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The Meaning of Spiritual Care for Behavioral Health Nurses

Rowan Sirri Teboh
Walden University

Walden University

College of Nursing

This is to certify that the doctoral dissertation by

Rowan Sirri Teboh

has been found to be complete and satisfactory in all respects,
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Review Committee
Dr. Cynthia Fletcher, Committee Chairperson, Nursing Faculty
Dr. Maria Ojeda, Committee Member, Nursing Faculty
Dr. Donna Bailey, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2022

Abstract

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by

Rowan Sirri Teboh

MSN, Drexel University, 2018

BSN, The University of Texas at Arlington, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Patients with mental and substance use disorders who are under the care of behavioral health nurses (BHNs) frequently present with spiritual needs. However, there is no information related to how these needs are addressed. It was relevant to explore the lived experiences of the BHNs as they attend to the spiritual needs of this patient population. Therefore, this qualitative study explored the meaning of spiritual care and the lived experiences for BHNs as they attend to the spiritual needs of patients with mental and substance use disorders. Using the descriptive phenomenological design, open-ended interview questions were administered via telephone and zoom-audio to eight BHNs. Watson's theory of human caring informed the study and helped in exploring the lived experiences of the BHN participants. The data collected were analyzed using Colaizzi's method of qualitative data analysis. The results of this study indicated that BHNs understood the importance of providing spiritual care; however, most of them experienced some challenges. Three main themes emerged from the data analysis: believing in a higher power, providing spiritual care, and experiencing challenges to providing spiritual care to this population. The study's findings provide an understanding of how BHNs provided spiritual care to their patients and the challenges they encountered. This information can be used by healthcare practitioners, researchers, policy makers, and educators, especially within the behavioral health community, to develop policies and conduct further studies to understand and support the BHNs to provide spiritual care of patients with mental and substance use disorder with the potential to improve health outcomes.

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Dedication

I dedicate this dissertation to the Almighty God and giver of knowledge. To my children Bradley, Samuel, and Ryan who sacrificed their mommy time so that I could accomplish something that will be of benefit to us all. To my husband who jumped in from time to time to fill the gap and whom God used to position me where I am today. Honey, thank you for answering God's call to service. To my loving and caring mother who deserted her home to come live with me and watch over our children even with her poor health so that I could focus on my achievements. I will forever be indebted to you mother. You have a special place in my heart. To my very good friend who saw greatness in me, followed up on my progress, and frequently encouraged me not to give up during moments I thought I could not forge ahead, I say God bless the day I met you. May I use this opportunity to offer a minute of silence to my beloved father of blessed memory who travelled earlier to be with the Lord 11 years today. He always saw greatness in me and taught me at an earlier age how to position myself in life as a woman. I love you, Papa.

Acknowledgments

May I acknowledge and appreciate you Dr. Cynthia Fletcher, for not only accepting to be the chairperson of my dissertation committee but for being an example to emulate. Your resilience, care, and promptness in giving feedback to my work are a rare pearl. May God Almighty continue to bless you and the work of your hands. I would also like to sincerely thank Dr. Maria Ojeda, my second committee member, and Dr. Donna Bailey, my University Research Reviewer, for their tremendous support and patience in reading my work. I cannot forget Dr. Leslie Hussey, whom I met during the early stages of my residencies, and she helped refine my topic. To my younger brothers who have stood by me during all our struggling years and their loving and encouraging wives, I say thank you very much. Thank you to my entire family for their prayers and encouragement. Thank you everyone for every word of encouragement. No one should feel left out because I do appreciate every iota of support experienced during this dissertation.

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Chapter 1: Introduction to the Study

Introduction

Spiritual care is an integral part of holistic nursing care that includes mind, body, and spirit (Donesky et al., 2020). The term embodies religion, spirituality, and culture (Donesky et al., 2020). To provide spiritual care in nursing practice is to purposefully help others cope during stressful times and promote their spirituality (Burkhart et al., 2019). Researchers have frequently used spiritual care with spirituality, a multidimensional concept that is subjective (Veloza et al., 2016). Due to its subjective nature, it is understood and applied differently in nursing (Veloza et al., 2016). Important information from the nursing literature has shown how oncology nurses (Costello, 2018), palliative care nurses (Best et al., 2016; Ferrell, 2017), intensive care unit nurses (Abu-El-Noor, 2016), and emergency room nurses (Veloza et al., 2016) have provided spiritual care to their patient populations. Recent studies have also shown how psychiatric mental health nurses understand and provide spiritual care, with particular attention to patients with mental illness (Elliott et al., 2019; Hughes & Leigh, 2017; Lavorato-Neto et al., 2018; Neathery et al., 2020).

However, there is no literature that has explored the meaning of spiritual care for behavioral health nurses (BHNs) and how they experience the provision of such care in patients with mental and substance use disorders. The lack of information on how BHNs experience spiritual care is a gap in the literature that this qualitative descriptive phenomenological study sought to fill. In psychiatric nursing, behavioral health tends to be used interchangeably with mental health, likewise behavioral health nursing and

mental health nursing. Behavioral health includes mental health and substance use disorders, and that is how behavioral health nursing has come to be in use (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). While mental health focuses on managing mental illness (depression, anxiety, bipolar depression, and schizophrenia, for example), behavioral health embodies the management of mental illness and substance use disorders (SAMHSA, 2020). Behavioral health is a state of mental or emotional being, choices, and actions that affect overall wellness (SAMHSA, 2020). Some research studies have articulated how mental health nurses caring for patients with mental health disorders (depression, bipolar, schizophrenia, for example) have attempted to explain their understanding of spiritual care (Hughes & Leigh, 2017; Lavorato-Neto et al., 2018). However, no literature in the databases has addressed how BHNs caring for patients with cooccurring mental illness and substance use disorders provide spiritual care. This study was needed to include BHNs in the body of nursing and qualitative research literature to ensure that the nurses meet behavioral health patients' spiritual care needs. Meeting the spiritual needs of behavioral health patients is a whole-body approach, an essential part of holistic nursing care that can improve patient recovery and overall patient outcomes (Donesky et al., 2020). Exploring BHNs' meaning and experiences of spiritual care can help in identifying the presence or absence of spiritual caring relationships (Costello, 2018; Watson, 2008), and knowledge thereof. The information obtained has the potential to effect positive social change by contributing to the ongoing spiritual care conversation in the body of nursing literature and further educating nurses on spiritual care provision. The theoretical framework that informed the

study was Watson's theory of human caring, precisely some of the Caritas processes that focus on spiritual care (see Watson, 2008).

In Chapter 1, the background of the study, the problem statement, the purpose of the study, the research question, the nature of the study, and the significance of the study are presented.

Background

There is growing evidence from the nursing literature that spiritual care is an essential component of holistic nursing care (Southard et al., 2020). Evidence has shown ongoing discussions on spiritual care provision in the palliative, oncology, emergency, and intensive care nursing units, but no information has been found in the literature about spiritual nursing care in behavioral health units (Clark & Emerson, 2020; Elliott et al., 2019; Hughes & Leigh, 2017; Lavorato-Neto et al., 2018; Neathery et al., 2020). Existing evidence regarding spiritual care had been presented immensely in quantitative studies (Neathery et al., 2020; Sanders et al., 2016) but not in qualitative studies, suggesting the need for more qualitative studies in this practice area (Abu-El-Noor, 2016; Cooper et al., 2020).

Evidence has revealed that nurses recognize the importance and need to engage with spiritual issues, but exactly how they should achieve this has remained unclear (Burkhart et al., 2019; Clark & Emerson, 2020; Hughes & Leigh, 2017; Lavorato-Neto et al., 2018). Some studies have reported the lack of confidence and competence to provide spiritual care (see Clark & Emerson, 2020, Elliott et al., 2019). In the study by Elliott et al. (2019), mental health nurses expressed anxieties regarding the delivery of spiritual

care to their patients. The researchers recommended an increase in spiritual competencies. Increasingly, studies have identified that most nurses are not prepared to provide spiritual care (Costello, 2018; Hughes & Leigh., 2017; Liv et al., 2015). In the study by Liv et al. (2015), the nurses were not knowledgeable about spiritual care. Some of the reasons why nurses were not prepared to provide spiritual care included the lack of time, task-oriented culture, unclear knowledge of accessing resources, and unclear organization policy about spiritual care (Burkhart et al., 2019). More generally, recent studies have reported a lack of experience, theoretical, and practical knowledge about spiritual care (see Hughes & Leigh., 2017; Lavorato-Neto et al., 2018; Liv et al., 2015, Ntombizodwa et al., 2020).

In recognition of the importance of spiritual care in nursing practice, this study addressed the meaning and lived experiences of spiritual care for BHNs as they attended to the spiritual needs of patients with mental and substance use disorders. This was a gap in knowledge identified within the nursing literature (see Clark & Emerson, 2020; Hughes & Leigh, 2017; Lavorato-Neto et al., 2018; Neathery et al., 2020). Therefore, the study was needed to explore the meaning and lived experiences of these nurses to understand their spiritual care perspectives. This study added to the literature an understanding of how BHNs experience and provide spiritual care to their patients with mental and substance abuse issues. Including this information to the literature has the potential to inform nurses with the knowledge needed to design plans of care to increase the quality of care provided to patients with spiritual care needs. Meeting the needs of behavioral health patients is a whole-body approach, including mind, body, and spirit,

and is an essential part of holistic nursing care that can improve their recovery and overall patient outcomes.

Problem Statement

The situation that prompted a literature search was the lack of understanding of how BHNs integrate spiritual care practices when attending to their patients' spiritual needs and their understanding of the meaning of spiritual care (see Neathery et al., 2019). The need for understanding stemmed from the currency, relevance, and significance of this problem to the discipline of nursing, as evidenced by the recognition that spiritual care is an essential aspect of holistic nursing care (Donesky et al., 2020; Hawthorne et al., 2019; Hughes & Leigh, 2017). Spiritual care in nursing includes “caring for the human spirit through the development of relationships and interconnectedness between the nurse and the patient to promote spiritual health and well-being" (Hawthorne et al., 2019, pp.147-148). There is substantial literature on the provision of spiritual care by various nursing specialties, including oncology (see Costello, 2018), palliative care and hospice (Best et al., 2016; Ferrell, 2017), intensive care unit (Abu-El-Noor, 2016), and emergency room nurses (Veloza et al., 2016). However, no information exists regarding spiritual care in behavioral health nursing practice in the field of psychiatry (see Hughes & Leigh, 2017; Neathery et al., 2019; Neathery et al., 2020; Southard et al., 2018;). I found this absence to be a problem. The absence of information in the nursing literature related to the provision of spiritual care by BHNs is a gap that I sought to fill in this descriptive phenomenological study. There was a need to include BHNs in spiritual care discussions within the literature. Exploring the provision of spiritual care by BHNs and adding the

information obtained into the body of nursing literature have the potential for positive social change to this area of nursing practice in that plans of care could be developed to enhance positive patient outcomes and improve quality of life.

Expert patient care depends on accurate assessment to determine the patient's needs (Toney-Butler et al., 2020). Spiritual assessment is as crucial as assessing physical symptoms to meet the goals of patient care. However, spirituality is not usually included in routine patient assessment (Hughes & Leigh, 2017). Usually, spiritual assessment is acknowledged by simply documenting religious affiliations (Hughes & Leigh, 2017). Such behavior shows a lack of understanding of the meaning of spirituality and how to provide spiritual care (Asadzandi & Vafadar, 2018). Burkhart et al. (2019) recognized that spiritual care is essential in nursing practice. In addition, spiritual well-being and spiritual care are associated with better health (Burkhart et al., 2019). As a fundamental component of holistic nursing practice, spiritual care determines how people respond to their illness and associated expectations (Asadzandi & Vafadar, 2018).

According to Hvidt et al. (2020), spirituality designates the interior life with its beliefs, practices, emotions, and sources of meaning present as a source of hope and energy in every individual. Spiritual care is understood to address and attempt to meet the existential and spiritual needs and challenges connected with illness and crisis (see Hvidt et al., 2020).

Spiritual needs have been expressed in terms of one's spirituality, as in one's core beliefs, personal experiences, and thoughts regarding significant issues such as life and death, as well as sources of inspiration, personal strength, and meaning (Hughes &

Leigh., 2017). Spirituality is vital for people in times of vulnerability, crisis, and doubt in their lives, such as when experiencing mental health problems (Hughes & Leigh., 2017). Research has shown that spiritual care enhances patients' quality of life and that failure to provide spiritual care has been associated with the risk of depression and increased healthcare costs (Hvidt et al., 2020).

The SAMHSA (2020) defined behavioral health as a state of mental or emotional being, choices, and actions that affect overall wellness. The literature has addressed psychiatric mental health nurses in instances where spiritual care provision has been discussed (Hughes & Leigh., 2017; Lavorator-Neto et al., 2018; Neathery et al., 2020); however, the focus during such discussions has been on the provision of spiritual care to patients with mental illness. Behavioral health is inclusive of mental illness and substance use disorders (SAMHSA, 2020). The Centers for Medicare and Medicaid Services (CMS; 2020) further defined behavioral health as the emotional, psychological, and social facets that affect an individual's overall well-being. Behavioral health may sometimes be used to refer to mental health that includes substance use (CMS, 2020). Behavioral health, although behavior-focused, is used interchangeably with mental health in psychiatry. The nurses in this setting provide care to patients with behavior-related disorders, including some comorbidities (Lauerer et al., 2017). It involves a healthcare system that deals with the diagnosis and treatment of mental health, substance abuse, and associated physical disorders. Behavioral health embodies the integrated delivery of care by psychiatrists, primary care physicians, nurses, social workers, and other healthcare professionals (CMS, 2020; SAMHSA, 2020).

Studies have shown that nurses do not feel confident addressing patients' spiritual needs (Clark & Emerson, 2020; Hughes & Leigh., 2017; Neathery et al., 2019). As a result, patients' spiritual needs are not being met (Hughes & Leigh., 2017). On other occasions, the patients express reluctance to voice needs of a spiritual nature for fear that the need might be identified as an additional symptom of mental illness and be treated as such (Hughes & Leigh., 2017). Like all other patients, these patients have emotional, mental, and spiritual needs and need the support of their healthcare providers.

According to Clark and Emerson (2020), the Scope and Standard of Practice for Psychiatric Mental Health Nursing (2014) has recognized the importance of providing support for patients' spiritual needs. Despite this recognition, researchers have voiced their concern that most nurses rarely discuss spiritual matters with their patients (Hughes & Leigh., 2017). The authors further noted that although many tools exist to assess patients' spiritual needs, nurses are frequently unclear about incorporating the information they obtain into holistic and multidisciplinary care planning and delivery. Elliott et al. (2019) further noted that mental health nurses have a professional obligation to care for patients holistically and according to nursing standards of practice. However, in the absence of a solid understanding of spirituality, nurses struggle to accurately assess and address the spiritual needs of their patients (Clark & Emerson, 2020).

Literature that explains how BHNs provide spiritual care was not identified (Elliott et al., 2019). There is, therefore, a need for exploration and increased understanding in this area of nursing practice. Exploring the lived experiences of BHNs related to providing spiritual care to patients with mental and substance abuse disorders

addresses the knowledge gap identified in the literature and has the potential to identify care issues that can guide nurses to develop plans of care to improve care outcomes for patients with mental and substance abuse.

Purpose of the Study

The purpose of this qualitative study was to explore the meaning of spiritual care and the lived experiences for BHNs as they attend to the spiritual needs of patients with mental and substance use disorders. The descriptive phenomenological method of inquiry was employed. As a method of inquiry, descriptive phenomenology calls for exploring phenomena via direct interaction between the researcher and the participants, allowing the researcher to learn from other's experiences (Neubauer et al., 2019). Through phenomenology, the participants' lived experiences are used to provide a universal description of the phenomenon while keeping aside the researcher's biases or prior knowledge about the phenomenon, a process known as bracketing (Willis et al., 2016).

Spiritual care in nursing is the act of assessing and responding to the spiritual, religious, and cultural issues that concern patients and their families (Donesky et al., 2020; Spiritual Care, 2021). It addresses life satisfaction and completion issues in a manner consistent with the patient's cultural and religious values and spiritual needs (Donesky et al., 2020).

Research Question

What are the lived experiences and meaning of spiritual care for BHNs as they attend to the spiritual needs of patients with mental and substance use disorders?

The Theoretical Framework for the Study

The theory that grounded this study was Watson's theory on the philosophy and science of human caring, which was originally written in 1979 and revised in 2008 (McEwen & Wills, 2019; Watson, 2008). Watson (2008) reported that the work emerged from her quest to bring new meaning and dignity to the work and the world of nursing and patient care. Watson's caritas processes for spiritual care (Watson, 2008) provide the framework for developing caring and healing practices to facilitate spiritual care (Costello, 2017, 2018). Watson's 10 caritas processes were developed in 2008 from within the philosophical and ethical foundation of her human caring theory work (Costello, 2018; Watson, 2008). Watson's 10 caritas processes and caring practices that facilitate providing spiritual care to the patient and family include (a) practicing loving-kindness and equanimity within the context of caring consciousness; (b) being authentically present and enabling, and sustaining the deep belief system and subjective life world of self and one-being cared for; (c) cultivating one's own spiritual practices and transpersonal self, going beyond ego self; (d) developing and sustaining a helping-trusting, authentic caring relationship; (e) being present to and supportive of the expression of positive and negative feelings; (f) creatively using self and all ways of knowing as part of the caring process; engaging in artistry of caring-healing practices; (g) engaging in genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within other's frame of reference; (h) creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated; (i) assisting with basic needs, with an intentional caring consciousness,

administering “human care essentials,” that potentiate alignment of mind-body-spirit, wholeness in all aspects of care; and (j) opening and attending to mysterious dimensions of one’s life-death; soul care for self and the one-being-cared for; “allowing and being open to miracles” (Costello, 2018).

Caritas 4, 5, and 7 specifically address the concept of spirituality and spiritual care sought by my study. Caritas 4 is about developing and sustaining a helping, trusting, authentic caring relationship, which involves the nurse asking simple yet meaningful questions to understand the role spirituality plays in the patient's life. Caritas 5 entails being present and supportive of positive and negative feelings. It also involves exploring existential concerns and beliefs about the afterlife. Caritas 7 entails engaging in genuine initial spiritual assessment early during the patient's care to identify patient needs and elicit information about the patient's spiritual concerns.

Watson's caritas processes provided a framework for my study. They form the basis for providing spiritual care in nursing by emphasizing the very caring nature of the profession through being present and supportive of the expression of positive and negative feelings (Caritas 5). The theoretical framework aligned with the need to explore the meaning of spiritual care for BHNs explained in the problem statement, purpose, and nature of the study. The theoretical framework guides and informs the continuous search for meaning in areas of nursing where there is a lack of knowledge and understanding as in exploring the lived experiences of BHNs in providing spiritual care.

Nature of the Study

Descriptive phenomenology was the most appropriate approach for this study because it is concerned with revealing the essential features of any phenomenon under investigation -- those features that make the phenomenon what it is, rather than something else (Morrow et al., 2015). The term *phenomenology* refers to the investigation of the meaning of the first-person experience of subjective consciousness (Neubauer et al., 2019). Phenomenology is rooted in the Greek word *phaenesthai*, which means revealing itself or appearing (Moustakas, 1994). The origin of descriptive phenomenology lies in the work of the German philosopher Husserl (Neubauer et al., 2019; Willis et al., 2016). As a method of inquiry, descriptive phenomenology called for exploring phenomena via direct interaction between the researcher and the participants (Neubauer et al., 2019). It is a method that allows researchers to understand the participants' lived experiences without interjecting their own biases; this process is referred to as bracketing (Neubauer et al., 2019; Willis et al., 2016). Consistent with Husserlian tradition, BHNs who have experienced the phenomenon should be able to present their perspective of the phenomenon under study (see Abalos et al., 2016; Neubauer et al., 2019).

The data were collected and recorded using audio recordings for the planned research design. Written notes and transcription from in-depth, open-ended telephone interviews of the BHNs in the study were used (see Willis et al., 2016). The data analysis was done through the qualitative data gathering method proposed by Colaizzi and widely used in the health sciences (see Abalo et al., 2016; Wei & Watson, 2018). Colaizzi's 7-

step process of qualitative data gathering provides a rigorous analysis of data from rich first-person experience (Morrow et al., 2015). The steps are summarized below:

1. Reading and rereading descriptions to acquire general feelings for the experience under study. General feelings are acquired that relate to the provision of spiritual care,
2. Extracting significant statements to generate information pertaining directly to the phenomenon studied (spiritual care),
3. Formulating meanings to illuminate meanings hidden in various contexts of the phenomenon, in this case, spiritual care,
4. Categorizing into clusters of themes and validating with original text to identify experiences common to all informants,
5. Describing the phenomenon under study,
6. Returning to participants to validate findings,
7. Incorporating any changes based on the informants' feedback to present a theoretical model that comprehensively reflects the universal features of the phenomenon (Morrow et al., 2015; Wei & Watson., 2018).

Definitions

Following are definitions of key terms used in the study, some of which have multiple meanings, that help in clarifying the research question.

Behavioral health: Behavioral health is a broader term that refers to the connection between behaviors and well-being (Pacific Health Systems, 2021). It is the study of emotions, biology, habits, and behaviors and how they impact an individual's

overall health. Many behavioral health problems are technical, mental health problems, but unlike those listed above, they are directly related to behaviors. Examples of behavioral health problems or disorders include substance abuse, eating disorders, gambling addiction, sex addiction, and attention deficit disorder (Pacific Health Systems, 2021).

Behavioral health nursing: Behavioral health nursing involves providing care to patients with behavioral problems caused or aggravated by lifestyle or other mental health problems. BHNs use biofeedback, relaxation techniques, medication, and behavior modification tools to help patients change habits, alter thought patterns, or find ways to deal with pain or stress (SAMHSA, 2020).

Mental health: Mental health includes people's emotional, psychological, and social well-being (Centers for Disease Control and Prevention, 2021; U.S. Department of Health and Human Services, 2020). Mental health is further defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (Galderisi et al., 2015, p.231). Mental health problems (disorders) arise when the individuals' mental health is compromised. Examples of mental health problems include bipolar depression, generalized anxiety disorders, schizophrenia, personality disorders, and posttraumatic stress disorders and are not directly related to or caused by behaviors.

Mental health nursing: Mental health nursing involves providing care and support to individuals who have developed mental health problems (SAMHSA, 2020).

Religion: Religion involves the beliefs and practices that a community observes and is usually championed by rituals that acknowledge, worship, and communicate with the divine, God, or ultimate truth (Elk et al., 2017; Donesky et al., 2020). Koenig et al. (2004) had earlier defined religion as an organized system of beliefs, practices, and symbols, designed to facilitate closeness to a higher power, or God, and includes the understanding of one's relationship with him, and responsibility to others. Religion may be a way to express people's spirituality, but it is not the only way (Elk et al., 2017). Religion establishes rules or customs, such as attending church or synagogue and participating in prayers or bible study groups. However, there are nonorganizational religious activities that consist of more private and personal behaviors, such as individual meditation, reading the Bible, listening to religious radio programs, or watching religious television programs (All Answers Ltd, 2018; Koenig et al., 2004). In one study, the researchers used the religion, spirituality, and culture model to conceptualize religion as a subset of spirituality, one aspect of culture (Donesky et al., 2020).

Spiritual care: Spiritual care focuses on religion, spirituality, and culture, and nurses have been described as and encouraged to become "spiritual care generalists" or "primary spiritual care" workers who provide initial assessment and care for a broad range of concerns (Donesky et al., 2020), as opposed to the healthcare chaplain who is described as a "spiritual care specialist," a similar distinction between primary care providers and specialists in other disciplines of medical care.

Spiritual care involves assessing and responding to the spiritual and religious issues that concern patients and families. It addresses life satisfaction and completion

issues consistent with the patient's cultural and religious values and spiritual needs. This includes life review, hopes, fears, purpose and meaning, guilt and forgiveness, faith community, the inner source of power, and beliefs about the afterlife (Spiritual Care, 2021).

Spiritual care interventions: In times when nurses have unique openings to immediately offer the comfort of human presence, touch, kindness, empathy, reassurance, and emotional support in the presence of patient or family fears, misunderstandings, or distress, these have been described as providing primary spiritual care while, interventions mainly provided by chaplains can be labeled as "specialty" (see Table 1; Donesky et al., 2020).

Spiritual needs: Exemplified as loss of a sense of connection or belonging, feelings of loneliness, a search for meaning, and fear of the future, including pain, suffering, and death, all of which can arise in times when patients are alone and may be more vulnerable (Donesky et al., 2020). Patients with comorbid psychiatric illness, for example, are often alone in the hospital, feel isolated, and experience unmet spiritual needs for connection and a sense of common humanity (Donesky et al., 2020; Hughes & Leigh, 2017).

Spirituality: Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationships to self, family, others, community, society, nature, and the significant, or sacred. Spirituality is expressed through beliefs, values, traditions, and practices (Elk et al., 2017).

Substance use disorders: substance use disorders involve the recurrent use of alcohol and or drugs that cause significant impairment such as health problems, disability, and failure to meet major responsibilities at work, school, or home (SAMHSA, 2020).

Table 1

Nursing (Primary), Chaplain (Specialty), and Shared Spiritual Care Interventions

Spiritual intervention	Primary (Nursing)	Specialty (Chaplain)	Shared (Both)
Support when the patient is alone	✓		
Refer to specialized spiritual care	✓		
Affirm fundamental worth to patient and family	✓	✓	
Facilitate religious, spiritual, or cultural practices	✓	✓	
Recognize and act on openings for spiritual conversations	✓	✓	
Intervene with grief and bereavement	✓	✓	
Affirm values	(✓)	(✓)	
Provide supportive listening and empathy	(✓)	(✓)	
Practice of presence	(✓)	(✓)	
Provide religious resources and rituals		✓	
Mediate religious or cultural-based conflict		✓	
Identify sources of spiritual strength.		✓	
Offer legacy activities		✓	
Spiritual and theological reflection		✓	
Intervene in cases of moral distress		✓	

Negotiate exemptions for religious, spiritual, cultural needs	✓	
Create community		✓
Life support during cultural or religious rituals		✓
Produce religious and cultural ceremonies		✓

Note. Adapted from "A new perspective on spiritual care: Collaborative chaplaincy and nursing practice", by D. Donesky, E. Sprague, and D. Joseph, 2020, *Advances in Nursing Science*, *43*(2), p. 147. https://doi.org/10.1097/ANS.0000000000000298

Assumptions

Assumptions are judgments, strong beliefs, interpretations, and conclusions that researchers form when they do not fully understand a situation or problem. Three assumptions were associated with this study. The first assumption was that participants would respond truthfully and accurately. The participants could be tempted to exaggerate their responses regarding spiritual care provision because of fear that revealing the truth about their lack of understanding of the phenomenon might reflect poorly on their performance as nurses. Also, the participants might base their responses on what they have heard about religion, which is often confused with spirituality, and not on what they perceive spirituality and spiritual care to mean to them as individuals and how they have applied it. Similarly, the BHNs might provide positive responses because I was present in the interview with them. To promote accurate responses, I assured all the participants that their identities would remain confidential.

A second assumption was that BHNs would base their interview responses on educational achievement, spiritual background, or upbringing.

Lastly, I assumed that the questions that would be used in obtaining information from participants in this study would accurately assess their perspective about the meaning of spiritual care and how they provided such care to their patient population. The interview questions were carefully crafted to explore the perspectives of the BHNs in this study. For example, some questions were based on the previous application of spiritual care in practice and how the patients responded.

These assumptions were necessary in the context of this study because they helped me to think about possible dimensions within the problem to be studied and reach the desired conclusions.

Scope and Delimitations

This study was limited to exploring how BHNs in the United States understand the meaning of providing spiritual care in nursing practice in the behavioral health setting. This is regardless of whether spiritual care is provided in the inpatient or outpatient setting and considering all cooccurring comorbidities. As a researcher, I did not consider or control for other factors, such as providing spiritual care to the adult, geriatric, adolescent, or other populations, just the general behavioral health population. The decision to broaden the scope to the general behavioral health population was based on the exploratory nature of the research question. The study aimed to explore whether BHNs understand the meaning of spiritual care in nursing practice, whether such care is provided, and if so, how.

Secondly, I delimited my study to the use of Watson's caritas processes and a qualitative descriptive phenomenological approach because they aligned with the purpose of the study. A phenomenological methodology allowed for exploring BHNs' lived experiences and allowed them to describe their perceptions of spiritual care as experienced (see Willis et al., 2016). This contributed to the body of knowledge in nursing in this practice area and is transferable across the field of psychiatry and all other nursing departments.

Limitations

While recruitment of coworkers could have increased participation and convenience of recruitment, ethical implications limited this approach as a reasonable option. According to the Institutional Review Board (IRB), collecting data from the colleagues with whom I interact regularly is likely to be fraught with perceived coercion, presenting methodological and ethical challenges (Walden University, 2020). As such, BHNs were recruited using social media. Nurses employed by my employer were excluded from the study. Another foreseeable challenge was where invited participants failed to respond to invitations to participate in the study. In that case, more invitations were sent out until saturation was achieved.

An additional limitation to this study was that I did not have experience as a qualitative researcher. I was guided by my dissertation committee, who mentored me through the entire process.

Another potential limitation was that my personal biases and idiosyncrasies could influence the quality of the research. Qualitative researchers are required to assume a

neutral position in the interview process (Patton, 2015). However, neutrality is not always feasible, and the researcher must understand specific techniques for dealing with personal biases, perceptions, theoretical persuasions, and experiences of the interviewees (Patton, 2015). To find a balance between neutrality and empathy where needed, I bracketed my personal biases and offered empathy as the need arose (see Patton, 2015).

Finally, the data analysis and interpretation process tend to be very time-consuming because of the large volume of collected data (Malterud et al., 2016; Patton, 2015). I began coding the interview data as soon as collected. Also, sample size guidelines recommended that between 20 and 30 interviews were adequate (Vasileiou et al., 2018). This is usually at the point where no new information is emerging, termed saturation. I planned to collect as much information as available until saturation was reached, even if it resulted in the smallest sample size permitted by qualitative research (see Malterud et al., 2016). This helped reduce the volume of data available for analysis.

Significance

This study was significant in that information obtained relating to distinct lived experiences of BHNs can be used to develop programs to educate nurses about strategies related to providing spiritual care. Those can be applied when developing plans of care that have the potential to increase their interactions with behavioral health patients (Best et al., 2016). Incorporating plans of care that address the spiritual needs of patients with behavioral health disorders can increase their satisfaction with care and improve their quality of life (Elliott et al., 2019; Hughes & Leigh, 2017).

Furthermore, the study can contribute to the knowledge of spiritual care with its focus on BHNs. Nurse leaders may better understand BHNs' perspectives in providing spiritual care, develop relevant programs for this nursing population with practice, and further research, education, and policy implications. These have the potential to bring about positive social change in the field of nursing. The literature has indicated that most patient care professionals understand the importance of spiritual care; however, many are not prepared to provide such care due to lack of competence and confidence (Clark & Emerson, 2020; Costello, 2018; Hughes & Leigh, 2017; Ntombizodwa et al., 2020). This study was an additional step to understanding how other nurses perceive spiritual care by highlighting the meaning and essence of lived experiences of BHNs who have practiced spiritual care with patients with mental and substance use disorders. The importance of meeting behavioral health patients' spiritual needs, especially in the advent of the pandemic, with its concomitant rise in behavioral/mental health challenges, cannot be overemphasized.

Summary

Spiritual care is an essential component of holistic nursing care. Despite this recognition, little attention has been given to spiritual nursing care in behavioral health care delivery, as has been the case with other nursing departments, such as palliative care, oncology, intensive care, and emergency units. For the most part, this has been attributed to the lack of understanding of the meaning of spiritual care and how BHNs provide spiritual care interventions to patients who present with or express spiritual needs. This is a gap in the literature and the problem that prompted the present study.

The purpose of the study was to explore the lived experiences of BHNs as they provide spiritual care to patients with mental and substance abuse disorders. The study clarified terms with multiple meanings when discussing spiritual nursing care provisions and spirituality and religion. These concepts have been revisited in terms of new definitions presented in the nursing literature with hopes of clarifying the meaning of spiritual nursing care.

I earmarked some assumptions, delimitations, and limitations to the study. A qualitative study of this nature was very significant to nursing because information obtained relating to understanding the meaning of spiritual care by BHNs can be used to develop programs to educate nurses about strategies related to spiritual care. The strategies can be applied when developing plans of care that have the potential to increase their interactions with behavioral health patients (Best et al., 2016). I present a detailed description of the theoretical framework and literature review in Chapter 2.

Chapter 2: Literature Review

Introduction

The situation that prompted a literature search was the lack of understanding of how BHNs integrate spiritual care practices when attending to their patients' spiritual needs and their understanding of the meaning of spiritual care (see Neathery et al., 2019). The purpose of this qualitative phenomenological study was to explore the meaning of spiritual care and the lived experiences for BHNs as they attend to the spiritual needs of patients with mental and substance use disorders.

There is substantial literature on the provision of spiritual care by various nursing specialties, including oncology (Costello, 2018), palliative care and hospice (Best et al., 2016; Ferrell, 2017), intensive care unit (Abu-El-Noor, 2016), and emergency room nurses (Veloza et al., 2016). However, no information exists regarding spiritual care in behavioral health nursing practice in the field of psychiatry (Hughes & Leigh, 2017; Southard et al., 2018; Neathery et al., 2019; Neathery et al., 2020). The absence of information in the nursing literature related to the provision of spiritual care by BHNs was a gap that I sought to fill in this descriptive phenomenological study. There was a need to include BHNs in spiritual care discussions within the literature. Based on a study conducted to explore nurse educators' understanding of spiritual care (Ntombizodwa et al., 2020), it was evident that there was still a lack of understanding of the meaning of spirituality and spiritual care in nursing. Issues related to a clear definition of spirituality and spiritual nursing care have also been found (Clark & Emerson, 2020). This gap in knowledge about the meaning of spiritual care was also identified in a systematic review

of psychiatric nursing literature (Clark & Emerson, 2020). Novice and experienced nurses needed clarity about the meaning of spirituality and spiritual care and how it affects the client's well-being, especially in the context of behavioral health care, if they are to provide high-quality care to these clients.

Nurses in behavioral health settings frequently do not feel confident addressing the spiritual needs of patients and, as a result, patients voice that their spiritual needs are not being met (Hughes & Leigh, 2017). Of particular concern is that patients express reluctance to voice needs of a spiritual nature, for fear that the need might be identified as an additional symptom of mental illness and treated as such, thereby complicating or serving as a detriment to their treatment plan (Hughes & Leigh, 2017). Like all other patients, these patients have emotional, mental, and spiritual needs and need the support of their healthcare providers.

In this chapter, I provide a critical review of the empirical literature, exploring the key variables that relate to spiritual care practice in nursing. I also provide an overview of Watson's caritas processes that relate to spiritual care practices. This theoretical framework formed the basis for this study. Discussions about how these processes have been integrated into the literature related to nursing spiritual care are explored.

Literature Search Strategy

I conducted a literature search using ProQuest, CINAHL with Full-text, PubMed, Psych INFO, Medline, SOCIndex, and Sage Journals. The keywords and phrases that were searched for this study included *spirituality, spiritual care, the provision of spiritual care in nursing, behavioral health nurses in the provision of spiritual care, mental health*

nursing, and spiritual care, and *behavioral health.* The search was narrowed to full-text articles. A review of the literature from other areas of nursing, including hospice and palliative care, oncology, and intensive care unit, offered a balanced view. BHNs were the focus of this review, and most keywords were paired with spiritual care. Several results were obtained and filtered to meet the 5-year peer-reviewed publication limit. Some articles went beyond the 5-year limit because they provided valuable information that contributed to the gap and had not been explored in the literature since publication. Some of the articles chosen contained unclear definitions of spirituality as it relates to nursing, spiritual needs, religiosity, and there were suggestions for improving the confidence of providing spiritual nursing care that needed further exploration and understanding. Thirty articles are included in this literature review.

Theoretical Foundation

The theory that guided my study is Watson's theory on the philosophy and science of human caring. The theory was originally written in 1979 (McEwen & Wills, 2019) and revised in 2008 (Watson, 2008). The theory of human caring was developed to bring new meaning to the work and world of nursing and patient care (Watson, 2008). The theory evolved into the 10 caritas processes, developed from within Watson's human caring theory work (Costello, 2018; Watson, 2008). The processes incorporate the spiritual aspects of caring consciousness, intentionality, human presence, and the evolution of the nurse-patient relationship (Watson, 2008). The 10 caritas processes and caring practices that facilitate spiritual care to the patient and family are tabulated in Table 2 and include

1. Practicing loving-kindness and equanimity within the context of caring consciousness.
2. Being authentically present and enabling and sustaining the deep belief system and subjective life world of self and one-being cared for.
3. Cultivating one's own spiritual practices and transpersonal self, going beyond ego self.
4. Developing and sustaining a helping-trusting, authentic caring relationship.
5. Being present to, and supportive of the expression of positive and negative feelings.
6. Creatively using self and all ways of knowing as part of the caring process; engaging in artistry of caring-healing practices.
7. Engaging in genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within other's frame of reference.
8. Creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.
9. Assisting with basic needs, with an intentional caring consciousness, administering 'human care essentials,' which potentiate alignment of mind-body-spirit, wholeness in all aspects of care.
10. Opening and attending to mysterious dimensions of one's life-death; soul care for self and the one-being-cared for; allowing and being open to miracles. (Costello, 2018, pp. 641-642)

In this study, I focused on Caritas 2, 3, 4, 5, 7, and 10 specifically, rather than on the whole theory or caritas processes. These aspects of the theory specifically address the concept of spirituality and spiritual care sought by my study. Caritas 2 entails sitting at eye level with the patient and practicing deep listening. Caritas 3 allows the nurse to explore the meaning of spirituality in the life of the patient while developing an understanding of self-spirituality, asking themselves what gives their life meaning and hope and what role spirituality plays in their life. Caritas 4 is about developing and sustaining a helping, trusting, authentic caring relationship, which involves the nurse asking simple yet meaningful questions to understand the role spirituality plays in the patient's life. Caritas 5 entails being present and supportive of positive and negative feelings. It also involves exploring existential concerns and beliefs about the afterlife. Caritas 7 entails engaging in genuine initial spiritual assessment early during the patient's care to identify patient needs and elicit information about the patient's spiritual concerns. Caritas 10 involves determining what gives the patient hope and supporting that hope while being aware that not everything in life can be explained. It also includes caring for the nurses' own physical, spiritual, and psychological needs as they care for the patient (Costello, 2018). Figure 1 below shows the concept map of the theoretical processes.

Table 2

Watson's Caritas Processes and Caring Practices That Facilitate Spiritual Care to the Patient and Family

	Watson's 10 caritas processes	Caring practice
1.	Practicing loving-kindness and equanimity within the context of caring consciousness	Center self-prior to patient interaction, practice authentic presence and get to know the patient.
2.	**Being authentically present and enabling and sustaining the deep belief system and subjective life world of self and one-being cared for.**	**Sit at eye level with the patient, practice deep listening, resist the impulse to fix patient problems, and develop a level of comfort sitting in silence.**
3.	**Cultivating one's own spiritual practices and transpersonal self, going beyond ego self**	**Explore the meaning of spirituality in the life of your patient and the patient's family. Ask- what gives your life meaning, hope; what role does spirituality play in your life?**
4.	**Developing and sustaining a helping-trusting authentic caring relationship**	**Ask questions such as 'what gives you hope? Are you at peace?'**
5.	**Being present to and supportive of the expression of positive and negative feelings**	**Explore existential concerns, including life review, assessment of hopes, values, fears, meaning, purpose, belief about the afterlife.**
6.	6. Creatively using self and all ways of knowing as part of the caring process; engaging in the artistry of caring-healing practices	Engage in care modalities designed to enhance the patient's experience, such as guided imagery, reiki, music, progressive relaxation, therapeutic touch.
7.	**Engaging in a genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within others' frame of reference.**	**Initial spiritual assessment should take place early during the patient's care to identify patient needs.**

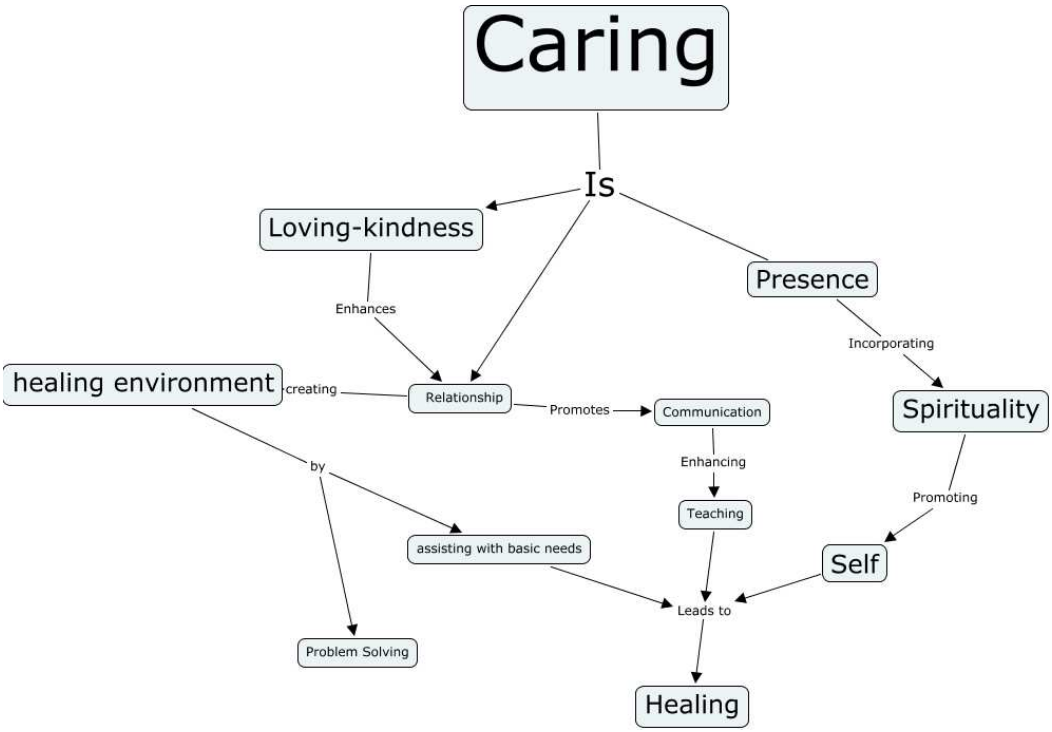
8.	Creating a healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.	Attention should be paid to the patient's physical space to ensure comfort, such as soft lighting and private rooms whenever possible.
9.	Assisting with basic needs, with an intentional caring consciousness, administering 'human care essentials,' which potentiate alignment of mind-body-spirit, wholeness in all aspects of care.	Offer comfort care, swabbing the mouth, lip, and mouth care, gentle repositioning, hand, and foot rubs, teaching the family to provide this care.
10.	**Opening and attending to mysterious dimensions of one's life-death; soul care for self and the one-being cared for; "allowing and being open to miracles"**	**Determine what gives your patient hope and support this hope. Be aware that not everything that happens in life can be explained. Help the patient to achieve the five tasks before the end of life. Recognizing this work is difficult. Care for your own physical, spiritual, and psychological needs as you care for your patient. Help celebrate each day.**

Note. The bolded text above informed this study. Adapted from "Watson's Caritas Processes as a framework for spiritual end of life care for oncology patients," by M. Costello, 2018, *International Journal of Caring Sciences, 11*(2), pp. 639-644.

Figure 1 below shows the concept map of the theoretical processes.

Figure 1

Concept Map of the Theoretical Processes/Caritas Processes



Note. The concept map further illustrates the connection between the caring practices. Adapted from 2008 Nursing: The Philosophy and Science of Caring, Revised Edition, by Watson, 2008 (https://maaz.ihmc.us/rid=1221608070507_1321778391_288/Jean%20Watson.cmap). In public domain

In conformity with Watson's human caring theory, some research studies have indicated that when human caring is applied in interprofessional teams, healthcare professionals find a caring consciousness to care for themselves and each other and promote patient care (Wei & Watson, 2018). Additionally, Costello (2017) applied Watson's caritas processes of spiritual care in a qualitative study that uncovered the characteristics and behaviors of nurses identified by patients as providing exceptional nursing care, with an emphasis on the notion of being present and knowing the patient. Costello found that spiritual needs are important to consider when providing patient care.

Subsequently, Costello (2018) employed Watson's caritas processes as a framework for spiritual end-of-life care for oncology patients. In this study, the caritas processes provided a framework for the development of caring and healing practices that facilitated spiritual care in this patient population, giving them the ability to connect with and embrace the spirit and soul of the other as they faced life-limiting illness (Costello, 2018; Ferrell, 2017). An important factor of Watson's theory is self-care, in which the nurse must develop healthy self-care practices to support the intensity of care they provide for their patients (Costello, 2018).

Watson's caritas processes (Costello, 2018; Watson, 2008) grounded my study in that they formed the basis for providing spiritual care in nursing by emphasizing the very caring nature of the profession through being present and supportive of the expression of positive and negative feelings (Caritas 5). The theoretical framework aligned with the need to understand the meaning of spiritual care identified in the problem statement, the purpose of the study, and the nature of the study. I employed a qualitative descriptive

phenomenological approach to understand BHNs' experiences when providing spiritual care to patients with behavioral health disorders (see Willis et al., 2016). As earmarked by the research question, this theoretical framework guided and informed the continuous search for meaning in areas of nursing where there is a lack of knowledge and understanding, as in exploring the lived experiences of BHNs in providing spiritual care.

Literature Review Related to Key Variables and Concepts

This section explored and detailed the variables influencing spiritual nursing care. I provided an overview of the primary areas identified in the literature that influence spiritual care provision, including efforts to define and understand the meaning of spirituality, spiritual care, spiritual needs, and religion. Also included was knowledge of spiritual assessment among nurses, conflicting beliefs regarding spirituality, spiritual care, nursing education, spiritual care in other nursing settings, and spirituality and research approaches**.**

The literature review also aimed to chronicle the primary barriers to nursing's ability to provide spiritual care and investigate what is known about BHNs by synthesizing the literature related to the provision of spiritual care in psychiatric nursing. I also briefly described studies related to the chosen methodology and methods consistent with the scope of this study. Also included were other areas of nursing that have attempted to provide spiritual care, such as hospice and palliative care, intensive care unit, oncology, and nursing educators. A synthesis of the literature revealed how these nursing specialties' provision of spiritual care contributed to the patient's overall healing.

Defining Spiritual Care, Spirituality, and Religion

The literature revealed the interchangeable use and application of the terms spiritual care and spirituality. Spiritual care is defined as the attitude, attention, and care (of a professional caregiver) that result in the patient's feeling of 'being seen, in which there is attention to life issues and in which finding balance, resilience, and inspiration are important (Ebenau et al., 2020). Discussions on spiritual care often involve the use of spirituality and religion. According to Hvidt et al. (2020), spirituality designates the interior life with its beliefs, practices, emotions, and sources of meaning that are present as a source of hope and energy in every individual. Religion is the practical expression of spirituality, including specific believes and practices (Elk et al., 2017). On the other hand, spiritual care is a type of care that is understood to address and attempt to meet the existential and spiritual needs and challenges connected with illness and crisis (Hvidt et al., 2020).

Spiritual needs have been expressed in terms of one's spirituality, as in one's core beliefs (Harrad et al., 2019), personal experiences, and thoughts regarding significant issues such as life and death and sources of inspiration, personal strength, and meaning (see Hughes & Leigh, 2017). Spirituality is vital for people in times of vulnerability, crisis, and doubt in their lives, such as when experiencing mental health problems (see Hughes & Leigh, 2017).

Knowledge of Spiritual Assessment and Care

Research has shown that spiritual care enhances the quality of life of patients, and the failure to provide spiritual care has been associated with the risk of depression

and increased healthcare costs (Hvidt et al., 2020). Spiritual assessment is as important as the assessment of physical symptoms to meet the goals of patient care. Costello (2018) emphasized the importance of an initial spiritual assessment early during the patient's care to identify patient needs.

Assessment is a nursing requirement that aligns with the foundation for the nursing process (Toney-Butler et al., 2020). The Scope and Standard of Practice for Psychiatric Mental Health Nursing (2014) emphasizes holistic nursing care and states that providing support for patients' spiritual needs is imperative in psychiatric nursing (Clark & Emerson, 2020). Hughes & Leigh (2017) identified that nurses rarely discuss the issue of spirituality with their patients. They further noted that although many tools exist to assess patients' spiritual needs, nurses are frequently unclear about how to incorporate the information they obtain with the tools into holistic and multidisciplinary care planning and delivery for the patient. For example, Elliott et al. (2019) interviewed mental health nurses in the United Kingdom on how they provide spiritual care to mental health service users and found that these nurses were uncertain about attending to spiritual issues as part of care. The nurses were also anxious about differentiating symptoms of mental illness and spiritual needs. The researchers reiterated that mental health nurses have a professional obligation to care for patients holistically and according to nursing standards of practice. Without a solid understanding of spirituality, nurses struggle to assess accurately and address spiritual needs in their patients (Clark & Emerson, 2020; Costello, 2018).

Many clinical settings rarely include spirituality as a routine assessment, while others limit spiritual assessment to simply documenting religious affiliations. Lavorato-Neto et al. (2018) found conflicting beliefs held by the nurses at a psychiatric ward in relation to spirituality that made it difficult for the nurses to address the spiritual needs of their patients. The researchers concluded that the nurses needed more guidance and education related to spirituality and nursing care.

The absence of spiritual assessment has contributed to the lack of understanding of spiritual care's meaning and provision (Asadzandi & Vafadar, 2018). Burkhart et al. (2019) recognized that spiritual care is essential in nursing practice and that spiritual well-being and spiritual care are associated with better health. Nurses must use the nursing process to assess, diagnose, and treat patients' spiritual concerns and thus ideally integrate spiritual needs into individualized plans of care (Clark & Emerson, 2020).

Spiritual Care and Nursing Education.

An analysis of the literature revealed that some students and qualified nurses are aware of the importance of providing spiritual care. However, they are hindered by a lack of education about implementing such care (Harrad et al., 2019). Those who believed that they had received sufficient training in the delivery of spiritual care felt more willing to provide such care to their patients (Harrad et al., 2019). Furthermore, Ntombizodwa et al. (2020) identified that spiritual care was a missing component in the nursing curriculum and perceived challenges and constraints in the teaching and learning of spiritual care. Elliott et al. (2019) and Snowdon & Ali (2017) identified that consistent approaches to including spirituality in nurse education were lacking. There was a need for clarity in

policy documents to ensure that education in this area is consistent. This may explain the lack of understanding and confidence in providing spiritual nursing care.

Literature Related to Spiritual Care in Other Settings

While there are abundance of research investigating spiritual care and spirituality, such as among intensive care unit nurses (Abu-El-Noor, 2016; Bäcklund et al., 2018), oncology nurses (Costello et al.; Ebenau et al., 2020), and palliative care nurses (Best et al., 2016), there were no findings that point to an understanding of how BHNs provide spiritual care (Elliott et al., 2019; Hughes & Leigh, 2017; Lavorato-Neto et al., 2018). There was, therefore, a gap in knowledge and understanding in the provision of spiritual care to behavioral health patients by BHNs (Elliott et al., 2019; Hughes & Leigh, 2017; Lavorato-Neto et al., 2018). There was a need for exploration and increased understanding in this area of nursing practice. The studies above show that some researchers have approached spiritual care in psychiatric-mental health nursing. However, the lived experiences of BHNs in the provision of spiritual care have not yet been explored qualitatively (Cooper et al., 2020). Patients in behavioral health units still voice concerns about their spiritual needs (Clark & Emerson, 2020; Elliott et al., 2019; Hughes & Leigh, 2017; Lavorato-Neto et al., Ntombizodwa et al., 2020; 2018;). This study sought to contribute to this body of knowledge by exploring the meaning of spiritual care to BHNs and how they provide such care to patients with behavioral disorders.

Liv et al. (2015) studied how nurses and care workers provide spiritual care for people with dementia who live in nursing homes. This qualitative study interviewed 8

focus groups with 31 participants (16 nurses and 15 care workers) in four Norwegian nursing homes. The researchers concluded that the nurses lacked experience, theoretical, and practical knowledge about spiritual care. Further studies on spiritual care were recommended to develop nurses' necessary knowledge and skills in practice. This study directed the need for more research with BHNs.

Literature Related to Spirituality and Research Approaches

Cooper et al. (2020) conducted a systematic review of articles from various databases on how nurses understand spirituality and spiritual care. Participants found a great diversity of meanings ascribed to spirituality and spiritual care, indicating that some confusion still existed among nurses in understanding these terms. The authors pointed out that most of the studies reviewed used quantitative approaches (Neathery et al., 2019; Neathery et al., 2020) to investigate how nurses understand spirituality and spiritual care. They recommended more studies using qualitative approaches to provide a deeper insight into how nurses understand these concepts and what influences their understanding (Cooper et al., 2020). This qualitative study filled the gap for more qualitative studies needed as it explored the meaning of spiritual care for BHNs.

Some researchers have approached spiritual care from the context of a focus group that involved both patients and caregivers across nine different countries, in which their needs, experiences, preferences, and research priorities were explored (Selman et al., 2017). One weakness inherent in their approach that could limit the transferability of findings was the absence of resources to conduct back translation to check the validity of

the translation. However, local researchers at the site checked the transcripts for accuracy (Selman et al., 2017). This current study focused on one participant sample, BHNs.

Summary and Conclusions.

The theory that guided this research study is Watson's theory on the philosophy and science of human caring. The theory highlights the ten (10) Caritas processes, developed from within Watson's human caring theory work (Costello, 2018; Watson, 2008). The processes incorporate the spiritual aspects of caring consciousness, intentionality, human presence, and the evolution of the nurse-patient relationship (Watson, 2008). The theory helps understand how spiritual care in nursing should be provided and that is why it was carefully selected to anchor this research study.

While there has been an abundance of research investigating spiritual care and spirituality, such as among intensive care unit nurses (Abu-El-Noor, 2016), oncology nurses (Costello et al.; Ebenau et al., 2020), and palliative care nurses (Best et al., 2016), there were no findings that clearly point to an understanding of how BHNs provide spiritual care (Elliott et al., 2019; Hughes & Leigh, 2017; Lavorato-Neto et al., 2018). Therefore, this revealed a gap in knowledge and understanding in the provision of spiritual care to behavioral health patients by BHNs (Elliott et al., 2019; Hughes & Leigh, 2017; Lavorato-Neto et al., 2018). There was a need for exploration and increased understanding in this area of nursing practice. This study filled the gap by providing an understanding of the meaning of spiritual care and the lived experiences for BHNs as they attend to the spiritual needs of patients with mental and substance use disorders. I

presented a detailed description of the research methodology that was used to explore the lived experiences of the BHNs in chapter 3.

Chapter 3: Research Method

Introduction

The purpose of the study was to explore and understand the embedded meanings in the experiences of BHNs when providing spiritual care to patients with mental and substance use disorders. I used descriptive phenomenology and unstructured, open-ended, in-depth interviews to allow participants to tell their stories using their voices (see Neubauer et al., 2019; Willis et al., 2016;). Using this qualitative descriptive phenomenological approach allowed for exploring this phenomenon of interest in a holistic and naturalistic manner. In Chapter 3, the rationale for the chosen research design is discussed. The role of the researcher is discussed in line with any personal or professional relationships that I may have had with the participants. I also discuss ethical issues related to conducting a study within one's work environment alongside related conflicts of interest or power differentials. Also critical in this chapter is a discussion of the methodology employed, and this includes participant selection, instrumentation, recruitment, data collection, and data analysis. The chapter concludes with a discussion of trustworthiness issues, including credibility, transferability, dependability, confirmability, and ethical procedures employed.

Research Design and Rationale

The research question for this study is the following. What are the lived experiences and meaning of spiritual care for BHNs, as they attend to the spiritual needs of patients with mental and substance use disorders? The phenomenon of interest was the meaning of spiritual care for BHNs and their lived experiences providing spiritual care to

patients with mental health and substance use disorders. The central concept in the study was spiritual care.

Spiritual care is the attitude, attention, and care of a professional caregiver that result in the patient's feeling of "being seen," in which there is attention to life issues and in which (re)finding balance, resilience, and inspiration are important (Ebenau et al., 2020). The research tradition used for this study was qualitative descriptive phenomenology. The rationale for the chosen tradition was to provide an understanding of what spiritual care meant to BHNs by allowing the nurses to describe their lived experiences in their own words (see Neubauer et al., 2019). The qualitative research methodology allows the researcher to study phenomena in their natural setting, with an attempt to make sense of the phenomenon in terms of the meanings that people or research participants bring to them (Aspers & Corte, 2019). It is important in nursing to gain a deeper understanding of the meaning of spiritual care to BHNs and how they provide spiritual care. The qualitative descriptive phenomenological approach was the appropriate design and method to identify and describe those perceptions.

The goal of phenomenology is to explore the way things present themselves or appear to people in and through their experiences (Moustakas, 1994; Neubauer et al., 2019; Willis et al., 2016). I selected a phenomenological approach to evoke, connect with, describe, and elaborate upon the qualities and inner meanings of the participants' lived experiences (see Morrow et al., 2015; Neubauer et al., 2019; Willis et al., 2016).

Descriptive phenomenology was the most appropriate approach because it is concerned with revealing the essential features of any phenomenon under investigation,

those features that make the phenomenon what it is, rather than something else (Morrow et al., 2015; Willis et al., 2016). Phenomenology refers to investigating the meaning of the first-person experience of subjective consciousness (Wirihana et al., 2018). It enables researchers to put aside their perceptions of a phenomenon and give meaning to participants' experiences. Exploring the experiences of others enables previously unavailable insights to be discovered (Wirihana et al., 2018). The word is rooted in the Greek word *phaenesthai*, which means revealing itself or appearing (Moustakas, 1994). The origin of descriptive phenomenology lies in the work of the German philosopher Husserl (Neubauer et al., 2019; Willis et al., 2016). As a method of inquiry, descriptive phenomenology calls for exploring phenomena via direct interaction between the researcher and the participants (Neubauer et al., 2019). It is a method that allows researchers to understand the participants' lived experiences without interjecting their own biases, known as bracketing (Neubauer et al., 2019; Willis et al., 2016). Consistent with Husserlian tradition (Abalos et al., 2016), BHNs who have experienced the phenomenon of providing spiritual care were, through the interview questions, able to identify and reveal such experiences (see Neubauer et al., 2019).

Role of the Researcher

Researchers assume varied roles during the data collection process in qualitative research, including participant, participant/observer, and observer. The researcher primarily collects and analyzes the data (Austin & Sutton, 2014; Lincoln & Guba, 1985). I functioned as a participant/observer to collect the data and analyzed them using Colaizzi's method of qualitative data analysis. I ensured a safe context for participants to

share detailed descriptions of their experiences during the interview (see Austin & Sutton, 2014; Patton, 2015; Poggenpoel & Myburgh, 2003). I personally conducted all the interviews to ensure consistency among the interviews. My interest and high involvement in the study as a BHN made it crucial to recognize all my assumptions and biases. I accomplished this by establishing a field notes journal and reflecting on the process to ensure that my biases and perceptions were managed, thereby ensuring credibility of the study (see Patton, 2015). I provided a $10 incentive for the interview participants.

Furthermore, I did not expect any power differentials between the participants and myself because I did not hold any administrative role that put me in a position to influence their decision. Finally, despite my closeness to the phenomenon of interest pool, there was no personal connection to participants who work as BHNs. Individuals who expressed interests in the study and had personal relationships with me were not selected to participate.

Methodology

Participant Selection Logic

The population for this study was BHNs who cared for patients with mental health and substance use disorders. A purposive, followed by a snowball sampling, strategy was used for this study (see Ames et al., 2019; Vasileiou et al., 2018). Purposive sampling helped to identify participants who provided rich, in-depth, and manageable data (see Ames et al., 2019). Purposive sampling was intended to increase the depth of information discovered (see Patton, 2015).

Furthermore, purposeful sampling tends to yield insights and in-depth understanding instead of empirical generalizations (Patton, 2015). Through this sampling method, the researcher can select description-rich cases to gain an in-depth understanding of the phenomenon under investigation (Palinkas et al., 2015; Patton, 2015). According to Patton (2015), how valid, meaningful, and insightful the qualitative inquiry is, depends more on the information richness of the cases selected and not on the observational or analytical skills of the researcher or the sample size. I gathered information from the participants that was rich and more descriptive of the phenomenon of interest. Participation in the study was voluntary.

The snowball sampling method served as a referral process in which identified participants referred their colleagues to me, if the initial response was low. I encouraged participants to share the recruitment flyer (Appendix A) with their colleagues to increase my participant pool. All participants in the study indicated their willingness to engage in active self-reflection and self-disclosure about their experiences.

Inclusion Criteria

Inclusion and exclusion criteria were used to identify participants who met or did not meet the requirements to participate in the study based on set characteristics. The inclusion criteria for participation included (a) being a registered nurse and (b) taking care of patients with mental health and substance use disorders in behavioral health for at least 6 months.

It was believed that the nurses understood the behaviors and presentation of patients with mental health and substance use disorders (see SAMHSA, 2020). The intent

was to ensure that recollections of their experiences providing spiritual care to this patient population remained fresh in their minds (see Bäcklund et al., 2018). Retrospective perception can be significantly different from prospective appraisals (Bäcklund et al., 2018). Nurses are usually very optimistic yet underestimate their ability to change lives through the challenges they face taking care of patients daily.

All study participants were registered nurses working within the behavioral health department and taking care of patients with mental health and substance use disorders. Participants met the study's inclusion criteria if they self-disclosed their experiences of providing spiritual care in accordance with the set inclusionary criteria. The willingness to participate was indicated during our first email or phone communication.

Exclusion Criteria

The exclusion criteria were individuals who expressed interest in the study but had personal relationships with or knew me.

Sample Size and Saturation

The sample size in qualitive research depends on saturation, quality, and depth of the information provided by the research participants to enable the researcher to gain insight into the phenomenon (Gray et al., 2017). I recruited 8 participants. Morse (1994) suggested at least six participants for phenomenological studies. However, the researcher must be careful not to have too small a sample size; otherwise, the quality of information obtained will be affected and reduce the credibility of the research results (Gray et al., 2017). I conducted interviews until data saturation was reached by the seventh participant, and no new themes emerged after the eighth participant (see Saunders et al.,

2018). The proposed small sample size was defensible by the homogeneity of the study's participants (see Dworkin, 2012). All participants were nurses who worked in the department of behavioral health. Therefore, their account of their shared experiences reflected their experiences of caring for patients with mental and substance use disorders. Each participant interview lasted between 30 and 50 minutes. The 45- to 60-minute time was given to allow participants to have enough time to describe their experiences.

Procedure for Recruitment, Participation, and Data Collection

Upon receiving approval from Walden IRB,

1. I recruited participants using a recruitment flyer (Appendix A) that I placed on Facebook pages. I approached Facebook pages where BHNs meet to seek peer support. The flyer informed participants of the research study, its purpose, criteria for participation, and my email and phone number. The flyer informed individuals who were interested in learning more about the study to contact me by phone or email. In addition, I included a statement in the flyer requesting participants to share the flyer with other BHNs whom they believed might be interested in learning more about the study. I continued to post flyers on these sites until I obtained the required consented participants.

    Participants ideally came from diverse backgrounds from one another, and that ensured the possibility of rich and unique information about the phenomenon under investigation (see Laverty, 2003; Patton, 2015). Diversity in the participant pool was shown by participants' differing lengths of service

as a behavioral health nurse and their nursing background. I used criterion-based selection, or purposive sampling, to select the participants.

2. When they contacted me, I informed them about the purpose of the study, the criteria for participation, and what they were expected to do. They were then screened to determine if they met the inclusion criteria. Those who did not meet criteria were thanked for their willingness to learn more about the study.
3. I emailed the informed consent document to those who indicated their willingness to participate in the study. I requested in the email that they return the signed consent document to me within 10 days.
4. After receiving the participants' informed consent, I scheduled a telephone or Zoom audio interview with them within a 1- to 2-week period. I encouraged the participants to choose an interview method that was most convenient to them and a location for the interview where their conversations would not be heard and where there would be less likelihood for distractions.
5. I interviewed each participant. At the beginning of the interview, I reminded the participants that their participation was voluntary, the interview would be recorded, the information they provided would be kept confidential, and their names will not appear on any written report of the study.

Interview Procedure

I reminded the participants before the start of each interview that the interview would be audio taped to ensure the accuracy of the data obtained. The interview would last 45 to 60 minutes, beginning with a brief introduction and greeting, thanking them for

their participation (Appendix B). The research question was gradually unfolded to the research subjects to obtain data that were important to the focus of the study. The interview recording and transcription were assigned pseudonyms such as Participant 1, Participant 2, and Participant 3. A brief closing statement followed the completion of the interview, and an opportunity was given for each participant to ask questions.

Instrumentation

Data were collected by phone and zoom audio using open-ended interview questions (Appendix C) to uncover the lived experiences of the participants. The broad initial question was designed to expand on the research question and elicit each participant's experience. I asked follow-up questions and probes, engaged in active listening, and audio recorded all experiences. Depending on participants' responses, follow-up questions drew out detailed descriptions of their experiences. I secured consent before the start of the interview procedure. I conducted in-depth interviews to understand the subjective meaning of spiritual care and spirituality for each behavioral health nurse participant and the experience of providing such care (see Patton, 2015; Rudestam & Newton, 2015).

The interview began with a question that built rapport with the participants. This was followed by more specific questions designed to increase the depth of the information obtained about the phenomenon. I continued to interview participants until saturation was achieved; that is, until no new information was obtained. At that point, I interviewed one additional participant to ensure saturation was reached. Two interviews were scheduled a day for 45 to 60 minutes to prevent participant fatigue and to ensure

enough data were collected for analysis and interpretation. The voluntary nature of the interview, privacy considerations, risks, and benefits of being interviewed were also made known ahead of the interview. I also took field notes to capture observations of participants during the interview (see Willis et al., 2016).

Data Analysis Plan

The data were analyzed through a qualitative data analysis method proposed by Colaizzi in 1978, which is widely used in the health sciences (see Abalos et al., 2016; Morrow et al., 2015; Wirihana et al., 2018). Colaizzi's 7-step process of qualitative data gathering provides a rigorous analysis, in which each step stays close to the data (Morrow et al., 2015; Wirihana et al., 2018). This method depends upon rich first-person accounts of experiences and involves the following:

1. Reading and rereading descriptions to acquire general feelings for the experience under study. General feelings will be acquired that relate to the provision of spiritual care.
2. Extracting significant statements to generate information pertaining directly to the phenomenon studied (spiritual care).
3. Formulating meanings to illuminate meanings hidden in various contexts of the phenomenon, in this case, spiritual care.
4. Categorizing into clusters of themes and validating with original text to identify experiences common to all informants.
5. Describing the phenomenon under study.
6. Returning to participants to validate findings (not included for this study).

7. Incorporating any changes based on the informants' feedback to present a theoretical model that comprehensively reflects the universal features of the phenomenon (Morrow et al., 2015; Wei & Watson 2018; Wirihana et al., 2018). Step 7 was not included for this study, as explained in the next paragraph.

For this study, Steps 6 and 7 were not included due to concerns regarding having the participants validate findings (Robert Wood Johnson Foundation, 2008). Studies show that member checking leans on the assumption of the existence of a fixed truth that the researcher can account for and confirmed by a respondent (Robert Wood Johnson Foundation, 2008). No objective truth or reality exists that ensures this comparison of the results of the study (Robert Wood Johnson Foundation, 2008). This can be complicated. For these reasons, my committee chair reviewed the codes that I developed from the transcripts and the resulting themes throughout the data analysis process. These were my interpretations of the data that the participants provided.

Colaizzi's method of data analysis is rigorous and robust, and therefore, a qualitative method that ensures the credibility and reliability of its results. It allows researchers to reveal emergent themes and interwoven relationships (Wirihana et al., 2018). This means that units such as phrases and sentences related to the experience of providing spiritual care were determined. The related meaningful units were then labeled with codes and sorted into categories and subcategories based on similarities and differences. Lastly, similar categories were abstracted and labeled with themes and subthemes indicating a latent meaning in the text.

Microsoft Word software was used to help with data classification and management during analysis. Qualitative software for data analysis and coding is well-supported in the literature (Ose, 2016). Studies show that computer-assisted qualitative data analysis software is too advanced and sophisticated when all that is needed is assistance with sorting and structuring the text (see Ose, 2016). The advantage of using Microsoft Word was that a flexible document was manually produced of interview data separated into codes, themes, and subthemes (see Ose, 2016). This method aimed to sort and structure large amounts of unstructured data. It is suitable for coding and structuring answers to open-ended questions in Web-based interviews. All text was manually coded, and the codes corresponded with headings in the final document. Systematic manual coding ensures that all the content is coded, not just words or terms that are extracted from the text (see Ose, 2016).

I also used field notes to contextualize and clarify themes from the interview data. I recorded field notes during and after each interview and re-examined them along with the transcripts and audio-recorded interviews during the process of analysis. Bogdan and Knopp-Biklen (2003) described field notes as the written account of what a researcher sees, hears, experiences, and thinks while collecting and reflecting on the data in the qualitative study. The field notes offered a way to describe each participant and reconstructed our dialogue and interactions during the session, reflected on the significance of what transpired in the interview, and speculated on connections, emerging themes, methodological difficulties, or reflected on my subjectivity (see Bogdan & Knopp-Biklen, 2003).

In addition to field notes, I kept an audit trail. An audit trail is a collection of researcher notes of detailed information about the methods, procedures, and decisions made during the study (Korstjens & Moser, 2018). I kept a journal that contained information about all the activities related to the project and made notes of any emotions that arose during data analysis and interpretation. This journal served as evidence for any decisions made during the project (see Korstjens & Moser, 2018). Another vital consideration to my study's rigor was the manner of treatment of discrepant cases. McPherson and Thorne (2006) claim that researchers must ask probing questions of each outlying instance. Is the observation a mistake in measurement or recording? Alternatively, is there something else that could account for a mistake in recording or interpretation? Each outlier cannot simply be discarded without further investigation and questioning to maintain integrity in the research process.

In qualitative research, discrepant cases can provide researchers with unique opportunities to consider a study's findings from different viewpoints at each stage of the analytic process. Additionally, these cases can push the researcher towards deeper thinking and more complex and sophisticated conceptualizations of the phenomenon of interest (McPherson & Thorne, 2006). Along with my other findings, any potential discrepant cases are presented in chapter 4.

Issues of Trustworthiness

I employed the criteria proposed by Lincoln and Guba (1985), including credibility, transferability, dependability, confirmability, and reflexivity (Johnson et al., 2020), to ensure the overall trustworthiness of my research results. Prolonged

engagement with and persistent observation of the study participants, determination of data saturation, ethics in research design, and triangulation of data sources further increased the rigor and trustworthiness of this qualitative study (Johnson et al., 2020; Korstjens & Moser, 2018; Lincoln & Guba, 1985). Credibility ensured that the results accurately represent what was studied. This was achieved by thoroughly describing participants' accounts of their experiences (see Johnson et al., 2020).

Credibility.

Credibility is the faithfulness of the researcher's depiction of participants' accounts. Lincoln and Guba (1985) suggested that credibility be the criterion against which the true value of qualitative research be evaluated. The data that was gathered represented depth from the interviewees who had explicit experience and meaningful and comprehensive perspectives of the phenomenon under exploration (Rubin & Rubin, 2012). Triangulation methods were used to appraise consistency as needed (Patton, 2015). Triangulation involved verifying research findings through various sources or methods. I accomplished this using field notes noting observations of participants, in-depth, and multiple interviews (if needed) with participants, and a reflexive journal to interpret meaning.

The transcripts were reviewed independently by my committee chair, and the data analysis results were compared with my findings to maintain the credibility of the data analysis process. Any differences were discussed to reach a consensus (Willis et al., 2016; Morrow et al., 2015). Colaizzi's method of data analysis is rigorous and robust, and

therefore a qualitative method that ensured the credibility of its results (Wirihana et al., 2018).

Transferability

Transferability is the degree to which results of qualitative research can be transferred to other contexts, settings, and/or with other respondents (see Korstjens & Moser, 2018). Thick description is a means for describing the behaviors and experiences of participants with a detailed narrative of the context in which they occurred. This ensured that the behaviors and experiences were meaningful to an outsider. I achieved this by providing an account of the context in which the research was carried out, the setting, the sample, the sample size, participants' demographic information, interview procedures, changes in interview questions based on the iterative research process, and excerpts from the interview guide (Korstjens & Moser, 2018).

Dependability and Confirmability

For this study, dependability involved continuously collaborating with my committee chair, and other members who audited and reviewed my work. Dependability also included the effective management of all records and documents of the study. I saved and backed up my reports from the beginning to the end of my dissertation. Studies showed that dependability in qualitative research can be afforded by how accurate and diligent the researcher complete and keep records for the study (Bryman, 2016).

In addition, I described the study process in sufficient detail such that the work could be repeated.

With confirmability, the researchers' interpretation of the participants must be believable. Lincoln and Guba (1985) recommended including detailed descriptions of the following information: (a) the decision trail that guides research procedures (audit trail), (b) characteristics of the participants and criteria for sample selections, and (c) the selected strategies used to collect, code, and analyze data. As previously described, I ensured dependability, transferability, and confirmability using an audit trail.

Reflexivity

Bracketing describes the process of abstaining from one's presuppositions or ideas regarding the phenomenon being investigated and is used frequently with descriptive phenomenological approaches (Willis et al., 2016; Langdridge, 2008; Osborne, 2011). Furthermore, outlining presuppositions was worthwhile for my study. Outlining one's presuppositions involved self-reflection that made implicit biases and preconceptions about the phenomenon of interest held by the researcher explicitly known (Osborne, 2011). I used a diary as my lens for this study (see Korstjens & Moser, 2018). Using a diary ensured reflexivity and enhanced the credibility and confirmability of the researcher's data analysis (Lincoln & Guba, 1985). Like reflexivity, confirmability served as a measure of my neutrality. The process of outlining my presuppositions aided me in bringing awareness to my personal biases (Kvale, 2009; Osborne, 2011).

Ethical Procedures.

My study adhered to Walden University's guidelines for research with human participants. Confidentiality was strictly maintained. All study transcripts and demographic information was kept on my home/office computer that is password

protected and encrypted. All paper documents and taped recordings were stored in a locked cabinet in my home office. I alone have the key to the cabinet. The names of the participants were kept separate from transcripts and recordings of the interviews. I masked the identity of participants by using a pseudo-ID for each one. The files for participants were marked with numeric and letter-coded symbols rather than names. Following the study, the computer and paper files associated with the study will be kept for five years as required by Walden University IRB (# 04-21-22-1016237), then deleted and shredded. Participants were informed of the purpose of the study, the voluntary nature, potential risks, and their right to withdraw from the study at any time. A participant would submit in writing their intent to withdraw. At that time, I confirmed the use of the participant's interview data leading up to the time of withdrawal.

Summary

The rationale for choosing descriptive phenomenology as the design for this study was because it ensures that participants describe their lived experiences in their own words (see Neubauer et al., 2019). The researcher was the interviewer as well as the observer in this study. The researcher personally conducted all the interviews to ensure consistency. Participants were recruited online on Facebook where the BHNs meet for peer support. Recruitment flyers were posted on Facebook to inform participants of the research purpose and criteria for participation. To be included in this study were registered nurses taking care of patients with mental health and substance use disorders for at least six months. A sample size of 8 participants were intended for this study and the process was repeated alongside snowballing until saturation was attained. Nurses who

had interest in the study but identified to have personal relationships or knew the researcher were excluded. Audio telephone and zoom interviews were conducted based on participant preferences. The data collected were analyzed using Colaizzi's data analysis method. Chapter 3 concluded with issues of trustworthiness including credibility, transferability, dependability, confirmability, and reflexivity. In Chapter 4, I discuss the setting, demographics, data collection, data analysis, evidence of trustworthiness, and the results.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to explore the meaning of spiritual care and the lived experiences for BHNs as they attend to the spiritual needs of patients with mental and substance use disorders. I used the descriptive phenomenological method of inquiry to explore the lived experiences of BHNs (see Neubauer et al., 2019). I conducted interviews to understand the meaning of spiritual care to BHNs and their lived experiences attending to the spiritual needs of patients with mental and substance use disorders. I used phenomenology to describe the participants' understanding of spiritual care and their lived experiences providing spiritual care to their patients (see Willis et al., 2016). I framed the research question broadly and used open-ended interview questions to collect data that were analyzed to answer the research question. I generated prompt questions to solicit for depth and details to gain understanding and answers to the research question.

The research study answered the following question: What are the lived experiences and meaning of spiritual care for BHNs as they attend to the spiritual needs of patients with mental and substance use disorders? In this chapter, I discuss the research setting, demographics, data collection, data analysis, evidence of trustworthiness, and results.

Setting

I conducted interviews via telephone and zoom audio based on the choice of individual participants. The participants chose a location that was convenient and

comfortable for them and where there would be privacy and no distraction. The participants reported being in the comfort of their homes at quiet locations where no one could hear their conversations during the interview. The consenting process was completed by email on a separate day from the day of the interview to avoid taking too much of the participants' time at one sitting. Most of the interviews lasted between 30 to 50 minutes. The interviews were conducted as planned. There were no personal or organizational conditions that influenced participants or their experience at the time of the study that may influence interpretation of the study results.

Demographics

I recruited eight registered nurses who had worked in behavioral health, for at least 6 months, taking care of patients with mental and substance use disorders. All participants met the inclusion criteria. Other demographic characteristics such as age, gender, and ethnicity were not indicated for this study. The characteristics of the study participants are shown in Table 3.

Table 3

Demographic Characteristics of the Study Participants (N = 8)

Length of service as a BHN	Number of participants
6-9 months	2
1-5 years	2
>5 years	4

Data Collection

Participant Number and Selection

Data collection occurred as outlined in Chapter 3, and data were collected from eight BHN participants by interviews using open-ended questions between May 4, and June 11, 2022. Field notes and in-depth interviews with a question guide (Appendix C) were used to collect the data. The data were analyzed following Colaizzi's method of qualitative data analysis. After obtaining permission from Facebook group administrators, flyers were posted on four Facebook pages where BHNs meet to seek peer support. The study was also posted in Walden University's participant pool from where participants saw the information about the study and indicated their interest via my Walden email.

A sample size of eight participants was planned for this research. All eight BHN participants who indicated interest and attended the interview met the inclusion criteria. Some participants had to reschedule their interview dates and time and that prolonged the duration for data collection. Three other participants indicated interest in the study but later decided not to proceed for various reasons. One of them noted that she was involved in travel nursing out of state and would not have time for the interview. Another participant decided not to respond to the follow up request while a third potential participant reported that she had just returned from a travel assignment and would get back to me. The participant never got back and all attempts to follow-up failed. After consenting, the data were collected via telephone or zoom audio on a scheduled date, time, and location that was convenient for the participants.

Data Recording

The data were audio-recorded using the dictate feature in Microsoft Word software that recorded and transcribed the data at the same time. An additional audio recorder device was used at the same time to ensure that data were efficiently collected. All recorded information is kept secure at a locker in my home where I alone have access. The transcripts generated from the interviews were saved in a folder on my personal computer and password protected. Participant names were removed from the transcripts and replaced with pseudonyms to ensure confidentiality.

Location, Frequency, and Duration of Data Collection

Data were collected between May 4, and June 11, 2022. Most of the interviews lasted between 30 and 50 minutes. Within the first week when participants started scheduling, I interviewed two participants within 2 days. The rest of the participants scheduled several days apart over the rest of the interview period. Saturation was met by the time I finished interviewing Participant 7. I interviewed the eight participants, and no new themes were identified. After interviewing the eight participants, no further interests were indicated for almost 2 more weeks thereafter, and I ended the data collection.

Field Notes, Nonparticipant Observation, and Audit Trail

Field notes were written during the interview. The notes were later used to cross-check the transcribed data to ensure consistency and accuracy. The participants were not directly observed. I paid attention to the tone of participant's voices and emphasis made on their responses, which helped with writing the field notes and analyzing the data. An

audit trail helped with monitoring the interview process, data collection, and ensured that any personal bias did not interfere with the data collection process.

Data Analysis

The data analysis process was conducted using a Microsoft Word document in which codes, themes, and subthemes were generated from the transcripts of information provided by the participants. All the eight interviews were transcribed and reviewed for accuracy. After completion of the transcription process, the first coding cycle began with the identification of the initial codes. After analyzing data across the eight participants, approximately 65 initial codes were documented. From the 65 first-cycle codes, 3 main themes and 13 subthemes emerged. The emergent themes and subthemes are displayed in Table 4. There were no discrepant cases noted.

Theme 1 emerged from the data as believing in a higher power, and the subthemes included having faith and hope for the future, having respect for the things of God and believing in something greater than oneself. Theme 2 emerged from the data as providing spiritual care, and the subthemes included understanding patients' spiritual care needs through engaging the patient, respecting their belief, providing support, being present, being nonjudgmental, and being an advocate for treatment and for patients to express themselves. Theme 3 emerged from the data as experiencing challenges to providing spiritual care, and the subthemes that emerged included limited time and meeting resistance.

Evidence of Trustworthiness

I employed four criteria to ensure trustworthiness for this study: credibility, transferability, dependability, and confirmability (see Johnson et al., 2020). Prolonged engagement with the study participants, determination of data saturation, ethics in research design, and triangulation of data sources further increased the rigor and trustworthiness of this qualitative study (see Johnson et al., 2020; Korstjens & Moser, 2018).

Credibility

Credibility ensures that the results accurately represent what was studied. This was achieved by thoroughly describing participants' accounts of their experiences through triangulation of the data sources (field notes, transcripts) and persistent observation (see Johnson et al., 2020). Colaizzi's 7-step method of data analysis was employed in which each step of the analysis stayed close to the data (see Morrow et al., 2015; Wirihana et al., 2018). This involved reading and rereading the descriptions of the participants to acquire general feelings for the experience of providing spiritual care. Next, significant statements, words, or phrases in the form of codes were extracted to generate information pertaining directly to spiritual care. The codes were then categorized into clusters of themes and subthemes validated with the original text to identify experiences common to all the informants. Colaizzi's method of data analysis is rigorous and robust, and therefore, a qualitative method ensured the credibility and reliability of study results. It allows researchers to reveal emergent themes and subthemes, revealing latent meanings in the text (see Wirihana et al., 2018).

I used Microsoft Word software to help with data classification and management during analysis. Qualitative software for data analysis and coding is well-supported in the literature (see Ose, 2016). Studies have shown that computer-assisted qualitative data analysis software is too advanced and sophisticated when all that is needed is assistance with sorting and structuring the text (see Ose, 2016). The advantage of using Microsoft Word is that a flexible document is manually produced of interview data separated into logical themes and subthemes (see Ose, 2016). This method aims to sort and structure large amounts of unstructured data. It is suitable for coding and structuring answers to open-ended questions in interviews. All text is manually coded, and the codes correspond with headings in the final document. Systematic manual coding ensures that all the content is coded, not just words or terms that are extracted from the text (see Ose, 2016).

I also used field notes to contextualize and clarify themes from the interview data. I recorded field notes during and after each interview and reexamined them along with the transcripts and audio-recorded interviews during the process of analysis. Bogdan and Knopp-Biklen (2003) described field notes as the written account of what a researcher sees, hears, experiences, and thinks while collecting and reflecting on the data in the qualitative study. The field notes offered a way to describe each participant and reconstruct the dialogue and interactions during the session, reflect on the significance of what transpired in the interview, and speculate on connections, emerging themes, methodological difficulties, or reflect on my subjectivity (see Bogdan & Knopp-Biklen, 2003).

In addition to field notes, I kept an audit trail. An audit trail is a collection of researcher notes of detailed information about the methods, procedures, and decisions made during the study (see Korstjens & Moser, 2018). I also kept a journal that contained information about all the activities related to the study and made notes of any emotions that arose during data analysis and interpretation. This journal served as evidence for any decisions made during the study (see Korstjens & Moser, 2018). Another vital consideration to my study's rigor would be the manner of treatment of discrepant cases. However, there were no discrepant cases in this study.

The transcripts were reviewed independently by my committee chair, and the data analysis results were compared with my findings to maintain the credibility of the data analysis process. Any differences were discussed to reach a consensus (see Morrow et al., 2015; Willis et al., 2016).

Transferability

Transferability is the degree to which results of qualitative research can be transferred to other contexts, settings, and/or with other respondents (Korstjens & Moser, 2018). Thick description is a means for describing the behaviors and experiences of participants with a detailed narrative of the context in which they occurred. This ensures that the behaviors and experiences are meaningful to an outsider.

I achieved transferability by providing an account of the context in which the research was carried out, the setting, the sample, the sample size, participants' demographic information, interview procedures, changes in interview questions based on

the iterative research process, and excerpts from the interview guide (see Korstjens & Moser, 2018).

Dependability

Studies have shown that dependability in qualitative research can be afforded by how accurate and diligent the researcher completes and keep records for the study (Bryman, 2016). For this study, dependability involved continuously collaborating with my committee chair, and other members who audited and reviewed my work. Dependability also included the effective management of all records and documents of the study. I saved and backed up my reports from the beginning to the end of my dissertation. I also described the study process in sufficient detail such that the work could be repeated.

Confirmability

To establish confirmability, I implemented a reflexive journal to identify and eliminate my biases. This self-reflective journal was helpful to document my impressions during data collection, after the interview, and as themes and subthemes emerged. I abstained from presenting my ideas or presuppositions about spiritual care, a process known as bracketing (see Willis et al., 2016). I used the journal as my lens for this study to bring awareness to my personal biases and to ensure that the findings were clearly derived from the data (see Korstjens & Moser, 2018). An audit trail was also used to verify and ensure that participant responses were accurate. These ensured the confidence that the results could be corroborated by other researchers (see Forero et al., 2018; Korstjens & Moser, 2018).

Results

I organized the study results into themes and subthemes. Approximately 65 codes were developed from the data collected. Themes and subthemes were developed and prioritized during the data analysis process, with three emerging themes: believing in a higher power, providing spiritual care, and experiencing challenges to providing spiritual care. Subsequently, subthemes were developed: having faith and hope for the future, having respect for the things of God and belief in something greater than oneself, understanding patients' spiritual care needs through engaging the patient, respecting their belief, providing support, being present, being nonjudgmental, being an advocate for treatment and for patients to express themselves, limited time, and meeting resistance. Table 4 illustrates the themes and subthemes identified.

Table 4

Emergent Themes and Subthemes From the Data

Theme	Subtheme
Theme 1: Believing in a higher power	Having faith and hope for the future Having respect for the things of God Believing in something greater than oneself
Theme 2: Providing spiritual care	Understanding patients' spiritual care needs Engaging the patient Respecting their belief Providing Support Being present Being nonjudgmental Being an advocate For treatment For patient to express themselves
Theme 3: Experiencing challenges to providing spiritual care	Limited time Meeting resistance

Theme 1: Believing in a Higher Power

To explore the meaning of spiritual care for BHNs taking care of patients with mental and substance use disorders, I asked the participants to first explain what the words spirituality and spiritual care meant to them. Studies have shown that spirituality and spiritual care are interconnected, and that one can hardly be mentioned without the other (see Donesky et al., 2020; Mamier et al., 2019). Definitions of spirituality in nursing have been shown to include the element of a higher power (Harrad et al., 2019). The participants expressed their understanding of spirituality in terms of believing in a higher power and having faith and hope for the future as echoed in Harrad et al. (2019). One BHN participant noted the meaning of spirituality to her:

> the act of being spiritual, having respect for the things of God or the supernatural or whatever people consider as that higher power that they are afraid of and have respect for. It is about who people believe in as the one responsible for their very own existence.

These perspectives are illustrated in Table 5.

Table 5

Theme 1: Believing in a Higher Power

Subthemes	Participants' responses
Having faith and hope for the future	P1, P2, P3, P4, P5, P6, P7, P8
Having respect for the things of God	P1, P2, P3, P4, P5, P6, P7, P8
Believing in something greater than oneself	P1, P4, P5, P6, P7

Having Faith and Hope for the Future

One participant mentioned spirituality to mean "hope for the things not seen, hope for the future, faith about the future." Another participant noted about spirituality is "having faith in the supreme being." A third participant shared that spirituality is,

> the act of being spiritual, having respect for the things of God or the supernatural or whatever people consider as that higher power that they are afraid of and have respect for. It is about who people belief in as the one responsible for their very own existence.

Having Respect for the Things of God

The behavioral health nurse participants identified having respect for the things of God to also mean spirituality. The subtheme on having respect for the things of God was echoed in the participants' continuous expression of their understanding of the meaning of spirituality and spiritual care. Participants identified having respect for the things of God to include making sure their patients "have time to pray" and that "if a Christian want to pray to their God, I want to meet them wherever they are spiritually because it is their belief not mine."

Believing in Something Greater Than Oneself

One participant said, "having faith in the supreme being." Another stated that "I look at it from that aspect that there is a greater being that I believe exists."

Theme 2: Providing Spiritual Care

The spirituality level of nurses has been shown to have a positive effect on their frequency of providing spiritual care (Dündar et al., 2022). This was expressed by this

study's participants under the main subtheme of understanding patients' spiritual care needs including engaging the patient, respecting their beliefs, providing support, being present, being nonjudgmental, and being an advocate for treatment and for patients to express themselves respectively. Table 6 illustrates the participants' experiences.

Table 6

Theme 2: Providing Spiritual Care

Subthemes	Participants' responses
Understanding patients' spiritual care needs	
Engaging the patient	P1, P2, P3,4,
Respecting their belief	P1, P2, P3, P4, P5, P6, P7, P8
Providing support	P1, P2, P3, P4, P5, P6, P7, P8
Being present	P1, P2 ,5,8
Being nonjudgmental	P1, P2, P3, P4, P5, P6, P7, P8
Being an advocate	
For treatment	P1, P2, P3, P4, P5, P6, P7, P8
For patients to express themselves	P1, P2, P3, P4, P5, P6, P7, P8

Engaging the Patient

One participant reported how she engaged her patients when providing spiritual care by stating, "When I assess my patients, I always ask, is there any cultural, spiritual, religious beliefs or ideas that you honor or practice?'' One other participant stated that "the goal is to keep expressing a willingness to respond to spiritual needs and display my

own peaceful nature to people, so that maybe they will observe that and seek spiritual support in a future time."

Respecting Their Belief

One participant said that "it is very important to respect the beliefs of others including our patients." Another mentioned that "I've had patients who told me that they have what could be delusions or hallucinations of God talking to them, or they receive messages from their higher power. I always honor that part of what they are telling me." One other participant stated that "everyone needs to be respected, that's about it." Another participant further noted that "we cannot give them our opinions about their beliefs unless they allow us."

Providing Support

Providing support was identified by many participants. One of the participants noted that "If their religion of choice provides, like a counseling center or peer support, maybe encourage them to go in that direction to make them more likely to be compliant with aftercare and to continue their care in the community." Another participant stated that "I feel like more care in terms of linking them with a church group or associating the patients with a priest can really help."

Being Present

In establishing the need for presence, one of the participants stated that "I needed to be there for her" while another mentioned that "I also feel like the gift of presence, like being there, is also something very ideal for someone who is undergoing a lot, wanting to know what you can do to help them." Yet another participant noted, "The main thing I

did was listening, being present for the patients as they wanted to express their emotions or anything they needed to say."

Being Nonjudgmental

One participant noted, "I did not judge them." Another participant shared that "I provide privacy, and not judging them, and maybe that is the right direction, provide any kind of advice that is therapeutic for them." One other participant talked about "being nonjudgmental about what they may have or hold on to." Studies have confirmed that nurses should ask what give patients hope, inquire about what patients' value and also try to understand them and not judge them (Ressallat, 2017).

Being an Advocate

In expressing her lived experience being an advocate for treatment, one participant shared that "I really wish my patients can be listened to and supported accordingly." Another participant stated that they also "advocated for her to be enrolled in one-on-one counseling therapy."

For Patients to Express Themselves

For patients to express themselves, one participant noted that "they should be given an opportunity to express themselves on what can really help them first, let them give their insights." One other participant advised to "find out what is acceptable to them as far as their spirituality." Another stated that "we should follow up on whatever it is they belief in because that belief could help in their healing process."

Ressallat (2017) reported that if one could hear the patients articulate what spiritual support they would want from their nurse, one would hear common sense

encouragements such as be kind, be authentic, be open, be patient, be accepting of the differences between you as the nurse and us, the patients and family, strive for empathy, ask us about ourselves, our lives, our relationships, our faith, and our religion, and not just to check it off some clinical checklist..

Theme 3: Experiencing Challenges to Providing Spiritual Care

Participants described in detail how they experienced challenges to providing spiritual care. As the participants shared their experiences, sub themes emerged that reflected their struggles including limited time and meeting resistance. Table 7 illustrates those perspectives.

Table 7

Theme 3: Experiencing Challenges to Providing Spiritual Care

Subthemes	Participants' responses
Limited time	P1, P2, P3, P6, P7
Meeting resistance	P1, P2, P3, P6, P7, P8

Limited Time

Ressallat (2017) noted that nurses do not feel they have the time or bandwidth to tackle such pressing personal and spiritual needs of their patients that should be addressed. This was confirmed by one of the participants in this study who reported that "nurses do not have the time to participate." Another participant stated that "the issue most times is that as nurses we have very limited time to perform this task with our

patients because of time constraints." A third participant included that "the nurse-to-patient ratio remains high leaving us with little time to work with."

Meeting Resistance

Meeting resistance to provide spiritual care was also identified in such words as "she didn't trust me, she was rebellious." One participant stated that,

> I have had patients staunchly decline or respond negatively ("I'm atheist, I don't believe in God" or "I hate God because He hates me"). I will explore the reasons behind these beliefs but if they do not seem receptive, I just acknowledge their statement and keep it moving.

Summary

In summarizing their lived experiences providing spiritual care to patients with mental and substance use disorders, the behavioral health nurse participants concluded that they experienced a "feeling of connection, other energy attained different from what the nurse holds, inner peace, and developed respect for people who are at peace because of their beliefs." The evidence presented in this study confirms Watson's Caritas processes that informed this study. Caritas 2, for example, required the nurse to be authentically present and enabling and sustaining the deep belief system and subjective life world of self and one-being cared for. Caritas 5, in addition, informed the nurse to be present and supportive of the expression of positive and negative feelings (Costello, 2018). Some of the participants in this study manifested caritas 2 and 5 by expressing how the main thing they did was being present for the patients, listening to how they

expressed their emotions, or anything they needed to say, confirming Watson's theory of human care.

In Chapter 4, I discussed the research question, the research setting, the participant's demographics, the data collection method, and analysis process. I also discussed evidence of trustworthiness and the results of the study. In Chapter 5, I discuss the interpretation of the findings, limitations, implications for the future, recommendations, and conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative study was to explore the meaning of spiritual care and the lived experiences for BHNs as they attend to the spiritual needs of patients with mental and substance use disorders. The descriptive phenomenological method of inquiry was employed. Descriptive phenomenology calls for exploring phenomena via direct interaction between the researcher and the participants, allowing the researcher to learn from other's experiences (see Neubauer et al., 2019).

Spiritual care in nursing is the act of assessing and responding to the spiritual, religious, and cultural issues that concern patients and their families (Donesky et al., 2020; Spiritual Care, 2021). It addresses life satisfaction and completion issues in a manner consistent with the patient's cultural and religious values and spiritual needs (see Donesky et al., 2020). This study was conducted to explore what spiritual care means to BHNs and their lived experiences providing spiritual care to their patient population. The data analysis was done through the qualitative data gathering method proposed by Colaizzi and widely used in the health sciences (see Abalo et al., 2015; Wei & Watson, 2018). Themes and subthemes were developed and prioritized during the data analysis process, with three emerging themes: believing in a higher power, providing spiritual care, and experiencing challenges to providing spiritual care. Eleven subthemes were developed: having faith and hope for the future, having respect for the things of God and believing in something greater than oneself, understanding patients' spiritual care needs through engaging the patient, respecting their belief, providing support, being present,

being nonjudgmental, being an advocate for treatment and for patients to express themselves, limited time, and meeting resistance.

Interpretation of the Findings

Findings in this study confirmed information found in the literature. Participants in this study reported how they spent time listening to, being present with, praying with, and being nonjudgmental of the expressions of fears and concerns of the patients they cared for. This confirms information reported by Costello (2017) in which nurses were identified by patients as providing exceptional nursing care because they were being present and made efforts to know them. One of the major themes that emerged in the current study was believing in a higher power. The subthemes identified from the reports of the participants were having faith and hope for the future, having respect for the things of God, and believing in something greater than oneself. These findings are like those reported by Hvidt et al. (2020). They identified that spirituality designates the interior life with its beliefs, practices, emotions, and sources of meaning that are present as a source of hope and energy in every individual.

Additionally, Hughes & Leigh (2017) identified that nurses rarely discuss the issue of spirituality with their patients. This finding was confirmed in the current study in which some BHN participants reported limited time as one of the challenges that they experience providing spiritual care. One participant noted that “the issue most times is that as nurses we have very limited time to perform this task with our patients because of time constraints.” Another participant reported that “the nurse-to-patient ratio remains high leaving us with little time to work with.” However, it is important to note that

although the nurses reported that they believed that addressing the spiritual needs of the clients were important to them, time and assignment constraints hindered this interaction. Reiterating from a behavioral health nursing standpoint that spiritual care enhances and integrates all dimensions of health including physical, mental, emotional, and social, is a confirmation of previous findings and, an extension of knowledge within the discipline of nursing (see Costello, 2017; Donesky et al., 2020; Hughes & Leigh, 2017; Hvidt et al.,2020).

Watson's theory of human science, particularly the caritas processes, informed this study. Caritas 2 presupposed the nurse to be authentically present and enabling and sustaining the deep belief system and subjective life world of self and one-being cared for, and Caritas 5 was about being present to and supportive of the expression of positive and negative feelings (Costello, 2018). Some of the themes that emerged from the current study in confirmation of Caritas 2 and 5 included being present, providing support, engaging the patient, and respecting their beliefs as an understanding of the patient's spiritual care needs and providing spiritual care. Caritas 4 involved developing and sustaining a helping-trusting authentic caring relationship. The caring practices reported by the participants included asking questions such as "What gives you hope? Are you at peace?" having faith and hope for the future, having respect for the things of God, and offering to pray with the patients.

Limitations of the Study

There were no limitations to trustworthiness encountered during the execution of this study. However, one challenge encountered was that some participants indicated

interests, scheduled an interview, but before the day of the interview, they backed out stating that they were busy and would not have time for the interview. Some respondents ignored my follow-up requests. Data collection was dependent on the availability of the participants; waiting for their availability to conduct the interviews extended the anticipated time for completing other stages of the dissertation. To facilitate the response to my requests, I continued to repost flyers until data saturation was reached with the anticipated number of participants.

It was anticipated that the data analysis and interpretation process would be very time-consuming because of the large volume of collected data (see Malterud et al., 2016; Patton, 2015). However, I began coding the interview data as soon as they were collected and that minimized the length of time that would have been spent on data analysis.

Recommendations

The results of this study emphasize the need for future research. First, the challenges experienced in providing spiritual care by BHNs must be explored further. Participants in a previous study found a great diversity of meanings ascribed to spirituality and spiritual care (see Cooper et al., 2020). The results of this study indicate that confusion still exists among nurses in understanding these terms. Some of this study's participants reported struggling with the meaning of spiritual care and as such found it difficult to express how they would provide spiritual care to their patients. The meaning of spiritual care for these nurses and others must also be explored further.

Equally important is the need for researchers to explore BHNs' perspectives regarding their experiences and challenges in caring for patients with mental and

substance use disorders. Although saturation was reached, interviews with other BHNs may generate comprehensive perspectives and experiences of BHNs taking care of mental and substance use disorder patients including that of incorporating spiritual care practices. Also, this study did not identify age, gender, or ethic characteristics. This maybe a consideration for future studies.

Implications

Implications for Positive Social Change

Addressing the spiritual needs of patients is of utmost importance in holistic nursing care. Understanding the meaning of spiritual care and the provision of spiritual care has been proven to improve patient's health outcomes. This study's findings have significant social change implications. First, the study revealed the lived experiences of BHNs that can help the profession to have a better understanding of how patients with mental and substance use disorders receive spiritual care. Healthcare practitioners, policymakers, and spiritual care advocates may develop relevant education initiatives and policies to incorporate spiritual care information in nursing school programs and during hospital orientation. Incorporating guidelines within the hospital that prioritize providing spiritual care to hospitalized patients can empower BHNs as well as nurses working in other areas of the hospital to develop plans of care that includes providing spiritual care to their patients. Increasing the emphasis on spiritual care has the potential to improve quality of care and the quality of life for all patients.

This study adds to the knowledge base in the field of nursing by highlighting specific perspectives regarding spirituality and the provision of spiritual care by BHNs.

The healthcare of the patient population that these nurses care for may improve with the relevant information that this study has provided.

Methodological and Theoretical Implications

Through descriptive phenomenology, participants were able to describe their lived experiences in simple terms that confirmed the conceptual framework of Watson and helped to answer the research question for this study. Other practitioners will be able to adopt this methodology for future research as needed.

Conclusion

This study employed a phenomenological approach to explore the meaning of spiritual care and the lived experience of BHNs who take care of patients with mental, and substance use disorders. I interviewed the BHN participants to explore their understanding of the meaning of spiritual care and their lived experiences providing spiritual care to their patient population.

The take home message is that BHNs equally believe that addressing the spiritual needs of patients is important (see Hughes & Leigh, 2017); however, the diversity of meanings ascribed to spirituality, time, and assignment constraints hinder this interaction. Like other nursing departments revealed in the literature (see Costello, 2017; Hughes & Leigh, 2017; Hvidt et al., 2020), the results of this study indicated that confusion still exists among nurses regarding the meaning of spirituality and spiritual care. This made it difficult for some of the BHNs to express how they would provide spiritual care to their patients.

BHNs who understand spirituality to mean a belief in a higher power use this knowledge as the basis for providing spiritual care through engaging with the patient, being present and supportive, and listening to and showing respect for the patient's spiritual background, their belief in God or in a higher power, or their nonbelief. They also offer to pray with them, comfort them, give them reassurance, and remain nonjudgmental about what they may have or hold on to.

By exploring the perspectives of BHNs, this study contributes new knowledge to the literature and helps provide significant information regarding BHNs' understanding of and lived experiences providing spiritual care. Spiritual care is important in holistic nursing care. Research studies that evaluate holistic nursing care among mental and substance use disorder patients yet fail to address spiritual care perspectives can be problematic. Hence, the findings of this study provide significant implications for practice, policy, and education.

The study unveiled themes and many subthemes that healthcare practitioners, researchers, policy makers, and educators especially within the behavioral health community could use to develop further studies to understand and support the spiritual needs of mental and substance use disorder patients and improve health outcomes. This study fulfilled the call researchers have made for further qualitative research that reflects spiritual nursing care perspectives in other areas of nursing.

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Appendix A: Recruitment Flyer

VOLUNTEERS NEEDED

THE PROVISION OF SPIRITUAL CARE BY BEHAVIORAL HEALTH

You are invited to participate in a research study that explores the lived experiences of behavioral health nurses as they attend to the spiritual care needs of patients with mental health and substance use disorders.

You are eligible if:

-You are a registered nurse

-Have been a behavioral health nurse for 6 months or more

The study will serve to further the current body of knowledge regarding the provision of spiritual care in nursing.

The study involves an interview lasting approximately 45 to 60mins (one hour)

If you are interested in participating or have any questions about the study, please contact me below

Please you are also permitted to share this flyer with fellow behavioral health nurses so that they might consider participating in this study.

Rowan Teboh

Appendix B: Letter to Participants

Dear _____,

I am a doctoral student at Walden University's PhD in nursing program. I am conducting a study for my dissertation focusing on the experiences of behavioral health nurses (BHNs) as they attend to the spiritual care needs of their patients. The purpose of my study is to explore the meaning of spiritual care and the lived experiences for BHNs as they attend to the spiritual needs of patients with mental and substance use disorders. I am using a phenomenological method to explore and understand these experiences from the nurses' point of view. My interest in this topic stems from my own experiences as a behavioral health nurse. I expect my research to provide a foundation for future empirical research on how behavioral health nurses provide spiritual care to patients with behavioral health disorders. I am seeking registered nurses working in behavioral health for at least 6 months or more and who take care of patients with mental, and substance use disorders and willing to speak with me about their experiences providing spiritual care to their patients. Participation in this study will require about 45mins to an hour of your time for an interview. Please be assured that all information shared with me will be confidential. If you are willing to share your experience with me, please email, text, or call me so that we can arrange a mutually convenient meeting time. Interviews will be held via telephone, face-to-face, or on zoom audio. Thank you for your time and consideration,

Rowan Teboh RN BSN MSN PhD(c)

Appendix C: The Interview Guide

Introductory Statement

Thank you for taking the time to speak with me today. I am grateful for your cooperation and willingness to participate in this study. I know time is valuable to you, so let me begin the interview right away. Before I do so, do you have any questions or concerns you need me to address before we begin? The purpose of the study is to explore the meaning of spiritual care and the lived experiences for BHNs as they attend to the spiritual needs of patients with mental and substance use disorders.

Questions:

1. Please explain what spirituality or the provision of spiritual care means to you.
2. Tell me about a typical day when you engaged with a patient on matters of spirituality
3. What did that experience mean to you?
4. Is there anything else you would like to include before we finish this interview?

Concluding/closing statement

Thank you for taking this time to share your experience with me. If you have any concerns or questions, please do not hesitate to contact me. Here is my cell phone number .... I can be reached Wednesdays through Saturdays between 10 am and 2 pm CT.