (c) health promotion and maintenance, (d) psychosocial
integrity, (e) physiological integrity, and (f) professionalism. In the clinical evaluation
tool, the Christian caring theme encompasses such items as "incorporates spiritual care into the development of a whole person plan of care" and "provides hope, empathy, and comfort when interacting with others." Faculty use the spiritual care textbook entitled *Spiritual Care, Nursing Theory, Research, and Practice* by Elizabeth Taylor (2002) to help them teach the Christian caring concepts identified in the curriculum described above.

Nursing students begin patient contact during the clinical experience in the first semester of the program. In their final semester, clinical experience intensifies in a preceptor-student relationship for 16 hours of clinical exposure per week. Faculty endeavor to incorporate spiritual care elements into the student's nursing practice in a variety of ways. Faculty and students begin classes and clinical experiences with a devotional thought and prayer, which is a very unusual experience for students who have not previously been in a religious environment. Spiritual care assessment begins in Nursing Foundations course and continues throughout all the clinical experiences. Spirituality is also introduced with various other concepts students learn in the program, such as learning about fear, grief and loss, and developmental issues. Examples of student assignments in second year include a student presentation in Family and Newborn Nursing about grief and loss. Students are expected to incorporate spiritual influences during times of crisis, including nursing interventions and the role of spiritual leaders. In the course Wellness and Health Alterations in Children, students conduct an extensive spiritual assessment for a child. They record their preparations for doing the assessment, a detailed description of the child and the environment, their assessment findings, and an
evaluation of the experience. They conclude by writing a spiritual nursing problem or potential problem based on their assessment findings.

Nursing students from Health Sciences College also have a chaplain observation experience in which they shadow a hospital chaplain for a clinical day. They are then asked to write a reflection paper answering these questions:

1. Describe your day. What did you do?
2. What was the role of the chaplain?
3. What is your assessment of how the patients responded?
4. In what specific ways has this experience increased your understanding of providing spiritual care?
5. How has this experience impacted you in a personal way?
6. How has this experience impacted you in a professional way?

My analysis of the nursing department included a review of many curriculum materials and a clarifying conversation with the curriculum specialist. Some additional insights about the program were gleaned from a joint interview with two nursing department faculty members, Carlene and Patricia. For example, according to faculty member Carlene, who teaches psychiatric nursing, the psychiatric nursing rotation has traditionally been a rich environment for exploring spiritual care because there is time for conversation with patients and because spiritual needs are often so obvious. Questions such as, What is your purpose in life? What gives your life meaning? and Have you done things for which you need forgiveness? are relevant and important in the psychiatric setting. Students must include at least one spiritual need or spiritual diagnosis on their daily clinical data sheets.

In addition to learning spiritual care for the purpose of giving their patients "whole-person care," Carlene said that recognizing human spiritual needs in general also raises opportunity to discuss more specifically the spiritual needs of the students. She
said she did not know how much other faculty focus on the students’ own spiritual growth, but in mental health the students are assigned a reflection summary paper where they are asked to creatively demonstrate how they have personally grown during the semester. Seeing the growth students make in 15 short weeks is “so exciting. It is what keeps me teaching,” said Carlene. Perhaps because a number of students come from a non-religious background, the faculty said they try to focus the discussions toward spirituality, rather than religion, because it is perceived to be a more common ground. As Carlene said,

To me, religious preference is like politics. You need to walk on eggshells for a little while until you find out where the other person is. Spirituality is not as dangerous a topic to talk about even to a person who may not recognize that they have that kind of component in his/her life.

She also believed that spirituality within a Christian healthcare educational institution is integral to character building, and the object of “true education.”

There were few explicit methods for growing the spiritual nature of students. Faculty felt that the Christian “environment” of the college was an attraction to some students seeking a place with spiritual roots. Other students became aware of the spiritual component only when they arrived. Faculty member Patricia acknowledged that some students are afraid that they will have to discuss religion—their own and their patient’s—and this fear may produce a negative impact. The student may think, “Maybe I’m not going to do very well because I’m not religious.” So the faculty make efforts to help them see a difference between spiritual needs and religious needs. When asked how students could enhance their ability to give spiritual care to their patients, Carlene and Patricia both replied that the student’s own inner spiritual growth was the most important factor. They also stated that faculty must themselves commit to the spiritual journey.
Patricia felt that she has grown spiritually in the past 3 years since coming to teach at Health Sciences College because there is “some talk of religion” and because she felt the need to feed herself spiritually so that she could share with her students the ways that growth can happen. “I think that as we grow, then we can have a more solid base from which to teach them how to do this.” Both faculty emphasized the journey of growth and wished they had a forum with their fellow faculty to explore issues of personal spiritual growth.

This section described the nursing program at Health Sciences College. Next, I will describe the student sample from this college.

Health Sciences College’s Interview Sample

Twelve students participated in the interview phase of this research. One was excluded from the sample because sampling criteria were not met. Eight females and three males were in the final sample. Eight were single; three were married. Nine were Caucasian and two were of African-American/Black ethnicity. Five intended to graduate in May 2004, four in December 2004, and two in May 2005. The mean age was 24.64, with $SD = 5.63$. The faith maturity scores ranged from a low of 46 to a high of 59, with a mean score of 54.64 and $SD$ of 4.08.

Narrative description about the nursing students’ past experiences which influenced their choice of nursing is now shared. One student mentioned the practical nature of the nursing job market, but there were four students who always wanted to be a nurse. For example, Diane said, “I don’t even know why or when I wanted to become a nurse. I don’t ever remember wanting to do something else.” Tina used to play with a little nursing kit when she was a little girl. As a third grader, she wrote in her journal that
she wanted to be a nurse when she grew up. Catherine’s early desire to become a nurse was solidified when her grandmother was in the hospital. “I saw the care the nurses gave. Some were good; some were bad. I wanted to do an even better job and thought that I could.” Deann remembered wanting to be a nurse “when I was a young one.” But her dream did not become a reality until after raising her children. After her alcoholic brother-in-law came to live with her and ultimately died, she promised herself that she would give back to nursing if possible, so she began pursuing the goal about 10 years ago.

Being intimately involved with the care of two infant daughters who died, Amanda’s experiences with nursing were very personal. “I had a daughter in intensive care for a year and a half before she passed away. I know how I liked to be treated, what nurses I didn’t like, what nurses I did like.” Caring for one of her daughters at home, Amanda had to learn about many nursing activities, such as nasogastric tubes, central lines, tracheostomies, and ventilators.

I figured that after learning as much as we did, I could help somebody go through what I went through, because I didn’t have anybody. I can be the nurse that says, “I know what you’re going through.” Others can’t imagine what you’re going through because they haven’t been here. Having lost two daughters, I think I can be a good nurse. I think I have a lot to offer people, knowing what it is like when you think you have nowhere to turn.

April first thought about nursing when in high school. She began college as a communications major, but kept thinking about a nursing career. “It’s just in my nature to care for people. I believe my spiritual gifts encompass caring.” Having elderly parents, she also has had the opportunity to see the difference a good nurse can make, which influenced her to once again think about nursing.
I wasn’t feeling fulfilled in the profession that I had chosen. I didn’t have a passion for it and I wasn’t excited about the things I was learning. And I didn’t feel that I would touch lives the way that I wanted to, and the way that I feel like God would want me to. You know, I always joked with my family, there’s so much time sitting in hospital waiting rooms that I might as well do something productive while I was there.

The interview sample from Health Sciences College is varied in gender, marital status, race, age, backgrounds, and to some extent, faith maturity levels.

**Research Question 1: Personal Spiritual Formation Themes**

How do life experiences influence personal spiritual formation in nursing students? Personal spiritual formation of the Health Sciences College students was influenced by the same four themes as the students from Liberal Arts University: personal spiritual disciplines, relationships, an environment of Christian teaching and growth, and struggle and/or loss. These themes are described below.

**Personal Spiritual Disciplines**

Personal spiritual disciplines were very important to the spiritual formation of students from Health Sciences College. Most frequently, the disciplines of prayer and Bible reading were highlighted. Alicia affirmed, “Of course, you have to be in the Word and you have to pray. These are the basics and if you don’t have that, you are just going to struggle and you are not going to be able to hear what you need to hear.” Diane said, “I try to read my Bible every day. I don’t always, but I try to. I pray all the time and I go to church.” Deann believed,

Reading the Word is the most important thing. I pray and I fast. I stand firm on my moral belief. That’s who I am; that’s who I want to be. Don’t get me wrong, it doesn’t mean that I always do what is right. But I know that there is an answer for everything in His word and if I stay in that, then I am safe.
John likes to read philosophical writers such as Martin Buber, as well as the Bible. April said that we cannot understand what it is like to be a Christ follower except by getting to know Christ. “I believe we do that through prayer, reading the Bible, and being plugged in somewhere to learn with others.” Amanda thinks to the contrary. She said that she does read the Bible and she writes her spiritual thoughts down on her computer. But she and her family choose not to attend church because she does not want others telling her how she should think or feel. She stated,

I know what it’s like to be completely close to God and to be completely distant from Him. To me it’s hard to have somebody stand up in front of me and preach to me about what I should feel. So we tend to learn about God on our own.

Catherine said that she reads the Bible only “every once in a while,” but she prays every night for herself, her family and friends, and for her patients. Carolyn searches for devotional topics on the Internet.

Peter meditates. He said that taking time to listen to God speaking to him, “being real sensitive to what that voice is saying,” has helped his Christian growth because God is experienced in the stillness and the quietness. Three students suggested inspirational music as something that nurtured their faith. In addition to reading the Bible, Tina listens to Christian music on the local Christian radio station. Peter said, “I read my Bible, I pray, and I love Christian worship songs. All the CDs I have are Christian CDs.” Charles echoed this, “Music is important to me, so I listen to a lot of CDs.”

Charles focused on the discipline of service, “Showing others the love of Christ is a great outlet for me. The way I get ministered to the most is when I am giving out, when I am helping others. Through that emptying, God fills me up.” April also finds service
as a means for spiritual growth. “It’s really important to be involved in ministry in the church, serving in some way. I think you grow a ton by doing that.”

Students from Health Sciences College mentioned various personal disciplines when asked how they nurtured their faith, for example, “I pray” or “I read the Bible.” However, the majority of students did not describe their use of spiritual disciplines in such a way that implied intentionality and planning.

Relationships

Relationships also influenced the personal spiritual formation of students from Health Sciences College, with most students identifying the home relationships as significant. For example, Alicia’s story is that as a child of 7, she realized one evening as she was getting ready for bed that she needed God in her life. She recounted,

I went to my mother and I told her I didn’t want to be just me and the world. I wanted to have Jesus be in my life. And I remember that very vividly. I remember her taking me back to my room and we sat on my bed. She explained salvation to me and we prayed. I accepted Jesus as my Lord and Saviour. That is probably one of my most clear memories as a child.

Alicia’s spiritual life now is influenced by her accountability partner. “She asks me how I am doing and how things have been going in my walk. ‘Are you staying in the Word? Are you struggling with anything? Can I pray for you?’” Additionally, her family is a close support to her growing faith.

Charles’s Christian family has been close, both in proximity and emotionally. With several generations of Christians in his life, a father who was an associate pastor, and a best friend who is a pastor’s son, Christian relationships abounded in Charles’s life. Deann said she has experienced the support of her family, who believes as she does. She reflected,
Sometimes when things seem a bit tough for one of us, the other one says, “Remember what the Word of God says.” Sometimes it’s easy when you are going through some hard times to forget to go and read, to forget to pray, or to forget not to talk negative, but we enhance the positive in each other and that’s important.

For April, it has been the people in her life “hands down” who have helped her to grow as a Christian. In church from the time she was a little girl, April’s mother has been a big influence. “She prayed with me every night, and just seeing her walk and her faith for a little girl who’s going to be like her mom had a huge impact on me.” In high school she became involved in helping to start a ministry called “Young Life” that does outreach to high-school-aged students. Beginning with four students, they grew to nearly 200 high-school students attending Young Life events. April remembered,

It was the relational aspect of Young Life that touched me so much. You earned the right to be heard. Nothing was forced; it was about loving people and loving God. Everything was done through building a friendship with someone and showing them that you care about them. That was what my Young Life leader did with me.

April suggested that relationships are the key for anyone to be able to understand and accept God’s love. She said,

We can go to church as much as we want, and sit in a pew, but unless somebody comes after us and loves us the way that God loved us and made us, we can never fully grasp and understand and grow if we do not have another person pursuing us. I definitely felt pursued and I still feel pursued. I’ve got amazing people in my life.

Tina’s father is a “great Christian man” with whom she loves to spend time talking. She felt her spiritual life has “taken a leap” in the past year and a half, to a large extent because of attending a Christian school and having Christian friends. “There’s just something different about it.” Tina has felt separation from the friends she grew up with, and so the Christian friends she has made at college have provided a meaningful common bond. As Tina said,
The friends I have now are just more “give and take” on both sides. Before it felt like I was giving and the other person was taking. A lot of things were on their terms. Now it's more mutual, more caring, more openly loving. Some people in the world they just seem to hold back on being loving.

Likewise, Diane said that she tries to make time for her friends who hold the same values. She feels coming to Health Sciences College has helped because there are not “a lot of bad influences here and all our teachers pray.”

An Environment of Christian Teaching and Growth

Learning and growing in faith has been influenced by faith environments. Alicia said she found church, Sunday School, youth camp, and her campus ministry group helpful to growing her spiritual experience. Likewise, Charles grew up in an environment where his home schooling and church life gave solid faith instruction.

“Church was everything,” he said. Carolyn learned about the Christian’s responsibility to serve others through the weekly teachings of her priest whose parting benediction was “Go forth to love and to serve.” She said she had always come to church, but had not done anything to serve others, except raise her children. “I wanted to live up to the potential that God put me on this earth to do.”

Diane identified how the college had been helpful to her growth: “Definitely coming here to [this college] has helped to nurture my faith. There are not a lot of bad influences here. All of our teachers pray and we have devotions. It has helped a lot to do this every day I’m here.” The psychiatric nursing course was of particular value to her personal growth. Tina has found the prayer experiences in her college classes to be very uplifting to her faith.

John described a mission experience in the Philippines that helped him adopt faith as his own. He was helping to meet the basic needs of people who were “in the middle of
'nowhere.' Seeing the vast changes between the United States and this rural region of the Philippines was a "surreal" experience for him that forced him to think open-mindedly about life and to ask questions about his faith and what he believed. Ultimately, the challenge provided growth. John said,

When your faith is being questioned by others, you don't always get stronger. Sometimes you get weaker, but I think you need that. It weakens me to the point where I realize that I don't have all the answers. I need to look more, so it makes me stronger. You have to take a step back, slow down a little bit, every once in a while.

Struggle and/or Loss

Experiences of struggle and/or loss also occurred with students from Health Sciences College. The experiences varied: Academic challenges, parental divorce, relationship issues, emotional difficulties, death, and loss. Yet they were the catalyst for spiritual growth and serving others.

Alicia did not feel much need for God during high school. She excelled academically. She had wonderful friends. On one hand she knew she needed God in her life and knew that God was active in her life, but life was going fine. She said, "OK, school is mine. God gave me the brains to do school. I was very sure that I could excel in whatever I wanted to do." Yet she was lonely in high school because none of her friends were Christians. She said she knew her friends needed God and she knew God was in her life, "but I was doing the things I wanted to do, and the way I wanted." While Alicia did not live a "wild life," she was living independent from God. Then college happened. Alicia felt God was saying to her through her academic struggles, "No more. You know you really can't do anything in life without me." She began to struggle in things that she had never before been a problem. She said, "And the struggle re-awakened a sense of need for Him."
Diane said she finds that God allows circumstances to happen in her life that help her to “get back on track” spiritually when she has been too independent and has separated herself from Him. She recounted being engaged to be married and feeling as though God was telling her to end the relationship. Diane said,

I didn’t know why and I couldn’t understand. I was very frustrated. It was probably one of the hardest things I ever had to do, just not knowing why, but knowing I was doing the right thing. We are back together now. And looking back, we’ve both grown a lot closer to God. I try to live how I think God would want me to live. It’s not always easy, but I always feel better if I do that.

Catherine’s story began at the early age of 10 when her parents divorced. “I thought I was being punished by God because I did something. And it was hard when my mom remarried.” A few years ago when her grandmother was ill and her mother was feeling stressed, she found herself drawing closer to God. “There’s a purpose for everything, and I prayed a lot then. I think that’s when things kind of came together.”

Carolyn described her many years of church attendance as a “social thing” to gain approval from those who were significant in her life. Her faith experience was simply “going through the motions.” Following the premature birth of her second child, life became complex as she managed the medical challenges and the financial burdens, while still caring for her firstborn child. Though she juggled her various responsibilities, the resulting depression left her searching for healing. She entered therapy and also diligently sought to understand the tenets of her Catholic faith to discover emotional and spiritual healing. “I wanted some meaning in my life. I had all the superficial stuff, but was afraid for a long time to look at the other parts of my life.” Her exploration led her to respond to the challenge of her priest to serve others. “I feel good taking care of people in the hospital. I am doing for them, and my own faith is nurtured.”
Amanda and her husband have lost two daughters to death in the past 5 years. Their first daughter, Kristin, was in the hospital for 3 weeks before she died. After her death, Amanda was angry and felt God had let her down. She asked, “Why is this happening to me? Why me?” Knowing of her struggle, a dear aunt and uncle chose to take Amanda out West for a time. Her uncle convinced her to climb a mountain with him to have some time and space to “get close to God.” Amanda’s hike up the mountain became like a metaphor of her life. “The first part was really easy; the second part was a little harder. The last part we actually had to push each other up over the top because it was so steep.” But when she was at the top, seeing the whole world before her, God came to her in a “big spiritual moment.” She realized that God made everything for her, and she had indeed made it this far.

After deciding to try to have another baby, Amanda also determined she was not going to go into a second possible pregnancy and childbirth thinking, “God, I hate you because of what you did to me.” Each day with Elyssa, her second child, she said, “God, thank you for today that you have given us with this child. If you could see it in your heart to give us one more day, we would love that, too.” Amanda said that she and her husband “lived every day like it was our last day with her.” Sadly, this child had a birth defect that could not be corrected in the overseas hospital that was available at the time. Amanda and her husband knew it was possible for this child to also die. “So, we prepared ourselves for it mentally.” She added, “I think God expects us to think. I don’t think He expects to hand you the answers right here. Sometimes you have to figure it out for yourself and hope you are doing it right.”
In summary, in response to research question 1, the life experiences influencing the personal spiritual formation of nursing students included the themes of personal spiritual disciplines, relationships, an environment of Christian teaching and growth, and struggle and/or loss.

**Research Question 2**

In what ways do these life experiences described by nursing students and students’ experiences within the nursing curriculum influence how they provide spiritual care? The data follow.

**Providing Spiritual Care**

The spiritual care themes reflected in the interview with students from Health Sciences College were holism, presence, and witness. These themes are discussed below.

**Holism**

Students from Health Sciences College often used the words “whole person” or “holistic” in describing spiritual care, consistent with the instruction about spiritual care that they received from their nursing faculty. Carlene, one of the faculty members, summarized what she sees as the primary goal for teaching students how to provide spiritual care to patients—care for the whole person. She said,

You can give good physical care, you can even give good emotional care, but if you don’t complete that third element, you have just cheated that patient from one third of their care. I know that it is not equally divided, but it’s important for students to know that in order for them to treat a person as a whole, the spiritual component is as important, if not more important, than all the other elements that we are teaching along the way.

Here are some examples of how the students understood the concept of holism.

John said, “Spiritual care means caring for the whole person, caring for someone’s every
need, including their spirit or soul.” Amanda believed, “Spiritual care is the total care of the whole person’s being, not just their physical, but their mental as well as their emotional needs.” Peter, a student for whom English was not his first language, stated, “Spiritual care is a big picture. It involves the body, the temple of God. Spiritual care is everything; it’s the whole picture. If you are not nourished in your spiritual life, then the body will be beaten out [sic].” When Charles hears the phrase “spiritual care,” he said he thinks of holistic care. Charles said,

It’s easy to have knowledge to treat the specific illness. But all those other aspects—emotional, psychosocial—I think a lot of that is wrapped up in spirituality. Those are the things that make [patients] comfortable and give them fulfillment. So, when I think of spirituality, I think holistic care, providing for all the needs of the patient.

Deann described spiritual care as taking care of her patients according to what their needs are. “It means praying with my patient, if that is what my patient needs. It means being silent, if that is what my patient needs. It’s not always about prayer because I can pray without them knowing.” She discovers their needs by watching their non-verbal behaviors and by allowing them to verbalize “because their needs may not be what we think they are.”

Tina told a story about caring for a female patient who was struggling with cancer. She went through the typical ups and downs of cancer with her patient and the patient’s family, and was her caregiver the night she passed away. Tina accompanied the nurse’s aide to prepare her patient’s body. Tina said,

I wanted to make sure it was a good job. I happened to reach into the desk drawer at the side where she had some perfumed lotion her daughter brought in. I grabbed it because it smelled good and I wanted to clean her up well and get her presentable as best we could. The lotion happened to be the one thing that really touched her daughter. She said to me, “You have no idea. That is what I remember my mother smelling like.”
Tina said that her small action brought back good memories for the daughter and proved to be a great comfort to her. “But it was such a small thing. It really taught me a lot. It always reminds me to push myself and do those extra little things because they mean more than anything.”

Two students described holism from a personal perspective, having been in situations of personal need themselves. Catherine, who recently entered the emergency department because of a hypertensive crisis, was fearful about having a stroke or possibly dying. “I was very, very upset about it, and it’s the second time that [my needs] were pushed over. It was like people were saying, “You’re too young to be having these problems; nothing is going to happen.” She was unable to share her concerns with the nurses because “it’s hard to address it when they aren’t even focusing on your physical needs.” She felt that her physical, emotional, and spiritual needs were interrelated.

Another student, Deann, interviewed with me just 8 days after she and her family sustained a house fire that destroyed her home and belongings. She said,

I have really been hurting and I have really been in pain. The people at my school have made sure that all my needs have been met. I can’t complain. The people at the school have made me feel whole. Even in not having, I feel whole. So, I would say that is how I would want to feel in any situation if I were a patient. It’s a really good feeling, to have your needs met and to feel whole.

**Presence**

The theme of presence was richly described by the Health Sciences College nursing students. Offering time, touch, and/or silence were evidenced in the narratives, and the importance of availability and nonjudgmental listening to the provision of spiritual care was also discussed.
Alicia was able to offer presence to an elderly woman she had known when working at a nursing home. “I saw this person go from a healthy, active woman to someone who couldn’t do anything for herself. She couldn’t eat anymore. I was able to be there for her, just being right by her side; and when I wasn’t doing physical things for her, I was just sitting there holding her hand. She really needed someone.” Alicia had cared for this woman for 3 weeks in the hospital and was able to be with her on the morning when she passed away. The family had spent the whole night with the patient waiting for her to die, but she did not. She had not eaten anything or taken any liquids. Alicia thought that perhaps she did not want to die with her family there. She said,

She wasn’t responding for any of the other nurses that morning, and I was the student nurse assigned. When I went into the room, I talked to her, “Hi, Dorothea, it’s me, and I get to take care of you again today.” She turned to look at me, and she hadn’t done that for anyone, so she knew I was there. She cracked a little smile, but she really didn’t do much anything else that morning. I could have left because she didn’t have any physical needs that I could have taken care of. But I didn’t want to leave her alone. I felt that she needed me more than anyone else.

April and her family vacationed with dear friends; sadly, she was given an unusual opportunity to provide presence to one of her friends who collapsed. His wife had called the student immediately, “[My husband] has fallen down and he can’t get up and he can’t talk.” April stayed with him as he lay dying. She reflected,

I was given the opportunity to be with him. It was really precious to look into his eyes. At that moment, I think he knew that I looked at him with love. I hope that I did. His eyes were open and started closing as the paramedics were pulling into the drive. I just kept thinking, “Oh God, don’t let me have to do CPR on [my friend].”

Deann described three situations of dying patients for whom physical needs were minimal. The common elements of her care were offering presence and prayer. In each situation she experienced a profound “connection” with these individuals that was difficult for her to put into words. She stated,
I know when I identify with people's needs. I cannot explain it. But I truly do not believe that this work I am in has anything to do with me as a whole. If has to do with Christ and what he's doing in the process, that he's trying to take in people's lives at their end days. I truly believe that in every situation, God puts people in your path. I believe he can use whomever he chooses. And I thank Him for using me in situations like that because I am glad that he finds me worthy enough to use me.

Alicia described ideal spiritual care as "just being available, being attuned to a patient's needs . . . offering yourself to listen, taking extra time to sit down with the patient. When you sit down, they see that you're going to listen and give them attention."

Peter believes that it is through listening that nurses detect patients' distress. "It only comes from listening. When you sit down and listen to them, you do a greater job than any other thing." Charles reflected, "One thing I really value is being able to spend one-on-one time with my patients. There have been hundreds of patients I have been able to touch that way, just spending time with them and listening to their needs."

John and a classmate provided presence to a man who had been socially isolated, down and out, and overlooked. He was "a little bit different socially, and very large as well." The two students gave him a bath, changed his bed and gown, and assisted him out of bed, "which was a big effort because he was a very large man." He remembered, when we first came in, I think he expected us to be there for fifteen minutes. We left the first time to get supplies, and I think he expected us to come back later. He was excited as we just kept staying. He kept opening up more and more because people were there and they weren't just leaving. He talked about his personal interests. He told us his whole story. He had faith, but he didn't want to get out. He didn't feel welcome. He didn't want to go into it much.

The needs of a 92 year old man diagnosed with an inoperable abdominal aortic aneurysm deeply impacted Amanda. The patient had been very active and wanted to have the surgery, but his age prevented his doctors from doing it. Her patient talked
about heaven and God, and his fears about what it felt like to die. He also talked about his concerns for his family. She stated,

For us, the whole world stopped outside while we sat there and talked about God and heaven and our different feelings on it. I really don’t remember exactly what we said. It was just the whole moment where you are part of somebody’s life so deep that they’re willing to share their biggest fear in life with you, the fear of dying or losing someone close to you. He cried. He talked about his wife and the times they had together. He almost relived his whole life with me. He did feel better afterwards, maybe not about dying, but just being able to let it all go. He died [a few days later] on the day he was going to be discharged.

Carolyn has had a number of experiences with oncology patients. She told about caring for an elderly woman with stage-four kidney cancer that had metastasized to her brain. As Carolyn walked into the patient’s room to care for her, her patient began to cry, then apologized for crying. Carolyn reassured her that she need not apologize for crying and offered, “If there is something you want to talk about, you can talk with me.” Carolyn pulled up the chair and sat next to her. “I wanted her to feel as though she could open up and that I was actually there to listen.” The patient was a Christian, but was going through a time of doubt because of what was happening to her. Carolyn felt very comfortable offering her presence to her patient in need.

The students’ desire to offer presence is understandable because a primary reason they appreciate the nursing profession is because they have opportunity for interpersonal relationships with their patients. Interpersonal relationships motivated them to be nurses and they expressed this motivation in a variety of ways. Alicia liked the opportunity to get to know her patients through the contact of daily care. “I like to be there for them and listen to them. You can recognize on patients’ faces when they are anxious because you are right there.” Carolyn felt the same. She said,
I like to concentrate on their feelings when I’m in the room during those brief moments that I’m with them. Then I try to come back and help them express their feelings. I like the interpersonal aspect the best.”

April said that she loves being present for some of the most precious moments in people’s lives which are not shared with many other people, such as births and deaths.

“As a nurse you are one of very few people that get to share intimate times with patients. That’s such a special responsibility.” April described seeing two births during the previous semester. She said,

Spirituality speaking, it was just so amazing to see those babies come into the world. I don’t know if anybody else in their lives were praying for them, but the second they took their first breath, I was able to praise the Lord for them and pray that they can get to know Him someday. And it is just an awesome opportunity to be there for times like that. You just have special access to people.

Charles said he finds enjoyment in caring for a person during the clinical day and experiencing their gratitude for the service that he provided. He finds patients to be encouraging when they recognize the good job that he did in caring for them. “It has also helped me academically, because it urges me to learn well so that I can provide the best care that I am capable of.” Catherine said she appreciates the hands-on experience with patients, especially when patients talk to her and confide in her. For Tina, the most rewarding experiences with patients come when she has time to get close to them and their families. “You make a lasting impression on them. They are comfortable when you are there, and they trust you.” Amanda’s big rewards in nursing come from spending time with her patients.
Witness

Health Sciences College nursing students also offered spiritual care to their patients through witnessing in primarily one way: They offered a verbal witness of their personal faith through prayer and testimony.

Carolyn decided she would be a listening ear for her patient one morning, so she stayed with her patient while she ate her breakfast. She asked her patient if she attended church or any social groups in the area. Her patient said that her neighbors took her to church. “That’s my chance to get out and be in the community. I really feel linked to God when I am there.” Her patient verbalized that she “didn’t feel she had much going for her.” Carolyn offered, “Well, I am only going to be here for a little while, but your breakfast is here. Do you pray before breakfast usually?” Her patient replied, yes, but added that she felt funny praying in front of the student. Carolyn said, “Well, we can pray together.” Carolyn offered a short prayer and then her patient prayed. It was the first time Carolyn had ever done anything like that with a patient, but she felt she had gained enough trust with the patient to do so.

Peter cared for an elderly female dying patient who was in a coma. He knew she would probably die on his shift and felt compelled to give her something more than just comfort measures. As he prepared to leave the patient’s room, he felt something holding him back. He remembered,

It came to my mind, maybe this person never knew God. I didn’t know what to do because she couldn’t respond. But sometimes [patients] can hear. So I just laid my hand on her forehead and prayed in a low tone, “God, you know her more than I do. Bless her and claim her into your kingdom. Lord, forgive her. Let her know that Christ is the Son of God, the one truth, the way of life. Grant her the chance of going to see your kingdom.” I thanked God for hearing my prayer. I knew I was now confident to go out of the room. Ten minutes later the patient died. And I was glad I had done that.
Diane was doing an observation experience in the emergency department and noticed a woman in her late 30s or early 40s having chest pain. The patient was waiting alone while her husband handled the sign-in process with the clerical staff. Diane thought, “If I was in that situation, I would appreciate it if somebody did something, but there wasn’t anything medical I could do.” So Diane asked the patient if she could have prayer with her. Her patient looked much calmer after Diane prayed. “It really seemed to help. She just said thank you.” Charles cared for a woman who came from his small hometown. His patient was somewhat confused from the morphine she had been taking, unsure of where she was and what was happening to her, and very anxious. As Charles talked with her, he discovered she attended the same church as he and his family, which helped him to know that she could be open to spiritual measures. He said,

I sat down and talked with her, held her hand, and asked her if she wanted me to pray with her. It was amazing to see her go from a complete anxiety attack to basically feeling really calm. The rest of the day she was as calm as could be.

One cancer patient whom Deann cared for was very sick. “I can remember the first time I ever went into the room to see her. I was so frightened to go into the room because she looked like death to me,” said Deann. Her patient’s mouth was dry, and she was in obvious pain. Lying in her bed, unable to do anything for herself, the patient could not even tell her nurses what she needed. Deann said she was frightened that her patient was going to die while she was caring for her. Surprisingly, the patient’s level of alertness changed; she became more awake and aware of what was happening. She asked Deann to pray with her, which she did, and then asked her to pray for her every time she went into the patient’s room. Deann never saw her patient again, but she felt comforted in knowing that her needs were met, “according to what it was that I could do.”
April also captured an opportunity to pray with her patients. One gastric bypass patient who had been hospitalized for 3 months was blaming herself for what she had gone through because she had chosen to have the surgery. She had missed Christmas and her grandchild’s first birthday and was depressed about her situation. April offered to pray with her. The patient’s eyes filled with tears and she said, “That would be wonderful!” And so April prayed for her. In a second situation, a 99-year-old woman had had an accident in her bed after April had just finished cleaning her up. Amid tears of frustration, this elderly woman said, “This is not my life. I’m used to caring for myself and being independent.” April offered to pray with her, as well.

Learning how to share a personal witness takes skill, thoughtfulness, and sensitivity. Tina seemed to be trying to find that balance, as she stated,

Sometimes you use the opportunities that come up to witness about the Lord, to ask if they have received the Lord in their hearts. If they are open to it, it’s not like you’re pushing it on them. A lot of time patients may bring up spiritual things in a conversation. Then I just might talk about my own walk with the Lord and what peace it brings me through tough times and things like that. They can either completely not even answer it, or they can say, “Oh, yeah.” It’s not me pushing it on them, but just sharing from my own personal experience.

In the psychiatric clinical rotation, Tina selected a male patient who had attempted suicide. She went into his room to spend time talking with him and her patient mentioned that he had at one time attended church, been baptized, but no longer went to church. As the conversation progressed, Tina shared with him what being close to God had done for her life and how her life had changed. “Everything can turn around,” Tina said. Tina then offered to pray with him. He replied, “You know, it wouldn’t hurt.” Tina held his hand and prayed for him. “He really seemed to be touched by that. He said
it definitely made a difference to have somebody show that kind of care and attention to him.”

April has thought through her beliefs about personal witness and concluded that even though, as a Christian, she believes that Jesus is the way, the truth, and the life, nurses need to meet their patients’ needs just by loving them. She said,

I think there is an honesty that comes with spiritual care. I think that you have to have a deep respect to whatever other people consider spirituality. If you had someone with another religion who had a ritual that could be done in the hospital, I think that needs to be done. I think they need to have that access and then continue to love them and care for them just the way you would anybody else. Jesus respected lots of different people. He loved them no matter what.

April entered into a spiritual assessment of a patient who had been hospitalized for a long time by commenting, “I noticed on your demographic form that you are Catholic.” As they continued talking, she asked her patient if he had had the opportunity to take communion. This was one of the first patients with whom she had engaged in a spiritual discussion. “It made me see caring for people differently. It helped me to know that it’s OK to mention spiritual things because patients are whole persons, and this is a part of being whole.”

Related to the provision of spiritual care through the act of “witness,” several students from Health Sciences College talked about how nursing is a calling or a ministry for them. Deann said that she strives to give the very best care that she can, to make a difference in the lives of her patients. She loves helping people, being present when they are dying, being able to do the simple things that make them comfortable. Deann stated,

Nursing is a true ministry for me. I love my patients and I love the things that they teach me in the process. Sometimes it’s difficult and sometimes I walk away feeling discouraged. But all in all, it’s a process that is equally rewarding for me, because I know... that I’ve given my best care. And when you have done your best, it is a rewarding feeling.
Carolyn responded to a call from her priest to service. She recounted that her acceptance of the call to serve was a gradual experience over a period of several months. Because she had to work through some family resistance, she began her education slowly with a few classes each semester. Going from a stay-at-home mom to a student was a big adjustment for her family, but Carolyn persevered and her family has given her strong encouragement during times when she was exhausted and discouraged.

Peter is an international student from Kenya who decided to pursue a medical career. Searching for a Christian college, he found and came to Health Sciences College. After exposure to nursing, he shifted his career choice to nursing because he felt it would give him satisfaction and not take him out of his culture for an extended period of time. But what he ultimately found was a career in which he could serve others.

Tina felt that her desire to become a nurse was the result of a calling from God. She herself does not understand her drive to become a nurse. Tina said,

More than once I have struggled and God has brought me through. It has been very evident that God gives blessings here and there, which makes me think that it is a calling. My friends still look at me today and say, “I never would have imagined.”

April said she did not realize when she entered nursing the spiritual impact that nurses can have on a patient. Since then, she has come to see nursing as a ministry, and greatly values the opportunity to care for patients’ spiritual needs.

Enabling Spiritual Care

The same two themes for enabling spiritual care emerged from the data of Health Sciences College students as did those from Liberal Arts University: Personal faith and preparation.
Personal Faith

Personal faith was very important to providing spiritual care for the students from Health Sciences College. Three characteristics of personal faith include (a) spiritual mindedness, (b) a sense of God’s leading, and (c) experience and practice, thus further enhancing one’s effectiveness in giving spiritual care. Examples of these sub-themes follow.

Spiritual mindedness

Awareness of one’s own spirituality and beliefs is characteristic of these student comments. Diane stated, “It was important to be comfortable myself [with spirituality], and how I felt. If you aren’t comfortable with how you feel and you don’t practice [faith] and feel close to God, then you can’t provide that care for anybody else.” Catherine asserted, “My own faith has helped me be a spiritual care provider. If you don’t have it, how can you provide spiritual care to someone else? It’s kind of like being a hypocrite. I think it has to be your own faith to provide [spiritual] care.” Tina offered, “A daily walk with the Lord, spending time one on one with God every day praying and reading the word, is the most important thing to giving effective spiritual care.” Alicia said it was her own background and her own personal relationship with God that enabled her to give spiritual care to her patients. Since “we really don’t have guidelines for giving spiritual care,” she begins by treating her patients the way she would want to be treated. She suggested that nursing students look into their own spiritual needs, what they believe in, and what helps them cope, “because it’s hard to offer support when you need support yourself and if you are unsure of things yourself. It’s hard to be there for someone.”
Charles also believed that his Christian heritage has given him a good background to begin giving spiritual care. He thinks it is important to be assured of and secure in your own beliefs. Charles said,

It's hard to offer care to others unless you yourself are firm in what you believe. How can you even understand the importance of spirituality unless you, yourself, have spirituality? I have seen that with other students who are not spiritual; they have a much more difficult time providing that for their patients.

Deann asserted that caring is so important to nursing that nothing can prepare people for “this type of ministry, except you have to pray and be honest about your own feelings.” She believes that prayer and supplication to God, and being true to her belief in Him, are what have enabled her to give spiritual care.

A sense of God’s leading

Students approaching spiritual care were very reliant on God’s direction. Peter said,

God is the one who takes care of the whole day. I pray before I go out. I tap into patients’ spiritual needs more quickly when I’m tapped into God. If you have peace with God, then you can relate to other people very well.

Carolyn said she prays on her way to clinical assignments. “Please let me be there for my patients in whatever way that I can be. Help me address difficulties that come up for them or me. Give me the courage to keep going.” Because she prays for God’s presence, she said she knows He is always with her, which gives her a good feeling. “Just being in the Lord is what enables me to provide spiritual care.” Tina also said she prays before her clinical day and has felt promptings from God to pray with her patients. She said,

You know, you hear that still small voice and sometimes you don’t follow it because you get nervous. But in this patient situation, He guided the conversation. I actually
prayed for my patient out loud. But I think God takes over for you, otherwise you would fumble. My walk with the Lord enables me to give spiritual care. That’s the whole answer.

Catherine, who earlier described caring spiritually for a woman with metastatic cancer, said she felt nervous when her patient expressed doubt about her faith. Carolyn wondered,

How do I talk to her now? But it just seemed to flow, like something inside me clicked and someone was talking for me. It felt like someone else was there. When I started talking, I thought, “Where’s this coming from?” All of a sudden I knew what to say and I wasn’t scared. It made it easier [to give spiritual care] the next time.

In caring for a suicidal patient, Tina recounted a similar experience. She said,

I pray before I go to clinicals. I hear that still small voice and sometimes I don’t follow it because I get nervous. But in this case, He guided the conversation.

Deann described God’s leading in somewhat different fashion. She said she believes that God puts people in her path to be helpful to her growth and then allows her to be of service to them. And then when she connects with another human being in meeting their needs, she is God’s vehicle.

Experience and practice

Experience and practice were valuable to improving students’ abilities to give spiritual care. Catherine said providing spiritual care was so much easier after the first time. “And after a couple more times, it’s easier because you begin to know the signs of people who need spiritual care and who need time to talk.” Peter said that he sometimes finds it difficult to give spiritual care. “Sometimes you go into a room and you feel stranded. What am I going to say?” But he believes that God is teaching him. “As a first-year student, it’s sometimes hard to get it all together.” Over time, however,
learning how to give spiritual care begins to make sense. Charles also said, “The more I do it, the easier it becomes.”

Even with more experience, some students voiced that situations will always be new and the no one can always know how to give spiritual care. Amanda said,

You can never, ever, ever go into a room feeling totally prepared, knowing what that patient is going to ask you, or what they are going to say. Some things you are never prepared for what you hear. You just have to make it up as you go along.

John has found that he cannot always grasp where patients are coming from because he has never had a similar experience. He sees each situation as “brand new,” so he thinks it is hard to be prepared to give spiritual care. “You pretty much never know exactly what patients are going to say. It’s ‘improv’ when you’re in there. You don’t have a script to follow.” John believes that experience teaches him much more about spiritual care than his years of formal education can ever teach. “The more you do it, the better you get.” He sees rich opportunities for gaining experience not only through his nursing education, but with friends, and with people in general within the community.

Preparation

The theme of preparation to provide spiritual care was evidenced in the narratives of Health Sciences College students and includes (a) instruction and discussion, (b) modeling and encouragement by faculty and nurses, (c) gauging student readiness, and (d) other data.

Instruction and discussion

Several students suggested some specific areas of spiritual care instruction that they perceived to be helpful. John has found the therapeutic communication skills
helpful because "it makes you think before you open your mouth." Tina also cited the benefits of learning communication skills and learning a more effective way to pose questions. "The communication strategies have helped me learn how to talk with people easier and how to help them open up." Charles offered, "I think here at this college we are exposed to a lot of the things we need to know in terms of doing spiritual care." But he would like to know more about different religious backgrounds, different denominations, and different faith preferences. "I wouldn't know exactly what to provide for a Catholic or a Jew. [So] it's important to be aware that there are other resources available, like the chaplain."

Conversely, Alicia felt she had not learned very much about spiritual care in nursing, except to support patients and ascertain their varied needs. "People are in different places in their lives, with different beliefs." She believed instead that it would be helpful to focus on developing the students' own spirituality. She said,

I think students need some time to contemplate and reflect on their own spirituality. Maybe classes where you just stay and think about questions like, "What do you think about this? Where are you at in your life? How do you deal with this or that? How do you cope? Who has been there to support you?" Maybe it would help to have chaplains in the room to help support and answer questions.

Students have also learned to become more effective spiritual care providers from their patients. For example, April cared for a woman who was experiencing severe depression and had attempted suicide and discovered that the patient was her teacher. She said,

I learned honesty from her. She was just so open with God. She said, "This is who I am, God. I know you made me and that you love me and that my intrinsic value is being your creation." I think it's so easy to be prideful, especially as Christians because we know that we are redeemed. She just confessed it. I don't have vulnerability like that. She was just so honest.
April concluded that this type of openness and vulnerability would make her more effective in sharing Christ with other people. “I don’t know if she took anything from me, but I definitely took a lot from her.” Peter said that he learns from patients who talk. Spiritual patients sometimes ask Peter about his life and his relationship with God. By expressing their concerns and feelings, Peter finds that “they sort of groom me into being a person who God controls. You think you are delivering care to them, but in reality, they are teaching you a lot.”

Modeling and encouragement

Faculty and others who provide modeling and encouragement to students assist them in becoming spiritual care providers. As Diane remarked, “It helps to have encouragement from teachers and the college who tell us to take the opportunity to offer spiritual care.”

A couple of students commented about the importance of devotionals before class and clinical experiences. Peter said, “Every morning we read devotions before we start nursing classes. That is very important. It’s been instilled within us, before we do anything.” April affirmed the importance of this activity by saying,

Instructors include the students in giving devotion and leading prayer within the clinical group. This is very special because it opens you up to the people in your clinical group. It opens up a floor of opportunities to make Christ attractive to people. They know that’s where my joy comes from.

Students like to see spiritual care modeled in real-life situations. John said, “You can’t really teach nursing students enough about spiritual care because it’s not what you learn; it’s how you do it. It would be good if some nurses or instructors could be there with you to do a ‘visual’ to show how it’s done.” April learned very personally about
spiritual care by seeing the way nurses interacted with and gave spiritual care to her parents when they were hospitalized. Additionally, instructors have been good models.

April said,

Our instructors talk about their own experiences which is so helpful because they have been there and they have done it. They are very honest about their successes and mistakes. They tell stories about how they have totally put a wall between themselves and their patients by saying the wrong thing, or totally opening a wall so they can care for patients spiritually. I learn a lot from them.

Amanda learned from the chaplain-shadowing experience. She offered,

The chaplain kind of “wings it” when she goes into a room. The chaplain did none of that therapeutic communication stuff, yet she was very therapeutic. She held people’s hands and sang songs to them. She told them that everything may not be OK. She was truthful with them, but she also gave them a lot of information, and gave them a lot of strength within themselves to deal with what was going on in their lives. So the chaplain thing really helped me out.

Alicia commented about the importance of having permission from the faculty to approach their patients’ spiritual needs. When she learned that spiritual care was an expectation, she remarked, “Good, we are allowed to give spiritual care.”

Deann said she noticed a difference in sense of permission within different organizations. She appreciates being able to pray at the college and within its health care facility. She has been in other environments where prayer was not permissible. “It was not illegal, but it was an unsaid, ‘You don’t do that.’ And at this college, the message is, ‘You can do that.’”

Gauging student readiness

The sub-theme of gauging student readiness was not expressed by a majority of students from Health Sciences College. However, several students spoke very strongly and descriptively about their concerns about readiness.
April spoke at length about the impact of negative reactions from fellow students who were not comfortable being spiritual care providers. She explored ways to positively impact the attitudes of her classmates and to increase their openness to spiritual matters because she wanted to improve their abilities as spiritual care providers. She also expressed a desire to be a witness in order to grow the personal faith of her classmates. She wished for a better way to introduce spiritual care to a nursing class.

You have people from all walks of life that believe different things. A lot of them are thinking, “I don’t have spirituality. I don’t go to church. How am I going to minister spiritually to a patient?”

She thought that sometimes faculty assumed that “everybody is at the same place and has the same experiences.” She did not believe that was the case. She said that the students who felt negatively about giving spiritual care did not even understand what spiritual care was. “I didn’t understand and I feel like I have deep spirituality and faith.” She believed that the expectation to provide spiritual care created anxiety for many students. April said,

Maybe it’s a fear thing. But it wasn’t talked about much between instructors and the class. It was talked about more among the students. There were a lot fewer questions when we went over spiritual care in class than when we discussed physical aspects of care.

She suggested the faculty consider ways to heighten the discussion about spiritual care.

“This is new to people and it makes them uneasy.” Catherine also felt that many of her classmates were closed-minded about spiritual care. She said,

They are fearful about “What do I say? What do I do? What if the patient is not the same faith as me?” It doesn’t matter. If you are a Christian, you’re a Christian. Even if you don’t know how to pray, you can help them some.

Alicia felt that the non-Christian students avoid spiritual care altogether, leading into another issue that April raised. April said,
I don’t even think some students understood the expectation of this Christian school when they came. They come here and there are devotions and there’s prayer and it throws them off, I think. There are people here who have probably never consciously prayed a prayer in their whole life.

She suggested that students should understand before entering the nursing program that caring for the spiritual needs of patients “is a core value for us.” If students were reluctant about caring for patients’ spiritual needs, she suggested that the nursing program find a way to help students develop their own spirituality. “Spirituality and God can be scary if you’ve never learned about it because a lot of people’s spirituality deals with our immortality or our mortality.”

April also had suggestions for how the religion courses could be more relevant to the students. One of the religion classes she took “assumed that people were at certain places in their spiritual walk. I don’t think it’s safe to assume that everybody has been to church or that everybody has a belief in God or in Jesus.” While she personally thought the teaching was very good and the faculty member knew the subject very well, she thought the course was not taught at the level of most of the students. “I even think the translation of the Bible that we used was confusing. It was not one I would have chosen, for an associate degree program.” Her ultimate concern was that when the subject is taught over the students’ heads, “they get overwhelmed and stop listening.”

Other data

Students were the initiators of spiritual care given to their patients, generally in response to perceived needs they identified in their patients. But many also felt nervous and hesitant about offering spiritual care. Others indicated they felt comfortable as spiritual care givers.
A few students discussed the need to maintain a focus on the patient when providing care. Peter believed that nurses need reminding to focus on listening to patients. "We rush in there and do our own stuff. Every nurse can listen to what their patients want. When you do that, you do a greater job than any other thing." Deann said,

You just can't come into this field thinking about you and what your needs are. This whole process of nursing has nothing to do with me. It has to do with the people that I care for, and what their needs are. Sometimes caring just takes a simple word. Sometimes when people are ill they are hostile. Being able to comfort them through that, and help them through that, means everything to me.

Deann suffered a total loss of her home to a house fire only 8 days before our interview; she had not missed a single clinical day, even the morning after the house fire. Knowing this, I asked Deann how she dealt with her own personal needs, amidst caring for her patients' needs. She replied,

You can't detach yourself from what is going on in your own life, but you have to be able to put it into perspective and keep it where it needs to be while you are taking care of your patient. If your needs get to a point where it is getting muddled, you sometimes have to take a step back and say, "I need to take care of my needs first." But it is not fair to the patient to bring in your own personal needs into their care.

Deann also commented that she sometimes finds herself taking the brunt of a patient's anger. But she said, "It's OK because I never know where I'll be some day. I never know where my children will be some day. I treat patients the way I hope and pray that we will be treated some day."

Several students expressed desire to have enough time in relationship with their patients to be able to effectively explore spiritual issues with their patients. Carolyn especially enjoyed the psychiatric nursing rotation because she perceived having more time with her patients. She wants to be the type of nurse who spends time with her patients, even when the workload is busy. "I have to get this time thing down, realizing
that time is very precious. But so is the patient.” Another student, Catherine, said that she unintentionally tends to push away her spiritual side when she is busy. “If I were more aware all the time about spiritual care it would help. I know when I’m busy I don’t think about it. If I did, I could help more people and I could provide that care for everyone.”

Requisite to spiritual care is “not getting caught up in the busyness and stress of the job,” according to Tina. She believed spiritual care means learning to take the time to be personal with patients, whether by a touch, a word, or doing the little things to make a patient more comfortable. Tina also mentioned taking the opportunity to ask her patients if they had received the Lord in their hearts, “if they are open to it and it’s not like you are pushing it on them.” Amanda expressed concern that she will not have the same kind of time when she is a staff nurse as she has as a student nurse. She said,

I now have time to sit down and listen to how somebody was a butcher for 50-something years, where a regular nurse wouldn’t have time. I’ve seen it happen with nurses. I can sit and talk with a person for ten minutes and tell the nurse something she didn’t know. And she had been taking care of the patient all week. I hope I will still have time to listen when I become a nurse. I want to work in a job where I have time.

In summary, Health Sciences College students enabled spiritual care through their personal faith and through preparation.

Summary

Chapter 5 described Health Sciences College, its nursing program, and its interview sample. The two key research questions were explored, as in chapter 4. Pertinent to the first question, the spiritual formation of Health Sciences College nursing students was influenced by (a) the practice of personal spiritual disciplines, (b)
relationships, (c) an environment of Christian teaching and growth, and (d) struggle and/or loss.

Experiences explored in response to the second research question demonstrated that the spiritual care the students provided to their patients encompassed patterns of (a) holism, (b) presence, and (c) witness. The ways that spiritual care is enabled for the nursing students from Health Sciences College are through development of personal faith, and through preparations, specifically instruction and discussion, modeling and encouragement, and gauging student readiness.
CHAPTER SIX

THE DATA COMPARED

Introduction

How did the spiritual care themes differ between Liberal Arts University and Health Sciences College? This chapter presents a cross-case analysis of data from the two educational institutions, with spiritual care stories illustrating the three patterns of spiritual care provision. Theoretical foundations are explored in light of the data findings and literature considerations are shared.

Cross-Case Analysis: The Interview Samples

This section compares and contrasts the interview samples from Liberal Arts University and Health Sciences College. The total population sample and the pool of students available to interview from each institution were closely equivalent in size and in faith maturity scores (FMS). From a total population sample of 97 from Liberal Arts University compared to 90 from Health Sciences College, 32 and 31 students, respectively, volunteered to interview. I believe that faculty encouragement for student participation made a positive difference in the numbers of students who volunteered to interview. Each educational institution had one class in which the faculty member enthusiastically encouraged their students to participate; in each of these classes, a large number (20 and 16) of students volunteered. The FMS of the Liberal Arts University

166

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students who volunteered to interview ranged from 51 to 60, with a mean of 55.50 and $SD$ of 3.08. The FMS of the Health Sciences College interview sample ranged from 46-59, with a mean of 54.64 and $SD$ of 4.08. Health Sciences College students were older than those from Liberal Arts University, 24.64 years ($SD = 5.63$), compared to 21.13 years ($SD = .72$).

Table 3 presents the demographic frequencies of the two interview samples. There was more diversity in features of marital status, ethnicity, and anticipated graduation dates among the Health Sciences College sample than the Liberal Arts University sample.

Table 3

Comparison of Demographic Frequencies Between Two Interview Samples

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The final interview sample from Liberal Arts University could have been larger than 16 students if I had chosen to continue the interview process. Liberal Arts University students responded quickly to the e-mail invitations I sent to interview and arrange a mutually convenient time. Those who interviewed expressed appreciation to me for choosing to research the topic because they felt it was important. At Health Sciences College, it was more difficult to achieve the final interview sample of 11 students. I sent multiple e-mail reminders to students who had volunteered to interview in order to arrange a time to meet. Needing several more interviewees to enhance the Health Sciences College sample, I finally asked a faculty member for assistance to encourage students who had already volunteered to contact me for an interview time. Four additional students then contacted me and arranged a time to interview.

I sensed a more pronounced spiritual atmosphere in the discussions of students from Liberal Arts University; the nursing curriculum also gave a definite focus to growing students spiritually. Additionally, students were taught about nursing as ministry. The integration of spiritual faith is also required in every course taught within the University. The Liberal Arts University faculty and students I interviewed were clearly unapologetic about their faith focus; the students decidedly supported the spiritual mission of the institution and appreciated the sharing of faith between fellow classmates.

Faculty from Health Sciences College recognized the faith diversity within the campus, and attempted to convey spirituality in an inoffensive manner to their diverse population. The integration of spiritual faith by faculty is expected within the nursing curriculum, but the integration of faith throughout all courses on campus is less predictable. Christian students from Health Sciences College seemed to easily identify
fellow students who were not of faith. Opportunity to verbalize faith between fellow classmates was appreciated, but it was not necessarily a routine experience for these students.

The above section compared and contrasted the interview sample. Next I present an analysis of the data pertaining to each research question.

**Research Question 1**

How do life experiences influence personal spiritual formation in nursing students? The data exploring the spiritual formation of students from Liberal Arts University and Health Sciences College revealed the same four themes: (a) personal spiritual disciplines, (b) relationships, (c) an environment of Christian teaching and growth, and (d) struggle and/or loss. Some differences were observed, however, in the ways some of the themes were expressed. The differences are described below and literature is referenced.

The narratives from Liberal Arts University students illustrating how they engaged in spiritual disciplines were richer and more descriptive. The types of spiritual disciplines Liberal Arts University students used were also more varied than those used by students from Health Sciences College. As a whole, the personal spiritual disciplines for Liberal Arts University students seemed more intentional and deliberate than for the Health Sciences College students. What accounts for these differences? Is it possible the more pronounced spiritual formation practices at Liberal Arts University contributes to the difference? Or perhaps the more homogeneous religious commitment and faith background of students from Liberal Arts University accounts for more expressiveness as these students discuss their personal spiritual disciplines?
Drawing from the literature, the practice of personal spiritual disciplines has long been recognized by religious writers as the fertile path for growing faith (Foster, 1988; Mulholland, 1993; Willard, 1988, 1998). Saying this, however, does not negate the essential, mystical influence of the Holy Spirit to faith development. As Anderson (2002) stated, “Spiritual formation begins with God’s initiative, power, and work within us but it continues through human participation, response, choice and the exercise of will” (p. 58). Several studies affirm the value of personal spiritual disciplines. Valuegenesis\textsuperscript{2} studies, a large study of Seventh-day Adventist youth, affirmed the predictive role of personal devotional practices to growing mature faith (Valuegenesis 2, 2001). Tasker (2002) also discovered the importance of spiritual disciplines to spiritual growth in her study of seminary students, as did Barber (1999) in his study of the effectiveness of a spiritual formation curriculum offering for traditional undergraduate students. Two research studies by nurses who explored the concept of spirituality found that activities such as reading Scripture, keeping spiritual journals, and making space for contemplation and reflection were helpful to the spiritual growth (Larson, 2001; Lickteig, 2003).

Relationships influenced Liberal Arts University’s students’ faith development more than Health Sciences College students, particularly the family and church influences and the friendships which facilitated accountability to Christian growth. Issues of relationship in spirituality were supported in the literature. From her research, Dunajski’s (1994) stated, “Spirituality and caring are best expressed through relatedness” (pp. 196-197). Golberg’s (1998) analysis of literary works also found spirituality as a product of physical and emotional relationship. Parks (2000) spoke about the mentoring
community as helping to ground young adult faith. Estep (2002), using Vygotsky’s theory in the study of spiritual formation, said, “The community of faith is an essential element for spiritual formation” (p. 161). Lickteig’s (2003) theoretical study was grounded in the belief that reflection on relationships, or connection with others, is the means through which spiritual transformation emerges.

The influence of the college environment upon the students' spiritual formation was mentioned often and in rich detail by Liberal Arts University students compared with Health Sciences College students. From my review of the educational institutions, it was evident that Liberal Arts University integrates the personal spiritual formation of their students more deliberately into the collegiate experience than does Health Sciences College, both in the overall University mission and in the nursing program specifically. Studies such as those by Barber (1999) and the Valuegenesis study evidence the role the of an environment of Christian teaching can have on an individual’s spiritual formation.

Finally, the theme of struggle and/or loss took a larger stage for the Health Sciences College students than occurred for the students from Liberal Arts University. Stories of struggle and/or loss were less frequent for Liberal Arts University students; a couple of the students who shared stories of struggle even stated they felt different from their student peers in that regard. Perhaps the older mean age of Health Sciences College students contributed to their different experiences with struggle, compared with Liberal Arts University students. Turning to the literature, we find support for the influence of struggle and/or loss on personal spiritual growth. Parks (2000) very beautifully illustrates this thought using a shipwreck metaphor. She writes that in surviving shipwreck, we discover a life that unfolds with new meaning and new knowing, experienced “as a force
acting upon us... We typically would not wish to return to the ignorance that preceded coming to the new shore” (p. 29). Fortosis (2001, Winter), in his description of Christian growth, identifies how crisis or dissonance can spur more intense spiritual growth. Additionally, one of the themes uncovered by Larson (2001) in her exploration of contemplative spirituality was what she called “initiators” of the spiritual journey. “Overwhelmingly, participants described life-events, often situations causing profound personal pain and disconnect, that prompted them to go deeper in their spiritual pursuit” (p. 122). Lickteig (2003) and Larson (2001) also found that personal discomfort creates an opportunity for spiritual movement, or in Larson’s words “as the launching pad for desiring a deepened spirituality” (p. 210). Lastly, O’Brien applies Nouwen’s (1979) wounded healer analogy to the nursing experience.

Two literature references are worth noting here as they relate to more than one theme identified above. In Newman’s study (1998) of faith development of first-year college students on faith-based campuses, several influences she cited which contributed to faith development of college students were consistent with the influences of growing personal faith found in my research. Newman identified strong ties with parents, peers, and significant others, and faith instilled by parents; these relate to the theme of relationships found in my research. Newman also found a campus setting that promotes faith, and students who were in the process of sorting out their individual beliefs, which correspond to the theme of an environment of Christian teaching and growth in my study. Lastly, Newman found an influence of faith in God during challenging times, similar to the theme of struggle and/or loss in my study.
A study by Ma (1999) explored student perceptions of their personal spiritual formation within 18 Christian college campuses. Her findings support the four themes in my research. She found additional influences, including involvement in student ministry, short-term missions, and the professor's impact within the class.

**Research Question 2**

In what ways do these life experiences described by nursing students and students' experiences within the nursing curriculum influence how they provide spiritual care? In the next section, I will share themes that emerged from both institutions.

**Providing Spiritual Care**

Next, the study explored the ways in which students provided spiritual care. Once again, the same three themes, holism, presence, and witness, were reflected in the responses from students at both institutions. The themes will be illustrated by students' stories of spiritual care provision; the themes will then be described, comparing and contrasting between institutions, and relevant literature will be presented.

A word about the spiritual care stories: Out of the many touching stories of spiritual care the students told me, I have edited three stories which I believe to be descriptively the richest. These stories effectively illustrate all three themes of spiritual care provision discovered in this research, and each story also illustrates the specific theme being presented.

**Holism**

Amy's tender and loving care for an elderly man's physical needs became the entrée into caring for deeply felt spiritual needs. Her story is told below in her words.
Holism illustrated—Amy's story

Last semester I was doing a clinical rotation at a local hospital. I had been giving care to this particular patient, who was probably 93 years old, for two 8-hour days in a row. From my assessment, he didn’t have much family who came to visit him while he was in the hospital. One son would come every couple of days, but other than that, nobody visited him. I noticed that none of the nurses had taken time to go in and talk with him, or to assess any emotional or spiritual deficits he might have.

The first day that I cared for him, he didn’t talk very much. He was kind of “out of it,” you know, with a decreased level of consciousness maybe from some drugs and things that he’d been given. But I realized that even though he might not be up to par, alert, and oriented, it was still necessary to talk to him and try to give spiritual care. I recognized that even though he may not be fully aware of his surroundings, he was still aware that nobody was taking the time to really talk to him. That was the first day.

It was apparently the end of the road for this man. He was dying. It was just a matter of time before he would pass on. I don’t know what there was about him, but I just loved taking care of him, even that first day when he wasn’t very alert. The second day I came in, he was alert and oriented. He knew who I was and he knew I had been there the day before. He was more talkative and he was more open. He was so precious. There is something about elderly people that I love, that draws me to them. I decided that day it was my goal to get him cleaned up because he needed care, and I take pride in the work I do. Sometimes it’s so easy when they are not “with it” not to give thorough hygiene care, maybe not clean them up, or give them a shave, or take care of their feet because they don’t know. But for me I can’t walk into a room and not do that. He
hadn't been shaved in at least 5 days, I would guess. When I went in the second morning he knew who I was, but he was still a little bit “out of it” to some degree. But throughout the day, he became more alert, oriented, and active than he had been before. I think, honestly, his becoming more alert was the result of me caring for him. I think he became more open to talking with me as he saw that I was caring for him. I went in and I gave him a shave. It probably took me 30 minutes to shave him because I was trying to be so gentle with him, and after 5 days, his beard was rough. Here's this precious 93-year-old with such delicate skin! I took the necessary time to give him a good shave. And I did foot care with him and gave him a bath. I got him all cleaned up and sat him up in bed.

Throughout the day I went in and would talk to him and have little bits of conversation here and there. I really grew to enjoy spending more time with him. I didn’t have a lot of care to give to the other patients under my care that day. Other patients had family members visiting with them. However, nobody was in his room, and I assessed that he was lonely. So I would just go in periodically and talk to him. That was a really neat experience for me.

Near the end of the day, I was getting ready to go off the floor and I went in to see him because something was just tugging at me to go in and talk to this man. Earlier in the day he had asked about where I go to school and had known its reputation as a Christian school. That’s often how the conversation starts. I just kind of knew that he must be dealing with some end-of-life issues, knowing that he was dying and didn’t have a lot of family around. Though I can’t honestly remember the specifics of it, I remember talking to him about end-of-life issues. He told me about how his life had been before he was sick and before his family wasn’t around anymore. He told me that he used to go to
church all the time and that he was a Christian, but that he hadn’t been able to go to
church for a while. We just talked about a lot of different little things. I asked him how
he felt. Somehow we got on the subject of dying, and how he felt about having a
terminal illness. He kind of just broke down into tears at that point and he said to me,
“You know, you are the first person who has taken the time to actually come in and get to
know me and to talk to me.” He started crying. Though I don’t remember all of the
details of the conversation, I know he opened up to me, and it was the first time he had opened up to anyone in the week or more that he had been in the hospital.

I knew that I had to go. I had a quiz waiting for me after I was off the floor, but I just felt at that point in time that I couldn’t leave him. I couldn’t open up that kind of
discussion and then say, “OK, bye, I’ve got to go take a quiz.” So I stayed with him and I talked him through some things. I asked him about his faith and if he knew for sure that he knew the Lord and if he was content with going to see the Lord when he passed on. And he just got such joy from that. I asked him if I could pray for him. As I sat there next to him, he reached out, grabbed my hand. I held his hand and I prayed for him. That was such a special thing for me. He was still crying a little bit, but I felt like he was more at peace and more reassured. He said some words to me as I was getting ready to go. I told him, “If you’re feeling all right, I think I’m going to go ahead and go.” But I told him what a pleasure it was to have taken care of him for the 2 days and I thanked him for letting me pray with him. I told him that I enjoyed talking with him and hearing about his life’s experiences. He called me by name and said, “I can tell that you are going to be a good nurse. You love people and you care for them, and it shows.” He said, “There’s something different about you and I just knew it.” At that point, I was
crying, too, because it was such a precious time. And then I didn't want to leave him. I wanted to stay, because I didn't think that anyone else would talk to him after I left. I asked him if it was OK if I gave him a hug, and he just embraced me. I think he just would have held me forever if I didn't let go. But he just hugged me so tight and said, “God bless you,” and I told him, “God bless you too.” I told him that I would see him in heaven.

Holism discussed

The theme of “holism” was evident in both institutions. Spiritual care held equal footing with caring for patients' emotional and physical needs. Students acknowledged that often in a hospital setting the physical needs predominate, but their view of the person encompassed a multi-dimensional perspective. Additionally some students believed that when a nurse’s focus is totally on the patient, addressing spiritual care needs will be an inevitable outcome. The vocabulary used to describe the theme of holism differed between the two educational institutions, consistent with the instruction represented in the respective nursing programs’ curriculum models. Students from Liberal Arts University referenced holism using the phrase, “the five dimensions of care,” which draws from their curriculum model. Likewise, students from Health Sciences College use terms such as “holism” and “whole-person care,” as reflected in their curriculum model.

For many years now the profession of nursing has acknowledged its responsibility for holistic care for patients, even to the extent of forming specific organizations over 20 years ago to advance holistic care within the profession (American Holistic Nurses Association, 2000). Authors who approach nursing from a Judeo-Christian perspective
certainly consider holism as integral to nursing care. As Taylor (2002) stated in the preface to her text on spiritual care, “Because spirituality represents an innate, integral dimension of all human beings, to nurse the whole client we must also nurse the spirit” (p. xiii). Equally, O’Brien (1999) describes nursing from a holistic perspective, and spirituality is integral to holism. “For the nurse seeking to provide holistic health care, then, the spiritual dimension and needs of the person must be carefully assessed and considered in all therapeutic planning” (p. 9). Research by Denham (1990) confirmed that nursing faculty perceived spiritual care encompassed in holistic care, and nurses in Grotbo’s (2000) study also viewed spiritual care as part of holistic patient care.

Presence

Christy promptly identified a patient’s need for presence and responded immediately with compassionate caring.

Presence illustrated—Christy’s story

One day I walked onto an adult medical-surgical floor and was just going to put my stuff in the nurses’ lounge. As I walked by a room, an elderly gentleman was calling out, “Nurse, nurse! Someone come in here.” I looked around and there was no one else going in there. He called out again. Here I was with all my stuff, but I went in there and said, “Can I help you with something? I’ll be on the floor in just one moment, but can I get you anything right now?” He said, “I’m just in so much pain right now and no one is coming. I am in so much pain and I need help. I need help now!” I asked him, “Could you tell me the name of your nurse? I don’t have your patient information, but I can go ahead and find that out. Let me put my things in the room real quickly and I’ll go find
your nurse. We’ll see what kind of medication we can give you.” He replied, “OK, but just hurry up. I’m hurting.”

Of course, I didn’t know what was going on. I didn’t know his diagnosis. I didn’t even know his name. But I dropped my stuff off and went to the nurses’ station to find out what nurse was assigned to this patient. I talked with his nurse and I found out I was going to be caring for him that day, so it worked out very well.

We were able to give him some narcotic analgesic. I went in with the nurse to give it to him and then the nurse left. After she left, I stayed by and asked him how he was doing, how he had slept that night. He said he had slept poorly; it had been a bad night. He wasn’t doing well and was in so much pain. I felt that I needed to stay with him for a moment. I asked him if we could just talk for a little bit and we did. Then I asked him if I could pray with him. I said, “You know, I’m going to be your student nurse today. I’m going to be helping take care of you and I just wondered if I could pray for you and pray that God will help take away this pain. I want to pray that you and I can just work together today and that I can help meet your needs.” He became teary and said, “Yes, that would be great!” So I prayed for him, that God would help take his pain away and that I would be able to serve him in whatever way I could. I held his hand when I prayed for him. When he opened his eyes, he was crying. He said, “Thank you so much. No one had come and I was just scared. You know, it’s going to be a good day!” I replied, “Yes, it is.”

His attitude completely changed. The nurse who was there caring for him had just gotten report and she said, “He’s going to be a tough one. He needs a lot.” It’s funny. He really didn’t need a lot throughout the day. I think it was through offering.
prayer for him and spending the time to talk with him and just touch him that he realized
I cared about him. And somehow that was enough. People anywhere, all of us, whether
in the hospital or wherever, need to know that we are cared for as individuals.

Presence discussed

Students from both educational institutions agreed about the theme of “presence.”
They conveyed ease and comfort in offering presence through being available and
listening non-judgmentally, through offering time, touch, and silence. The stories of
spiritual care provision of “presence” from both institutions were interesting and
descriptive. Students from Health Sciences College were especially comfortable offering
presence as their primary examples of spiritual care provision.

Turning to the literature, Dunajski’s (1994) research found that nurses believed
“as long as the nurse touches, looks, listens, shows caring and understanding, she would
be meeting spiritual needs.” Ultimately, “the motivating factor behind the nurses’ actions
is what may be the deciding factor between psychological and spiritual needs” (p. 154).
In her study, caring was seen as the expression of spirituality, and psychological and
spiritual needs were interrelated; some nurses believed the spiritual needs existed on a
“higher plane” than psychological needs.

Brown’s (2000) research identified spiritual actions of nurses as caring and
comforting patients and their families, through touch, eye contact, listening, spending
time, allowing for self-expression, prayer, conversation about God, and going the extra
mile to help meet spoken and unspoken needs. Dettmore (1986) likewise found specific
interventions such as prayer, touch, emotional support, as well as personal traits of the
nurse like warmth, caring, optimism, serenity, and self-confidence. Golberg (1998) also
discussed the concepts of presencing, touch, and healing in her concept synthesis research to explore the meaning of spirituality in nursing care.

**Witness**

Jane made a decision to show Christian love to a difficult patient and was sensitive to an opportunity to introduce her to Jesus Christ.

**Witness illustrated—Jane’s story**

When I worked in the nursing home, there was a lady who came in just for a couple of weeks. She had previously been a patient there, so everybody knew who she was, except me. Nobody had anything good to say about her. They said that she was just whiny, that nothing was ever right, and that she was always very demanding. Everybody was annoyed by her. Well, I thought, “Hmm, it can’t be that bad.” I hadn’t been working as a nurse’s aide very long, and I thought, “I’ll befriend her.” So I set out with that goal. I got to know her and, yeah, she was whiny and irritating. She just rubbed on me the wrong way. But I decided to stick it out and to really, really love her. It was amazing the kind of supernatural love that God gave me for her. Everybody noticed it. It was kind of funny. I had staff calling me a “goddess” or “angel woman.”

The day before she left the nursing home, I had an opportunity to talk to her. She was very scared. The people who had worked the shift before hadn’t helped her pack up her stuff and she didn’t know what she was going to do. So I helped her with that and tried to calm her down. I ended up sharing the gospel with her and praying with her. Both of us cried. It was a really, really neat experience that we had. The next day when I came to work, she was ready to leave. She was sitting out in her wheelchair with all her
stuff. She called out, “There’s my sister in Christ,” because I had told her, “You’re my sister in Christ, now.” She doesn’t have any family. Everybody else wondered, “What is she talking about? Is she crazy?” But it meant so much to me. I gave her a big hug. I will never forget her and the experience we had together. It was really neat, the most significant spiritual thing that I’ve experienced with a patient.

Witness discussed

The sub-theme of “verbal witness of personal faith through prayer and testimony” was the consistent aspect of witness demonstrated by students at Liberal Arts University and Health Sciences College. In addition to the first sub-theme of “verbal witness,” three more sub-themes of witness emerged from the data, but were only evident in the descriptions from Liberal Arts University students. Second, Liberal Arts University students engaged in “discussions of religious beliefs and/or practices” with patients. The third sub-theme, “a non-verbal expression of personal faith,” through behaviors such as compassion, patience, and demonstrating a joyful, loving spirit with patients was described as important by Liberal Arts University students. A fourth and final witness sub-theme was “inviting patients to faith and affirming faith.” Though a theme evidenced only by Liberal Arts University students, there was not agreement about how or whether to approach patients with an invitation to accept Jesus Christ. Several students believed it was their responsibility to present the gospel; without a gospel presentation, spiritual care was not really provided. Others attempted to be very cognizant of the patient’s point of readiness and believed that spiritual care could be provided even without inviting the patient to accept the gospel. Some Liberal Arts University students also drew a distinction between providing spiritual care to “believers”
versus “non-believers,” citing that it was easier to find commonalities for initiating
spiritual care with believers. Inviting patients to faith has not been evident in any of the
research of nursing students or nurses and spiritual care that I have found. However,
other studies (Brown, 2000; Conco, 1993; Golberg, 1998; Grotbo, 2000) speak to
spiritual care encompassing activities such as prayer, compassion, and discussion of the
patient’s religious beliefs. Piles (1990) attempts to draw a distinction between care that
provides for patients’ psychosocial/emotional needs versus their spiritual needs by
saying, “A need is emotional or psychosocial when it is between the individual and
others. The need is spiritual when it is between the individual and his God” (p. 40).

Somewhat related to the theme of witness was the belief, primarily of Liberal Arts
University students, that nursing is a calling, a ministry, and a way of making a difference
in the lives of other people. Faculty from Liberal Arts University instilled the concept of
nursing as a ministry into their instruction, and this was clearly and descriptively
reflected in the students’ comments. The importance of calling or ministry to the
motivations for nursing was also found in the works of Grotbo (2000) and O’Brien
(1999). Additionally, subjects in Dunajski’s (1994) research believed that spirituality
plays a motivating factor in how nurses meet their patients’ needs. “The nurse who
carries out interventions with a spiritual approach has a different philosophy than the
nurse who does not call it spirituality” (pp. 152-153).

Enabling Spiritual Care

Research question 2 asks, “In what ways do these life experiences described by
nursing students and students’ experiences within the nursing curriculum influence how
they provide spiritual care?” The final section of this research question explores the
enabling of spiritual care by nursing students. What made it possible for students of high
faith maturity to provide spiritual care to their patients and what recommendations about
learning spiritual care did they suggest?

The same two themes emerged from Liberal Arts University and Health Sciences
College students. Spiritual care is enabled by the personal faith of the students and by
specific preparations for learning spiritual care.

**Personal Faith**

Three sub-themes which described personal faith were demonstrated by students
from both Liberal Arts University and Health Sciences College:

1. *Spiritual mindedness*, being mindful, confident, and unselfconscious about the
   student’s personal faith

2. *A sense of God’s leading*, recognizing the need for God’s direction as an
   inspiration to see and handle spiritual care opportunities

3. *Experience and practice*, leading to greater skill and effectiveness in managing
   spiritual care situations.

The results of Dunajski’s study (1994) of nurses did not confirm the evidence in
my research that personal faith was essential to providing spiritual care. Subjects in
Dunajski’s study were equally divided about the need to believe in God in order for
nurses to be of therapeutic use in meeting a patient’s spiritual needs. However, many
other researchers who have studied the topic of spiritual care in nursing point to the
influence of personal faith in the nurse’s ability to be an effective spiritual care provider
(Brown, 2000; Dettmore, 1986; Fulton, 1996; Getzlaf, 1996; Harris, 1994; Kemp, 1998;
Meyer, 2002).
Nursing literature has now begun to consider how the nursing education process can influence the students’ own spirituality. For example, Pesut (2003) suggests nursing educators assist nursing students to explore their world views. She writes,

Developing a well thought out world view is an integral part of spiritual maturity. Although it is unrealistic to expect students to arrive at this state of maturity within the limited time available in a nursing curriculum, there is the potential to set the stage for lifelong development. (p. 291)

She believes it is important for faculty to structure dialogue in such a way to encourage openness and critical evaluation by students about their own beliefs and the impact of their beliefs on their attitudes and behaviors. She said, “How can we expect students to explore beliefs and meaning with their patients if we are not willing to do the same in the classroom?” (p. 292). Additionally, she recommends other changes to the curriculum which facilitate critical reflection, and intrapersonal and interpersonal connectedness.

Catanzaro and McMullen (2001) reported using teaching strategies such as reflection, journaling, literature research about spirituality, and conference presentations with students in a community health practicum course specifically to increase their spiritual sensitivity. Meyer (2003) studied students and faculty in nursing programs, six from private schools with religious affiliation and six from public programs. Like other studies mentioned above, Meyer also found that “the student’s own spirituality was a strong predictor of their perceived ability to provide spiritual care” (p. 188). She therefore recommends teaching strategies for both classroom and clinical settings to enhance students’ spirituality.
Preparation

The second general theme of preparation was evidenced in both institutions, but there were differences in how the sub-themes were experienced.

Students from both institutions demonstrated the sub-theme of instruction and discussion in the narratives. Two common areas of instruction included learning about communication skills that proved helpful to providing spiritual care, and desiring more information about different religious beliefs and world views. But more often the nature of their comments about the sub-theme differed. Liberal Arts University students spoke more readily about the spiritual care instruction they had received from faculty than did students from Health Sciences College. Health Sciences College students generally did not reference learning didactically about spiritual care; nor did most students express a need for additional didactic instruction.

Students from Liberal Arts University referenced learning about five dimensions of care, about gaining a mind-set as a spiritual care provider from their faculty, and the influence their Bible minor degree had in helping them prepare to witness about their faith. Several expressed a desire to understand better how to handle end-of-life issues with spiritual care. They also wished to have more opportunity to discuss spiritual care experiences with classmates and faculty in classroom and clinical settings. Health Sciences College students indicated ways they had learned spiritually from their patients.

The sub-theme of modeling and encouragement was voiced by students from both educational institutions. Devotional experiences before classes and on clinical days, the care of faculty for the spiritual concerns of students, modeling by nurses and/or chaplains, and feeling supported and encouraged in giving spiritual care affirmed to
students the importance of providing spiritual care. Hearing faculty share their stories about giving spiritual care created practical learning for the students, but they also would like to have more opportunity for exposure to “real-life” situations where spiritual care is provided by nurses and fellow nursing students.

One “preparation” sub-theme was evidenced by several students from Liberal Arts University, but not by students from Health Sciences College. Some Liberal Arts University students were unclear about how to handle perceived societal boundaries regarding discussion of spiritual issues. What is appropriate? What is permissible within the environment? What is legal? How can spiritual care be discussed without being offensive to patients? How can spiritual care discussions be appropriately initiated? Learning how to recognize and seize opportunities would help students feel less intimidated about offering spiritual care.

One sub-theme, “gauging student readiness,” occurred with students from Health Sciences College, but not from Liberal Arts University. While this sub-theme was not represented by a majority of the students, those who discussed gauging student readiness presented rich and descriptive concerns. Because Health Sciences College students come from a heterogeneous background, religiously and spiritually speaking, some of the Health Sciences College students felt more attention needed to be given to how non-Christian students, or students with nominal faith, could relate to the topic of spiritual care.

My study confirmed some of the suggestions Schnorr (1988) offered to nursing education in an early study she conducted to develop theory for teaching spiritual care. Several concepts she offered to learning spiritual care were the importance of religious
education, role modeling, and personal experience. She also suggested that nursing education include viewing the patient as a person for whom spirituality is important, psychosocial and spiritual assessment skills, plus exploring the nursing student's own spiritual journey. DeWitt-Weaver's (2001) study confirmed all of the above areas of preparation except the sub-theme of "gauging student readiness."

Lastly, I wish to mention some disconfirming data from both institutions. A few students mentioned wanting enough time in relationship with their patients to build rapport and understand them in order to better identify and approach their patients' spiritual needs. Bath's (1992) study of nurses and nursing students found that lack of time was perceived to be an obstacle to patient spiritual care. However, Conco's (1993) study of spiritual care recipients reported that spiritual care was not time consuming. Grotbo (2000) also argued that time limitations could be worked around by addressing spiritual needs while attending to physical needs.

Theoretical Integration

Issues of faith played an important function in helping the participants of this study become effective spiritual care providers in their nursing role. The majority learned faith at an early age and were strongly influenced by relationships in the home, church, and collegiate settings. Their desire to use nursing as a ministry, a calling, and a service to make a difference in the lives of others was influenced by their faith. Participants in this research study had answered some of the key questions that James Fowler's (1981, p. 3) stages of faith study explored, questions such as, "What are you spending and being spent for? What are you pouring out your life for? What powers do you rely on and trust? To what or to whom are you committed in life?" I believe some
participants in this research reflected stage three, synthetic-conventional faith (conforming faith). For participants in stage three, their faith was an ideology that had not yet survived exposure to threat and serious personal questioning. Students held some positions that undoubtedly reflected their community of faith, and had not yet endured the distancing or individual choice points apart from their external sources of authority. I believe this is particularly evident in the comments of a few students who had a desire to “tell others” about their faith, sometimes even before making a careful assessment of the individual patient’s needs and points of readiness to listen. Several Health Sciences College students responded to my questions about spiritual care from a deeply felt emotive experience, while simultaneously discussing issues of biblical knowledge, beliefs, and involvement in a faith community in a somewhat superficial manner. For example, Amanda who found her faith to be a crucial support as she and her family weathered personal crises stated,

We don’t go to church much. But we do a lot of reading with the kids, in the Bible. I think being through what we’ve been through, we have our own idea about what heaven and God is about. A thousand people can read the Bible and interpret it a different way. I know what it’s like to be completely close to God and to be completely distant from Him. To me, it’s hard to have somebody stand up in front of me and preach to me about what I should feel. So we tend to do our own learning about God and spiritual things.

Catherine, who described herself as very tender and emotional in responding to patient situations, said, “I don’t go to church as often now, but I attend every once in a while. It’s kind of hard when I work weekends. I pray every night and I tend to read the Bible every once in a while."

I also believe that a number of students in this study had made the shift to stage four, individuative-reflective faith (choosing faith, either/or faith), as defined by Fowler.
Many had given careful consideration to their beliefs and their faith, and had embraced the opportunity that the college or university experience afforded them to grow deeper in their faith. They welcomed, and even sought out, situations to expose themselves to other ideas, which they could then compare against their faith. Nursing experiences, in particular those that involve end-of-life issues, provided wonderful opportunities for astute nursing students to engage in healthy questioning of faith.

Next, I turn to DeWitt-Weaver's (2001) conceptual model to discuss its integration with my study. DeWitt-Weaver described the first stage of becoming ready to provide spiritual care as the process of "learning faith," a process influenced by students' personal spiritual receptivity, family role models, and groups. A "congealing of personal spirituality and values . . . culminates in spiritual development or formation that is an outcome of 'learning faith'" (p. 49). All of these influences, personal spiritual receptivity, family role model, and groups, were evident in my research as participants described a rich background in which to learn faith. I conceptualized the themes in my research somewhat differently from the three themes DeWitt-Weaver used to describe the process of "learning faith." Four strong themes related to the life experiences of nursing students and their personal spiritual formation emerged in my research. The first theme, personal spiritual disciplines, involved more intentional and deliberate actions on the part of the student to nurture their faith, particularly with students from Liberal Arts University, compared with DeWitt-Weaver's description of "receptivity to the spiritual." The second theme, relationships, encompassed both family role models and group influences. Two additional themes that were not discovered in DeWitt-Weaver's process
of “learning faith” emerged in my research: An environment of Christian teaching and
growth, and struggle and/or loss.

The second stage of becoming ready to provide spiritual care is described by
DeWitt-Weaver’s (2001) as “thinking it through.” In this stage, several factors facilitated
professional and spiritual integration, leading to formation of nurses as spiritual care
providers: Information, an encouraging environment, role modeling of nurses and
faculty, and involvement in small groups. Each of these factors was evident in the
experiences of the students in my research, but did not emerge easily in the same concept
formation. The concept, “involvement in small groups,” was discussed by some students
in my study under the theme of relationships. The concepts of “information,” “an
encouraging environment,” and “role modeling” were supported under the theme of
preparation.

DeWitt-Weaver’s third stage of becoming ready to provide spiritual care is
“trying it out.” In this stage students have appropriate knowledge, skills, motivation, and
confidence. They recognize opportunities to provide spiritual care, including verbal and
non-verbal clues. A supportive environment was important, conveyed through the
agency mission, an unhurried environment, and one-on-one situations with the patient.
Once students begin providing spiritual care, they report feeling more comfortable. In
my research, all the elements above which DeWitt-Weaver described in the “trying it
out” phase were affirmed by at least some of the participants under the themes “personal
faith” and “preparation.”

Additionally, many students believed that experience and practice were crucial to
enhancing their personal faith expressions and their spiritual care abilities. Seizing
spiritual care opportunities was highlighted as an important area of continued learning, even for these high faith maturity students. They wanted to learn how others initiated spiritual care. These ideas could enlarge DeWitt-Weaver's "trying it out" stage.

DeWitt-Weaver indicated several limitations in her study (pp. 92-93). Her sample size was small. It contained only participants of Christian faith, and did not reach saturation. She stated that the data did not reflect the in-depth descriptive information that she would have liked to have seen, possibly resulting in a premature determination of the basic social process she developed in her grounded theory research. However, I believe from interviews with high faith maturity students in my research, data support each of DeWitt-Weaver's stages. The stages could be enlarged with further study, as evidenced by additional themes discovered in this research which fit with the "learning faith" stage of DeWitt-Weaver's research, and more areas evidenced in the "trying it out" stage.

Lastly, Nouwen's wounded healer metaphor was relevant to a small segment of the students I interviewed. A number of students identified some type of personal struggle or loss which influenced their decision to enter nursing and gave them a background from which to work out their own ministry to their patients. Their own personal challenges provided a sensitivity and motivation to nurse others borne of empathy and understanding.

This section reviewed the study results in light of the theoretical constructs selected for this research.
Summary

Guided by the research questions, chapter 6 compared and contrasted the data and themes from Liberal Arts University and Health Sciences College. Stories of student experiences in providing spiritual care illustrated their skill and sensitivity, and the rich, descriptive data the students provided to me during the interviews. Data were compared to the study’s theoretical frameworks of Fowler (1981), DeWitt-Weaver (2001), and Nouwen (1979).
CHAPTER SEVEN

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

The purpose of this study was to explore how students with high faith maturity provide spiritual nursing care to patients. Using two faith-based educational institutions, 187 nursing students within three semesters of graduating completed a brief demographic survey and a 12-item faith maturity scale. From this sample, 62 students who had experienced an intentional spiritual encounter with a patient volunteered to participate in semi-structured interviews. The sample was further refined to those who claimed commitment to Christian faith and scored high on the faith maturity scale. Of the 27 students who were interviewed for this study, all except one scored higher than 50 on the 60-point faith maturity scale; one student scored 46. The interview sample included 16 students from Liberal Arts University and 11 students from Health Sciences College. The interview data were transcribed, analyzed, and the salient themes extracted. In addition, data from the interviews were triangulated with written documents describing the schools and their curricula, and with interviews with faculty from each educational institution.

This chapter summarizes the data findings, presents conclusions, and offers implications for nursing education and recommendations for future research.
Summary of Data Findings

The guiding research question for this study was: How do students with a high faith maturity provide spiritual nursing care to patients? The themes derived from the study data are summarized and presented below in response to the specific research questions.

Research Question 1

The first research question was, “How do life experiences influence personal spiritual formation in nursing students?” What experiences in personal faith did these nursing students bring to their role as spiritual care providers? Four themes emerged from the data:

1. Personal spiritual disciplines of engagement, such as prayer, Bible and devotional reading, service, and worship
2. Relationships with others significant to the students’ lives, such as parents, friends, spiritual mentors, and discipleships groups
3. An environment of Christian teaching and growth, where students are taught Christian faith and exposed to Christian influence, and where they experience the freedom to question and try out faith for themselves
4. Struggle and/or loss, with situations such as family strife, personal illness or loss, and hardship.

Research Question 2

The second research question was, “In what ways do these life experiences described by nursing students and students’ experiences within the nursing curriculum
influence how they provide spiritual care?” Three patterns of care were evident in the stories the students recounted of providing care to patients:

1. **Holism** means caring for the multidimensional needs of patients, including spiritual needs, based on a sensitive assessment of needs made by the nurse. Students who address the whole needs of patients willingly meet whatever needs their patients’ present.

2. **Presence** is being available and listening non-judgmentally, offering time, touch, and silence.

3. **Witness** encompasses offering a verbal witness of personal faith through prayer and testimony, discussing patients’ religious beliefs and/or practices, giving a non-verbal expression of personal faith, through behaviors such as compassion, patience, and demonstrating a joyful, loving spirit with patients, and inviting patients to faith and affirming faith.

As the students considered how to become prepared to provide spiritual care to their patients, two areas of enabling contributed to their growth:

1. **Personal faith** was viewed as the essential element of providing spiritual care by every student. Personal faith was characterized by spiritual-mindedness, a sense of God’s leading, and experience and practice.

2. **Preparation** to provide care occurred and/or specific preparations for enabling spiritual care were recommended, including instruction and discussion, modeling and encouragement, handling perceived societal boundaries regarding spiritual issues, and gauging student readiness.
The above sections summarized the themes uncovered in this study. Next, I explore the relationship among the various themes.

**Conclusions**

This study has explored a number of themes related to the topic of spiritual care provision by nursing students. Next, I wish to postulate about the interrelationship of these themes. Are some themes more important to build upon as we discover how to better prepare nursing students for providing spiritual care? I believe yes.

The students in this study identified four ways in which they learned personal faith: Personal spiritual disciplines, relationships, an environment of Christian teaching and influence, and struggle and/or loss. With a high level of personal faith maturity, many of these nursing students viewed nursing as a ministry, a calling, and they were drawn to the interpersonal relationship aspects of the nursing profession. I believe many of these Christian student nurses experience the nurse-patient relationship as O'Brien (1999) describes it, a “sacred calling” (p. 90). Their faith influenced their perceptions of nursing, particularly in viewing the nursing profession as ministry or a way to “make a difference” in the lives of others.

Participants believed personal faith is the essential element to providing spiritual care. I believe that being persons of high faith maturity influenced the importance these students placed in preparing to give spiritual care, their willingness to incorporate spiritual care as part of their nursing practice, and ultimately the way spiritual care was provided. Borrowing from Campinha-Bacote’s (2003) model of cultural competence, I suggest that spiritual desire or spiritual faith “provides the energy source and foundation for one’s journey” toward spiritual care competence (p. 22). One can have the
awareness, knowledge, skill, and an encounter for providing spiritual care, but the true spirit of spiritual care competence relies on one's own faith. Thus, personal faith was foundational to all of the other themes involved in learning and providing spiritual care.

In summary, I believe the themes are interrelated in this way. Students came to learn personal faith through (a) practicing personal spiritual disciplines, (b) forming relationships with others who influenced their faith development, (c) placing themselves in an environment of Christian teaching and growth, and (d) using experiences of struggle and/or loss as spiritual growth points. As these student nurses engaged in thinking through and trying out provision of spiritual care to their patients, their personal faith enhanced their preparation to be a spiritual care provider. The outgrowth of their personal faith and their preparation in spiritual care enabled them to provide spiritual care to their patients, evidenced by holism, presence, and witness.

**Recommendations for Nursing Educators**

I began this study with the statement that little research exists to inform us about how students emerge with beginning skills as spiritual care givers. The value of this research rested with its potential to improve the abilities of nursing educators to teach spiritual care to undergraduate students. So, what has been learned?

The results of this study demonstrated that in this participant sample of Christian nursing students with high faith maturity, spiritual care was enabled by students' growth in both personal faith and through specific preparations in spiritual care. I will explore each of these in greater detail and offer implications for nursing education.
Forming Personal Faith

It is clear that the development of personal faith is not something to ignore if nursing educators wish to promote effective spiritual care skills in their students. Some of the factors which contributed to growing the personal faith of students in this study occurred prior to their nursing education. But there were ample experiences of growing and nurturing personal faith that also occurred during the collegiate experience of many students, particularly those from Liberal Arts University. Contrary to DeWitt-Weaver's (2001, p. 86) conclusion in her study, that nurse educators have no direct influence on the "learning faith" stage of becoming ready to provide spiritual care, certainly faith-based Christian educational institutions can intentionally impact personal spiritual formation in nursing students. For faith-based institutions, the process of forming faith in the lives of students should be unequivocal and the faculty, staff, and administrators who work in these institutions must seriously consider their role in fostering this outcome. Here are some opportunities of which we as educators can be mindful and take actionable steps to implement with our students.

1. Relationships between students, fellow classmates, and faculty within a faith-based environment can be effective avenues for learning faith and/or strengthening faith. Educators such as Parker Palmer talk about "critical moments" in teaching students where they will be encouraged to open themselves, or will close down, depending on "how the teacher handles it" (p. 145). Kyle Klemcke (2001) states,

   The college years contain many critical moments and many of them are spiritual in nature. There is a real need for someone to walk beside students during their college years to teach and model the Christian life during this rich time of learning and development. (p. 2)
He heralded a clarion call to higher education to build a spiritual foundation in the lives of college students through mentoring relationships when he said, "There is a real danger that college students will not find the mentoring that they need to equip them for a lifelong pursuit of godliness because they have few sources of deep spiritual education" (p. 9). He then offers a model of spiritual formation for colleges to consider. Authors such as Parks (2000) and Newman (1998) who have studied the spiritual formation of college students agree about the important influence of spiritual mentoring.

2. Learning personal spiritual disciplines in a variety of ways can be facilitated through the religious curriculum, chapels, and ministry groups, and by faculty and staff modeling.

3. Struggle and/or loss occur in the lives of at least some college students. As educators, we need to recognize this as an opportunity for spiritual growth to occur, particularly with the caring involvement of faculty and staff mentors.

4. An environment of Christian teaching and influence within the college setting offers continued exposure to Christian beliefs and values at a time when young adults are trying out faith for themselves. For those students who do not come to a Christian college with an intact faith experience, they are exposed to new ideas at a point in life when many life adventures occur. Facilitating the freedom to uncover and explore one’s world view, to question faith and try it out are pivotal roles of colleges during important young adult transitional years. As Pesut (2003) said, "The effective approach would be to encourage students to reflect critically on their own beliefs and the impact of those beliefs on their attitudes and behaviors" (p. 292). Creating the type of learning environment where exploration of students’ spiritual journey is not only safe, but
encouraged, with faculty and staff who themselves are solidly grounded in personal faith is an enormous gift we can provide to young adults.

Preparation for Spiritual Care Provision

Before offering some specific ideas of how educators can better enable spiritual care provision by nursing students, let me first acknowledge that this research was admittedly situated within the context of Christian higher education. The sample was intentionally limited to students of high faith maturity to discover their approaches to spiritual care and the factors that contributed to the development of their spiritual care skills. However, although the sample was limited to those of Christian faith, I believe it is important for all students to provide spiritually and culturally sensitive spiritual care. While my suggestions are more directed toward faculty members within the Christian educational environment, some of these suggestions may be appropriate for the public arena as well.

Faculty members have the responsibility to assist nursing students in learning spiritual care provision. This can be accomplished in a variety of ways. Here are some suggestions learned from this study:

1. Classroom and clinical instruction about holistic care is important and useful to continue. In addition, envisioning nursing as a ministry definitely assists students to formulate a unique mind-set about themselves as spiritual care providers and outlines a ministry responsibility for the Christian nurse to assume. Viewing nursing as a ministry changes the way students think about their nursing role and gives them access to a divine power beyond their human ability to make a difference in the lives of their patients.
Clearly, as this research demonstrated, teaching nursing as ministry effectively expanded students’ awareness of the field of nursing beyond that of a career.

2. When we recognize the great variation in spiritual situations and approaches to patients, having a venue for reflection and discussion with classmates and faculty about how to capture spiritual care opportunities and experiences becomes an important teaching method for improving students’ comfort and skill levels in the spiritual care provider role. To understand the impact of varying world views in the spiritual care discourse is essential and this is best accomplished through reflection and discussion. We learn and try out our ideas about faith within community, and the educational institution is an appropriate venue for this discussion in the young adult’s life.

3. Intentionally exploring methods of Christian witness within a pluralistic society warrants attention. Students in this study struggled to find the balance of telling versus living the Christian witness, as they attempted to be obedient to the Matt 28:19 Great Commission given to Christians to “make disciples.” I urge educators to help students within a homogenous faith population find ways to seek feedback about witnessing methods from people who do not think as they do. For students within a heterogeneous faith population, I invite them to use this diversity as they seek to understand and learn from others’ faith experiences.

4. Helping students “get started” in a spiritual discussion and knowing how to successfully navigate the perceived environmental and patient boundaries regarding appropriate discussion of spiritual issues with patients is important. Students are seeking more role modeling in this area; examples of spiritual care stories from other nursing students would be particularly useful. The faculty can also help students explore how to
provide presence with their patients using spiritual mindedness, rather than psychological
mindedness, and how to nurture openness to the opportunity of transcendence within the
present moment. As Lickteig (2003) states,

We cannot approach relations with others as an intentional monologue and force a
spiritual union. . . . Connections happen without human control by being fully aware
and present in any situation. People do not control spiritual power, we only realize
and are affected by it. (pp. 140-141)

5. To round out the preparation, intentionally and sensitively engaging the
perspectives of those students who do not possess strong personal faith or who are not
Christians could also serve to broaden the perspectives of spiritual care for all students.
As noted in this study, those without strong personal faith tended to withdraw from
discussions, so thoughtful and provocative viewpoints from this group are less likely to
be inserted into the discourse unless they are invited.

6. In order for faculty to facilitate discussions about spiritual care, they must
themselves be comfortable with and prepared for this teaching role. Just as students
continue to grow and mature in faith, so do faculty members, thereby providing them
with a more solid base from which to teach students how to give spiritual care. Faith-
based educational institutions in particular are encouraged to recognize the “journey”
aspect of spirituality and create opportunities within the academic community to nurture
and grow the faith of its faculty and staff.

This section explored the implications for nursing education arising from this
research, specifically in the areas of forming personal faith of nursing students and
preparing them to provide spiritual care. Next, I will present ideas for future research.
Recommendations for Future Research

A number of additional questions arising from this research are worthy of future study. My suggestions for future research include the following:

1. How would different world views affect the results of a similar study? How do student nurses who do not avow any religious faith, or student nurses who are of non-Christian faith, approach spiritual care and what factors contribute to their development of spiritual care skills?

2. What commonalities and differences exist between the ways Christian and non-Christian student nurses provide spiritual care?

3. What methods for developing the personal faith of nursing students are the most and least effective? How does a specific course for developing personal faith of nursing students within a faith-based curriculum affect their abilities as spiritual care providers?

4. What constitutes effective spiritual care from both the perspective of the nursing student providing care and the patient receiving care? How does the world view of the student and the patient affect the perceptions of effective spiritual care?

5. The Faith Maturity Scale used in this study is a simple instrument to administer. Using it to assess spiritual growth of college students before and after a program of study could provide useful information to a faith-based educational institution about effectiveness in meeting the spiritual mission.

Summary

The guiding research question for this study is: How do students with a high faith maturity provide spiritual nursing care to patient? The simple answer is that they
provided holistic spiritual care to their patients primarily through a sincere expression of their personal faith. The stories these students shared demonstrated their engagement in genuine love and caring for another human being, a quality which is born of personal faith. While specific preparations to provide spiritual care were important, the students’ personal faith superceded any level of technical preparation the nurse could undertake as a spiritual care provider. Their faith provided the energy source and the foundation for spiritual care competence.

Nursing education, particularly when offered within a faith-based educational environment, affords opportunity to teach holistic care—the physical, mental, and especially the spiritual aspects.

To teach holistic care of patients also mirrors what faith-based education institutions avow about the holistic view of the development of the students. The richness of this opportunity, particularly to influence the spiritual development of our students, often dims in the busyness of everyday life. Sometimes we as Christian educators are more mindful about influencing students’ competence in their chosen career. However, I believe that when we aim to instruct students primarily about a career or a course of study, our aim is too low. God has given us a broader, higher aim.

True education . . . means more than a preparation for the life that now is. It has to do with the whole being, and with the whole period of existence possible to man. It is the harmonious development of the physical, the mental, and the spiritual powers. It prepares the student for the joy of service in this world, and for the higher joy of wider service in the world to come. (White, 1903, p. 13)

This study has demonstrated how growing students’ personal faith and preparing them in specific ways about spiritual care equipped them as sensitive providers of spiritual care. As a Christian educator who believes that life on earth is a temporary
assignment, I want to emphasize that helping students to grow their personal faith in an everlasting God will mature them in a most significant way. When we can help students learn to live their lives in light of eternity, they will view nursing as a ministry and a trust from God to use in fulfilling His purposes for their lives.

Therefore, if the starting point is learning and growing personal faith in God, the words of the Apostle Paul are a fitting ending to this study. He writes,

And now, just as you accepted Christ Jesus as your Lord, you must continue to live in obedience to him. Let your roots grow down into him and draw up nourishment from him, so you will grow in faith, strong and vigorous in the truth you were taught. Let your lives overflow with thanksgiving for all he has done. (Col 2:6-7).
APPENDIX 1

MY PERSONAL REFLECTIONS
My Personal Reflections of
Faith Stages, Spirituality, and Spiritual Care

Faith Stages

Faith and spiritual concerns have been a part of my life for as long as I can remember. Raised in a conservative Christian home by parents whose first calling was pastoral ministry, God was introduced to me early in my life as a personal friend and savior. Unquestioned love and acceptance from my father created positive, loving images of God from the beginning of my childhood years.

I have always been sensitive to doing the “right thing,” driven by a desire to not disappoint those individuals significant to my life. As a middle child, with a mischievous older brother who had to try out life experiences for himself and a much younger sister who grew up in many respects an only child, I was the dependable, predictable child who could always be relied upon to make wise choices in life.

With this backdrop, many aspects of my life have gone smoothly. I have not reaped some of the harsh consequences that can come from ill-conceived choices at tender, vulnerable years of life, such as adolescence. Rebellion and distrust of parental authority have been strangers to me. But seeds of pride sowed their destructive product, particularly in adolescent years as I compared myself to my older sibling. The drive to make right choices, to be perceived as responsible and “put together” as a young adult, and to avoid acknowledging that parts of my soul and character were deeply flawed left

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me with a litany of “shoulds” to personally live up to. The “shoulds” undoubtedly also
transferred to silent expectations for others, expectations that remained unspoken lest I
offend someone and not be considered “a nice person.”

Reminiscing to my early adult years, Fowler’s (1981) third faith stage, synthetic
conventional faith, was visible. To paraphrase Fowler, I genuinely believed that I made
choices and commitments, but “mediated by the significant others in my life,” I clarified
and ratified the values which chose me. I perceived God as a guide, a companion, a
support, and as someone who loved me. I felt an “oneness” with my community of faith,
including my immediate environment of home, church, and parochial educational milieu.

I believe my shift to faith stage four originated with an extended foreign mission
experience after completing graduate school. Institutional church and church authority
disappointed me in ways I never anticipated. I was also physically very distant, with
limited communication abilities, from the values and culture I had shared in my previous
26 years. During this time of challenge, I clearly remember a conversation I had with an
American couple who visited my husband and me. The woman, who was near my age,
explained how she seriously and methodically examined the tenets of our denomination
during college. Following this study, she made the decision to reject our church doctrine
and convert to another denomination. Deliberate renouncing of doctrine, rather gradual
slipping away from faith, was an experience I had not previously encountered with
anyone I knew in my conservative, evangelical tradition. I reflected upon our
conversation for a long, long time. All of these “foreign land” experiences created
opportunity to re-examine my own values and beliefs, as well as tension and struggle to
make my faith world fit together.
Since the previous period of my early thirties, I believe my faith development has continually modified to where I currently am—at Fowler’s stage five—conjunctive faith. I acknowledge the momentary nature of my life in the scheme of eternity. I believe in a powerful God who cannot be explained in human terms. I am aware of the immense complexity of faith. I don’t have all the answers about the challenges of human existence for myself, let alone for others, and so am less inclined than in my earlier years to attach “shoulds” to others’ behavior. I eagerly embrace the experience of worship, ritual, and reading spiritual perspectives outside my doctrinal boundaries. I have endeavored to crystallize my faith into its simplest form and feel impatient with what I perceive to be hair-splitting theological conjectures for which the answers are not clearly evident in Biblical study. I believe in a transcendent God who does what he says he can do, and who enables me to do all things through Christ. However this belief needs continual, day-by-day renewal.

I am clearly not at stage six, “selfless faith.” Though I experience pain when fractures and divisions within the human family exist and want justice and unity to prevail, I am not yet able to disregard my own security, comfort, and well-being to risk involvement and leadership in the larger community to advance the cause.

Spirituality

My perspectives about spirituality are based on a Christian world view, and the following views of spirituality reflect my current understanding of Scripture.
Spirituality and the Believer

Spirituality, or faith, is a relationship to the one true creator God through Jesus Christ. The Holy Spirit is the means through which we understand God’s thoughts and spiritual realities. It is the purpose of the Spirit of God to reveal and to disclose the person of Christ to us. The Spirit provides the power, encouragement and energy to the Christian to live out the ultimate purpose for our existence: To love God and our neighbor with all our heart, soul, and mind (Matt 22:36-40). Apart from the Spirit, there is no spiritual understanding; the deep things of God are unknown to us (1 Cor 2:10-16). The full extent of human wisdom and human training apart from the Spirit of God will not enable us discern spiritual matters.

The Bible tells us that the Holy Spirit dwells in every Christian (John 3:5-8, Acts 2:38-39, Rom 8:9). But not every Christian’s experience is characterized by a “walk,” or continual yielding to the guidance of and experience with the Holy Spirit (Gal 5:16-18). For many Christians, the sinful nature crowds out the full benefits the Spirit. Lewis Sperry Chafer, in a 1967 book published by Zondervan, entitled He That Is Spiritual, writes on page 44,

To be filled with the Spirit is to have the Spirit fulfilling in us all God intended Him to do when He placed Him there. To be filled is not the problem of getting more of the Spirit: it is rather the problem of the Spirit getting more of us. We shall never have more of the Spirit than the anointing which every true Christian has received. On the other hand, the Spirit may have the entire believer and thus be able to manifest in him the life and character of Christ. . . . A spiritual person then is one who experiences the divine purpose and plan in his daily life through the power of the indwelling Spirit. The character of that life will be the out-lived Christ. The cause of that life will be the unhindered indwelling Spirit (Ephesians 3:16-21; II Corinthians 3:18).

He further describes in pages 44 to 59 how the spiritual life is characterized by seven manifestations evidenced within the lives of those who are filled with the Spirit.
The spiritual life crowds out other desires and behaviors just as a new bud in spring naturally pushes out dead leaves.

1. Character. The Bible calls it the “fruit of the Spirit” (Gal 5:22, 23). These characteristics include love, joy, peace, patience, kindness, goodness, faithfulness, gentleness and self-control. Human nature does not naturally produce these characteristics; they are produced by the power of God. Such character is not developed through our human energies. Humans do not generate these fruits nor are we helped to generate these fruits. The Spirit graciously provides them.

2. Service to others. When the Spirit has filled us, any attention or focus on our own talents or on ourselves is lost. The Spirit does the service, accomplished through the lives of people yielded to the Spirit (1 Cor 12:4-11).

3. A teachable spirit. Spirit-filled people are humbly attuned to the Spirit guiding into truth of God’s word (John 16:12-15). They eagerly learn the things of God and await the Spirit’s enlightenment about themselves.

4. Praise and thanksgiving. Our human nature is thankful for situations and conditions that please us. Yet those who are filled with the Spirit give praise and thanks to God in all circumstances (Eph 5:19, 10).

5. Guidance. One who is filled by the Spirit is guided by the Spirit. A willingness to obediently change and adapt as the Spirit leads is the unbroken pattern of those who are filled (Rom 8).

6. Experiencing the unseen. Belief becomes real, an experience of the heart, not just the head (Eph 3:16-19).
7. Praying for others. Those filled with the Spirit are empowered and enabled to pray for others, even when the reasons for pray are not clearly evident (Rom 8:26).

How can a person experience the filling of the Holy Spirit, enabling the manifestations of the Spirit to be evident? How can the Spirit so infill a person that the desires of the person are exactly those of the Spirit (Gal 5:16, 17)? Chafer is quoted below, pp 66-67, 69:

It is possible to be born of the Spirit, baptized with the Spirit, indwelt by the Spirit, and sealed with the Spirit and yet to be without the filling of the Spirit. The first four of these ministries are already perfectly accomplished in every believer from the moment he is saved; for they depend upon the faithfulness of the Father to His child. The last of these ministries, the filling of the Spirit, has not been experienced by every Christian; for it depends on the faithfulness of the child to his Father.

Spirituality is not gained in answer to prevailing prayer; for there is little Scripture to warrant the believer to be praying for the filling of the Spirit. It is the normal work of the Spirit to fill the one who is rightly adjusted to God. The Christian will always be filled while he is making the work of the Spirit possible in his life... Neither prayer nor waiting, therefore, are conditions of spirituality.

Chafer further enumerates three conditions of spirituality that emerge from Scripture.

1. Living moment by moment in union with the Spirit. The Spirit is grieved by sin (Eph 4:30). A spiritual life depends upon a right understanding of sin and making adjustments in one's life. The Spirit does not withdraw from a believer who sins. But the grieved Spirit now must minister to the sinner, rather than through him or her. The antidote for this situation is to confess known sin to God and repentance, or a change of mind (1 John 1:6-9).

2. Saying "yes" to God. The Spirit is stifled when individuals say "no" to the will of God, as the Spirit reveals it (1 Thess 5:19). An attitude of complete yielding to God breaks the power of sin (Rom 6:13, 14).
3. Reliance upon the ability and the power of the Spirit. Such reliance demonstrates a life of faith that (a) God is who he says he is, (b) he can do what he says he can do (Jer 32:17), and (3) the believer can do all things through Christ who gives strength (Phil 4:13).

In summary, the life of a Christian, likened in the Bible to a race (Heb 12:1) or a fight (1 Tim 6:12, 2 Tim 4:7), requires continual appropriation of the power of God, through the Holy Spirit. The spiritual life is manifested in real, identifiable ways and it is produced in the Christian who does not grieve or stifle the Spirit and who demonstrates an attitude of dependence upon the Spirit of God alone. A person is spiritual because he or she is Spirit-filled. It is then the responsibility of the Holy Spirit to accomplish the purposes and desires of God for his or her life.

**Spirituality and the Non-Believer**

This issue is more difficult for me to understand and piece together from Scripture. Admittedly, my beliefs are still evolving. I believe that individuals from all societies, cultures and eras have been, are now, and will be facing existential questions surrounding the meaning of joy, suffering, and hope, the purposes for which one lives, and the values for which one would give everything. It appears that spirituality encompasses a uniquely human quality of the human race. Other forms of life on this earth, such as animals, share what we know as physical, emotional and intellectual qualities, but not spirituality.

The Bible states that humankind is created in the image of God. It is reasonable to believe that the image of God is manifested through every person, whatever his/her situation. Perhaps the reflection of God is seen dimly, in almost imperceptible ways.
The yearnings for meaning, purpose, and hope, and the quest for joy, transcendence, and personal identity felt deeply in one's soul may be evidences of reflected glory from God. The search itself gives evidence to a God who plants spiritual desire in the human heart.

It is also possible that spiritual concerns give evidence to the Holy Spirit drawing people to God. Chafer gives helpful insights into the biblical perspective of the work of the Holy Spirit in the lives of those who have not accepted God. Describing a three-fold work, the Bible says that when Christ left this earth, the Spirit (or Counselor) was given to convince the world of its sin of unbelief, of God's righteousness, and of a divine judgment that has already occurred (John 16:7-11). Thus, the Spirit enlightens those who are unsaved about their sin of unbelief, rather than condemning them about all their sins. He unveils the incomprehensible truth that righteousness is available by believing in Jesus Christ. He casts a spotlight on the judgment that is past, and the victory over sin that was achieved. And then he illuminates a God who welcomes, receives and saves sinners. But despite the Counselor leading people into all truth, not everyone will discern this leading. “The world at large cannot receive him, because it isn’t looking for him and doesn’t recognize him” (John 14:17). For all, the yielding to God is a divinely-enabled human choice, and some will choose not to follow (Rom 12:1, 2).

I also believe that Satan, the adversary of God, is capable of counterfeiting God-inspired spirituality through any number of ways. Some look for naturalistic explanations for spiritual longings in the psychological or biological realm. Some explain it by inventing other gods. Discerning between the true and counterfeit spirituality can occur over time by evaluating whether the manifestations of the Spirit are present.
In summary, our creation in the image of God and the wooing of the Spirit of God may be two ways to explain attentiveness to spiritual concerns in the lives of unbelievers. In addition, Satan can generate what may be identified as spiritual counterfeits to divert people from the true source of spiritual life.

Spiritual Care

My limited clinical background as a nurse has not enabled me to personally apply spiritual care within the typical nurse setting. As a psychiatric nursing educator and nurse administrator for 12 years, my personal experience in patient care has been an indirect, rather than direct, focus. And for the past eight-plus years, my work has encompassed broad areas of responsibility in higher education administration. Nevertheless, particularly as I now engage in the reflective process common to mid-life, the spiritual aspect of nursing care captures my heart.

In a nutshell, spiritual care can be explained in this way: Spiritual care is the provision of care to another human being by one who is Spirit-filled and in whom the manifestations of the Spirit are present. Spirit-filled caregivers believe that their highest calling is to demonstrate, by whatever means indicated, unselfish, inclusive love to a fellow human being who has been made in the image of God, and to invite the person to the Source of spiritual infilling as the opportunities present.

It is this type of spiritual care that I endeavor to provide to those whom God leads me to encounter.
APPENDIX 2

DEMOGRAPHIC QUESTIONNAIRE AND

FAITH MATURITY SCALE
**Demographic Data**

*Please complete the following information*

**Age:** □

**Gender:** □ Female □ Male

**Marital Status:** □ Single □ Married □ Divorced □ Widowed

Other (specify) _____________________________________

**Ethnicity:** □ Asian □ African American □ Caucasian □ Hispanic

□ Native American □ Other (specify) __________________

**Faith Experience:** □ Not a Christian

□ Nominal Christian

□ Committed Christian

**College/University:** □ Cedarville University

□ Kettering College of Medical Arts

**Anticipated Graduation date:** □ May 2004 □ December 2004 □ May 2005

Other (specify) _____________________________

Do you recall a time when you intentionally provided spiritual care to a patient?

□ Yes □ No

If you marked “yes” to the above question, would you be willing to talk with me about a time when you provided spiritual care and how you feel you became prepared to do so?

□ Yes □ No

If you would be willing to talk with me, please complete the following information so that I may contact you.

First Name: ____________________________

Last Name: ____________________________

(Please print) (Please print)

**Phone Number:** ( ) ________________

Area Code

**E-mail:** ____________________________

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Faith Maturity Scale
By Benson, P., Donahue, M., and Erickson, J.
Used by Permission

How true are the following statements for you? Mark one answer for each. Be as honest as possible, describing how true it really is now and not how true you would like it to be. Choose from these answers:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Once in a While</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I help others with their religious questions and struggles.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I seek out opportunities to help me grow spiritually.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I feel a deep sense of responsibility for reducing pain and suffering in the world.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I give significant portions of time and money to help other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I feel God's presence in my relationships with other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I feel my life is filled with meaning and purpose.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I show that I care a great deal about reducing poverty in my country and throughout the world.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I apply my faith to political and social issues.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. The things I do reflect a commitment to Jesus Christ.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I talk with other people about my faith.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I have a real sense that God is guiding me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I am spiritually moved by the beauty of God's creation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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APPENDIX 3

INTERVIEW PROTOCOL AND QUESTIONS

AND CONSENT FORMS
Interview Protocol

Research Study: Nursing students’ spiritual formation and spiritual care

Time of interview:
Date:

Interviewee’s Name: Interview Code # _________

(Briefly describe the study)
(Consent form reviewed and signed)

Thank you for taking the faith maturity index. This instrument was used to help identify students who would be appropriate for the research purposes. You have been chosen because the results of this inventory indicated you have a high level of faith maturity.

Opening Questions:

Talk to me about how you came to be interested in the nursing profession.

Probe:
What experiences in nursing have you particularly enjoyed/appreciated?

Introductory Questions:

Thinking back on your life, what kind of experiences have helped you to grow as a Christian?

Transition Questions:

In what ways do you nurture your own spiritual life?

Key Questions:

Talk to me about what spiritual nursing care means to you.

Probes:
A particular experience or story
What helped you to be prepared to give spiritual care?
What would have helped you to feel more prepared to give spiritual care?
If you were a patient, what would the ideal spiritual care look like for you?

Ending Question:

If you had to suggest one thing that would improve nursing students’ abilities as effective spiritual care providers to their patients, what would it be?

(Thank individual for participating in this interview. Assure participant of confidentiality of responses.)
Faculty Interview Questions

Tell about myself:
• Nurse for 30 years
• In higher education for nearly 20 years, including nursing education and higher education administration
• Doctoral student at dissertation phase

Opening Question:
Tell me about your role in the nursing program.
For how long have you been a faculty member in this program?
What attracted you to nursing education?
What attracted you to this college/university?

Introductory Questions:
Describe the nursing program’s primary goal(s) for teaching students how to provide spiritual care to patients.

Transition Questions:
Describe the curriculum plan for teaching spiritual care to students.

Probes:
Integrated throughout curriculum?
Inclusion of specific nursing courses on spiritual care?
Impact of non-nursing courses in helping teach spiritual care?
What written curriculum data could you provide to help me understand the curriculum plan for teaching spiritual care in this nursing program?

Key Questions:
1. Describe ways faculty encourage nursing students to be sensitive spiritual care givers in their clinical experiences.

2. What conditions do you think foster nursing students being skilled as spiritual care givers?

3. What conditions do you think make it difficult for nursing students to be skilled as spiritual care givers?

End Question:
If you had to choose one thing that nursing students could do to enhance their ability to provide effective spiritual care to their patients, what would it be?
School of Education
Leadership Program

NURSING STUDENTS' EXPERIENCES IN PERSONAL SPIRITUAL FORMATION AND IN PROVISION OF SPIRITUAL CARE TO PATIENTS

Phase 1

Beverly Cobb, Doctoral Student

Attention Student: Your completion of the demographic questionnaire and faith maturity index described below will indicate that you have given permission to participate in phase 1 of this research study. If you do not wish to participate in phase 1, please do not complete the questionnaire or the faith maturity index. I invite you to read below for more information.

I am a nurse by profession and I have worked in Christian higher education for nearly 20 years. I am conducting a research study about nursing students' spiritual formation and the experiences that influence their provision of spiritual care to patients.

In the first phase of this study, nursing students within three semesters of graduation are requested to complete a short 12-item faith maturity index and a brief demographic questionnaire. I would greatly appreciate your willingness to participate in this phase of the research. I will code your responses in order to preserve your anonymity. At no time will your name be used in the research study or in any subsequent publication of the research. The data will be kept secure during the research process and destroyed after the research has been approved. All information collected will be held in strictest confidence.

Your decision to participate or not to participate will not affect your standing at your college/university in any manner.

In phase two of the study, I will be seeking to conduct interviews with about 15 nursing students who have provided spiritual care to a patient or patient’s family. Should you be requested to participate in phase 2 and would be willing to interview with me, you will be given a different consent form to review and sign.

The entire data collection process will extend from December 2003 to February 2004. You are free to withdraw from the study at any time. If you have any questions concerning this project or the consent, please call Beverly Cobb at 513-897-9910 or Dr. Shirley Freed at (269) 471-6163.
Andrews University
School of Education
Leadership Program

NURSING STUDENTS' EXPERIENCES IN PERSONAL SPIRITUAL FORMATION AND IN PROVISION OF SPIRITUAL CARE TO PATIENTS

Phase 2

Beverly Cobb, Doctoral Student

Thank you for volunteering to participate in my dissertation study. This study explores nursing students' spiritual formation and experiences that influence their provision of spiritual care of patients. I believe the study will add valuable knowledge for nursing educators who desire to better understand how to teach spirituality to nursing students.

Data collection will begin in December, 2003 and conclude in February, 2004. The data gathering process will involve an interview at a mutually agreeable time and location. The interview will last approximately one hour in duration and will be tape recorded so that I can assure accuracy in reflecting your thoughts and perspectives as I analyze the data. During the interview I will ask you a series of questions pertaining to your experiences in providing spiritual care to patients. There are no "right" or "wrong" answers to the inventory or to the questions I will pose. I am seeking your perceptions.

The audio tapes will be transcribed by an independent person not affiliated with your college or university. I will then review the audio tape and transcription, word for word, to ensure accuracy. I will provide you with the interview transcription and with ask you whether it accurately reflects your perceptions. We can accomplish this review through e-mail and phone contact.

I will code your responses in order to preserve your anonymity. At no time will your name be used in the research study or in any subsequent publication of the research. The data will be kept secure during the research process; the tapes and consent forms will be destroyed after the research has been approved. All information collected will be held in strictest confidence.

Your decision to participate or not to participate will not affect your standing at the college in any manner. You are free to withdraw from the study at any time. If you have any questions concerning this project or consent, please call Beverly Cobb at 513-897-9910 or Dr. Shirley Freed at (269) 471-6163.

I, ______________________________ hereby give my consent to participate in the research study described above. I have read and understand the statement and have had all my questions answered.

______________________________  ______________________________
Date                        Student

______________________________  ______________________________
Date                        Witness
LIST OF DOCUMENTS

Liberal Arts University

1. University description and doctrinal statement
2. University lifestyle commitment: Spiritual life issues
3. Application requirements checklist
4. Undergraduate application
5. Nursing curriculum plan
6. Nursing vision statement and philosophy
7. Nursing curricular model
8. Nursing end-of-program objectives and curriculum mapping
9. Spiritual care textbooks
10. Published article explaining nursing department education model
11. Course description, syllabus, and outline for Adult Child Health Nursing
12. Clinical evaluation form for Adult Child Health Nursing
13. Notes from classes
   a. Alternative/Complementary Therapies
   b. Professional Nursing
14. Brotherly kindness assignment
15. Ethical analysis assignment and grading criteria
16. Class handouts
   a. Preparing for approaching death
   b. Code of ethics for nurses
   c. Biblical model for morally excellent nursing practice

Health Sciences College

1. College description and mission statement
2. College spiritual identity statement
3. College admissions procedures
4. College admissions application
5. Nursing department mission/purpose/philosophy statement
6. Nursing department conceptual framework
7. Nursing department course and teacher evaluation forms
8. NRSA 131, 221, 222, and 230 mid-term and summative final clinical evaluation instruments
9. Spiritual care textbook
10. Examples of class assignments
    a. Psychiatric clinical data sheet
    b. Chaplain observation experience
    c. Child spiritual assessment
    d. Grief and loss in maternity nursing assignment
**APPENDIX 5**

**EXAMPLE OF DATA ANALYSIS GRID**

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230


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Miklaceic, M. A. (2001). *The spiritual lived experience of nurse educators within the context of their teaching practice*. George Mason University, Fairfax, VA.


Tasker, C. M. (2002). *The impact of intentional learning experiences for personal spiritual formation on seminary students*. Andrews University, Berrien Springs, MI.


VITA

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1995 PhD Student – Andrews University
1977 Masters of Science in Nursing, Psychiatric Nursing Emphasis, Loma Linda University, Loma Linda, CA
1974 Bachelor of Science in Nursing, Andrews University, Berrien Springs, MI
1972 Associate of Science in Nursing, Kettering College of Medical Arts, Kettering, OH

PROFESSIONAL EXPERIENCE:

1995-present Dean of Student and Support Services
Kettering College of Medical Arts, Kettering, OH
1989-1995 Director, Division of Nursing
Kettering College of Medical Arts, Kettering, OH
1986-1989 Director of Nursing
Sycamore Hospital, Miamisburg, OH
1986 Assistant Professor
Kettering College of Medical Arts, Kettering, OH
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238

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