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Assessing Spirituality Among Hospice Patients: A Phenomenological Study of Hospice Nurses

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MA, Forensic Psychology Argosy University 2006

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The shift in health care and nursing philosophy and practice from a holistic approach to a highly technological, cure-oriented approach has been attributed to effective pharmaceuticals made to prolong life. Recently medical professionals have shifted their focus to a combination of spiritual healing and medicine. Hospice care in particular have taken a key interest in integrating spirituality within their health care. The problem is that due to the complications in defining spirituality and appropriate training and education of spirituality within nursing curriculum, assessing patients' spiritual distress may be difficult for many hospice nurses which may be at a loss when attempting to integrate spirituality within their practice. This study used a phenomenological approach to explore the infusion of spirituality in nursing practice and the hospice nurses perceptions of assessing spiritual distress needs of terminally ill patients. Frankl's existential theory and Kubler- Ross's stages of grief theory framed the study. Participants included VIII hospice nurses working in a Pacific Northwestern state. Face-to-face interviews were conducted to explore the essence of the experience of integrating spirituality as well as their views and concerns regarding assessment instruments used to assess spiritual distress. Data was analyzed for content themes. The study found that spiritual courses were merged into hospice nursing as a teaching unity making it difficult for hospice nurses in a Pacific Northwestern State to fully grasp the concept of spirituality. Further findings suggested that only a handful of schools had spiritual nursing as an independent course. The study may impact social change by informing the advancement of hospice nurses and hospice administrators in the practice of including spirituality within healthcare and integrating extensive existential support training within nurses' curriculum.

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Dedication

This dissertation is dedicated to all those individuals that strive to find peace and solace when faced with a terminal illness. It is also dedicated to those strong, selfless Angels that give of themselves unconditionally and help guide these fragile souls to a place of reconciliation, peace and ultimately acceptance. It is only through acceptance that we can face death with dignity and not despair.

Acknowledgments

This dissertation is dedicated to my best friend, partner in life and Huckel-Berry Fin Dr. Ronny. You taught me to keep moving forward and to reach the highest star. Because of you I am complete. You are truly my "everything." To my five, wonderful children that have been by my side through the difficult times and have made me stronger, more sensitive and definitely more patient. To my father, who passed away while I was pursuing this goal...you taught me through persistence, dedication and passion, anything can be accomplished. And finally, this dissertation is dedicated to Dr. Barbara Benoliel, who pushed me along and made me feel that this was possible. She gave me strength to move forward and for this I will truly be forever grateful. I would also like to thank Dr. Pamela Denning for providing me with her feedback which helped me fulfil this dream.

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Chapter: 1 Introduction to the Study

Introduction

The impact that spirituality has on the emotional, physical, and psychological wellbeing of individuals is a significant area of study (Cobb, Puchalski & Rumbold 2012). The authors at The American Nursing Association (ANA) have purported that hospice nurses in particular have recognized the need to infuse sensitivity to patients' spirituality within their nursing practice. According to the ANA newly qualified graduate nurses in partnership with their patient, their healthcare team and the patient's family make a holistic, person centered and systematic assessment of the physical, emotional, psychological, social and spiritual needs of their patients and develop a comprehensive personalized plan of nursing care.

In order to adjust to this personalized healthcare plan as the strategy of choice, Stoney and Dossey (2009) suggested integrating spirituality within their nursing practice because of the overall benefits it has on patients. For example, Puchalski, Ferrell and Virani et al., (2009) established the impact that spirituality had on terminally ill patients. The authors stated that hospice nurses address not only the emotional needs of their patients but their physical and psychological needs as well. This initiative may be significant for all person-centered and holistic approaches to counseling terminally ill patients and managing care. However, many times due to the elusive definition of spirituality many hospice nurses as well as social workers and other counselors may find it difficult to integrate spirituality within their clinical care and assess the spiritual distress needs of their patients.

Timmons, Murphy, Neil, Begley and Sheaf (2014) discussed that infusing spirituality within the nursing profession as well as other person-centered treatment plans may be difficult due to

the operational definition of spirituality. The authors purported that hospice nurses' and other counseling professional's perception of spirituality may mean different things to each individual. Due to this confusion, challenges assessing spiritual distress may occur within healthcare. This misperception was collaborated by the American Holistic Health Association (AHHA 2012), who reported that spirituality may be overlooked in a patients' health care approach due to this misunderstanding.

Koren and Papamiditriou (2013) stated that there are an array of definitions associated with spirituality and what it means to individuals. However, in the midst of these differing definitions there are some common themes. For example, some have claimed that spirituality involves a relationship to a God, higher power, spiritual being or a reality greater than the self. Pattison (2013) suggested that although religion is many times linked to spirituality religion emphasizes an organized system of practices and beliefs in which individuals engage and interact. Cohen, Holley, Wengel and Katzman (2012) believed that religion is the platform for the expression of spirituality.

Much controversy and debate encompasses the definition of both religion and spirituality. Pattison, Hannigan, Pill, & Thomas, (2010), argued that many individuals see religion as the manifestation of their spirituality, yet an individual can be spiritual without being religious. Koenig (2013) claimed that for patients both religion and spirituality are not static entities, but rather interchange with the dynamic of chronic illness and prognosis.

The AHHA (2012) recognized that spirituality played an important role that is oftentimes overlooked in a patient's healthcare, regimen and healing process. Part of the problem may be due to the undefinable definition of spirituality as well as the training and education that nurses receive on the topic of spirituality. Although hospice care addressed a patient's spirituality as an

important component of who the individual is and how they cope with disease, pain, loss and grief many hospice nurses as well as other mental health professionals may find it difficult to assess the spiritual distress needs of their patients. The AHHA, proposed that spirituality helps patients cope with physical or mental complications and brings about wellness and acceptance of prognosis. Spiritual health is demonstrated by patients signifying the ability to be authentic, face their fears, let go of their past, and develop insight, forgiveness, peace, compassion, and ultimately acceptance.

Burge et al., (2014) conducted a study through telephone interviews asking 1,358 after-death bereaved family members to discuss whether or not they believed the emotional, and spiritual needs of both patient and family were met. Sixty-seven percent of participants expressed their dissatisfaction with their family and the patients' emotional and spiritual care (Burge et al). One reason for this dissatisfaction may be attributed to hospice nurses' poor understanding of what spirituality is and what such care entails as well as their deficiencies of education and training.

In a study by Henoch, Danielson, Strang, Browall and Melin-Johansson (2013) the authors suggested that training health care staff in the provisions of existential support may be beneficial. The authors claimed that many times existential issues come into play when a terminal or serious prognosis is given. Thus the authors determined that through this training, nurses would be more comfortable and have a more positive attitude when speaking to their patients about spirituality and their fears, anxieties and spiritual distress needs (Henoch et al).

The study was conducted on 102 nurses, hospice wards and palliative healthcare teams working with patients diagnosed with terminal cancer. The participants were randomized and placed in either in training courses or non training groups as well as combined individual and

group reflection. The purpose of the study was to determine if healthcare workers, nurses and palliative healthcare teams were more comfortable speaking of spirituality with their patients after the training course. It was determined that immediately after the training course 5 months after the course in existential support that confidence in communication regarding spirituality with terminally ill patients significantly improved.

Mayers and Johnston (2008) determined that many hospice nurses may misinterpret patient spiritual care needs, mainly because spirituality was not a pivotal focus in the basic nursing curricula. Likewise, according to the standards of the Council of Accreditation of Counseling and Related Educational Programs (2011), many counselor educators are perplexed and unsure of how to infuse spirituality within their courses. The Council of Accreditation of Counseling and Related Educational Programs examined the topic of integrating spiritual courses within their master's and doctoral counseling curriculum due in part to the needs that counselors strive for when integrating spirituality within their holistic approach. Despite these existing guidelines, many counselors may not be prepared to address their clients' spiritual concerns due in part to their inadequate training and education deficiencies of the curricular knowledge that is needed for counselors and other human service professionals to feel comfortable when assessing spiritual distress and speaking to their patients about spirituality (Burke et al 2014).

Ku (2010) concurred that in the United States the majority of spiritual courses are merged into hospice nursing as a teaching unity. The author stated that only a few schools had spiritual nursing as an independent course. Due to this merge, many hospice nurses complain about not understanding how to apply spiritual care to assist their patients in a clinical setting.

Koslander, Da Silva, and Roxberg (2009) agreed stating that many hospice nurses may feel inadequately prepared to assess and address patients' spiritual needs due to the lack of

knowledge and education on how to deliver spiritual care. The problem may be due to a clear and distinct definition of what spirituality is. MacKinlay (2008) suggested that continuing education on spirituality from a nursing perspective would better prepare hospice nurses to address patient's spirituality.

Murphy and Walker (2013) found that many hospice nurses have expressed the need to partake in further education addressing spirituality and developing a consensus of how hospice nurses should infuse spirituality within their healthcare approach. Numerous hospice nurses expressed the need for developing the appropriate use of active listening skills, therapeutic touch and open discussion of faith as future academic consideration. (Murphy & Walker, 2013). Hospice nurses also addressed the fear of inappropriateness that many of them may feel when attempting to integrate spirituality within their practice. Some of their concerns and feelings expressed were problems dealing with their personal beliefs and views of what spirituality involved and how to address the spiritual distress needs of their patients when defining spirituality (Murphy & Walker, 2013).

According to NetCE an accredited provider for continuing nursing education the nursing curriculum may be approving clock hours for programs in specific universities on spirituality and religious orientation. Despite the general population's reliance on spirituality and the impact it has on patients the field of social work, mental health counseling and nursing have been unwilling to introduce and integrate spirituality and religion within their professional training curriculum. Due to this reluctance, faculty and practitioners are many times ill-equipped to discuss the impact that spirituality and religion has on patients (NetCE, n.d.). Other factors impacting the comfort levels for practitioners and faculty to integrate and discuss spiritual distress within their training and curriculum are the nurses' and practitioners' understanding,

appreciation, biases and examination of religion, spirituality and faith which for many individuals is interconnected with their cultural values.

Problem Statement

Despite understanding the importance of integrating spirituality within the healthcare system and the benefits associated with this holistic care approach, the practical applications of this systematic understanding does not seem to have trickled down to front line care such as hospice nurses thus making it difficult to meet the spiritual needs of their patients. (Nixon, Narayanasamy & Penny, 2013). While literature and measurements about spirituality in hospice care is available, I have found few studies that addressed the spiritual beliefs and understanding of what spirituality is and the challenges that many hospice nurses face in this area of study. Hospice nurses may be in the most significant position to assist patients with their spiritual distress needs due in part to their placement with terminally ill patients as front line care providers, and key participants to providing the holistic care to this vulnerable population.

Part of the problem besides defining spirituality and the deficiencies of training and courses could be the lack of appropriate assessment tools used by hospice nurses and the training of these instruments to assess their patients' needs (Monod et al., 2010). Although numerous assessment tools have been developed to assess patient's spirituality most of them only focus on the measurement of attitudes and behaviors associated with having a strong spiritual belief (Monod et al., 2010). These assessment tools provide little to no information on the patient's current intimate feelings regarding spirituality such as addressing the meaning of life or feelings of anxiety when faced with death (Monod et al., 2010).

The assessment instrument utilized should be able to assess the spiritual distress needs of patients to determine the need for specific interventions (Monod et al., 2010). Moreover, in a

study by Balboni (2013) only one of the 35 instruments utilized to assess spirituality appeared adequate enough to assess a patient's current spiritual state. However, the instrument was developed only to assess spiritual well-being specifically rather than spiritual distress.

This current study was necessary because it revealed areas of deficiencies in the current research on the challenges that many hospice nurses may face when assessing spiritual distress. There has also been minimal current research addressing the need for hospice nurses to understand the assessment instruments utilized to assess spiritual distress and their training in using them. The study will assist hospice nurses and other healthcare workers, counselors and social workers in preparing themselves through training or education in understanding the benefits of spirituality and their comfort level in speaking to their patients about their patients' spiritual distress needs.

Purpose of the Study

The purpose of the study was to explore how hospice nurses addressed the spiritual distress needs of terminally ill patients and their training and education of spirituality as well as their desire to assist this vulnerable population in expressing their fears, anxieties and hopes when faced with a terminal illness. By addressing the human service perspective of hospice care, The American Holistic Health Association (AHHA, 2012) has prioritized spiritual health care among their top care concerns. The reason for this prioritization of spiritual care is the need for terminally ill patients' desire to be understood and feel the interrelationship of their mind, body, and spirit when faced with a terminal illness. Hospice nurses should be aware of the assessment instruments utilized to assess spiritual distress and should have the appropriate training and courses on spirituality when interacting with their patients. Puchalski (2013) postulated that healing can be actualized when hospice nurses interact with their patients and assist them in

alleviating anxieties and fears. Hospice nurses practice healing the whole person as its primary goal. Since hospice nurses are the front line service providers to terminally ill patients, it is significant for them to learn the empowering impact that spirituality has on patients and assist them in identifying their spiritual distress needs.

For the purposes of this study spirituality was defined as a connection to something bigger than oneself and a search for finding meaning and purpose in life (Waaijman, 2002). When addressing spiritual needs it is essential for hospice nurses to take a genuine interest in the patient as a person, show genuine empathy, kindness, compassion, and take the time to listen and respect their patients' beliefs (Kellie, 2013). Ku (2010) focused on the spiritual needs of the patient not being properly met due to the nurses' lack of education, lack of time, confusion in understanding spirituality, training and lack of knowledge of the assessment tools available when assessing spiritual distress.

Research Questions

Based on the conceptual framework the following research questions were developed.

R1: What beliefs, perceptions, experiences and challenges do hospice nurses face when attempting to infuse spirituality within their healthcare?

R2: What is the experience of nurses in the use of existing tools and guidelines when assessing spiritual distress?

Theoretical Framework

When addressing the needs of terminally ill patients and how counseling this vulnerable population may impact the human need to improve the quality of life and assistance to accept death in a positive manner, hospice nurses are strategically placed at the bedsides of their population to ameliorate their patients' problems and enhance the quality of their patients' lives.

The whole-person approach is identified through techniques and skills of hospice nurses and other counseling professionals to look beyond the malady of their patients' circumstance and instead focus on the whole person Puchalski, 2008). In utilizing a holistic approach, counseling professionals that deal with death and dying can efficiently and effectively advocate for positive social change within their communities. Practitioners such as counselors, hospice nurses and all medical professionals involved in caring for vulnerable populations can engage in advocating so that human systems remain accessible, integrated, efficient and effective.

This study integrated Frankl's (1962) existential theory addressing the positive resources of spirituality and how it is utilized within counseling and other person-centered professions for coping and acceptance of illness and subsequent death. Frankl, addressed the "*will to meaning*" as the main focal point when assessing the purpose and meaning of life. He purported that an individual's fundamental preoccupation was searching for the meaning of life and finding purpose, drive and inspiration through all stages of life even the final stage of life (Frankl, 1962). Hospice nurses in particular assist their patients' address their spiritual distress needs and help them find the purpose and meaning of their circumstances with acceptance and strength. Thus, assessment tools and the criteria used to assess spiritual distress is a vital part of a holistic care approach.

Existential Psychology

As a holocaust survivor Frankl (1962) chronicled his experiences in an Auschwitz concentration camp. His psychotherapeutic method addressed the need for individuals to identify a positive purpose in life and then imagine themselves immersed within the outcome of that purpose. He introduced a theory named *logotherapy* which literally means "meaning." Logotherapy is often subsumed under the headings of humanistic psychology and existential

psychology. Frankl believed that the meaning of life was found in every moment of living and that life never ceased to have meaning even in suffering and/or death. Frankl believed that individuals have the freedom to either be depressed and/or miserable when life events are difficult or choose to accept their circumstances and move forward with strength. He proposed that once an individual in a dire situation loses hope…all is lost (Frankl, 1962).

According to the ANA (2012), hospice nurses must address the needs of their patients and help them accept their prognosis. Through their emotional connection hospice nurses are able to assist patients move forward with integrity and not despair. It is through this emotional connection that hospice nurses help their patients not lose hope and move forward with strength and acceptance. Hospice nurses connect with their patients to help them find peace, reconciliation and the deep meaning and purpose of life. They strive to assist them in finding their "true self" and through this process reach death with acceptance and integrity (ANA, 2012).

Evolution of the death and dying concept can alter psychological, physical, social as well as spiritual wellbeing (Waaijman, 2002). Frankl's (1962) therapeutic modality addressed the need for individuals to look within to find the meaning for their circumstances and to connect with others to find comfort and solace (Frankl, 1962). According to the National Hospice and Palliative Care Organization (NHPCO, 2010) nurses' main purpose is to identify the needs of their patients and assist them in finding solace, acceptance and comfort, with their prognosis.

Frankl (1962) believed that healing of the mind, body and soul needed to take place in the spiritual level. Through his existentialistic views and beliefs Frankl ascertained that in order for patients to accept and ultimately die with integrity they needed to be aware of their spirituality and capacity for meaning. Frankl suggested that individuals can always discover meaning and purpose in life regardless of circumstances. Logotherapy attempts to awaken individuals,

especially those that are suffering, in pain or dying of the importance of spirituality, freedom and personal growth all leading up to acceptance of death.

The Stage Theory of Grief

Kubler-Ross (1969) developed her theory of the five stages of grief identifying the emotions and feelings that individuals may face when they find they have a terminal illness. The five stages stemmed from the notion of not a neat little package that addressed each stage individuals must go through when facing death, but rather the stages that help identify some emotions that people may be feeling when faced with death. Denial, anger, bargaining, depression and acceptance are stages that help identify the emotions that may be present when dealing with death and dying.

The grief cycle may be considered a change model that helps identify how individuals deal with personal trauma and their reaction to it. It is used not only with death and dying but with any serious trauma that individuals may face (Kubler-Ross, 1969). Emotional trauma and shock are relative in terms of the impact they have on individuals. Life challenges are just a part of the cycle of life when speaking of not only death but events that significantly impact emotional balance. This model is meant to remind hospice nurses that the other person's perspective on situations may be different than their own, whether one is in shock or the one helping another to deal with the upset. Hospice nurses help patients face death by understanding the grief cycle and their spiritual distress needs to better assist them in facing these challenges.

Thanatology the study of death and dying stems from the Greek word thanatos meaning death. Kubler Ross (1969) is a thanatologist and considered her to have contributed to the creation of the genre of thanatology. Kubler-Ross was a catalyst in speaking and addressing death and dying and addressing the spiritual needs of individuals facing death. In her five stage

model which includes denial, anger, bargaining, depression and acceptance she initiates the importance of going through emotions that eventually and subsequently leads one to acceptance and spiritual wellbeing. The emotional response to trauma was viewed as a personal and sometimes unspoken. The five stage model although simplistic helps identify the emotions that people may face when dealing with a traumatic event.

The grief cycle is not a stringent step by step guide to emotions but rather a model or framework that helps individuals address their feelings (Kubler-Ross, 1969). Many times a stage may be revisited or skipped altogether depending on the individual and his or her interpersonal needs. Transitions into the stages may also be a smooth flow rather than a progression. In the five stage model Kubler-Ross (1969) acknowledged there to be an individual pattern of reactive emotional responses that individuals feel when coming to terms with a traumatic event such as death and dying. The five stage model emphasizes the words "time to heal" or "life goes on" and how people may be aware of the emotions that may be present when life challenges take place. The five stage model is based on the grief cycle model (Kubler-Ross, 1969).

Denial. Denial is a conscious or unconscious refusal to accept facts, information, reality, and so forth relating to the situation concerned. It is a defense mechanism and perfectly natural. Some people can become locked in this stage when dealing with a traumatic change that can be ignored. Death of course is not particularly easy to avoid or evade indefinitely (Kubler-Ross, 1969).

Anger. Anger can manifest in different ways. People dealing with emotional upset can be angry with themselves, and/or with others, especially those close to them. Knowing this helps keep individuals detached and non-judgmental when experiencing the anger of someone who is very upset (Kubler-Ross, 1969).

Bargaining. Traditionally the bargaining stage for people facing death can involve attempting to bargain with whatever God the person believes in. People facing less serious trauma can bargain or seek to negotiate a compromise. In this stage the individual is desperate and in need of believing in something larger than the self (Kubler-Ross, 1969).

Depression. Also referred to as preparatory grieving, in a way it's the dress rehearsal or the practice run for the 'aftermath' although this stage means different things depending on whom it involves. It's a sort of acceptance with emotional attachment. It's natural to feel sadness and regret, fear, uncertainty, and so forth. It shows that the person has at least begun to accept the reality (Kubler, Ross, 1969).

Acceptance. Again this stage definitely varies according to the person's situation. It is an indication that there is some emotional detachment and objectivity. People dying can enter this stage a long time before the people they leave behind do. Each individual must pass through their own individual stages of dealing with the grief (Kubler-Ross, 1969).

When Kubler-Ross published the book "*On Death and Dying*" in 1969, she became a trail-blazer for the hospice movement in the United States writing numerous books and articles. One of the books entitled *Living with Death and Dying* enlightened readers to prepare for death by encapsulating the fears associated with passing. Kubler-Ross was one of the first theorists to break the taboo of speaking of death and dying and helped medical professionals and individuals recognize that death is a natural part of life. Kubler-Ross's five-stage model introduced the need to identify the emotions that individuals may experience when a death occurs. Finding the meaning and purpose of life's circumstances and addressing the spiritual distress needs of their patients in Ross's opinion will lead patients to acceptance and ultimately spiritual well-being. Kubler-Ross believed that hospice nurses must connect with patients in order for them to

understand their spiritual distress needs. Ross is credited by the medical community for bringing mainstream awareness to the sensitivity required of hospice nurses and other medical professionals for compassionate treatment of their patients helping them find the meaning of yesterday and the purpose of their prognosis which will ultimately lead them to spiritual well-being and the acceptance of death.

Changes in Healthcare

It was determined by the Flexner Report in 1910 that there was no place for religion or spirituality in medicine. In the report Flexner claimed that it was strictly a scientific field, not a philosophical or theological one. However, in the mid 1900's there were several lay movements that began to emphasize the significance of incorporating religion and spirituality within the medical field finding that these factors were important in individuals accepting chronic illness and coping with suffering pain and anxiety and that these factors were significant when inner healing was necessary for survival (Duffy, 2011).

The American Association of Colleges of Nursing (2009) substantiated the implications of implementing spiritual care within health care stating they viewed spirituality as an essential feature of nursing. The majority of hospice nurses believed that spiritual care applied to atheists and agnostics as well as religious individuals (AACN, 2009). However, they struggled to differentiate each term between spirituality and religion and their personal beliefs of what spirituality was. Raffay (2010) identified the most significant spiritual needs as respecting the patient's privacy, dignity, religious and cultural beliefs; taking time to give patients support, reassurance especially at times of need; demonstrating genuine empathy and kindness and, allowing the patient to discuss his or her anxieties and fears.

Markland and Morley (2010) purported that spirituality must be clearly defined to recognize spiritual wellbeing or spiritual distress in patients. The process of holistic healing entails that hospice nurses provide care clearly and recognize the healing process and the power that spirituality has on their patients. According to Waaijman (2002) spirituality is about finding meaning in life and relationships to others (including a god or gods) and can be conveyed in many ways through art, music, nature, community or family.

Ross and Clark identified four themes when discussing spirituality in nursing and health-related literature: spirituality as the same as religion; spirituality as meaning and purpose in life as well as connection with others; spirituality as non-religious beliefs and value systems and spirituality as transcendent or metaphysical. Through these themes, it was apparent that spiritual needs can be viewed as completely non-religious or incorporated without religious beliefs (Ross & Clark, 2012). For many patients however, spiritual needs are religious in nature and to exclude religious features or separate them from spiritual needs could be detrimental to patients (Abbas & Dein 2011).

Spirituality deals predominantly with meaning and purpose to one's life. Although patients are going through pain, suffering and fear, spirituality impacts those in such a way that these negative feelings subside and acceptance is obtained (Waaijman, 2002). Hospice nurses should be able to ask patients questions that could enlighten them as to what concerns they are feeling or if they have any questions, fears or requests (Kellie, 2013).

Cohen, et al (2012) purported that individuals that were alive during the upper Paleolithic revolution believed that religion was a belief in worship of or obedience of supernatural power considered to be divine or to have control over human destiny. Pattison et al (2010) proposed that in a culturally diverse and multi-faith society, spirituality may be highly subjective and

uniquely personal. To some individuals spirituality is about giving meaning to life and understanding the purpose of one's life. To others, spirituality may provide hope which may influence overall health and attitude.

Evidence has shown that spirituality and religion play a crucial role in how terminally ill patients cope with chronic illness. (Koenig, 2009). In a meta-analysis of 1,200 peer- reviewed studies on religion, spirituality and health Koenig (2009) found considerable evidence to support the belief that spirituality and religious beliefs were positively correlated with coping skills and positive attitude health outcomes. Pargament (2007), a leading expert in the psychology of religion and spirituality substantiated this when he found that mental, emotional and physical health was positively influenced by a strong spiritual belief. The author alleged that a strong spirituality impacted the overall emotional wellbeing and psychological equilibrium of individuals especially patients going through chronic illness.

Campbell, Yoon, and Johnstone (2010) reiterated Pargament's views that meeting spiritual needs was correlated with improved quality of life and proposed that spiritual care can enhance a patient's overall emotional, psychological and inner-self wellbeing at the end of life. In a study conducted by Balboni (2013) 230 patients from diverse, ethnic backgrounds were interviewed. He found that 72% felt that their spiritual needs were overlooked and/or ignored completely which impacted their overall wellbeing. Balboni et al (2014) found that spirituality can contribute to the decision making process at end of life such as the choice to have or not have aggressive high risk treatments or resuscitation procedures.

Through these studies it was apparent that some researchers have considered spirituality a positive resource for coping and acceptance of illness, mental health problems and other emotional, psychological and physical concerns (Puchalski, 2008). Hospice nurses as well as

other counseling professionals need to differentiate between spirituality and religion when integrating a holistic approach within their care and utilize assessment tools and guidelines that will assist them in identifying the spiritual distress needs of their patients (Puchalski, 2008). Recognizing the differences between spirituality and religion is essential when attempting to understand the needs of patients.

Numerous studies suggested that effective assessment tools were needed to better understand the differences between religion and spirituality when attempting to integrate a holistic approach within the care of patients (Puchalski, 2008).This is especially significant in hospice care where emphasis is placed on the quality of life instead of the quantity of life and meeting a patient's spiritual and emotional needs (Wynne, 2013). Waaijman (2002), posited that the human spirit and/or spirituality is not easy to define. The author suggested there is an argument that the human spirit is indescribable and undefinable. The problem then becomes how to understand and investigate a phenomenon that is transcendent.

Nature of the Study `

A phenomenological design was selected for this study because I wanted to fully understand the criteria and guidelines that hospice nurses utilize in their practice to identify the distress needs of their terminally ill patients. Moustakas (1994) stated that in this type of study the researcher collects data from individuals who have experienced the phenomenon, and then develops a composite description of the essence of the experience for all of the individuals. Moustakas suggested that the description consists of "what" and "how" they experienced it. By using transcendental phenomenology, Moustakas argued that the procedure consisted of identifying the phenomenon being studied, bracketing out one's experiences and then collecting data from several individuals who have experienced that phenomenon. The researcher will then

be able to analyze the data by reducing the information to statements and then combine the statements to themes (Moustakas, 1994).

As the researcher, I collected data from eight hospice nurses working in the Pacific Northwest by interviewing them to better understand their perspective of the "what" and "how" of their experiences of implementing spirituality within their healthcare as well as their opinions of the effectiveness of the assessment instruments they utilized when assessing spiritual distress. Moustakas (1994) alleged that a qualitative approach offers a broad description of the lived experiences of participants and portrays the essence of that experience. In addition, phenomenology is used to explain the phenomena of behaviors that come alive in the moment they are perceived and offers the researcher the principal structures of the experience. I asked questions that were geared to stimulate conversation regarding the participants work with terminally ill patients and the criteria they utilized to assess the spiritual distress needs of their patients.

This qualitative study may enhance the understanding of how hospice nurses assess spiritual distress and the manner in which spirituality impacts the emotional, psychological and physical needs of patients. The key concepts investigated were the effectiveness of current reviews of the assessment instruments utilized to assess spiritual distress. A review of the nursing curriculum was also examined.

Definition of Terms

Definitions of important terminology in this study are provided in this section.

Holistic approach: A specialty in the field of nursing based on the philosophy of Florence Nightingale, who espoused treating the whole spiritual person rather that a single physical symptom or disease. Hospice nurses gain certification through special programs and often

become certified in complementary practices as well as in holistic nursing in general (Mueller, Plevak & Rummans, 2001).

Meaning: The way in which a person makes sense of his or her experience (Keegan, 1982).

Meaning-making: The state of deriving personal knowledge and significance from an Experience. It involves a person's interest, passion, or sorrows (Carlsen, 1988).

Nurse: A nurse is a person who is professionally trained to render healthcare services to another (ANA, 2012).

Hospice nurse: A hospice nurse practitioner is an advanced practice nurse who specializes in managing the symptoms of serious illnesses while also addressing the psychological and practical needs of his patients and his or her families. The scope of practice of a hospice nurse practitioner varies by jurisdiction, but may include providing ongoing health care services to patients, with an emphasis on relieving pain and helping patients to develop ways of coping with debilitating symptoms so that they can maintain a high quality of life for as long as possible. If it becomes clear that a person's condition will eventually result in death, the hospice nurse practitioner may provide assistance in making various types of end-of-life decisions. It should be noted, however, that palliative care is not restricted to patients who have terminal conditions and is not the same as hospice care, which is typically reserved for those who are expected to die within six months and does not have recovery as its goal (The national hospice and palliative care organization, 2012).

Purpose: One's determination or intention of accomplishing a task (Kabalarian Philosophy 1930).

Religion: An organized set of beliefs and principles relating to a particular faith (Barry, 1998)

Spirituality: It is an active process in which growth occurs, therefore, the person becomes increasingly aware of meaning, purpose, and values in life. There is a two-directional process occurring, horizontally and vertically. The vertical process moves the individual into a closer relationship with a higher being, as conceived by the individual. It is not unusual for a person to develop the horizontal and not the vertical process. Individuals may describe their spirituality in terms of relationships, art, or music and never develop a relationship with a divine being (Carson, 1989).

*Spiritual care: A*ny service rendered to another person that positively influenced his or her life (Carson, 1989).

Spiritual need: The desire of finding satisfaction to that which gives meaning and purpose to life, as defined by that person, whether it relates to a higher power or the relationships with others (Stallwood, 1975).

Spiritual distress: Experiencing a disruption in one's life. (Kim, McFarland & McLane, 1987).

Spiritual wellbeing: A nurturing relationship that exists between oneself, a higher power or an ultimate reality or with others that contributes to wholeness (Cook, 1998).

Terminally Ill: An individual has a fatal illness, something that can't be cured and will eventually lead to death (Maxen, 2000).

Transpersonal: The profound and superior experiences that go beyond the ordinary or average experiences (Scotton, Chinen & Battista, 1996).

Assumptions, Limitations, Scope and Delimitations

This study was based on the following assumptions:

- Hospice nurses have the skills, awareness and knowledge of spirituality to work with terminally ill patients.
- Hospice nurses will be authentic when responding to the interview questions.
- Hospice nurses use spirituality within their healthcare.

The study was conducted using a sample of eight hospice nurses working in Pacific Northwestern State. The hospice nurses were employed by a single site. A delimitation of the study was the omission of the other routines and responsibilities of nursing care such as blood tests, blood pressure assessment and medications utilized by nursing professionals.

Significance and Social Change Implications

This study was significant because it explored how hospice nurses and other human service professionals such as counselors, psychologists and person-centered practitioners assess the spiritual distress needs of vulnerable populations such as the terminally ill and those individuals facing excruciating circumstances. Through analyzing the perception of eight hospice nurses I identified some challenges that they faced when assessing spiritual distress. Some of the challenges included the effectiveness of the assessment instruments utilized to assess spiritual distress, their training and spiritual courses and their personal biases of spirituality. A possible contribution to social change will be to enlighten healthcare administrators, counselors, psychologists and other human service professionals of the importance of providing further education, training and workshops in spirituality.

Summary

Hospice nurses provide not only medical attention to their terminally ill patients but also must address their emotional, psychological and spiritual distress needs. Part of the holistic approach is the need for hospice nurses to first define and understand the meaning of spirituality and secondly to assess the spiritual distress needs of their patients. Many times as addressed by Puchalski (2008) hospice nurses are confused as to how and when to utilize a spiritual approach with their patients and as a result become frustrated and unable to fully grasp the importance of utilizing spirituality within their practice.

Chapter 1 presented an overview of the problem, nature, purpose and significance of the study as well as social change implications. This chapter addressed the methodology that I used to better understand the purpose and significance of this study. Chapter 2 will provide a detailed literature review of peer reviewed articles, journals and the theoretical foundations that contributed to the overall understanding of the impact of spirituality in healthcare.

Chapter 2: Literature Review

In Chapter 2, I present an extensive literature review to address the impact that spirituality has had on the overall emotional, physical and psychological health of terminally ill patients and the assessment instruments utilized by hospice nurses to assess their patient's spiritual distress needs. Along with the literature review, I provide a theoretical foundation that allowed me to delve deeper into the topic of spirituality and the impact it has on terminally ill patients. I also address the manner in which hospice nurses have assessed spiritual distress. I explored the core of information to better understand the importance of spirituality on health and healing and provide a literature search strategy to assist the reader in understanding where the information originated from.

In this study, I addressed the assessment instruments utilized to assess spiritual distress in a detailed, comprehensive literature review. The study highlighted the immense power that spirituality had on several areas of the brain and the benefits of infusing spirituality within healthcare to assists in the emotional, psychological and physical wellbeing of terminally ill patients. In Chapter 2 I addressed the challenges that many hospice nurses have faced when assessing spiritual distress.

Literature Search Strategy

When visiting the Walden, Argosy, Grand Canyon and Purdue University libraries and the United States National Library of Medicine/Nursing and Institutes of Health, I came across many peer reviewed articles, journals and books related to my topic of interest. My search narrowed when using and following these databases: Academic Search Premier, MEDLINE, PsycARTICLES, CINAHL plus, PsycINFO, PsycBOOKS and SocINDEX, PROQUEST religion. The search was expanded to include death anxiety and different terms that could be

linked death and dying. The expansion of terms also included: Spirituality, fear of recurrence, fear of death and dying and Erik Erikson's Psychosocial Theory of Human Development, Viktor Frankl's Meaning of Life and spiritual wellbeing, nurses, holistic approach, despair, spiritual distress and spiritual wellbeing which were the keywords/phrases used to search. The search was then expanded to include death anxiety, spirituality, Belief in a higher power and logotherapy. Further expansion of the search included identifying references for the articles found and then narrowing to the specific title, author, phrases that were and could be applicable to my topic of interest.

I drew references from not only the original works and theorists but also the sections of specific articles. These articles and sections accounted for the most used to make up this literature review. However, more emphasis was placed on literature written in the 5 five years.

Theoretical Foundation

Here I addressed Frankl (1962) and Kubler-Ross (1969) theories. In the rest of the chapter, I provide a detailed review of the studies examining the importance of utilizing spirituality within healthcare and the stages that many patients and family members may face when a terminal illness is evident. I also discuss the impact that spirituality has had on not only the emotional and psychological needs of terminally ill patients but their physical needs as well.

Existential Theory

Frankl's (1962) psychotherapeutic method addressed the need for individuals to identify a positive purpose in life and then imagine themselves immersed within the outcome of that purpose. He introduced a theory and named it logotherapy which literally means "meaning." He believed that the meaning of life was found in every moment of living and that life never ceased to have meaning even in suffering and/or death.

Existential theorists such as Frankl (1962) and Maslow (1954) shared the belief that individuals had the capacity of self-awareness and choice. Maslow developed the hierarchy of needs pyramid addressing the largest most fundamental physiological needs at the bottom of the pyramid and the most advanced, self-actualization needs at the top. Maslow believed that each layer of the pyramid must be fulfilled before moving up the pyramid to higher needs. The first four needs include only deficit needs which are the basic requirements for physical and emotional well-being. The highest of the pyramid is self-actualization which is associated with growth, and being needs these needs create a desire for fulfillment, meaning, purpose and resolution. Maslow suggested that once an individual acquires and fulfills a need, he or she can and will advance to the next level throughout his or her lifespan. Both Maslow and Frankl believed that with understanding the need to find fulfillment and meaning in life individuals move forward with strength and accept their destiny with integrity.

For example, Rogers (1961) another influential existentialist suggested that individuals had the capability of finding philosophical meaning in the face of anxiety by choosing to think and act authentically and responsibly. Perls (1969) a prominent existentialist who developed Gestalt therapy addressed the need for individuals to become aware of their sensations, perceptions, bodily feelings, emotions and behavior and to live in the present moment even when faced with death. Existentialists have agreed that individuals had the greatest stress from anxiety over loneliness, isolation, despair and ultimately death. These existentialists purported that individuals had the freedom to choose to be depressed and hopeless when life events were difficult or choose to accept their circumstances and move forward with strength. Frankl proposed that once individuals in a dire situation lose hope…all is lost.

Existentialists have posited that true human existence represents the desire to touch others

and to find the purpose of one's life (Frankl, 1962). The evolution of the death and dying concept can alter psychological, physical, social as well as spiritual wellbeing. These theorists addressed the need for individuals to look within to find the meaning of their circumstances and to connect with others to find comfort, solace and ultimately acceptance (Frankl, 1962).

Existentialist identified the search for meaning in life as the primary force in human beings. In Frankl's (1962) approach there are three philosophical and psychological concepts: the freedom of will, the will to meaning and meaning in life. The first concept the freedom of will refers to human beings as being free to achieve goals and purposes. The second concept the search for meaning, suggests that meaning is the primary motivation of humans. When individuals cannot identify their third concept the will to meaning they will experience a dreadful doom of meaninglessness and emptiness (Frankl, 1962).

For example, as human beings strive to search for meaning and purpose, in doing so individuals reflect on their lives and experiences and those they have touched and connected with. When faced with death individuals have a need to look towards others for guidance, connection and assistance. According to Frankl (1962), humans' primary motivation is their will to meaning even when faced with death. Frankl postulated that human beings have the inner freedom to conquer their fears and anxieties by finding the meaning of their circumstances and to move forward with strength. Frankl believed that life was unconditionally meaningful no matter what dire circumstances were present. Frankl suggested that ultimate meaning must exist in order to find a meaning in all life situations, even death. Existentialists such as Rogers (1961) believed that in order for individuals to grow and find purpose and meaning in life they must have an environment with individuals that will provide them with genuineness, positive regard and empathy. These are the same qualities that hospice nurses should have when working with their

patients.

Accepting Death

According to Kubler-Ross (1969) and O'Rourke (2010), there are numerous stages of death, dying and grief. These stages attempt to identify the need to view death as a transition of life itself and not to fear. The authors each believed that accepting death as a friend and not an enemy would enable individuals to be at peace with their own finiteness. For example, O'Rourke (2010) addressed the five stage model of family grief. The author purported that although all families grieve differently and may not go through each stage there is a consensus of stages that one may go through when a family member is faced with death (O'Rourke, 2010).

The first stage is the crisis stage. This stage is initially felt with anxiety and disrupts the entire equilibrium of family members. If the relationship with the terminally ill family member was strained or alienated many members may initially feel guilt, resentment and many times anger. Stage two is considered the unity stage. This stage is when all family members come together to discuss the needs of the dying patient. The role of each family member is defined and a medical team is chosen. Family members begin to discuss critical legal work, wills, living wills and navigate through social services.

Stage three according to O'Rourke (2010) addressed the upheaval that family members may face. At this point, if the patient's process of dying goes on for an extended period of time family members undergo significant changes. They are not as unified as in stage two. Many emotions such as guilt, anger and resentment are likely to emerge. Family members find the need to honestly communicate their feelings with other family members and trusted loved ones. Many times during this stage, families begin to fall apart if some members choose to suppress their thoughts and feelings about their upheavals. Stage four consists of resolution. This is the stage

when family members begin to have more memories of their terminally ill loved one. Good and bad experiences are shared and reflected upon. Some of these memories may evoke feelings of nostalgia and joy while other memories can arouse anger, jealousy envy and hate.

In this stage each family member has an opportunity to resolve longstanding issues, some may find the need to heal old wounds and clear their mind allowing the family's roles to change. It is a time to resolve problems and move forward. Stage five the final stage according to the authors is considered the renewal stage. This stage consists of the funeral and the celebration of life for the deceased. This time involves mixed emotions which may include sadness and relief. If the family members resolved and successfully negotiated the previous 4 stages the fifth stage should be a time of acceptance and remembrance. It is a time to look forward, revitalize relationships and to create new family traditions.

Just as O'Rourke (2010) addressed the stages of family grief, Kubler-Ross and Kessler (2005) pioneered approaches in counseling, personal trauma, grief and grieving related to death and dying. Through her efforts to improve the understanding and practices of bereavement and hospice care, Ross was able to dramatically improve the personal impact that trauma had on individuals. For example, Kubler-Ross and Kessler suggested that when an individual's spiritual self as well as physical self-meet there is a mind and body connection.

Kubler-Ross and Kessler (2010) believed that this connection between the mind and spirit was an extension of the physical body and will live on forever. Kubler-Ross and Kessler proclaimed that hospice nurses must connect with their patients and show genuine empathy and compassion in order to assess their spiritual distress needs. She purported that the values accumulated in ones' life and the values one holds dear are the core systems that will shape and guide their acceptance and views of death.

Kubler-Ross (1969) developed her theory of the five stages of grief identifying the emotions and feelings that individuals may face when they find they have a terminal illness. The five stages stemmed from the notion of not a neat little package that addressed each stage individuals must go through when facing death, but rather the stages that help identify some emotions that may be felt when facing with death. Denial, anger, bargaining, depression and acceptance are stages that help us identify the emotions that may be present when dealing with death and dying.

The grief cycle may be considered a change model which helps identify how individuals may deal with personal trauma and their reaction to it. It is used not only with death and dying but with any serious trauma that individuals may face (Kubler-Ross, 1969). Emotional trauma and shock are relative in terms of the impact that it has on individuals. Life challenges are just a part of the cycle of life when speaking of not only death but events that significantly impact our emotional balance. This model is meant to remind individuals that the other person's perspective on situations may be different to their own, whether they are in shock or the one helping another to deal with the upset. Hospice nurses assist patients face death by understanding the grief cycle and where within the cycle the patient is to better assist them in facing these challenges.

In Kubler-Ross's (1969) five stage model denial, anger, bargaining, depression and acceptance the author initiates the importance of going through emotions that eventually and subsequently leads one to acceptance and spiritual wellbeing. The five stage model, although simplistic helps identify the emotions that individuals may face when dealing with a traumatic event. The grief cycle is not supposed to be a stringent step by step guide to emotions but rather a model or framework that helps us address our feelings (Kubler-Ross, 1969).

Many times a stage may be revisited or skipped altogether depending on the individual and their interpersonal needs. Transitions into the stages may also be a smooth flow rather than

progressive. The five stage model acknowledges there to be an individual pattern of reactive emotional responses which individuals feel when coming to terms with a traumatic event such as death and dying.

Kubler- Ross (1969) laid the foundation for future researchers addressing the need to understand that certain events in life lie outside one's control. Acceptance of change is ultimately what this theorist strived to address. The theorist was a trail blazer for hospice nurses in helping them understand the importance of connecting with their patients in order to assist them through the process of death and dying and ultimately find spiritual wellbeing. Through Kubler- Ross's (1969) theory the spiritual and holistic approaches and end-of-life issues found that no matter what culture, differing experiences and/or physical handicaps individuals may go through the overall goal was to seek out the meaning and purpose of life and existence and to find spiritual wellbeing and acceptance.

Spirituality and Health Care

Puchalski, Ferrell and Virani (2014) believed that spirituality was a fundamental facet of nursing and that spiritual care had little to do with religion. The authors purported that even atheists and agnostics relished in the spiritual care approach. These authors suggested that spirituality is predominantly concerned with meaning and purpose in life. For example, for many individuals having a strong spiritual belief may consist of family, friends, significant others and anything that is sacred to the individual. For others, spirituality may consist of following a higher power and serving others through their understanding of what is expected of them through their spiritual beliefs. When addressing spiritual needs it is then essential for hospice nurses to take a genuine interest in the patient as a person and understand what spirituality means to them. For example, The ANA (2012) suggested that the hospice nurse must connect with their patient and

show genuine empathy, kindness and compassion. They must also take the time to listen and respect the opinions, views and beliefs of their patients without personal biases.

Despite understanding the importance of integrating spirituality within the healthcare system and the beneficial components associated with this implementation there are still hospice nurses that feel they are not meeting the spiritual needs of their patients (Ferrell & Baird, 2012). Part of the problem is differentiating between spirituality and religious beliefs. According to a recent Gallup Poll, 81% of Americans say that religion is fairly or very important in their life (Gallup, 2012) Although religion and spirituality are not the same, the words are often used interchangeably making it difficult for many hospice nurses to pin-point just what spirituality means to each unique patient.

For example, an individual may feel a strong, immense spirituality and yet have no affiliation with any particular religion. Due to this problem many hospice nurses find it difficult to assess their patients' spiritual needs and thus address their medical care to align with these needs. According to the National Hospice and Palliative Care Organization (2012), spiritual care's predominant concept of spiritual needs is to find a sense of purpose and meaning in one's life when a terminal illness is diagnosed.

The purpose of this study was to explore how hospice nurses assessed the spiritual distress needs of their patients and how they perceived the assessment instruments utilized in assessing spiritual distress. Hodge and Limb (2012) purported that the development of spiritual assessment instruments at end of life should be considered from the perspective of palliative care patients, their families and healthcare professionals. For example, these authors addressed the need to utilize assessment instruments that were simple enough to use in everyday clinical settings

however, assessed that few instruments were cross-culturally effective and simplistic enough to do so.

Hodge and Limb (2012) addressed the complex construct of defining spirituality and thus a unique, face-to-face assessment of what spirituality is for each patient must be explored before using a specific assessment instrument. Hodge and Limb (2012) asserted that yearly assessment instruments should be available to assess and screen individuals throughout their life within annual visits to their physicians and throughout follow-up visits. The authors purported that spiritual needs may change and modify during the progression of the disease and thus should be assessed more than once with each patient.

According to Puchalski et al., (2009) there are numerous advantages of becoming familiar with patients' spirituality. In the USA Weekend Faith and Health Poll (WFH, 2012) 65% of patients felt that it was a good idea for health care professionals to speak with them about their spiritual beliefs, yet only 10% felt that medical professionals had such a conversation with them. In a study by Ehmen and Short (2011) of pulmonary outpatients at the University of Pennsylvania found that 66% agreed that a medical professional's inquiry about spiritual beliefs would strengthen their trust in their medical practitioners. Ninety-four percent of patients to whom spirituality was significant wanted their medical team to address their spiritual beliefs and be sensitive to their values and beliefs. Fifty percent of those patients whom spirituality was not important felt that their medical team should have at least inquired about spiritual beliefs in cases of serious illness.

According to Pargamenti (2007) a leading expert in the study of religion and spirituality at Bowling Green State University, from a medical health professional's standpoint understanding patients' spirituality is valuable because spirituality may be a dynamic in understanding the

disease and many times religious convictions may impact health care decision making. For example, spirituality may be a patient need and may be important in patient coping and acceptance of prognosis.

In order to provide spiritual care, the Joint Commission on Accreditation of Healthcare Organization (JCAHO, 2013) purports that hospice nurse's practice compassionate presence by being fully present and attentive to their patients' needs and being aware of their physical, emotional and spiritual needs. They should also attentively listen and be aware of their patient's fears, hopes, pains and dreams by obtaining a spiritual history. It is imperative that they are attentive to all the dimensions of their patient's body, mind and spirituality and implement a spiritual approach as appropriate.

According to the JCAHO (2013) the spiritual history of patients is significant and should be addressed with each patient individually. It is important for hospice nurses not to ridicule or judge patients' beliefs and spiritual views. When addressing the spiritual needs of patients it is significant to understand that patients come to medical professionals to seek care for their medical needs and condition. In delivering this care, medical professionals must be respectful and understand the spiritual dimension in patients' lives. Hospice nurses are in the position of power with patients and patients seek assistance in vulnerable times. If hospice nurses suggest a specific religion/spiritual belief or mock a patient's belief the patients might adopt that professional's belief out of fear of disagreeing with a perceived authority.

According to Puchalski and Ferrell (2011), the past few decades have brought about a more caring, spiritual and service oriented approach to care for terminally ill patients. The authors purported that a more balanced and thorough healthcare approach has been infused when caring for the terminally ill. This change is primarily due to healthcare regaining a much more spiritual

perspective. Hence, the medical field has once again infused a combination of technological advancements and a holistic approach to care for their patients (Puchalski, 2013). For example, a holistic approach is fulfilled by hospice nurses spending time with their patients and attempting to fully connect with their patients to understand their religious or spiritual distress needs (Puchalski & Romer 2011).

Muldoon (2010) purported that the word compassion means to "suffer with." Hospice nurses should have compassion for their patients and emotionally connect with them in the midst of their pain to attempt to understand their spiritual distress needs and assist them in accepting their circumstances. Frankl (1962) wrote "Man is not destroyed by suffering; he is destroyed by suffering without meaning" (p.117). One of the many challenges that hospice nurses may face is to assist patients to find meaning and acceptance in the midst of suffering and chronic illness.

Terminally ill patients are not only struggling with the physical aspects of their disease, emotional and spiritual suffering is also felt leading to an inability to engage the deepest questions of life (Puchalski & Romer 2011). Many patients may be asking questions such as why is this happening to me. What will happen to me after my death? Will my family survive my loss? Will I be missed? How will I be remembered? Many hospice nurses are expected to respond to these questions and thus need to understand the spiritual needs of their patients (Puchalski, Cobb & Rumbold, 2012).

According to Anandarajah (2014) hospice nurses need to respond to the questions and concerns that patients may have and assist them in accepting their prognosis. Through this acceptance healing can be experienced emotionally, psychologically and physically. Puchalski and Romer (2011) suggests that this healing at its core is a spiritual healing.

Balboni (2014) identified two examples that dealt with questions related to meaning and

purpose in life. The author suggested that either patients desired to be remembered through family and friends or through life's accomplishments or individuals desired to be remembered through their personal achievements. For example, Balboni (2014) purported that when patients reflect on their lives after being diagnosed with a terminal illness they are more at peace if their lives have had strong connection with others and they had made the world a better place.

Spirituality has been recognized by numerous authors as an essential evolving task for those with terminal illness (Berg, Crowe, Wong & Siebert, 2010). The authors argued that the impact that spirituality has on health and healing is significant and that spirituality plays a major role in determining the extent of pain and suffering the patient will endure. For example, numerous studies have addressed the positive impression that spirituality has on individuals, these studies are categorized into three major areas.

Mortality

Some observational studies suggest that individuals who have regular spiritual practices tend to live longer (Koenig, 2009). For example Koenig (2009) purports that individuals that are involved in religious or spiritual activities or are personally more spiritual feel better emotionally which helps them live longer and healthier lives. For instance, in a study by Murphy and Walker (2013) the authors purported that individuals that are spiritual experience lower levels of depression and anxiety, display signs of better health and have lower blood pressure and fewer strokes than those individuals that were not spiritual.

Coping

Many individuals that are spiritual may use their beliefs in coping with illness, pain and life stresses (Puchalski, 2014). For example, in a study by Koenig (2009) individuals who are spiritual tend to have a more positive outlook and a better quality of life. In a study of 150

patients diagnosed with advanced cancer who found comfort and solace from their spiritual beliefs were more satisfied with their lives, were happier, and had less pain, depression and anxiety than those that had no spiritual connection.

Puchalski, Ferrell and Virani (2010) reiterated the significance of a strong spiritual belief and the essential part of the existential domain measured in quality of life scores. Positive reports on those measures, a meaningful personal existence, fulfillment of life goals and a feeling that life to that point had been worthwhile. This was correlated with a good quality of life for patients with advanced, chronic and terminal illness.

Spirituality and Pain Control

Many studies have also addressed the role that spirituality had on pain. For example, a study conducted by Monod, et al., (2011) suggested that spiritual wellbeing was related to the ability to enjoy life even in the midst of symptoms, including pain. The authors believed that spirituality may be a significant important clinical target. The authors purported that the results of a pain questionnaire distributed by the American Pain Society (n.d.) to hospitalized terminally ill patients demonstrated that personal prayer was the most commonly utilized non-drug method of controlling pain. Seventy-six percent of the patients expressed experiencing less pain after prayer (Monod et al., 2011). Through this study it was significant to view how spirituality helped patients cope with chronic illness and pain. In another study by Nelson-Becker (2009) ninety-three percent of 108 women expressed that prayer and a strong spiritual belief assisted them in coping with their diagnoses of gynecological cancer. In addition, seventy-five percent of these patients stated that spirituality had a significant place in their lives and 49% addressed that they had become spiritual after their diagnosis.

In a study by Ironson (2008) ninety-percent of HIV-positive patients who were spiritually

active had less fear of death and less pain. This is substantiated by Nixon et al. (2013) where a random gallop poll asked individuals what concerns they would have if they were diagnosed with a terminal illness. Their top issues were finding companionship and spiritual comfort, chosen over advanced directives, economic/financial concerns, and social concerns. Those who were surveyed cited several spiritual reassurances that would give them comfort and solace.

For example Anandarajah (2014) reported that the most common spiritual reassurance cited were beliefs that they would be in the loving presence of God or a higher power, that death was not the end but a passage, and that they would live on through their children and descendants. In a study by Wynne (2013) bereavement was considered one of life's greatest stressors. For example, in a study of 145 parents whose children had died of cancer, 80% received the most comfort due to a strong, spiritual belief. Those parents had better physiologic and emotional adjustment than those parents that had no spiritual connection. In addition, 40% of those parents reported a strengthening of their own spiritual commitment over the course of the year prior to their child's death.

Recovery

Spirituality tends to enhance recovery from illness and surgery. In a study by Balboni et al., (2014) heart transplant patients that participated in religious or spiritual activities and stated that these activities were significant had improved physical functioning at the 12 month follow up visit, had higher levels of self-esteem, less anxiety and fewer health worries. The authors concurred that in general, individuals who don't worry as much tend to have better health outcomes.

Kaptchuk et al., (2009) suggested that the ability to tap into one's inner spiritual soul to heal was significant. The authors viewed the physician-patient relationship as having a placebo effect

as well. The authors suggested that there were three components that contributed to the placebo effect of the patient-physician relationship: 1) Positive beliefs and expectations on the part of the patient 2) Positive beliefs and expectations on the part of the physician or health care professional and 3) a good relationship between the two parties.

According to Kaptchuk et al., (2009) spiritual practices have been shown to improve health outcomes. For example, in the 1960's Herbert Benson a medical doctor and founder of the mind/body medical institute in Massachusetts was one of the first western physicians to bring spirituality into his medical practice. Benson (1998) began research on the effects of spiritual practices on health. He suggested that individuals who practiced transcendental meditation for ten to twenty minutes twice daily led to a decreased metabolism, heart rate, respiratory rate and slower brain waves.

Kaptchuk et.al (2009) reiterated Benson's research and findings stating that meditation was beneficial for the treatment of chronic pain, insomnia, anxiety, hostility and depression, and was a useful aide to treatment for patients with cancer or HIV. The authors also purported that the relaxation response in meditation was an effective aide when working with terminally ill patients. They concluded that any disease that is caused or made worse by stress, would lessen and even heal when the relaxation response is a part of therapy.

The Spiritual Distress Assessment Instrument

Of the thirty five spiritual assessment instruments used by hospice nurses only one came closest to assessing spiritual distress although was not developed for that purpose. It is The Spiritual Distress Assessment Tool (SDAT). This instrument was developed to assess spiritual distress in hospitalized elderly patients and specifically developed for Chaplains working with this population. The hypothesis was made by the developers of this instrument that spiritual

distress comes about from unmet spiritual needs. The greater the degree to which a spiritual need remains unmet the greater the disturbance in spiritual distress (Monod et al., 2010).

The validity of the SDAT was assessed by the authors and was not possible since there was not a consensus as to the definition of spirituality or the dimensions that characterized spirituality. However, face validity, considered as being a particular type of content validity was assessed. Face validity refers to whether individuals not involved in the development of an instrument perceived it as measuring what is intended to be measured (Monod et al., 2010). Hospital chaplains experienced in hospital pastoral care, who had not been in any way involved in the development or use of the SDAT, perceived the assessment tool as able to measure a patient's spirituality (Monod et al., 2010). The results suggested that the SDAT is an acceptable tool when assessing spiritual distress in hospitalized elders however further research is needed to assess the SDAT's effectiveness with other populations (Monod et al., 2010). Further exploration is also needed to test its psychometric properties before it is applied in intervention studies and the impact of spiritual distress on health outcomes and patient prognosis (Monod et al., 2010).

The Spiritual Distress Assessment Tool (SDAT) although developed for hospitalized elderly patients has been used to assess spiritual wellbeing in other hospitalized patients (Monod et al., 2010). A semi-structured interview within the SDAT allows patients to speak about spirituality and express their views and beliefs in their own words and from very different perspectives (Monod et al., 2010). Ultimately, the limitations and quality of the SDAT will be judged by the dissemination and sustainability of its use by hospice nurses and chaplains (Monod et al., 2010). The use of the SDAT is conditional on the availability of staff experienced in interdisciplinary care and with access to appropriate training and education of the SDAT (Monod et al., 2010).

The FICA Assessment Instrument

The FICA assessment instrument was developed by Christina Puchalski (2010) a medical Doctor at the George Washington School of Medicine and international leader in the movement to integrate spirituality into healthcare in both the clinical setting and in medical education. The FICA instrument is a yearly assessment tool used to assess and measure patients' spiritual needs. It is a spiritual history tool and used as a guide for clinicians to combine open-ended questions regarding spirituality into a comprehensive, standard history of the patient. The instrument was developed to provide clinicians and all medical professionals working with patients a quick and easy means to conduct a spiritual history. The FICA should be utilized in all yearly follow-up visits to physicians which enables clinicians to make the appropriate referrals depending on the findings and the tool should be integrated within the chart of the patient when admitted to hospitals or hospices.

FICA stands for the *F: Faith and Belief* of patients the *I: Importance* and the *Influences of others.* The *C: Community* asks the question are you part of a spiritual or religious community? And the *A: Address /Action* think about what you as the hospice nurse or medical professional needs to do with the information that the patient has shared. The FICA gathers pertinent information from the patient and addresses their spiritual needs. According to Puchalski and Ferrell (2011) the spiritual history of patients is as important as the social history. For example, a spiritual history may help medical professionals recognize the spiritual distress needs of patients and if a referral would need to be made based on the findings. It opens the door to conversation about values and beliefs, uncovers coping mechanisms and support systems, reveals positive and negative spiritual coping, and provides an opportunity for compassionate care.

The Nursing Curriculum

According to JCAHO and the North American Nursing Diagnosis Association (NADA) meeting the spiritual distress needs of patients is a requirement for hospice nurses. However, due to the vague definition of spirituality and the lack of education in spiritual care many nurses are reluctant to develop and use skills in providing spiritual care. Many hospice nurses have expressed the fear of invading a patient's privacy, lack of time, education, training and lack of awareness of their own spirituality as the primary reasons for this deficiency. According to Becker (2008) many hospice nurses do a good job of addressing the mind and the body of patients, however leave the spiritual part out due to their inability to understand spirituality.

According to Sessanna, Finnell, Underhill, Change, and Peng (2011) preparing nursing students to address spiritual distress needs is oftentimes a challenge. While hospice nurses confirm the importance of meeting the physiological and psychological needs of their patients, acknowledging the spiritual needs of their patients is many times overlooked. Although the (JCAHO) as well as the American Association of Credentialing Nursing (AACN) and the National Council State Boards of Nursing (NCSBN) require nurses to recognize the spiritual care of patients many times this mandate is disregarded.

In a study conducted by Tiew and Creedy (2010) there is a scarcity of information addressing the graduate nurse's perception of what spirituality is and the role that they play when addressing the spiritual distress needs of their patients. An examination of senior graduate nursing student's perceptions of spirituality and the challenges of including spiritual care within their clinical practice was addressed. In addition to graduate nursing perspectives of spirituality, nursing faculty provided their perspective on the inclusion and effectiveness of spirituality in the nursing curriculum.

According to Tiew and Creedy (2010) the nursing literature contained little to no information in directing educators when planning to integrate spirituality in the nursing education curriculum. An exploration of the nursing education curriculum from the beginning of course work until graduation to address the spiritual distress needs of the patient was explored. The authors found that many nursing programs, especially in secular nursing programs which were non-religious or non-spiritual included minimal content addressing the spiritual needs of patients and how to integrate spirituality within the healthcare approach.

According to Ku (2010) the greatest disconnect in nursing education is the failure to prepare nurses for spiritual challenges while expecting them to meet the spiritual distress needs of their patients. Minimal content is included in the nursing curricula addressing spirituality and there is little to no direction for faculty on how to develop spiritual values in the nursing curricula and to the student nurse. Mayers and Johnson (2008) believed that nurses' lack of preparedness and education to provide spiritual care is due in part by the lack of appropriate courses in nursing curriculum.

This is reiterated by Mackinlay (2008) addressing that many health care providers consider themselves as religious or spiritual however, may lack the formal education that could prepare them to integrate spirituality within their healthcare approach. In addition, many of them may not know where to obtain the appropriate courses to enhance the information they already have. There are few workshops or programs available and dedicated to the spiritual health care of patients and this lack of education may cause many hospice nurses to be uncomfortable when assessing their patients spiritual distress needs and provide them with spiritual care.

The Society of Critical Care Medicine (SCCM, 2012) recommends that both nurses and physicians receive extensive education, training and awareness of spiritual and religious issues to

properly assess their patients' spiritual needs. According to the SCCM (2012) many physicians and hospice nurses underestimate the degree to which patients would like their concerns and beliefs regarding spiritual or religious issues addressed. The deficiency of spiritual and religious care is substantiated by The American College of Physicians Organization (ACOPO, 2012). It was alleged at a consensus panel meeting that although medical professionals were aware of their responsibility to extend their care for patients with serious illness by attention to psychosocial, existential, or spiritual suffering it was determined that many medical professionals expressed their lack of expertise in those areas and disregarded the spiritual distress needs of their patients. In addition, the Association of American Medical Colleges (AAMC) convened a consensus group of Deans and faculty of medical schools across the U.S to determine key elements of medical school curriculum. The report listed the essential attributes of physicians and found that they should be altruistic, and must be compassionate and empathic in caring for their patients. They must also seek to understand the meaning of the patients' spiritual or religious stories in the context of the patients' beliefs and values.

Defining Spirituality

Puchalski, Ferrell and Virani (2014) claimed that spirituality was an integral part of healing however they believed that few hospice nurses met the spiritual distress needs of their patients. In part, the problem is the definition of spirituality and what it means to each unique individual. For example, the authors purported that spirituality would change at specific junctures of the illness and that hospice nurses needed to be astute enough to know when and how these changes took place and what alterations if any needed to be made by the healthcare team.

This is supported by Garcia and Koenig (2014) in a study of 4,000 hospice nurses were asked to express their opinions of spirituality within their practice and if they felt that they had

met the spiritual distress needs of their patients. Although it was found that spirituality was extremely important and may improve the overall quality of the patients' emotional and physical health, only five percent believed they addressed the spiritual distress needs of their patients due in part to the difficult task of defining what spirituality was to each patient. This is supported by Balboni (2014) who in a study of 230 patients from diverse ethnic backgrounds suffering from advanced cancer found that 72% believed that their spiritual needs were overlooked or minimally supported by their healthcare team.

Part of the problem according to Ferrell and Munevar (2012) was the lack of a clear definition of spirituality. Many times spirituality is associated with religion and while they may interlink they are not synonymous. The authors purported that spirituality was about finding meaning and purpose in life and understanding the meaning in relationships to others including a god or gods. Religion on the other hand is oftentimes about being an active member of a religious community which may involve prayer, attending religious services and believing in a common god.

Understanding the differences between spirituality and religion is an integral part of incorporating it within such a science-based setting (Puchalski, Cobb & Rumbold 2012). Clear, detailed and comprehensive definitions are essential. Hospice nurses need to be aware of these differences in order to assist their patients and assess their spiritual distress needs.

In a study by Koenig (2009) both religion and spirituality were reviewed. The author addressed the importance of defining and differentiating between religion and spirituality and how they each influenced mental and physical health. Koenig (2009) purported that there was much controversy and disagreement concerning definitions within research, particularly over the term "spirituality." The author suggested that religion involved beliefs, practices and rituals

related to the transcendent or God, Allah, Hashem or a Higher Power. Western religions involved the Brahman, Buddha, Dao, or truth/reality in Eastern traditions the supernatural or mystical are involved. Most religions have precise beliefs regarding life after death and rules, rituals, practices within a social group. Beliefs, behaviors, rituals and ceremonies are often times associated with religious practices that may be conducted in public or private settings. Koenig (2009) suggested that religion is an organized, structured and systematic system of beliefs, symbols and practices designed to facilitate closeness and a commonality. Religion fosters an understanding of relationships and responsibilities to others within the community (Koenig, 2009).

Spirituality is connected to the transcendent (Koenig, 2008). The transcendent is that which is outside of the self, and yet very much within the self. Spirituality is closely connected to the supernatural, the mystical and many times to organized religion, however extends beyond organized religion. Spirituality embraces the search for transcendence and allows individuals to question their beliefs in order to allow them to become devoted to spirituality and ultimately surrender to it. Koenig (2008) purported that although spirituality is very similar to religion and may overlap they are not the same.

According to Puchalski, Ferrell and Virani (2014) spirituality and religious beliefs should be an integral part of patient care. The authors addressed the difficult task of defining what spirituality entails and how hospice nurses assess the spiritual needs of their patients. For example, Puchalski (2013) purported that spirituality helped patient's cope with their illness and accept their prognosis. Although many hospice nurses are aware of the power that spirituality has on their patients, few of them feel they meet the needs of their patients. One of the reasons is that it is difficult to describe and define in detail what spirituality is. The second reason may be the

confusion as to when spirituality is best utilized within the patient's pathway such as end of life or when the prognosis is given.

According to The Spirituality Healthcare Network (SHCN, 2013) the term spirituality is interlinked with religion however, they are not the same. An individual may be deeply spiritual however not affiliated with any particular religion. Spirituality signifies finding the meaning and purpose in life through relationships to others including a god or gods and is expressed through many facets such as music, art, nature or any other forum. Spiritual practice may include yoga, volunteer work, and commitment to the community and/or other non-religious practices.

The authors of the SHCN (2012) suggested that religion and religious practices may include prayer, attending religious services and being an active member of a religious community. Ross and Clark (2012) stated that only a hand full of hospice nurses approximately six percent believed that spirituality only involved going to a place of worship. Puchalski, Ferrell and Virani (2014) addressed the need for hospice nurses to respect the privacy, dignity, religious and cultural beliefs of their patients as well as taking the time to support and reassure them in times of need. Hospice nurses should also show genuine kindness, compassion and concern for their patients and allow them to discuss their anxieties and their fears.

The SHCN (2013) highlighted two difficulties encountered when defining spirituality. The first difficulty was that Atheists and Agnostics may have great meaning and purpose with high personal values in their lives and experience connectivity with others yet deny being spiritual or religious. The second is defining spirituality as psychological wellbeing which connects it directly with mental health making the link between spirituality and health especially mental health impossible. Muldoon (2010) contended that in order to acknowledge spiritual wellbeing or spiritual distress it should clearly be defined in detail, otherwise holistic processes will be

misunderstood.

Four themes were identified in nursing and health related literature when defining spirituality. The first is that spirituality be considered as meaning and purpose in life as well as connecting with others. The second was that spirituality was transcendent or metaphysical. The third was that spirituality was a non-religious belief and value system (SHCN, 2011).

According to the SHCN (2011) from these themes it is evident that spiritual needs can be completely non-religious or incorporated within religious beliefs. However, for many patients completely excluding religious traits or separating them from spiritual needs could be damaging since their spiritual needs are religious in nature. It could also be detrimental to atheists to include religious perspectives. Spiritual needs consists of more than religious worship and is highly individual for each patient (SHCN, 2011).

Finding meaning and purpose in ones' life is predominantly what spirituality means for many (SHCN, 2012). However, this could mean different things for different individuals. Some examples of what spirituality may mean to individuals is the connection they have with family, significant people in their lives, their friendships, their interaction with others, life achievements, their calling or career and other things that they consider sacred. In order for hospice nurses to understand their patients The American Nurses Association (2012) suggests that hospice nurses should take a genuine interest in their patient, show genuine concern, kindness and attentively listen to them to assess their spiritual distress needs. Many patients may find it difficult to express their spiritual concerns and many times will ask questions related to their fears and anxieties associated with death and dying. According to the ANA (2012) Hospice nurses should establish a strong rapport with their patients and show that they care, encouraging the patient to open up and share their worries. If hospice nurses are successful the patient should feel reassured

and better able to cope with their circumstances.

The American Academy of Hospice and Palliative Medicine (AAHPM, 2012) suggests that Spirituality is highly subjective and is defined differently by each unique individual. However, there is a consensus that spirituality gives meaning to life, provides hope, gives a reason to live and can influence health. There are numerous studies that show that spirituality and religion play a crucial role in how patients cope with illness. For example, in a meta-analysis of over 1,200 published peer reviewed articles, journals and studies on religion, spirituality and health substantial evidence was found to support the idea that spiritual and religious beliefs are essential in coping with illness and acceptance of death (AAHPM, 2012).

The Hospice and Palliative Care Association (HPCA, 2010) authors purported that having a strong spiritual belief has also been shown to be a positive influence of mental health outcomes such as with suicidal ideation, wellbeing and substance misuse. The impact that spirituality has on individuals may impact their lifestyle such as individuals are less likely to drink alcohol, take drugs or engage in promiscuous sexual practices. Murphy and Walker (2013) suggested that religion and spirituality have many positive effects on health however, also have several negative connotations. For example, many individuals may delay in seeking medical treatment and rely on god or a higher power to help them instead of seeking medical help. Others may feel excessive guilt, abused by religious advocates and may feel they are criticized or ostracized by their religious community. Each of these factors contributes to negative health outcomes.

Ferrell (2011) professed that improved quality of life was associated with a strong spiritual belief. The authors posit that spiritual care enhanced the wellbeing of patients at the end of life. They contended that spiritual views can contribute to the decision making process at the end of life and a correlation was found between spiritual beliefs and the wish for aggressive, high risk

end of life measures such as resuscitation in patients with chronic illness.

Ehman and Short (2011) argued that medical professionals should always consider a patient's spiritual or religious beliefs when a prognosis of death and treatment options are discussed. Coping skills are investigated and both the patient and medical professionals are aligned with the steps they will take to care for the patient after they are aware of their spiritual beliefs. Puchalski (2013) addressed that a strong spiritual belief also helped in the treatment of depression, arthritis, chronic pain, fatigue, mental health, advanced cancer or chronic obstructive pulmonary disease as well as hypertension and heart failure.

Spiritual distress not only applied to elders and those approaching death it also applied to individuals suffering from many diseases and of all ages. The author suggested that spirituality plays an important role in suicidal ideation prevention. The author also purported that a strong spiritual belief assists individuals with chronic illness.

Pattison (2013) believed that empowering patients to find meaning, peace, life purpose and acceptance resulting in improved health outcomes is what a strong spiritual belief entails. In the author's current study he expressed the power that spirituality had on women who recently completed treatment for breast cancer. The author suggested that when these women find meaning and purpose in life they were less likely to display depression and showed increased vitality than those women that had religious faith but low meaning in life.

Campbell, et al. (2010) emphasized the importance of being at peace when making critical medical decisions and the importance of having a strong spiritual belief when making these medical choices. For example the authors examined the link between faith and higher meaning/peace and purpose with quality of life and found that faith was unrelated to outcomes, whereas having a higher meaning and purpose in life was linked to having a higher quality of

life. This suggested that finding meaning and purpose in illness is more advantageous than religious faith.

Puchalski, Ferrell and Virani (2014) concurred the need for patients to explore the meaning of their illness to give them a different perspective on their life. The authors purported that many times illness gives individuals time to think and in terminal illness many times will re-evaluate their life and give renewed value to those around them. For example, Kellie (2013) suggested that the pain and challenging emotions experienced during illness may emphasize the need to have the support of others around them and that this connection is sometimes more powerful than the illness itself.

Cohen, et al. (2012) believed that the illness for many patients is the opportunity to live life differently or live a less stressful and complicated life. For example, the author suggests that in facing their mortality many patients enhance their appreciation for what they have and that this in turn motivates them to make new plans for their future and with those they love. The authors believed that the illness brought new hope and gave new meaning to life.

The God Spot

According to Johnson (2013) the human brain may feature a "God Spot" which is responsible for spirituality. The author suggested that multiple areas of the brain were responsible for numerous facets of spirituality and spiritual experiences. Johnson (2013) stated that he found that there is a neuropsychological basis for spirituality which is not isolated to just one area of the brain, instead spirituality uses many parts of the brain.

Johnson (2013) purported that certain areas of the brain are much more predominant than other areas and that they each work collaboratively to facilitate spiritual experiences. For example, Johnson (2013) studied 20 patients who had suffered traumatic brain injury affecting

the right parietal lobe. He asked the patients questions regarding spirituality such as their closeness to a higher power and if their lives were part of a divine plan. In his findings Johnstone concluded that those patients with more significant injury to their right parietal lobe showed an increased feeling of closeness to a higher power.

Johnson's (2013) findings stated that numerous tests have shown that the right side of the brain decreases focus on the self and that these individuals would demonstrate more spirituality. The author suggests that individuals from different religious beliefs tend to use the same electrical circuits in the brain to solve moral and ethical dilemmas. It was determined by the author that the same circuits were used when religiously-inclined individuals dealt with issues concerning and related to god.

Johnson (2013) established that specific areas of the brain involved in religious beliefs and spiritualty were located in the frontal lobes of the cortex. The other parts of the brain associated with spirituality and religious beliefs are located in the evolutionary-ancient regions deeper inside the brain. For example, Professor Dawkins (2013) an evolutionist and renowned atheist, studied the meditation of Buddhist monks. He found that the parietal lobes at the upper area of the brain were involved in controlling religious and spiritual feelings. He suggests that the area of the brain found in the parietal lobes were responsible for mystical elements that gave individual a feeling of being on a higher plane during prayer.

Hirai (2009) studied Buddhist by injecting radioactive isotope within the parietal lobes of their brain at the point that they had achieved meditative nirvana. Through the use of a specific camera, he was able to identify the distribution of the tracer in the brain. He found that the parietal lobes played a significant role during the transcendental state.

The Hospice Nurse

According to the HPCA (2012) hospice nurses need to allow the patient to find the meaning of their illness themselves. They must actively listen however also ask questions that encourage the patient to search for a deeper meaning, thus empowering them to come to a positive conclusion. For many hospice nurses understanding and differentiating between religious needs and spiritual needs is a challenge. For example, some patients may be non-religious but deeply spiritual and many times spiritual needs can be religious in nature. Although at times difficult, hospice nurses need to assess their patients' unique needs and address them accordingly.

According to Ferrell and Baird (2012) the benefits of meeting patients' spiritual needs is evident from the growing body of literature in health related articles, peer reviewed journals and medical testimony dedicated to spirituality and healthcare. The authors suggests that hospice nurses interact with their patients daily thus are ideally placed to contribute to the patient's positive health outcomes. This is substantiated by Puchalski, Ferrell and Virani (2014) that expressed the need to have a spiritual assessment in a clinical setting.

Religious or Spiritual Assessment Instruments

The instruments currently utilized to assess spiritual distress have numerous religious items with regard to the suitability for patients who may be spiritual but not religious Balboni (2013). However, the instruments are not clear as to what the threshold for religious items should be. The question than arises, how many religious items are too many to utilize in a spiritual assessment instrument? The connection between spirituality and religion has no clear consensus from either a conceptual or measurement perspective.

For many patients, spirituality is expressed through the context of religion (Ross & Clark, 2012). The inclusion items referencing religiousness in assessments of spirituality is necessary

for some patients however, for others who consider themselves spiritual but not religious, the same assessment instrument may not be appropriate. It is up to the hospice nurse to decide which measure would be the most beneficial and appropriate in any given circumstance and if they have the training necessary to effectively assess their patients. Through this study it was clear that more research would be necessary to fully address the assessment instruments utilized by hospice nurses when assessing their patients and their spiritual distress needs (Monod et al, 2010).

According to Puchalski (2013) the need to look at spirituality as a significant theme in health research is necessary since spiritual orientation assists patients cope with the consequences of serious illness and assists them in accepting their prognosis. However, knowledge on the role that spirituality plays is limited since most research is based on measures of religiosity rather than spirituality. Quantifying the importance of spirituality among individuals who adhered to a religion or non-religious perspective assessed ten questionnaires that addressed spirituality as a human experience (Burkhart, Schmidt, and Hogan 2011).

These Questionnaires were evaluated with regard to psychometric properties, item formulation and confusion with the terms "wellbeing and "distress." Although none of the questionnaires fulfilled all the criteria, "The Multidimensional Spiritual Wellbeing" questionnaire was the most favorable. However, still failed to address spiritual distress without inferring religion.

The rate of publications on spirituality and healthcare has increased 688% in the past 30 years (Burkhart, Schmidt and Hogan, 2011). Many individuals experience spirituality as a significant support aid while attempting to cope with chronic pain or a life threatening illness. For example, spiritual orientation has been linked to mental health. This link is especially strong, powerful and

important among individuals facing stressful life events. Nonetheless, knowledge on the role that spirituality plays among patients and their caregivers such as hospice nurses is limited since research is based on measures of religiosity rather than spirituality. The religiosity of the questionnaires utilized rely predominantly on monotheistic terminology inquiring about the belief in God or experience of being one with God.

According to Puchalski (2014) the questions used to assess spirituality may be appropriate in North America, where 83% of inhabitants consider God as significant and most important in their life. In Western Europe however, only 49% of inhabitants consider God as highly important. In many Western European countries however, spirituality is significant while believing in God was not.

An effective questionnaire that transcends specific beliefs, is a prerequisite for quantifying the importance and significance of spirituality among individuals who adhere to a religion or no religion at all (Puchalski, 2014). In the author's study the researcher focused on spirituality questionnaires that are applicable for a broad group of individuals with various religious or secular backgrounds. The author also purported that these questionnaires should consider spirituality as a universal human experience.

According to Ferrell (2011) most spirituality questionnaires focus on a religious theme. Although many questionnaires transcend a specific religion they only focus on the traditions within these religions, however, do not systematically evaluate the questionnaires in relation to the traditions of these religions. In addition, these reviews do not discuss the formulation of the items within the questionnaire.

Puchalski, Ferrell and Virani (2014) believed that in assessment instruments and scale construction the formulation of items is important; items should be coherent, have consistent

meaning and answerable by all respondents. Oftentimes spirituality is described and defined in vague terms, it is therefore critical to check whether the items on the questionnaires are comprehensible and have a consistent meaning. Borneman, Ferrell and Puchalski (2010) suggested that many times questionnaires neglect to include wellbeing items, which is a critical flaw within these questionnaires.

For example, Puchalski (2014) suggested that it is significant that hospice nurses investigate whether a spiritual attitude is associated with wellbeing and have follow-up questions addressing the reasons why there is a correlation between spirituality and wellbeing. Abbas and Dein (2011) purported that the following three themes were regularly allied through many of the spirituality questionnaires 1) psychometric properties 2) item formulation 3) confusion with wellbeing and distress. The authors assessed the two dimensional and multidimensional questionnaires. The authors suggested that depending on the specificity of the research question, a researcher will be either interested in the first type of questionnaire, which are global measures of spirituality, or the second type which delineates the different fundamentals of spirituality. The authors purported that a clear-cut definition of boundaries were necessary when defining spirituality since it is considered a complex and multidimensional concept. Character, wellbeing and health would also need to be applied to the constructs.

Waaijman (2002) defined spirituality as the manner in which individuals understand and live their lives. It is a part of their ultimate meaning and value system as well as a subjective experience of a sacred quality that goes beyond religious affiliation. Spirituality strives for inspirations, reverence, awe, meaning and purpose, even for those individuals that did not believe in any God.

According to Muldoon (2010) the advantage of this broad definition was that it could be

utilized to formulate various facets of spirituality. For example, the definition of spirituality reflected the experiences of individuals from different religious or secular backgrounds. These questionnaires also reflected current (Western) culture, where many individuals were searching for profundity and meaning in life through the basis of personal experience and insight.

Summary and Conclusion

Although there are numerous studies addressing the need to integrate spirituality within healthcare, there are still misperceptions when it comes to documenting the difficulties that hospice nurses have when attempting to assess the spiritual distress needs of their patients. According to the literature review the deficiencies of nursing curriculum and training in spirituality plays a large role. The other problem is due to the lack of assessment instruments utilized in hospice care to assess spiritual distress and finally a clear, concise definition of spirituality adds to the difficulty when attempting to infuse spirituality within healthcare. Although the literature review suggested that spirituality did not only benefit the emotional, psychological and physical wellbeing of patients but as discussed by the authors also impacted parts of the brain that were responsible for spiritual wellbeing.

This study addressed the need for hospice nurses to connect emotionally and spiritually with their terminally ill patients and express genuine empathy and compassion. The studies within the literature review also addressed the importance of understanding the power of spirituality and the need for hospice nurses to put aside their personal feelings and biases. The nursing curriculum was also investigated which found a deficiency of spiritual courses and training.

Education and training through nursing curriculum is significant when attempting to integrate spirituality within a holistic and person-centered approach to healthcare and to assist nurses feel more comfortable when speaking of spirituality with their patients. A qualitative

phenomenological approach was the most appropriate methodology since it provided in-depth, face-to-face interviews with eight hospice nurses working in the Pacific Northwest. These interviews addressed their perceptions of spirituality and the impact that it has on their terminally ill patients and their views and opinions of the current assessment instruments utilized to assess spiritual distress.

Moustakas (1994) purported that a qualitative approach to research offers a broad description of the lived experiences of the participants and portrayed the essence of that experience. In addition, phenomenology is used to explain the phenomena of behaviors that come alive in the moment they are perceived. These are the feelings that I as the researcher attempted to recognize when the eight hospice nurses I interviewed identified the importance of integrating spiritual care within their clinical setting and if the assessment instruments utilized were effective enough to assess their patient's spiritual distress needs. Lastly, a qualitative methodology offered me the principal structures of the experience by interpreting the initial descriptions of the situation in which the experience occurred (Moustakas, 1994).

Chapter 3 will address the research questions in Chapter 1 and define my role as the researcher. It will also provide clear ethical considerations and the specific procedures of the qualitative study and reasons for participant selection and sample size. In conclusion it will address the specific procedure for data collection and any biases and/or power relationships that emerged.

Chapter 3: Research Method

Introduction

The purpose of this qualitative phenomenological study was to better understand the impact that spirituality had on not only the emotional and psychological wellbeing of terminally ill patients but also their physical needs. I conducted face to face interviews of eight hospice nurses working in a Pacific Northwest State. Issues addressed included the assessment instruments hospice nurses used to assess the spiritual distress needs of their patients and if they felt they were effective in using these tools. While researching the topic, I was able to locate a profusion of literature on the positive impact that spirituality had on patients from all different cultures and religious backgrounds. However, after searching the data bases Academic Search Premier, PsycARTICLES, MEDLINE, CINAHL plus, PsycINFO, PsycBOOKS, SocINDEX and PROQUEST I could only locate a minimal number of peer review articles dedicated to the nursing curriculum administrators when providing courses, training and workshops geared to assist hospice nurses assess the spiritual distress needs of their terminally ill patients. I found after an extensive review of current literature that hospice nurses were not prepared or knowledgeable enough to assess the spiritual needs of their patients. Because there was a minimal amount of journal articles on the topic, I believed a gap in the literature existed, thus creating a need for further research on the topic.

Purpose of the Study

The purpose of the study was to explore how spirituality impacted terminally ill patients through the experiences of hospice nurses and the spiritual assessment tools available to them to assess these needs. A phenomenological study identified how hospice nurses integrated spirituality within their healthcare approach and the difficulties they encountered when

assessing their patient's spiritual distress needs. The perception of hospice nurses were explored addressing the assessment instruments utilized to identify the criteria to assess spiritual distress and the manner in which they infused spirituality within their clinical care.

Research Design and Approach

I utilized a phenomenological design because it illuminated the phenomenon of the meaning to the research study. Phenomenology offered a wide-range of descriptions that gave rich accurate interpretations of the experience rather than measurements, ratings, or scores that a quantitative design renders (Moustakas, 1994). While investigating the topic of spirituality within healthcare and the emotional, psychological and physical wellbeing of terminally ill patients I also investigated the assessment instruments utilized to assess spiritual distress. I discovered that there was a deficiency of literature addressing the effective instruments utilized by hospice nurses to assess spiritual distress as well as lack of adequate spirituality or existential courses to assist hospice nurses in assessing spiritual distress needs with their patients thus creating a gap in the literature worthy of further investigation.

Another reason I believed a phenomenological design was the best approach for answering the research questions was because phenomenology offered a complex, in depth understanding of the issues (Moustakas, 1994). Moustakas (1994) reported that this can only be accomplished if participants were allowed to tell their stories without being encumbered by the existing literature. The challenges facing the phenomenological research, according to Moustakas are to:

> Describe things in themselves, to permit what is before one to enter consciousness and be understood in its meanings and essences in the light of intuition and self-reflection. The process involves a blending of what is really present with what is imagined as present

> from the vantage point of possible meanings; thus a unity of the real and the ideal (pg. 34).

The research sample consisted of eight hospice nurses working in a Pacific Northwestern State hospice. I conducted face- to- face in-depth interviews asking open-ended, semi-structured questions in order to gather significant information by the participants (Moustakas, 1994). The interviews were electronically recorded and the data were transcribed later. In addition, I kept a journal and wrote down key information garnered from the participants during the face- to- face interviews (Moustakas, 1994). I also used inductive data analysis to form patterns, categories and themes by organizing the data into progressively more abstract components of information while establishing an all-inclusive set of themes (Moustakas, 1994).

The study utilized a phenomenological design in order to answer the following research questions:

R1: What beliefs, perceptions, experiences and challenges do hospice nurses face when attempting to infuse spirituality within their healthcare?

R2: What is the experience of nurses in the use of existing tools and guidelines when assessing spiritual distress?

Population

I interviewed eight licensed hospice nurses ranging from ages 30 to 61 who had been working in the Pacific Northwestern State. The hospice nurses were asked nine interview questions. They were also asked four demographic questions. The hospice nurses who participated were both men and women.

Setting and Sample

The purpose of this qualitative phenomenological study was to examine through the perspective of eight hospice nurses working in the Pacific Northwest the impact that spirituality had on the overall wellbeing of terminally ill patients and the effectiveness of current assessment instruments they were using to assess spiritual distress. A semi-structured, 1- hour interview procedure and a structured debriefing protocol (Appendix A) were utilized to identify perceptions and discover the insights and beliefs of the participants (Moustakas, 1994). After my proposal was accepted by the Institutional Review Board (IRB) and prior to recruiting participants for the study, I contacted the hospice for recruitment of participants. I also prepared a statement explaining the nature and purpose of the study and a statement of instructions and sent them to the human resource department and the perspective participants at their place of work.

The sample size consisted of eight hospice nurses working in a Hospice Hospital in the Pacific Northwest. The goal and purpose of this qualitative study was to gather in-depth, detailed understanding of human behavior and the reasons that governed that behavior. In other words, a qualitative method investigates the whys and how of decision making, not just the what, where, and when. Therefore, smaller yet focused samples are often times needed rather than large sample size (Onwuegbuzie & Daniel, 2003). To this end, the sample size and population for the current study was limited to eight participants.

Religion, age, ethnic and cultural factors and gender, political, and economic factors were not an issue in selecting and recruiting the participants for this study because I wanted to gain knowledge on the overall beliefs of a diverse sample of hospice nurses. Demographics of the participants were not revealed or recorded to safeguard their anonymity. An informed consent

form (see Appendix D) was obtained and an in-depth description of the study was distributed to each participant (Moustakas, 1994). In addition, each participant read and understood their right to confidentiality when signing the informed consent agreement.

The prospective participants had a detailed informed consent document that explained the purpose and procedure for this study. Each participant received a complete and detailed synopsis of the research project to allow them to be as objective as possible; however there were no certain methods to control objectivity (Barskey, 2010). Finally, the participants were not compensated for their participation in this study.

Each informed consent document explained in detail to the prospective participants the goal and purpose of the study and procedures utilized. The time allocated for the study was provided to each participant as well as all risks and benefits of the study. Before, during and after the study the participants had the opportunity to ask me questions and obtain any information related to the study. In addition, each participant was notified of the time and place of the interview via e-mail (Barskey, 2010).

I reviewed the data at the conclusion of each interview and analyzed, interpreted, and construed the data into themes and meanings in order to lay the foundation for codification. The information collected was stored in an Excel file and maintained on a password protected flash memory data storage device (Barskey, 2010). Each participant was informed that the study consisted of an interview lasting approximately 60 minutes at which time they were asked nine interview questions pertaining to the research topic and four demographic questions (see Appendix A) (Patton, 2002).

In addition, each participant was informed the study was voluntary and that they would be able to withdraw from the study at any time without repercussion, risk or penalty (Patton, 2002).

The participants were informed sufficient time was allocated to ask questions related to the construct and procedures of the study. Lastly, all of the participant's responses were coded to safeguard confidentiality, proper reporting, and data analysis (Patton, 2002).

Each participant was informed by me that they were taking part in a research study exploring the impact that spirituality had on their terminally ill patients as well as the current assessment instruments effectiveness in assessing spiritual distress needs. I was the main data collection instrument in the phenomenological research study and played a major role in conducting the interviews. Lastly, as the initiator of the interview, I played an active role in making specific decisions about the progress of the interviews (Patton, 2002).

Sources of Data

Participants are the principal source of data collection according to Moustakas (1994). Each participant shared their ideas, views, beliefs, knowledge and lived experiences. The interview questions were established during the review of literature and research inquiry. In addition, I developed the research questions in an attempt to discover the impact that spirituality had on terminally ill patients from the perspective of hospice nurses and the beliefs, views and opinions of hospice nurses as to the effectiveness of current assessment instruments used to assess spiritual distress. The administration of interviews established the complete methods of data collection for this qualitative study. Each interview consisted of an informal, interactive process where I asked open-ended, in-depth, semi-structured interview questions (Moustakas, 1994).

Each participant was informed that they were protected through the informed consent forms they previously signed and were assured that the field notes and transcripts would not have any personal identifiers. In addition, I established clear procedures that reduced the risks and maximized confidentiality. In conclusion, I kept the raw and processed data locked in a safe with

a protected password and only shared the data with those individuals associated with this study (Moustakas, 1994).

Validity

In a qualitative research proposal, perception of threats to validity and how they can be safeguarded are significant (Maxwell, 2013). According to Maxwell (2013) member checking is predominantly utilized in qualitative inquiry methodology and can be described as a quality control process. During this process, I improved the accuracy, credibility, and validity of the data collected during the interview process. Member checking or participant verification, occurs when the participants reach a decision whether the written summaries by me echoed their views, experiences, feelings and overall opinions at which time the study was credible (Maxwell, 2013).

According to Maxwell (2013), member checking occurs when the researcher restates or summarizes to the participants the information they disclosed during the interview process. When each participant affirms the accurateness and precision of their disclosures, the study will demonstrate credibility. Member checking transpires near the end of the data collection process when each participant is given the analyzed data and written report by the researcher. The report is then examined by each participant for truthfulness and accuracy. At this point, each participant should find the data collected to be a true and accurate representation of their responses and disclosures during the interview process. In addition, I shared the findings of the study with each participant and allowed each of them to scrutinize and comment on it (Maxwell, 2012).

Moustakas (1994) proposed that the purpose of phenomenology as a research method is to produce concepts and theories which can then be tested using other methods. Therefore, within a phenomenological paradigm its validity is in the exposed essence. Moustakas argued that the

reliability of analysis may be quantifiably challenging, however by interpreting each participant felt experience from their interview the methodology will prove to be both reliable and valid.

Both reliability and validity are theorized as consisting rigor and quality as well as trustworthiness and considered attributes in a qualitative approach to research (Moustakas 1994). In an effort to increase validity, I eliminated bias and increased truthfulness by searching for convergence from responses to the interview questions disclosed by each of the participants. Moustakas suggested that qualitative researchers should instill trustworthiness, quality, and rigor into their study in order to increase reliability and validity as this is essential to the research study.

According to Barskey (2010) virtuous researchers are investigators who are inclined to incorporate good values, ideals in all areas of their being and their morals. In addition, researchers that are virtuous are moral agents who act ethically because they are internally motivated to do so. Barskey (2010) proposes that researchers should show concern for others not by carrying out research ethics protocols and forms for informed consent established by their institutions, instead virtuous researchers safeguard against research participants being harmed by the research even when it means going beyond what is required by the institution. I exhibited trustworthiness by making certain that each participant understood the risks and consent to voluntarily participate in the research study (Barskey, 2010).

I respected participant's right to self-determination, by giving them informed consent forms, assuring confidentiality and by also respecting their dignity and self-worth (Barskey, 2010). Furthermore, I assumed a relationship of special care for the participants and assured them that they were given a safe environment during the interview. It was important for me to act honestly and with integrity by avoiding actions and relationships that put participants in positions of

conflict of interest. Lastly, I never imposed my values, beliefs or opinions onto the participants (Barskey, 2010).

Rigor was utilized by me during the study by demonstrating integrity and competence. Tobin and Begley (2004) proposed that rigor was the manner in which a researcher displayed competence and integrity. In other words, rigor is a process of measuring truth and consistency as a method of making certain the researcher's discoveries represent reality. The authors suggested that rigor is a manner by which integrity and competence is produced by building attributes such as creativity, innovation, transparency in a qualitative study. Lastly, I addressed how the respondents' views and my representation of them were compatible and provided credibility to the study.

"Goodness" is reported by Tobin and Begley (2004) as a method of applying rigor in a phenomenological approach to research and a way of bringing trustworthiness and authenticity to an interpretive research study. It is not a single construct rather a significant and necessary component of the research process that will be replicated in the relationship between the participants and the phenomenon being explored (Tobin & Begley 2004).

Reliability

Prior to conducting the interviews, I greeted each participant and had each one sign a consent form. I then conducted face-to-face interviews with eight hospice nurses working in Washington State. In addition, the interview questions were reviewed by individuals who were knowledgeable in the field of spirituality and the healthcare system. The interviews were audio-recorded for accuracy which were then transcribed at a different time and date. Golasfshani (2003) suggests "inquiry audit" is one measure that enhances and improves the dependability of a qualitative research study. An "audit" was utilized by me whereby others can examine the

documentation of data, methods, decisions and the completed product. I also kept a self-critical account of the research process integrating its internal and external dialogue (Golasfshani, 2003). Auditing was utilized to authenticate conformability establishing that the data and interpretations of the findings were not fabricated or created and were true and not a creation of the inquirers imagination (Golasfshani, 2003).

Golasfshani (2003) suggests that qualitative researchers are the instrument of credibility in a qualitative study. This is the reason that I needed to test and demonstrate that my study was credible and that my effort and terminology involved credibility, transferability, and trustworthiness. In other words, the term reliability in qualitative research is more closely aligned to the term dependability (Golasfshani, 2003). I achieved dependability by ensuring the process of research is traceable, logical and clearly documented.

At this significant stage of testing for reliability, I utilized the words garnered from each participant and placed them into themes and coded each with a highlighter. This included an individual textural description of the experience utilizing verbatim examples from the transcribed interview. A textural-structural description of the meanings and essences of the experience were the next procedure I utilized to ensure reliability. Lastly, I developed a composite description of the meanings and essences of the experience representing the group as a whole (Moustakas, 1994).

Data Collection Procedures Data

The sample consisted of eight hospice nurses recruited from a Hospice in a Pacific Northwestern State. After receiving permission from the Institutional Review Board (IRB), I sent an e-mail to each perspective participant explaining the nature and purpose of the study. An invitation letter (see Appendix C) was attached to the IRB application prior to the initial contact

with each potential subject. The letter was similar to the consent form informing each participant that they were being asked to voluntarily participate in a research study and what was expected of each of them (Moustakas, 1994).

Invitation letters (see Appendix C) were emailed to each prospective participant only after gaining permission from the IRB to conduct the study. The potential participants were asked if they would be interested in participating in a study regarding the impact that spirituality had on the emotional, psychological and physical wellbeing of terminally ill patients and their opinions of the effectiveness of the assessment instruments utilized to assess spiritual distress. Each participant was informed that they would not be compensated for their participation in the study. In addition, participants were asked to give written permission to participate in the study. I collected data through semi-structured interviews, and established a protocol for recording each interview. Safeguarding and destruction of the data will take place 5 years after the completion of the study (Moustakas, 1994).

Written permission by each participant was given to me to agree to have the interview electronically recorded. The interview was electronically recorded to bring continuity, clarity and authenticity to the data provided. Each of the participants was informed that their names would not be recorded and that the written research report would not have any identifying information (Moustakas, 1994). I also kept a hand-written journal to facilitate any ideas and impressions that may occur during the interview sessions and written transcripts (Moustakas, 1994). In order to not distract the participant during the interview I wrote in the journal. Instead, I waited for the interview to complete and then found a quiet area to reflect and write down some notes. (Moustakas, 1994).

A comparative framework was created by the content of the journal from all interviews. The phenomenological objective of the research was to hear the unique stories of each of the participants and their disclosures during the interview. During data interpretation any shared or common themes became active workings in my thinking (Bendal, 2006). All copies of documents, correspondences, research, recordings and written notes were placed safely in a fireproof safe in a secure location for five years. After the five years all data, recordings, and transcripts will be destroyed (Patton, 2002). I will also shred all handwritten and printed material and delete all computer drives, jump drives, and hard drives containing any confidential information disclosed by each of the participants.

Any question that the participant were not comfortable responding to were skipped entirely or partially. The participant were also informed that they may withdraw from the study without penalty or repercussion by me. In addition, the benefits and risks of the study were explained and the manner in which their involvement will enlighten others was discussed. Participants also understood the benefits from partaking in the study since they were contributing to the current body of literature associated with implementing spirituality into healthcare and the assessment instruments utilized to assess spiritual distress. None of the participants skipped any interview questions and none of the participants withdrew from this study.

Data Analysis Procedure

Each of the participants were asked a series of interview questions intended to induce a thorough account of the participant's experience of the phenomenon being explored (See Appendix A). Each interview question was aligned to the research questions in that they each were written to determine how spirituality impacted the emotional, psychological and physical wellbeing of terminally ill patients and the effectiveness of current assessment tools utilized by

hospice nurses to assess spiritual distress. The interview consisted of an informal, semi-structured, interactive process whereby I asked in-depth, open-ended, questions (Moustakas, 1994). I then read through each of the participant's responses searching for patterns and themes which provided a template of analysis and future interviews.

The phenomenon of the study was described through the collection of the interview transcripts and were reworked and reduced to identify major themes and categories. Categorizing patterns and themes found in the data from the analysis of each interview response was conducted by me and coding and categorizing patterns were a result through this analysis (Moustakas, 1994). According to Moustakas (1994) qualitative coding in general data analysis is accomplished by the researcher systematically categorizing data for the future purpose of theoretical abstraction.

The purpose of the analysis was to consolidate the responses of each participant in such a manner that the principle patterns became clearer (Patton, 2002). My role was to present the responses of the participant in a clear and rational manner that would integrate the numerous assortments of experiences and impressions by the participant through the interview process (Patton, 2002). According to Creswell (2009), phenomenological analysis seeks to grasp and elucidate the meaning, structure, and essence of the lived experience of a phenomenon for an individual or groups. A descriptive approach was utilized by me to analyze the data which involved verbal portraits, reconstruction of dialogues, complete descriptions of the physical setting, and accounts of each particular event. Details about documentation of gestures, body language and direct quotes were also addressed by me (Creswell, 2009). I also used reflective analysis which consisted of speculations of the data analysis and all emerging patterns and themes. In addition, comments of the research method such as accomplishments, problems,

decisions and records of ethical dilemmas and conflicts were also identified by me along with the analysis of my frame of mind, points of clarification, hunches, and confusions (Creswell, 2009).

Interpretive Phenomenological Analysis (IPA) was used in order to allow rigorous examination of subjective experiences or social cognitions of each of the participants (Biggerstaff & Thompson, 2008). The semi-structured interviews provided loosely collected data to establish a "prompt sheet" consisting of few key themes that were to be discussed with each of the participants. The interviews were not rigid or limiting since they allowed the participants to converse freely and express their true opinions. At the conclusion of each interview, the recordings were transcribed by me with thorough accuracy (Biggerstaff & Thompson, 2008).

My research journal had detailed accounts of the nature and origin of all emergent interpretations which identified themes as well as possible connections between the themes within each section of the transcript (Biggerstaff & Thompson, 2008). A theme according to the authors encapsulates important data in relation to the research questions and represents some level of patterned responses or meanings within the data set (Biggerstaff & Thompson, 2008). Constant comparisons or coding according to Leach and Onwuegbuzie (2007) is frequently utilized in qualitative data analysis. I used the entire dataset to identify essential themes presented through the data. Constant comparison of the data were undertaken deductively by me and codes emerged to identify prior analysis. I then identified codes objectively and noted each one (Leach & Onwuegbuzie, 2007).

To analyze clarification and present themes that related to the data a thematic analysis was utilized. Marks and Yardley (2004) argued that thematic analysis is considered to be the most essential and appropriate analysis for any study that seeks to discover themes using

interpretations. Thematic analysis provided a schematic element to data analysis and allowed me to associate an analysis of the frequency of a theme. This confers accuracy and intricacy while enhancing the meaning (Marks & Yardley, 2004).

Thematic coding was utilized to commence member checking with each of the participants. I allowed the participants to thoroughly read through the themes, arguments and assertions made by me through the interview responses and assert that they were correct and that they described their statements. I also asked each of the participants to read the definition and explanation of my interpretations garnered from the data from each of the interview questions to determine if it was accurate and correct (Leach & Onwuegbuzie, 2007).

The entire set and subset of the data was read and placed into smaller, more meaningful parts and labeled with a descriptive code. The data was then compared to each new piece of data and labeled with the same code (Leach & Onwuegbuzie, 2007). Each code was then grouped together by similarity and a theme was identified and documented based on each grouping. "Member-checking" was accomplished through the use of these codes. It gave the participants an opportunity to check the codes and to assert that the arguments, themes and assertions were correctly developed and that they described their statements accurately (Leach & Onwuegbuzie, 2007).

Rolfe (2006) argued that member checking involved soliciting participants' reactions to preliminary findings and interpretations. Member checking can be conducted either formally in an ongoing manner as the data is being collected and more formally after the data has been collected and analyzed. The author reports asking participants to evaluate the researcher's psychological interpretation of their own descriptions exceeds the role of the participants. In other words, searching for disconfirming evidence such as data credibility can be enhanced by

the researcher's systematic search for the data that challenge an emerging conceptualization or descriptive theory. Rolfe (2006), suggested that sampling of individuals who offer conflicting viewpoints can greatly strengthen a comprehensive description of a phenomenon.

The triangulation of each source was utilized in order to check the consistency of different data sources with the same method. This entailed comparing and cross-checking the consistency of information derived at different times and by different means within a qualitative method (Patton, 2002). By combining different observers, theories, methods and data sources I expect to overcome the intrinsic biases that comes from single-methods, single observer and single theory studies. The logic of triangulation is based upon the premise that no single method adequately solves the problem of rival explanations (Patton, 2002).

Bendal (2006) asserts that a researcher may have had similar experiences within the context of the proposed research objective which has the potential to be of heightened significance to the data. However, this is entirely governed by the success with which a researcher both designs and applies procedures for the operation of epoche and bracketing. At the very beginning of a phenomenological inquiry a structural relationship between researcher and the research respondents take place (Bendal, 2006). The researcher is then challenged to allow each of the participants to voice their subjective thoughts and then for the researcher to interpret these responses and views expressed in the data collection devices (Bendal, 2006).

I then separated any past knowledge or experience made regarding the impact of spirituality and the assessment instruments used by hospice nurses to assess spiritual distress. This allowed me to connect interpretatively to the meanings of the participants through epoche and bracketing (Bendal, 2006).

Biases in a study according to Marshall and Rossman (1999) can tarnish the scholarly value and validity of the research study. I investigated my beliefs and personal views regarding the research topic. Precautions to suspend judgment during data collection and analysis was thoroughly made. In order to safeguard against issues of bias, misdirected judgment, and leading in the interview process I bracketed and documented my experiences and current understanding of spirituality and how it impacted my emotional, psychological and physical wellbeing. I also bracketed and documented my experiences with the use of assessment instruments utilized by hospice nurses to assess spiritual distress. According to Marshall and Rossman (2009) bracketing the data will assist me in isolating my understanding from the research participants' experiences and meanings of the subject.

Gearing (2004), suggests that bracketing and epoche have generally been seen as being interchangeable or synonymous, however there are some underlying philosophical differences between the two terms. These differences according to Gearing (2004) can be described interchangeably to reflect the similarity of their core essence. Moustakas (1994) argued that bracketing described how true meaning within the social world of themes, concepts and events may be recognized by the researcher and a participant in a collective interpretive response to data.

Gearing (2004) suggested that the act of bracketing will occur at those interpretative moments when the researcher holds each of the identified phenomena up for serious inspection. This is when the researcher allows those personal ideas and feelings held in epoche to synthesize with those observations as interpretive conclusions. According to Gearing (2004) reintegration consists of the unbracketing and subsequent reinvestment of the bracketed data into the larger investigation. Epoche according to the author allows for empathy and connection, not

elimination, replacement or substitution of perceived researcher biases. In other words, bracketing can advance that process by facilitating recognition of the essence of meaning with the phenomenon under scrutiny (Gearing, 2004).

I read each interview transcript thoroughly in order to culminate the events of reintegration at the final data interpretation. I also flagged items in terms of their relevance to the general areas canvassed by the interview questions which included probing and follow-up questions (Gearing, 2004). I also flagged any textual references which seemed objectively part of my remembered experiences. However, no pre-suppositions about any flagged items were made in terms of its potential significance to data interpretation or as a potential answer to the precise questions posed by the research objective (Gearing, 2004).

Moustakas (1994) suggested that bracketing moves the process forward by enabling an acknowledgment of the essence of meaning of the phenomenon under investigation. Moustakas (1994) purported that bracketing described how true meaning within the social world of themes, concepts, and events may be recognized by a researcher and a respondent in a collective interpretive response to data. The researcher's analytic abilities will provide clarity and applicability of the findings which may include reporting and documenting the analytic processes and procedures fully and truthfully in order for others to evaluate the credibility of the researcher and her findings (Moustakas, 1994).

Ethical Considerations

Moustakas (1994), suggested that the true nature of the study must be revealed to the participants. Each participant must also be informed that their participation is essential to the success of the study. Prior to commencement of each interview, I read an opening statement

explaining how a typical phenomenological interview began and explained to the participants the primary purpose and intent of the interview.

The highest ethical standards were upheld by me at all times during the study. All documents and agreements were easy to understand and all procedures were developed to provide for informed consent which consisted of full disclosure of the nature, purpose and requirements of the study (Moustaskas, 1994).

Each participant was informed that partaking in this qualitative, phenomenological study was voluntary and that they could withdraw at any time without penalty. The participants were also informed that all damaging and/or private information revealed through the interviews would be removed or concealed to protect their identities. According to Kaiser (2009) internal confidentiality, also known as deductive disclosure, occurs when the individuals or participants become recognizable in research reports.

Many times through qualitative studies, confidentiality can be breached via deductive disclosure since often times interviews contain rich portrayals of the participant's opinions, views and thoughts. As a result, qualitative researchers can be conflicted passing on thorough and accurate accounts of the data collected in an attempt to protect the identities of each participant (Kaiser, 2009). All participants were informed of their right to confidentiality at the commencement of the data collection process at which time they were asked to sign a consent form. Confidentiality was addressed again during data cleaning at which time I removed all identifiers in order to produce a clean data set (Kaiser, 2009).

I addressed confidentiality during research development which consisted of writing the proposal and obtaining consent from the ethics review board (Kaiser, 2009). I also safeguarded confidentiality during data collection, data cleaning and the distribution of the research results. In

order to protect confidentiality of the participants, all identifying agents such as names, gender, religion and ethnicities were changed (Kaiser, 2009).

Some of the identifiers were replaced with pseudonyms that were deleted from the file once they were no longer necessary. I considered whether the specific quotations and examples presented by the participants' can lead to their identification through deductive disclosure. I was also responsible for determining what facets of the participant's life circumstances needed to remain confidential (Kaiser, 2009).

Kaiser (2009) purports that when the researcher cannot collect data anonymously, the data must be collected, analyzed and reported without disclosing the identity of the participant. According to the Belmont Report rule "beneficence" instructs researchers that they must never cause harm to their participants (Kaiser, 2009). The researcher must always safeguard the privacy of all participants and build trust and rapport. Ethical standards and the integrity of the research process will be maintained in order to safeguard the privacy of all participants.

Limitations

Limitations related with this study were determinant upon the interviewer's abilities and expertise to garner important data. Each participant was allowed to disclose their thoughts and views during the interview process and relay their opinions. In addition, due to the busy schedules of hospice nurses and their time constraints the study was limited.

Summary

In chapter 3 I provided through this qualitative phenomenological study the problem statement and research questions. The study utilized a qualitative methodology and phenomenological design in order to obtain and collect information from hospice nurses' perceptions of the impact that spirituality had on terminally ill patients and if they felt that the

current assessment instruments utilized to assess spiritual distress were effective tools. A qualitative phenomenological design was utilized in order to discover hospice nurses' perceptions regarding the impact that spirituality had on the emotional, psychological and physical wellbeing of their terminally ill patients and their opinions, views and beliefs of the effectiveness of the assessment instruments used to assess spiritual distress.

In addition, I utilized a qualitative design to better understand the deepest meaning of the participant's responses and this could only be accomplished utilizing qualitative methodology and a phenomenological design (Moustakas, 1994). I obtained relevant, essential information from the participants by asking in-depth, semi-structured, open-ended questions through face-to-face interviews. A qualitative design was utilized in order to codify trends or theories that could lead to discovery of the research questions (Moustakas, 1994). I allocated sufficient time for participants to ask questions related to the construct and procedures of the study. The researcher did not see any ethical concerns or problems in this study (Moustakas, 1994).

All of the participants were informed that their participation in this study was voluntary and that they could withdraw from the study at any time without penalty. The participants also signed a consent form informing them that they will not be compensated in any way for their participation in the study (Moustakas, 1994). Chapter four explained the results of the study by highlighting and emphasizing the results which were most significant. I determined the most important results based on each of the participant's responses to the research questions.

Chapter 4: Results

A qualitative phenomenological design was utilized to explore the phenomenon of the challenges that many hospice nurses faced when assessing the spiritual distress needs of their terminally ill patients. This chapter presents the findings of eight face-to-face, open-ended and semi-structured interview and the responses garnered from hospice nurses working in a hospice in the Pacific Northwest. The lived experiences of the eight participants were explored in relation to their beliefs and opinions of the challenges they face when assessing spiritual distress as well as their comfort levels in utilizing the assessment instruments to assess these needs.

The information in Chapters 1 and 2 elucidated the beliefs of Puchalski, (2008) of the importance of utilizing spirituality within healthcare and the positive benefits it had on the emotional, psychological, and physical wellbeing of patients. It was also identified in chapters 1 and 2 that the author at the ANA, (2012) recognized the need for hospice nurses to infuse sensitivity in their care for terminally patients' by incorporating spirituality within their healthcare. Developing the themes that emerged through the interviews was possible as a result of these participants sharing their life experiences and their willingness to respond to nine, open-ended, semi-structured questions.

Each theme was directly correlated to each participants' personal revelation and lived experience of the challenges they have encountered when attempting to integrate spirituality within their healthcare. The design, analysis procedure and the data collection process was discussed within this chapter as well as a brief description of each participants responses garnered through the interviews. The direct quotations from each of the participants were identified and highlighted and resulted in themes and codes that allowed me to categorize them in chronological order of the experiences most felt by each participant.

Demographic Characteristics of the Sample

The sample consisted of eight participants, two men and six women. Four participants identified themselves as Caucasian, one participant as Hispanic, and one as Chinese and two as European.

Table 1 presents all data from the demographic questionnaire.

Table 1 *Demographic Characteristic of the Samples*

Participant	Age	Gender	Race	Year Graduated	Years as a Hospice Nurse	Degrees
P-1	30	F	Caucasian	2011	2	B S
P-2	61	F	Hispanic	2008	1 ½	AA
P-3	57	F	Chinese	1990	25	BSN
P-4	57	F	Caucasian	1982	27	AA
P-5	52	M	Caucasian	1987	7	BS
P-6	59	M	European	1985	11	AA
P-7	53	F	Caucasian	1983	5	AA
P-8	59	F	European	1977	38	BS

Data Generation, Collection, and Recording

After the study was approved by Walden (IRB Approval number 05-19-15-00117588), I began recruitment of my participants as described in Chapter 3. I emailed the nursing clinical manager and sent him a copy of my proposal and cooperation letter (see Appendix B). After he agreed to participate in my study, he emailed me the contact information for all of the hospice nurses working within the hospice. I then emailed each participant and attached an invitation letter (see appendix C).

After the hospice nurses wrote back and agreed to be in my study we set up a date and time to meet. After we set up a time and date I met with each participant one by one and obtained a signed informed consent agreement prior to beginning the interview, (see Appendix D) at this point, I reminded each of the participants that their participation was voluntary and that they

could withdraw from the study at any time without repercussion. Data was collected through individual interviews with the use of an interview guide consisting of nine questions and five demographic questions (see Appendix A).

Three of the eight interviews took place on Monday, May 25, 2015. The other five interviews took place on May 26, 2015. All participants met at the hospice on the time designated. Only one participant arrived 20 minutes late, during this time I listened to the other audio recordings and wrote in my journal. I audio-recorded eight interviews from May 25-May 26, 2015. Each interview ranged between 60- 75 minutes, totaling 540 audio-recorded minutes. All eight participants signed the consent form prior to beginning the interview. During each interview I wrote the content and demeanor of each participant to assist me in capturing the essence of the interview. After completing each interview, I wrote my initial thoughts and impressions of the participant and their responses into my journal. This helped me remember each participant and reflect on each interview response, body language and demeanor.

Overview of Design and Procedure

This study examined the challenges that many hospice nurses face when assessing spiritual distress needs with their terminally ill patients. Each participant agreed to participate in this study and discuss their beliefs and views regarding their lived experiences. I utilized a qualitative, phenomenological method using semi-structured, face-to-face interviews with eight participants.

Data Analysis

The data gathered from this study was garnered through semi-structured, open ended, face-to-face interviews with eight hospice nurses. The data was collected by asking each participant nine interview questions and five demographic questions (see Appendix 1). All questions were

semi-structured questions that were directly linked to the research questions. The first step to begin the data analysis was to compile the demographic information of each of the participants which was collected prior to the interview. The demographic questions did not include any identifiable information such as participants' names, addresses, or contact information.

The participants for this study were hospice nurses working in a hospice in WA State. I contacted the clinical nurse manager through an email at the hospice to ask permission to conduct the study and to sign the cooperation letter (see Appendix B). A copy of my proposal was also emailed to him.

The following criteria was utilized to select the participants (a) the hospice nurse had to be licensed in Washington State (b) the hospice nurse must work within the hospice (c) the hospice nurse must be willing to be interviewed in person and recorded and (d) the participants must be willing to respond to each of the open-ended questions. If the participants was not comfortable responding to any question, they were allowed to skip the question. Interviews were scheduled for each participant at the date, time and location allocated for the interviews. Each interview question was based on the research criteria.

During the interviews an audio recorder was set between the participant and myself. Once the interviews were conducted and professionally transcribed, I attempted to obtain an understanding of the data collected. My goal was to understand the data gathered through the responses of each participant. During this stage, I made certain that no errors were made during the transcription process. To make certain errors were not made I reviewed each transcript carefully and listened to the audio recordings. I paused and made notes as I listened to each participant and wrote down specific responses of specific relevance to the phenomenon. I continuously wrote down repeated words that were used more than once per participant. I also

wrote down specific words that were mentioned several times for each specific question. For example, when I asked the participants what spirituality meant to them, I tabulated how many times each participant responded with the same words. I wrote what I heard to help develop ideas about each category and relationships within the data (Maxwell, 2007).

The data was then arranged into each category based on how the responses were related. I then proceeded to code each one using a highlighter. These categories were then utilized to identify the initial set of themes that formed each code. I reviewed each of the transcripts over and over again, and again pulled out key words/phrases that were constant across the mainstream of the interviews. I then placed specific themes and highlighted each of them in different colors after each review. Every time a new theme emerged, they were added to the already existing color highlighted codes. I continued to add new data to the already existing data which allowed for a continued analysis of the themes.

I utilized a journal to record my perceptions, thoughts, biases and any other relevant information after/during each interview. Through the audio recordings and journal entries I began to reminisce about the participant and remembered certain body movements. Every emotion that was expressed by each participant began to resonate even through several weeks past.

When all interviews were completed and I had analyzed each, I utilized member checking to help improve the accuracy and credibility of each of the responses. In order to do this, I emailed each participant and asked them a time and date we could meet. I set up a specific time and date for each participant and we met at the small conference room at the hospice. I asked each participant to read through the transcripts carefully and to make certain I had documented exactly what they had intended to say. Each participant read through the transcripts and made the

appropriate changes and modifications. I then went back and attempted to present their lived experiences in the most accurate manner possible. Once all their feedback was noted and changed, I analyzed the data once again. At this point I was certain that I had portrayed the participants' responses as accurate as possible.

Participant Profiles

This section provides a brief description of each participant. Pseudonyms represent participants listed in the order in which they interviewed.

Barbie

Barbie was a 30 year old, Caucasian female. She has worked as a hospice nurse for 2 years. She considers herself spiritual but not religious. When asked what spirituality meant to her she stated, "Spirituality takes many forms. Spirituality to me is a connectedness and a rapport to something that is outside of the self. It is bigger than oneself. It may or may not give you answers but it's a comfort to you so in my faith it is takes expression to believe in a God or Jesus, but in other people's faith and other people's expression sometimes it's communing with nature, sitting in their balcony, sipping tea, watching a herd of elk, sometimes it digging in my garden and connecting with nature or some peace that they can't get in any other way but to get to silence and get away from noise and confusion and stuff. It is bigger than we are."

Tabatha

Tabatha was a 61 year old female. She has worked for the hospice for 1 ½ years. When asked what spirituality meant to her she stated "Spirituality to me would be, I have a very, sort of rather logical view of spirituality. It would be truth finding. So spirituality to me would be understanding the universe."

Loretta

Loretta was a 57 year old Chinese female. She has worked as a hospice nurse for 25 years. When asked about what she felt Spirituality meant to her she stated "It addresses more of the essence of the soul, it's larger than we are. It is more than any regimented religious tenants. It's the thing that makes each of us who we are in our individuality. It's the thing that seeks good, but could be just my individuality."

Debra

Debra was a 57 year old Caucasian female. She has worked as a hospice nurse for 27 years. When asked about what she felt spirituality meant to her she stated, "I do not have a good answer for that… it is an inner thing that you just feel. It is larger than what my explanation can ever attempt to define."

Paul

Paul was a 52 Caucasian male. He has worked as a hospice nurse for seven years. When asked what he thought spirituality meant to him he responded, "It is my meaning, its emotional, it's physical. It's an intuitive place all wrapped into one."

Jerry

Jerry was a 59 year old European male. He has worked as a hospice nurse for 11 years. When asked what he thought spirituality meant to him he responded, "Spirituality means that there is a belief that there's more than just us. That there is something bigger, stronger than just us, whether that be God or whoever you believe that to be, be it nature or not.

Olivia

Olivia was a 52 year old Caucasian female. She has worked as a hospice nurse for 5 years. When asked what she thought spirituality meant to her she responded, "That's kind of a tough

question. It's kind of an inner kind of thing, it's something bigger than us, and it's our life meaning."

Miranda

Miranda was a 59 year old European female. She has worked as a hospice nurse for 3eight years. When asked what she felt spirituality meant to her she stated, "Uh, to me it's more of an inner personal thing. Um, well personally it's a religion. In one of my sociology classes, someone asked what was God to me…I said it is a combination of Mother Nature and the force. Although I am not a science-fiction kind of person, nature and spirituality are closely connected. It is an inner thing that is larger than us."

Data Analysis Results

Moustakas (1994) purports that qualitative research data is expressed through the words of the participants. It is not about graphs or descriptive narratives. Interviewing participants gives the researcher the opportunity to listen to the lived experiences of the participants and allows them to share and express their personal stories and beliefs. Table 1 will address the data as an alternative view of the demographics of the themes that were used more commonly by the participants.

Evidence of Quality

For this study I followed Moustakas (1994) steps which are described in chapter 3 to assure accuracy of the data. I asked the participants questions regarding their demographic information as well as collected their responses for the semi-structured, open-ended interview questions for the basis of data collection. I audio-recorded each of their responses and highlighted the themes and words most used within their responses. I then proceeded to read through my journal to collect the themes and to code them into categories. I began to establish solid themes and

repeated words and phrases. I was able to establish saturation which laid out several common themes that were utilized within the interviews.

My biases were not interjected within the data results due to the use of my journal. Although I consider myself spiritual, and I rely on my faith to provide peace and solace through hardships I respect the opinions of others and would not judge them for not having a spiritual belief. Crucial to this study was my commitment to suspend all judgement and only examine the phenomenon as presented by each participant.

Due to my commitment to the integrity and quality of this study, I did not allow myself to ask follow-up questions to any of my participants based on my personal feeling regarding spirituality and the importance of utilizing it with terminally ill patients. I was able to avoid interjecting my perceptions through each interview by eliminating interference with the data collected. I made certain that each participant felt comfortable and at ease while speaking of their stories and lived experiences by not interpreting the meaning at the time of the interview. The purpose of this study was to discover and not to interpret phenomenon.

Additionally, member-checking was used to make certain that I captured each of the participants' lived experiences and stories in their own words. Through the use of open-ended, semi-structured, interview questions I was able to produce the data. I utilized each of the responses, their demographic information and number of years as a hospice nurse to report the outcomes. The evidence is seen through all of the transcript excerpts throughout this chapter demonstrating trustworthiness, quality and accuracy.

When I concluded interviewing each participant and reviewing all of the transcripts, I again contacted each participant through email and asked them to set a time and date to see me to share the transcripts with each of them. I did this to ensure that I had captured the accurate portrayal of

each of their stories. Member-checking is used to assure that my interpretations of their lived experiences are accurately portrayed and in my findings (Merriam 2002). I asked each participant to provide any feedback, modifications of my transcripts and if they felt I had captured their true words. Each participant was very satisfied with my interpretations and transcripts.

Themes

It became apparent after a few interviews that although spirituality was difficult to define and agree upon some words and phrases resonated. Several participants expressed that spirituality meant believing in something larger than oneself, that it was an inner feeling. Many of the participants expressed that spirituality was about finding meaning and purpose in life. The lived experiences of hospice nurses began to emerge regarding the challenges that they faced regarding understanding their patients' spiritual distress needs as well as their own definitions of what spirituality meant to them.

All of the participants expressed their dissatisfaction with the training and education they had received from their nursing program regarding spirituality and assessing spiritual distress. They also expressed their dissatisfaction with the workshops and training in utilizing the assessment instruments to assess these needs. All of the participants also expressed their stories regarding what spirituality meant to them and how important it was to incorporate spirituality within their healthcare to assist patients' fears, anxieties and physical pain.

Paul stated "spirituality is the meaning, its emotional, it's physical. It's an intuitive place all wrapped up into one." Almost all responses from the participants referenced spirituality being about finding meaning, that it was larger than the self and that it was an inner thing. All of the

participants also stated that they would definitely use the assessment instruments if they had training in utilizing them.

Barbie best described this phenomenon by stating;

> "Spirituality takes many forms Spirituality to me is a connectedness and a rapport to something that is outside of the self. It is bigger than oneself. It may or may not give you answers but its comfort to you so in my faith it is takes expression to believe in a God or Jesus, but in other people's faith and other people's expression sometimes it's communing with nature, sitting in their balcony, sipping tea, watching a herd of elk sometimes it digging in my garden and connecting with nature or some peace that they can't get in any other way but to get to silence and get away from noise and confusion and stuff. It is bigger than we are."

As each participant discussed similar topics, common themes began to present themselves. Phenomenological analysis attempts to unravel the meaning of the phenomena captured from the point of view of the participant. The interview process enlightened many hospice nurses of the benefits of utilizing spirituality within their healthcare and learning about the assessment instruments used to assess spiritual distress. It also made hospice nurses aware of the deficiencies of their nursing programs training and workshops geared in understanding spirituality. Each participant found this topic important and relevant especially working with terminally ill patients.

All participants expressed their thoughts and views regarding spirituality and their feeling of better incorporating spirituality within their healthcare. Specific themes began to emerge through the interviews. The themes included (a) spirituality is important (b) spirituality means different things to different people (c) spirituality is larger than the self (d) Spirituality is about meaning

and purpose (e) spirituality is an inner thing. These themes directly related to the research question: (a) what beliefs, perceptions, experiences and challenges do hospice nurses face when attempting to infuse spirituality within their healthcare? (b) What is the experience of nurses in the use of existing tools and guidelines when assessing spiritual distress?

The themes are presented in chronological order and starting with the most commonly endorsed theme from each participant. According to Smith et.al (2009), a general guideline utilized to consider a theme relevant is if 50% or more participants endorsed that same theme. However, in specific cases, a theme may be relevant despite only arising in one participant's story. Following this guideline, primary themes are ones that were brought up with at least 2 or more participants when expressing their personal story. The cut-off point was four, representing at least half of the sample population. Each of the themes were briefly defined. Direct quotes illustrate salient themes. Each participant shares their own personal stories. Responses endorsing these themes are examples and not all inclusive (see Table 2).

Table 2

Emergent Themes from Constant Comparison Analysis: Interview Question 1.

What does spirituality mean to you?

Themes	Code for each Theme
Spirituality is something within. It is larger than the self. It gives meaning to life. Spirituality is truth-finding. Spirituality is an inner personal thing. Spirituality takes many forms and is unique to each individual. Spirituality is person, nature and spirituality. Spirituality addresses the essence of the soul. It is important for healing.	Spirituality is larger than ourselves. It is unique to each individual. It is an inner-thing. Important for healing.

Table 3

Emergent Themes from Constant Comparison Analysis: Interview Question 2.
How familiar are you with the assessment instruments utilized to assess patients' spiritual distress?

Theme	Code for each Theme
Not at all	Not at all

Table 4

Emergent Themes from Constant Comparison Analysis: Interview Question 3.
Which instrument do you utilize within your practice to assess spiritual needs?

Theme	Code for each Theme
No instrument used. Spiritual counselor uses them. I do not use any instruments. I am not familiar with any instruments. The instruments	I use no instruments. I am not familiar with any instruments.

I use are touch and listening. When I visit the family house I look to see if there are any indications of spirituality or religion and then I have the opportunity to speak about spirituality.

……....

Table 5

Emergent Themes from Constant Comparison Analysis: Interview question 4.
What do you know about the instruments to assess spiritual distress?

Themes	Code for each Theme
There needs to be more attention towards Spirituality. I am not familiar with them I wish I were more familiar of them. I am Not familiar with any, but wish I were. More training is necessary.	Not familiar with them at all. More training is necessary.

Table 6

Emergent Themes from Constant Comparison Analysis: Interview question 5.
Do you consider yourself spiritual?

Themes	Code for each Theme
Yes, I consider myself very spiritual. I wish there were more training in spirituality. There is a grey area when speaking of spirituality. I consider myself more spiritual than religious.	Yes I consider myself very Spiritual. More training is necessary to feel comfortable.

Table 7

Emergent Themes from Constant Comparison Analysis: Interview question 6.
What are your thoughts regarding the emphasis that nursing programs place in their courses to address patients' spiritual needs?

Themes	Code for each Theme
The nursing programs should incorporate more courses and training in spirituality. Since there are many issues in death and dying they should place more emphasis in teach hospice nurses. I have had courses but not training, making it Difficult to assess spiritual distress.	Nursing programs should incorporate more courses and training within their curriculum.

Table 8

Emergent Themes from Constant Comparison Analysis: Interview question 7.
How do you see practicing nurses assessing their patients' spiritual needs?

Themes	Code for each Theme
Listening to the patient. Asking questions one Their feelings. Spirituality is not an easy topic To talk about and many times it is difficult to Bring up the subject. More training would make It more comfortable to bring up the topic. It is difficult to assess my patients' spiritual needs and many times it could be harmful if I am not familiar with the topic.	Listening to the patient. More training is necessary.

Table 9

Emergent Themes from Constant Comparison Analysis: Interview question 8.
Do you feel you can competently and completely use the assessment tools available?

Themes	Code for each Theme
Yes, with training I would use the assessment instruments. I would you the assessment tools If I were more comfortable. More training is needed. It is important to understand all facets of not only physical pain and fear, but emotional and spiritual pain as well.	Yes, I would use the tools if there were more training.

Table 10

Emergent Themes from Constant Comparison Analysis: Interview question 9.
Do the spiritual beliefs of nurses affect their comfort level in meeting their patients' spiritual needs?

Themes	Code for each Theme
Our beliefs and our patients' beliefs should never Interfere with our comfort level in meeting their spiritual needs, but many times they do.	Our beliefs and patients' beliefs should never affect our comfort level. But they do.

Participants commonly endorsed the word spirituality to mean larger than the self and something that provides meaning and purpose to life. That spirituality was an inner feeling that brought peace. All of the eight participants described spirituality as an important source when faced with a traumatic event. When I asked them about what spiritualty meant to them, all eight participants agreed that it was important and significant. Many of the participants left the interview feeling that they are not doing all that is possible to assist their patients through this

difficult time and that understanding how to assess spiritual distress would be a positive for all involved. Here are the most common responses and themes:

Olivia: "Spirituality is kind of an inner thing. It's something bigger than us and it's our life meaning."

Miranda:

> "To me spirituality is a personal thing. Um, well personally it's a religion. In one of my sociology classes, someone asked what was God to me…I said it is a combination of Mother Nature and the force. Although I am not a science-fiction kind of person, nature and spirituality are closely connected. It is an inner thing that is larger than us."

Loretta: "spirituality to me addresses more of the essence of the soul, it's larger than we are. It is more than any regimented religious tenants. It's the thing that makes each of us who we are in our individuality. It's the thing that seeks good, but could be just my individuality.

> Debra: "she did not have a good answer for that… that it was an inner things that you just feel."

Each participant shared their feelings, thoughts, beliefs and opinions with ease. Each participant expressed the need to better understand these assessment instruments and to begin to learn about them through the internet and other resources. They all agreed that spirituality played an important role in the overall wellbeing of their patients.

Desire to better understand the assessment instruments. It was apparent from each participants' responses to question 2 that the participants were not familiar at all with the assessment instruments. All eight participants responded that they had no familiarity of any assessment instruments and that it was something completely new to them. Three out of the eight participants responded that they rely heavily on the spiritual counselors, social workers or

spiritual care workers to assess the needs of their patients and assumed they would be familiar with these tools. All eight participants expressed that many times the patient connects deeply with them and the conversation of spirituality begins to unfold making it difficult to refer them to a counselor. One participant stated that "as nurses we are taught to recognize there is an aspect to death and dying, and we encourage our patients to speak to a spiritual counselor however, because of the connection we have with our patients spirituality often comes up and we are at a loss."

What do you know about assessment instruments utilized to assess spiritual distress. All eight hospice nurses responded that they had no knowledge of any instruments used to assess spiritual distress and were upset their nursing program did not offer spiritual assessment courses and training. All eight participants agreed that treating the "whole" patient was most important and more emphasize on spirituality should be placed on training, workshops and courses.

Hospice nurses' perceptions of being spiritual. As the participants responded to the question of being spiritual and what it meant to them. All eight participants responded that spirituality was a big factor within. Each of the eight participants responded that they considered themselves very spiritual and that it was an important force when it came to facing challenges in life. One participant responded that many times spirituality and religious views and beliefs conflicted and thus was the reason for many hospice nurses not to speak of spirituality with their patients. That this topic could cause more harm than good if a conflict were to arise with patients when conflicting beliefs about religion and spirituality were present. Two of the eight participants responded that they would feel more comfortable if they had more education and training on the subject of spirituality. One participant responded by stating that they would not

walk away from a patient that was speaking to them about their spiritual needs, however, would feel there is a grey area when speaking to them about spirituality.

The assessment instruments. All eight participants agreed that they would utilize the assessment instruments if they were available to them and if they had the training. One participant responded by stating:

> I would use the tools if they were available however, don't like to step outside the box and would feel more comfortable with it if I had the training." Another participant responded stating that "Yes, I would use all the tools available to treat my "whole" patient and not just the physical. However, there are so many other elements that we do, we just can't do it all. We need to learn about patients that are in bed all day, to help patient eat when they are not swallowing well, I don't know if there is room for us to actually have a spiritual assessment tool and then be expected to do this as well." Another participant responded by stating, "I think that the spiritual beliefs of nurses do affect their patients' I think it would have an impact. Well let me think about that….I think about my co-workers I hope…. I can't speak for them. I think if I had no understanding of faith and how important faith can be to people, or how important a belief system is for people I think I would have a really hard time. You know if I was an atheist, because I have friends that are true blue atheists, and they love to argue about it, and I don't really get that… and I worry about them since they will get to the end of their life and will have no anchor when it comes to the end of life they will be missing an entire piece of our humanity by not having some spiritual aspect of themselves. They have no spirituality and can't believe the job I do. I say, honey, its coming for all of us, you can't ignore this we're all on this road. Death and the human experience we all get to do, and it's the most under prepared thing we do… we prepare for weddings, babies, graduation from

high school, graduating from college but we all get to do death and nobody is ready for it. Suddenly it's on them and then they are scrambling around thinking gosh what do I do? How do I think? How do I feel about what I think? It's huge.

Biases and comfort levels in meeting their patients' spiritual needs. As the interviews continued and the subject of their comfort levels came up when speaking of spirituality with their patients. One participant responded that "personal beliefs of nurses should not take over patients' beliefs, however, many times they do and this creates a problem not only for the patient but for the family and nurse. It is difficult to separate one's beliefs and faith and not share it with a patient that is suffering, but there is a fine line there." Another participant responded that "our beliefs should not affect our patients' spiritual beliefs, but it's hard not to let it. I think that this is a hard thing not to do. I am not sure what other nurses do or feel about this but I have found this very hard**.**" Another participant responded that "spiritual and religious beliefs of nurse's conflict with patients' beliefs many times but we need to be careful since it could cause turmoil and anxiety before death." Another participant stated that "It's hard when your patient wants to hang their heart on you. In these cases you are over-balanced… you're too close, your boundaries are not right. You're going to get lost yourself, you're going to burn out. As a hospice nurse you need to survive your experience or what happens you have a hospice nurse be a hospice nurse for a while then all of a sudden she's burnt out deep down and she's not a hospice nurse anymore. You want to last in this occupation, you need to know with each patient how tightly you need to hold and exactly when to let go, and not every nurse can have that balance."

Age, number of years as a hospice nurse and gender. The study had participants ranging from ages thirty to sixty-one and all had different number of years they have worked as hospice nurses. It did not seem to change the feelings and fears that many of these nurses felt when

speaking of their comfort levels when speaking of spirituality with their patients. All eight participants felt that they were not prepared or knowledgeable enough to discuss spirituality with their patients and assess their spiritual distress needs. The largest reason for this was their nursing program deficiencies of providing appropriate training and education on this topic. It was also apparent that the number of years as a hospice nurse did not make it easier to assess these needs. Gender was also not a factor when discussing the spiritual distress needs of their patients.

Summary

Chapter 4 provided a report of the findings based on my study of the challenges that many hospice nurses face when assessing the spiritual distress needs of their terminally ill patients. There were several section within Chapter 4 which included the demographic information of the participants, collection of data, recorded data, the design procedure and the relevant themes that were conjured through each interview. The relevant themes included (a) spirituality as a force larger than the self (b) spirituality being an important topic when working with terminally ill patients (c) spirituality as being a unique inner thing (d) spirituality as finding meaning and purpose for life and death (e) acceptance of death through spirituality. Some themes that developed through the interviews were the deficiencies of nursing programs when it came to providing training, workshops and courses geared in assisting hospice nurses prepare themselves when their patients bring up the subject of spirituality. Some of the common themes were (f) not enough training (g) conflict of beliefs (h) biases and conflict within their personal beliefs to that of their patients (i) comfort levels when speaking with their patients and (j) lack of education within their nursing programs.

Chapter 5 will address the findings and the strengths and limitations of the study. It will also disclose the evidence of the quality of this study along with the implications for social change. In conclusion, Chapter 5 will provide the recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Chapter 5 will present an overview of the study addressing the assumptions, limitations and recommendations. This chapter will also present the relevant findings of the study, themes, responses to each interview and a detailed analysis. Through the conclusion of the study I will address the implications for positive social change and the recommendations for application of the findings for future research. A summary of the study will conclude the chapter.

Study Overview

The purpose of this study was to garner information regarding the challenges that many hospice nurses face when assessing the spiritual distress needs of their terminally ill patients. The main interview question was utilized to find out how many participants were spiritual and their definition of what spirituality meant to them. The secondary interview questions were geared to address their familiarity of the assessment instruments used to assess spiritual distress and their comfort levels of assessing these needs.

I designed nine interview questions and four demographic questions (see Appendix A) that were semi-structured, open-ended and meant to illicit information from eight hospice nurses. Through these interviews my purpose was to better understand the challenges and personal experiences of hospice nurses when attempting to assess spiritual distress. Each interview question was relevant to the research questions in Chapter 1.

Eight participants were interviewed utilizing the semi-structured interview format. A hermeneutic, phenomenological method investigated the challenges that hospice nurses have when assessing spiritual distress and the reasons for these challenges. The primary goal of this study was to elucidate hospice nurses of the importance of integrating spirituality within their healthcare. The secondary purpose of the study was to enlighten nursing program administrators of the importance of integrating spiritual training courses within their nursing curriculum.

As discussed in Chapter 2 I found few peer reviewed articles addressing the need for nursing program administrators to provide courses, training and workshops geared to assess spiritual distress indicating a gap in the literature. Although there were a number of articles that discussed the importance of assessing spiritual distress in terminally ill patients, I found few articles that specifically focused on the nursing curriculum. The theoretical framework of existential theory (Frankl, 1962) and the stages of grief theory (Kubler-Ross, 1969) were utilized to frame this study. I also utilized a qualitative approach to gain insight into the perceptions of hospice nurses' views regarding their challenges of assessing spiritual distress. This study attempted to narrow the gap in the literature and provide significant information to serve as preliminary for future research on the deficiencies that the nursing curriculum offers their nurses regarding the assessment instruments for spiritual distress and spirituality in general.

Research Questions and Themes

Each of the themes derived from this research study directly related to the main research questions:

RQ1: What beliefs, perceptions, experiences, and challenges do hospice nurses face when attempting to infuse spirituality within their health care?

RQ2: What is the experience of nurses in the use of the existing tools and guidelines when assessing spiritual distress?

Individual responses identified the challenges that hospice nurses face when attempting to assess spiritual distress and the reasons for those challenges. All eight participants stated that although they were aware of the important role that spirituality had on the overall wellbeing of their patients they did not have the training or education needed to address these needs. All participants agreed that workshops and training through their nursing program were essential and

needed in order to assess these needs with their patients. Gender, age, race, and degree level were not found to impact the responses of the eight participants.

All eight participants believed that spirituality was important for the overall wellbeing of their patients and all participants stated that they were spiritual. It was also apparent that each of the eight participants would utilize the tools and instruments needed to assess spiritual distress if they had the training necessary to do so and if they had the tools available to them. Although there were numerous definitions of spirituality, four of the eight hospice nurses used the words, "larger than the self," an "inner thing" and "meaning and purpose to life" to define spirituality.

The secondary question asked the experiences of nurses in using the assessment instruments to assess spiritual distress. Eight out of eight participants answered that they were not familiar with any tools or guidelines; however they realized that it would be a significant resource to have when working with terminally ill patients that needed spiritual support. One participant even went as far as to say, "Although we are supposed to refer the patient to a spiritual counselor, the momentum sometimes disappears when having to wait for a spiritual counselor."

The words of each of the eight participants provided relevant and significant information suggesting that the nursing curriculum is not providing training, courses or workshops to address the need of hospice nurses to be better prepared to assess their patients' spiritual distress needs. The findings indicated that eight out of the eight participants wanted to know more about the assessment instruments to assess spiritual distress. Each participant responded expressing the need to have courses that emphasized spirituality and the many ways they can integrate it within healthcare.

In relation to the positive impact that spirituality has on the overall wellbeing of individuals, Puchalski (2008), purported that a strong spiritual belief helped in the treatment of depression,

arthritis, chronic pain, fatigue, mental health, advanced or chronic obstruction pulmonary disease as well as hypertension and heart failure. The author suggested that spirituality played an important role in suicidal ideation prevention in individuals with chronic illness. As stated in Chapter 2, Pattison (2013) purported that empowering patients to find meaning, peace, life purpose and acceptance resulted in improved health outcomes when a strong spiritual belief was present. Pattison (2013) expressed the power that spirituality had on women who recently completed treatment for breast cancer. The author suggested that when these women found meaning and purpose in life they were less likely to display depression and showed increased vitality.

Campbell, et al. (2010) emphasized the importance of being at peace when making critical medical decisions and the importance of having a strong spiritual belief when making these medical choices. For example the authors examined the link between faith and higher meaning/peace and purpose with quality of life and found that faith was unrelated to outcomes, whereas having a higher meaning and purpose in life was linked to having a higher quality of life (Campbell, et al). This suggested that finding meaning and purpose in illness is more advantageous than religious faith.

Puchalski, Ferrell and Virani (2009) concurred the need for patients to explore the meaning of their illness to give them a different perspective on their life. The authors purported that many times illness gives individuals time to think, especially in terminal illness thus giving patients the opportunity to re-evaluate their life and to give renewed value to those around them. For example, Kellie (2013) suggested that the pain and challenging emotions experienced during illness may emphasize the need to have the support of others around them and that this connection is sometimes more powerful than the illness itself.

Interpretations of the Findings

In this study the participants had the opportunity to discuss their personal stories regarding the challenges they face when assessing the spiritual distress needs of their patients. Through the study it became apparent that eight of the eight hospice nurses found spirituality to be an important resource to integrate within their healthcare, because of the positive impact it had not only on the emotional and psychological being of individuals, but their physical factors as well. All participants had the opportunity to discuss their personal stories regarding the confusion and biases that occur when conflicting beliefs between themselves and their patients arise. Eight out of the eight participants agreed that many times due to these conflicts, more harm than good arises, leaving both the hospice nurse and patient conflicted.

In my study, it was clear that there was a deficiency in nursing curriculum regarding spiritual assessment and spirituality in general. It was also apparent that spirituality played an important role in healing the "whole" patient. Although the AHNA, (2012) has prioritized spiritual health care among their top care concerns, there has continued to be a deficit of content hospice nurses when attempting to infuse spirituality within their healthcare.

Chapter 4 presented the common themes as each participant discussed similar topics. Through the use of a phenomenological analysis I attempted to disentangle the meaning captured from the participants lived experiences and perspectives. The primary theme endorsed by eight of the eight hospice nurses was the importance of integrating spirituality within their healthcare and the deficiencies of their training and education to do so. Chapter 2 discussed the importance of spirituality in all facets of the emotional, physical and overall wellbeing of individuals.

Previous research addressed the positive impact of having a strong spiritual belief on the emotional, psychological and physical wellbeing of patients. As expressed by Tiew and Creedy

(2010) study, there was a scarcity of information addressing the graduate nurses' perception of what spirituality was and the role that the hospice nurses played when addressing the spiritual distress needs of patients. An examination of senior graduate nursing student's perceptions of spirituality and the challenges of including spiritual care within their clinical practice was addressed. In addition to graduate nursing perspectives of spirituality, nursing faculty provided their perspective on the inclusion and effectiveness of spirituality in the nursing curriculum.

According to Tiew and Creedy (2010) the nursing literature contained little to no information in directing educators when planning to integrate spirituality in the nursing education curriculum. An exploration of the nursing education curriculum from the beginning of course work until graduation to address the spiritual distress needs of the patient was explored. The authors found that many nursing programs, especially in secular nursing programs which were non-religious or non-spiritual included minimal content addressing the spiritual needs of patients and how to integrate spirituality within the healthcare approach.

According to Ku (2010) the greatest disconnect in nursing education is the failure to prepare nurses for spiritual challenges while expecting them to meet the spiritual distress needs of their patients. Minimal content is included in the nursing curricula addressing spirituality and there is little to no direction for faculty on how to develop spiritual values in the nursing curricula and to the student nurse. Mayers and Johnson (2008) believed that nurses' lack of preparedness and education to provide spiritual care is due in part by the lack of appropriate courses in nursing curriculum.

Results of my study echoed the finding from the studies above which showed that participants were not prepared to assess the spiritual distress needs of their patients, although they were expected to assess these needs according to the authors of the ANA (2012). Data from

my research showed that eight out of the eight hospice nurses acknowledged the importance of integrating spirituality within their healthcare, however, were not prepared to do so due to the deficiencies of their nursing curriculum. This result implies that the nursing curriculum administrators are not providing adequate education in spirituality and that more training and workshops are necessary. It was also implied through the results that all participants would utilize the instruments, guidelines and tools to assess spiritual distress if they had the training to do so.

Previous literature discussed the importance of end of life resources and the important role that hospice nurses had when working with their patients. In Chapter 2, Mackinlay (2008) purported that many health care providers considered themselves as religious or spiritual however, lacked the formal education that prepared them to integrate spirituality within their healthcare approach. In addition, many of them did not know where to obtain the appropriate courses to enhance the information they already had. There are few workshops or programs available and dedicated to the spiritual health care of patients and this lack of education may cause many hospice nurses to be uncomfortable when assessing their patients spiritual distress needs and provide them with spiritual care (Mackinlay, 2008).

This study supported the contention that hospice nurses should be able to assess the spiritual distress needs of their patients. As the ANA (2012) stated the role of the hospice nurse is to infuse sensitivity to their terminally ill patients' by incorporating spirituality within their healthcare. However, nursing program administrators are not providing adequate, effective training or workshops to their nursing students. Additionally all eight participants agreed that it would be a benefit to patients, their family members and themselves to assess these needs and utilize the assessment instruments developed to assess spiritual distress. As the results of this

study found, many hospice nurses expressed the need to better address the pain, anxiety, depression and concern of their terminally patients however, were not prepared to do so using spirituality as the resource.

Although all participants expressed through the interviews that they were spiritual and found spirituality an important source for pain relief and other emotional ailments, they were not prepared to assess the needs of their patients. They did report that there were spiritual counselors they could call if a patient asked for spiritual support, however, many times the patient felt more comfortable with their hospice nurse and lost the need to speak to someone when waiting for the counselor to come into their room.

Existential Theory and Data Findings

This study utilized the existential theory in relation to spirituality and the benefit it has on the emotional, psychological and physical wellbeing of individuals. Viktor Frankl (1962), purports that finding the meaning of life was found in every moment of living and that life never ceased to have meaning even in suffering or subsequent death. Existentialists posit that true human existence represents the desire to touch others and to find the purpose of one's life. Frankl (1962) addressed the need for individuals to look within to find the meaning of their circumstances and to connect with others to find comfort, solace and ultimately acceptance of death (Frankl, 1962).

Since hospice nurses are the frontline providers for individuals that are terminally ill, it is imperative for them to learn the benefits of integrating spirituality within their healthcare. They should also learn to utilize the assessment instruments to assess spiritual distress. The Existential theory embraces the notion that spirituality helps terminally ill patients with their emotional turmoil as well as their physical pain, anxiety and overall wellbeing.

The search for meaning in life according to existentialists is identified as the primary force in human beings. In Frankl's approach there are three philosophical and psychological concepts: the freedom of will, the will to meaning and meaning in life. The first concept the freedom of will refers to human beings as being free to achieve goals and purposes. The second concept the search for meaning, suggests that meaning is seen as the primary motivation for humans. When individuals cannot identify their third concept "the will to meaning" they will experience a dreadful doom of meaninglessness and emptiness. This study attempted to narrow the gap in the literature and produce relevant information to serve as preliminary for future research on the reasons for hospice nurses to integrate spirituality within their healthcare and to enlighten nursing program administrators to provide training, courses and workshops on utilizing the assessment instruments to assess spiritual distress as well as spiritual support courses.

Interview Questions Relating to the Main Research Questions

Each interview question and theme that derived from the responses directly related to the main research question: what beliefs, perceptions, experiences and challenges do hospice nurses face when attempting to infuse spirituality within their healthcare? Each participant responded by expressing their challenges in the assessment of spiritual distress as very difficult since they did not have the tools, skills, training and education to do so. It became apparent that although the ANA (2012) stated that spirituality should play a role in healthcare through hospice nurses and that nursing curriculum did not provide this education.

The specific emotions of each of the 8 participants was frustration in understanding the spiritual distress needs of their patients and the misconceptions of how to incorporate spirituality within their care. All 8 participants believed that spirituality should be better integrated within their care. Each also felt that many times they would not know what to say and how to begin the

subject of speaking to their patients about spirituality because of the deficiencies in training and education. All 8 participants also expressed that they had the desire to assist their terminally ill patient through their impending death and each expressed that spirituality should be a part of this transitioning period however, felt they were not knowledgeable and educated enough to do so.

All 8 participants agreed that spirituality played an important role in their personal life. Some participants defined spirituality as being larger than the self and a deep inner feeling that provided comfort and peace within. Many of the participants also expressed that spirituality was about finding the meaning and purpose of life and thus also of death. The perceptions of each of the eight participants were that their nursing program did not provide the essential education to address spirituality with their patients thus leaving them to fend for themselves.

Although 4 of the 8 participants expressed that there were spiritual counselors that were trained to work with their patients, they also found that their patients trusted them far more and thus wanted them to talk to about this personal and deep subject. Through the interviews one participant stated that once the spiritual counselor did come to visit the patient, the momentum of speaking about their spiritual needs had already subsided. All eight participants also expressed their personal experiences when attempting to infuse spirituality within their healthcare. One participant stated that **"**I use touch and active listening when trying to understand their pain in all areas. However, sometimes it is a grey line and it is harmful if I do not know what they are truly asking. Training in this topic is definitely necessary."

Another participant responded by stating that "it would be best to understand spirituality better and have more knowledge on assessing spirituality with patients. Many times it is too difficult to understand the patient so I do not have the tools to assess spiritual needs with my patients." And yet another participant expressed **"**because I want to treat the "whole person" and

many areas of pain, including spiritual pain, I have difficulty assessing spiritual distress with my patients. I wish I had more training in this field." It became apparent through each of the interviews that they would find it less difficult to assess their patients' spiritual needs if they had more training in this area.

Results also applied to the secondary research question: What is the experience of nurses in the use of existing tools and guidelines when assessing spiritual distress. All 8 participants responded that they were not familiar with any assessment instruments, guidelines or tools to assess these needs. The interviews and words of the participants, provided information suggesting that they had no knowledge that these tools even existed. Two of the 8 participants expressed that they are not familiar with any tools and rely on their social workers, spiritual advisors and spiritual care workers to assess these needs, however that many times the patient only wants to talk to me.

The findings determined that although spirituality was looked upon by all 8 participants as a benefit to the overall emotional, psychological and physical needs of terminally ill patients, it was not being integrated within healthcare. Part of the problem was the deficiencies in the nursing curriculum. The other problems stemmed from the biases that many hospice nurses had when attempting to integrate spirituality within their healthcare.

In relation to the subject of existentialism and the role that spirituality has on individuals, it is fair to say that the incorporation of spirituality within healthcare is vital and that hospice nurses should be better prepared to assess these needs to assist the "whole" patient. Because of the many benefits that having a strong spiritual belief has on the overall emotional, psychological and physical needs of patients it is imperative that hospice nurses prepare themselves to infuse spirituality within their care. To this end, it is essential for nursing program administrators to

incorporate spiritual courses within their curriculum along with training of the assessment instruments utilized to assess spiritual distress.

Interpretations of the Challenges

In my study, participants discussed their perceptions, challenges and experiences of assessing the spiritual distress needs of their terminally ill patients. Each of the eight participants shared their personal life experiences and specific events that occurred. Chapter 2 reviewed prior research associated with spirituality and healthcare. However, previous literature minimally emphasized the nursing curriculums' deficiencies in providing training and education in this important, significant field.

My study wanted to investigate the challenges, experiences and perceptions of hospice nurses when infusing spirituality within their care as well as their familiarity with the assessment instruments to assess spiritual distress. I also wanted to determine their comfort levels in speaking to their patients about spirituality. I also wanted to elucidate the importance of providing spiritual courses and training within the nursing curriculum to prepare hospice nurses in integrating spirituality within their healthcare.

Chapter 4 presented the most repetitive and common themes each participant shared through their interviews. Through phenomenological analysis I attempted to unravel the meaning of each statement from each of the participants' perspectives. The primary theme endorsed by all participants was not understanding spirituality enough to incorporate it within their care, due to the deficiencies of their nursing program curriculum. Another common theme shared by eight of the eight participants was the important role that spirituality had on each of them as well as the benefits of infusing spirituality within their care.

Chapter 2 discussed the subject of spirituality and the many benefits it has when

incorporated within healthcare. Puchalski, Ferrell and Virani (2010) believed that spirituality was a fundamental facet of nursing and that spiritual care had little to do with religion. The authors purported that atheists and agnostics also relished in the spiritual care approach. These authors suggested that spirituality is predominantly concerned with meaning and purpose in life. For example, for many individuals having a strong spiritual belief may consist of family, friends, significant others and anything that is sacred to the individual. For others, spirituality may consist of following a higher power and serving others through their understanding of what is expected of them through their spiritual beliefs.

When addressing spiritual needs it is then essential for hospice nurses to take a genuine interest in the patient as a person and understand what spirituality means to them. For example, The ANA, (2012) suggests that the hospice nurse must connect with their patient and show genuine empathy, kindness and compassion. They must also take the time to listen and respect the opinions, views and beliefs of their patients without personal biases.

Results of my study revealed that 8 participants experienced some biases when speaking to their patients of spirituality. This may be because of the deficiencies of the nursing program in providing adequate and effective spiritual course training. Through previous studies it was determined that although there were assessment instruments specifically developed to assess spiritual distress needs, hospice nurses were not privy to this information.

Data from my research study determined that all participants would use the assessment tools, guidelines, and instruments to assess their patients spiritual distress needs if there were courses and training to do so. These results imply that the nursing program administrators are not providing these essential, relevant and significant courses to assist their nurses to better assist their patients. It was also found through my study that the comfort levels of the participants when

speaking to their terminally ill patients of spirituality were low because of fear they would overstep their boundaries and create a complex situation. Four out of the 8 participants stated that they rely on their spiritual counselors to do their job in assessing the spiritual distress needs of their patients, however, that many times the patient is more connected with them and trust in them to express their fears and anxieties rather than a counselor.

Previous literature discussed the benefits of medical professionals understanding the power of spirituality to assist their patients. According to Pargament and Koenig, (2004) leading experts in the study of religion and spirituality at Bowling Green State University, from a medical health professional's standpoint understanding patients' spirituality is valuable because spirituality may be a dynamic in understanding the disease and many times religious convictions may impact health care decision making. For example, spirituality may be a patient need and may be important in patient coping and acceptance of prognosis.

This study supported the contention that medical professionals which include hospice nurses should understand the spiritual needs of their patients because it may help them better understand their patients' needs and their healthcare decisions. This is an important and relevant factor when determining the choices patients' have at end of life procedures and end of life choices. Hospice nurses especially should have the education and training in spirituality to address these needs.

Limitations

The study is limited in geographical settings, and the fact that the participants were mostly Caucasian females. Only two of the eight participants were male which may or may not have changed the results. A more balanced sample of gender, ethnicity and race may have produced different results. The data from this study cannot be generalized beyond this group; expanded diversity, of this sample would be beneficial for future research. Future research should involve

the use of a large, diverse sample in a larger, more populated area to better identify consistent themes and establish saturation.

Delimitations

A delimitation of the study was the omission of the other routines and responsibilities of nursing care such as blood tests, blood pressure assessment and medications utilized by nursing professionals. Another delimitation was the assumption that the participants were forthcoming when responding to the interview questions. Because of the sensitive nature of the hospice nurses' role preconceived beliefs of their roles may interfere with their ability to respond truthfully to all interview questions.

Recommendation for Action

Based on the finding within this study, several recommendations for action have emerged. One being the need for hospice nurses to address the deficiencies of their education and training in spirituality and the assessment tools with the nursing program administrators so that future hospice nurses become aware of the positive impact that spirituality has on the overall wellbeing of patients. Secondly, for nursing program administrators to add courses and training in the assessment of spirituality. This recommendation would benefit not only the patients and their family members but the hospice nurses' themselves, as to not feel lost and anxious about speaking about spirituality.

It would also be helpful for hospice nurses to research this area of study in their own time to assure that if and when the subject comes up with one of their patients, they are more prepared and less anxious to do so. Biases only occur when one is not able to look at the perspective of others and respect their point of view. I believe through this education and knowledge, they will be able to feel more comfortable aiding the needs of their patients' spiritual distress.

Implications for Social Change

Death will inevitably be a part of each of us. We will all have to face death and prepare for the transition that this stage brings. Through this evolution we rely on others to help us through the struggles and anxieties associated with death. As stated by one of the participants, " death and the human experience we all get to do it, and it's the most under prepared thing we do… we prepare for weddings, babies, graduations from high school, graduating from college, but we all get to death and nobody is ready for it."

Hospice nurses work with one of the most vulnerable populations. They assist their patients through this difficult journey by providing pain control and a plethora of other services. However, as this study clearly identified, deficiencies in nursing curriculum regarding spirituality and the assessment instruments used to assess spiritual distress is evident. Hospice nurses are many times at a loss when attempting to infuse spiritual care within their practice due to this deficit.

The theories of social change make possible predictions of future change by reviewing the past events. The information provided by this study offers nursing program administrators the important and significant information to begin making the changes to their nursing curriculum. All individuals connected with hospice care will benefit from this change and will help future patients, family members and hospice nurses alike.

The data from this research study can lead to the awareness of the importance of incorporating spiritual courses within the nursing curriculum and enlighten nursing curriculum administrators of the benefits of doing so. Additionally, this study will help these administrators understand the overall benefits of providing the training necessary to utilize the assessment instruments to assess spiritual needs. Future application of this study may influence all medical

professionals and administrators of the importance of incorporating spirituality within their practice and train others to use the assessment instruments when assessing spiritual distress. With increased knowledge, not only will terminally ill patients and their family members benefit from this positive social change, medical professionals will benefit as well.

Recommendation for Future Research

For future research on this topic, it will be necessary to incorporate hospice nurses from other cities and states to participate in a similar study. In doing so, it will draw upon a larger demographic area where other factors such as race, ethnicity and beliefs can be studied as well. This would be significant since nursing programs differ in many states and perhaps they already incorporate spiritual courses within their curriculum and training on the assessment instruments and thus a comparison study could be reviewed. It would also be important for future research to compare the nursing schools curriculums from those that infuse spirituality within their courses to those that did not to identify the differences in patient and family satisfaction in end of life care. Wide-range sampling of hospice nurses from different countries will also benefit future research.

Summary

Spirituality plays an important role on not only the emotions and physical ailments of terminally ill patients, it is also a support system for the family members they leave behind. This study examined the many benefits that having a strong spiritual belief had on individuals especially those going through a traumatic event such as dying. The primary research question asked: what beliefs, perceptions, experiences and challenges hospice nurses face when attempting to infuse spirituality within their healthcare?

The purpose of this study was to garner information from 8 hospice nurses regarding these challenges and understand why these challenges exists through their perspectives. With the information gathered through face-to-face, semi-structured interviews I began to better understand why these challenges exist and what to do to make a positive social change within the nursing programs to change these challenges. A phenomenological, hermeneutic, qualitative method utilizing semi-structured, face-to-face interviews was applied.

The sample consisted of 8 participants' four women and two men hospice nurses ranging from ages 30 to 59. Many of the participants were from diverse ethnic backgrounds working in a hospice in the Pacific Northwest. The theoretical framework consisted of Frankl's (1962) existential theory and Kubler-Ross's (1969) stages of grief theory. All 8 participants reported that they were spiritual and that spirituality was an important component in their lives. Although all 8 participants' defined spirituality in their own unique manner, common themes began to emerge from the interviews to establish that spirituality meant something larger than the self, and that spirituality brought meaning and purpose to life, it was also garnered through the interviews that spirituality was a unique inner thing that brought peace and solace.

Through the lived experiences of these 8 participants, stories emerged regarding the challenges that they had faced when attempting to infuse spirituality within their healthcare and the reasons they did not feel comfortable addressing these needs with their patients. It became apparent that these nurses did not receive the courses or training in their nursing program to establish a better way of integrating spirituality into their care. It was also found that hospice nurses were not familiar with any assessment instruments developed to assess spiritual distress. Social change implications benefit nursing program administrators, medical professionals, terminally ill patients, patients, family members and future hospice nurses. Additionally,

knowledge providing a better understanding of the benefits of utilizing spirituality within healthcare has been established through this study.

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Appendix A

INTERVIEW PROTOCOL

1) What does spirituality mean to you?
2) How familiar are you with the assessment instruments utilized to assess patients' spiritual distress?
3) Which instruments do you utilize within your practice? Why?
4) What do you know about them?
5) Do you consider yourself spiritual?
6) What are your thoughts regarding the emphasis that nursing programs place in their courses to address patients' spiritual needs?
7) How do you see practicing nurses assessing their patients' spiritual needs? Sub-questions: How did you become familiar with the tools to assess spirituality?
8) Do you feel you can competently and completely use the assessment tools available?
9) Do the spiritual beliefs of nurses affect their comfort level in meeting their patients' spiritual needs?

Demographic Questions

1) Your age
2) Your race
3) Year graduated? With what degree
4) Years as a hospice nurse?

Appendix B

Letter of Cooperation

Community Research Partner Name:
Contact Information:
Date:

Dear_____

Based on my review of your research proposal, I give permission for you to conduct the study entitled **Assessing Spirituality Among Hospice Patients: A Phenomenological Study of Hospice Nurses** within the As part of this study, I authorize _____ to use a private room within our facility after I have emailed/contacted each potential participant and they have agreed to participate in the study.

The interview will consist of one on one, face-to-face semi-structured, open-ended questions with eight hospice nurses working at in a Pacific Northwestern State. The interviews will be approximately 15-25 minutes in duration. The interviews will be electronically recorded by_____ and the data will be transcribed at a later date. In addition, _____ will keep a journal and write down key information garnered from the participants during the face to face interviews.

_____ will also schedule a 15-30 minute follow-up session after the initial interview with the eight-10 hospice nurses to allow them to member-check their responses to assure the researcher that the information is correct.

Before, during and after the study the participants will have the opportunity to ask questions of _____and obtain any information related to the study by the researcher. _____ will review the data at the conclusion of each interview and will analyze, interpret and construe the data into themes and meanings in order to lay the foundation for

codification. The information collected will be confidential and each of the participants name or identifiers will be deleted. The data will be stored in an Excel file and maintained on a password protected flash memory data storage device and will be destroyed after three years of the study.

Furthermore, the participants will be informed that their participation is completely voluntary and at their own discretion and that they could withdraw from the study without repercussion. The participants will also understand that they will not be compensated for their participation in anyway.

We understand that our organization's responsibilities includes: A private, quiet room to conduct the interviews. We reserve the right to withdraw from the study at any time if our circumstances change. _____ will be responsible for complying with our site's research policy and requirements.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies. I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Authorization Official

Contact Information

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed

name, their email address, or any other identifying marker. Walden University staff verify any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

Appendix C

Invitation Letter

Date: May 19, 2015

To whom it may concern: ALL HOSPICE NURSES

I am a post-graduate learner under the direction of_____ in the College of Social and behavioral Sciences at Walden University. I am conducting a research study to discover how hospice nurses assess spiritual distress and the challenges that they may face when attempting to assess spirituality with their terminally ill patients. I am inviting your participation, which will consist of answering nine questions about the topic as well as a few demographic questions. The expected duration of your participation will be approximately 60 minutes. You have the right not to answer any question, and to stop the interview at any time. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. The responses to the interview will be used to help hospice nurses as well as other medical professionals' address the difficulties that they may be facing when attempting to assess spiritual distress with their patients. There are minimal foreseeable risks or discomforts to your participation.

Your responses will be anonymous and the results of this study may be used in reports, presentations, or publications but your name will not be used. I would like to audiotape this interview. The interview will not be recorded without your permission. Please let me know if you do not want the interview to be taped; you also can change your mind after the interview starts, just let me know. The tapes will be kept in a secure, safe, and fireproof storage facility for 3 years at which time all data, recordings, and transcripts will be destroyed. In addition, all handwritten and printed material will be shredded and deleted from all computer drives, jump drives, and hard drives containing any confidential information.

If you are interested in participating in the study or have any questions concerning the research study, please contact the researcher directly @

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the College of Doctoral Studies tele_____.

Sincerely,

Appendix D

CONSENT FORM

You are being asked to take part in a research study of **the assessment of spiritual distress in terminally ill patients from the perspective of hospice nurses**: The study will examine through the perspective of hospice nurses the challenges that many of them may face when assessing spiritual distress with their terminally ill patients.

The researcher is inviting eight licensed hospice nurses from diverse cultures and religious backgrounds, ranging from ages 25-65 working in a Pacific Northwestern State to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named_____ in the School of Social and Behavioral Sciences at Walden University.

Background Information:

The purpose of the study is to explore the challenges that many hospice may encounter when attempting to integrate spirituality within their healthcare. The challenges that the study will explore will be the assessment instruments that they utilize when assessing spiritual distress. The study will also address the difficulties that many hospice may encounter when defining spirituality and the training and academic courses they have had to feel comfortable and knowledgeable when assessing spiritual distress.

Procedures:

The research sample will consist of eight-10 hospice nurses working in a hospice in a Pacific Northwestern State. The researcher will conduct approximately a 60 minute face to face in-depth interview asking open-ended, semi-structured questions in order to gather significant information by you.

At the time of the interview a consent form will be provided, read and signed by you and you will then give permission to be electronically recorded. In addition, a follow-up session of approximately 30 minutes will be conducted at a further date for the purposes of sharing the data that the researcher has collected and making sure that there are no discrepancies of information. The 30 minute follow-up session gives you an opportunity to check the information provided by the researcher regarding your responses and to assert that the arguments, themes or assertions are correctly developed and that the researcher described your statements and responses accurately.

The researcher will also keep a journal and write down key information garnered from you during the face to face interviews.

- 60 minute face-to-face interview
- 30 minute follow-up session at a separate, designated time

Interview Questions

1) What does spirituality mean to you?

2) How familiar are you with the assessment instruments utilized to assess patients' spiritual distress?

3) Which instruments do you utilize within your practice? Why?

4) What do you know about them?

5) Do you consider yourself spiritual?
6) What are your thoughts regarding the emphasis that nursing programs place in their courses to address patients' spiritual needs?
7) How do you see practicing nurses assessing their patients' spiritual needs? Sub-questions: How did you become familiar with the tools to assess spirituality?
8) Do you feel you can competently and completely use the assessment tools available?
9) Do the spiritual beliefs of nurses affect their comfort level in meeting their patients' spiritual needs?

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at Walden University or Hospice Hospital, will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as time constraints and you may experience some minor risks, such as fatigue, stress or becoming upset.

Being in this study would not pose any risk to your safety or wellbeing. Some benefits of participating in this study will be that you will express your opinion, struggles, challenges that you as a hospice nurse may be experiencing when attempting to integrate spirituality within your health care. You will also be able to express how and if the assessment instruments utilized by hospice nurses actually assist you in addressing the subject of spirituality with your patients. You will also be able to provide your opinions and views regarding your training or lack of when addressing spirituality within your health care and your comfort level when attempting to infuse spirituality within your approach.

Payment:
No payment will be given to participate in this study.

Privacy:
Any information you provide will be kept confidential.
The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by: All data, notes, will be kept in a secure, fireproof safe for 5 years. Passwords on computer data will be secure. After the 5 years all data, notes will be destroyed.

All participants will be informed of their right to confidentiality at the commencement of the data collection process at which time they will be asked to sign a confidentiality agreement. Confidentiality will be addressed again during data cleaning at which time the researcher will remove all identifiers in order to produce a clean data set.

The researcher will address confidentiality during research development which will consist of writing the proposal and obtaining consent from the ethics review board. The Researcher will also safeguard confidentiality during data collection, data cleaning and the distribution of the research results. In order to protect confidentiality of the participants, all identifying agents such as names, gender, religion and ethnicities will be changed.

Some of the identifiers will be replaced with pseudonyms that will be deleted from the file once they are no longer necessary. The researcher will consider whether the specific quotations and examples presented by the participants' can lead to their identification through deductive disclosure. The researcher will also be responsible to determine what facets of the participant's life circumstances need to remain confidential.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via Phone Contact:

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By participating in a 60 minute face-to-face, semi-structured, open-ended interview and a 30 minute follow-up session I agree to participate in this face to face, semi-structured, open-ended interview.

Printed Name of Participant

_____

Date of consent

_____

Participant's Signature

_____

Researcher's Signature.