How Christian nurses converse with patients about spirituality

Jane Bacon Pfeiffer, Carla Gober and Elizabeth Johnston Taylor

Aims and objectives. To describe the experience of conversing with clients to provide spiritual care from the perspective of Christian nurses identified as exemplary spiritual caregivers. More specifically, findings presented here describe the goals and strategies of these nurses when conversing with patients about spirituality.

Background. Although verbal communication is pivotal to most spiritual care interventions recognised in the nursing literature, there is scant empirical evidence to inform such spiritual care. There is evidence, however, that many nurses have discomfort and difficulty with conversations about spirituality.

Design. Cross-sectional, descriptive, qualitative design framed by phenomenology.

Methods. Semi-structured interviews were conducted with 14 southern California registered nurses working in varied clinical settings. Data were coded and thematically analysed by three researchers who established equivalency. Methods to support the trustworthiness of the findings were employed.

Results. Themes providing structure to the description of how nurses converse with patients about spirituality included assessing and establishing connection, overt introductions of spirituality, finding spiritual commonality, self-disclosure, spiritual encouragement, spiritual advice or religious teaching, and prayer. Requisite to any spiritual care conversation, however, was ‘allowing them (patients) to talk’. Informants tread ‘gently and softly’ in approaching spiritual discourse, assessing for any patient resistance, and not pushing further if any was met.

Conclusion. Findings illustrate compassionate nursing with specifiable goals and strategies for conversations about spirituality; they also raise questions about how nurse religious beliefs are to ethically inform these conversations.

Relevance to clinical practice. The Invitation, Connection, Attentive care, Reciprocity mnemonic is offered as a means for nurses to remember essentials for communication with patients about spirituality.

Key words: communication, converse/conversing, nurse, patient, spiritual care, spirituality

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What does this paper contribute to the wider global clinical community?

• In an era of nursing where mandates and expectations for nurses to assess and care for patient spiritual health are prevalent, there is a paucity of evidence describing if and how nurses do this.
• Findings describe nurse goals and strategies for spiritual discourse with patients, including being open and flexible, asking questions to establish a connection, giving spiritual encouragement and counsel, and not pushing if a patient resists.
• These data illustrate spiritually intimate connection made through verbal communication, yet also raise questions about the presence of nurse religiosity at the bedside.

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Introduction
Nursing education, research and practice has increasingly placed emphasis on holistic care that addresses patient spiritual well-being. Nursing education curricular standards recognise spiritual assessment and support as an essential part of nursing care (e.g. Australian Nursing & Midwifery Council 2006, American Association of Colleges of Nursing 2008, Nursing & Midwifery Council 2010). Nurse researchers have also increasingly investigated spirituality from patient and nurse perspectives (Ross 2006, Cockell & McSherry 2012). Nurse clinicians are frequently expected to complete spiritual assessments, use NANDA-I diagnostic labels for spiritual and/or religious distress or potential for enhanced well-being, and in general, be generalist spiritual care providers (Ruder 2013, Taylor 2011b).

Many spiritual care ‘interventions’ have been identified (Cavendish et al. 2003, Taylor 2008). Although some of these approaches may simply be good care or psychosocial care (e.g. listening, caring touch), a theme throughout this literature is that nurses converse with patients about spiritual topics. Yet there is scant evidence about how nurses talk with patients about their spirituality. What do they say? What strategies do they use for discussions about spirituality? What do nurses wish to have happen as a result of such conversation? This study seeks to describe the verbal communication of spiritual caregiving. This focus allows in-depth exploration of one salient, yet neglected, constituent aspect of spiritual care. Findings will allow nurses to begin to think about how to talk with patients about spiritual matters, and to consider the ethics, effectiveness and efficiency of such discourse.

Background
The ability to converse with patients about spiritual concerns is considered by nurse scholars to be a core competency for spiritual care (Baldacchino 2006, van Leeuwen et al. 2009). When nurse clinicians are asked about what they think constitutes spiritual care, ‘interventions’ requiring conversation are always overtly identified. For example, about 90% of nurses in the UK responding to an online survey about spiritual care (n = 4054) believed that spiritual care included ‘listening to and allowing patients time to discuss and explore their fears, anxieties and troubles’ and ‘giving support and reassurance’ (McSherry & Jamieison 2011). Likewise, surveys of oncology nurses have documented ‘discussing an issue in-depth’ (Kristeller et al. 1999) and ‘verbally communicating about spiritual or religious concerns’ (Taylor et al. 1995) to be a frequent spiritual care intervention. Grant (2004) documented that 92% of 299 surveyed hospital nurses reported offering listening as a spiritual therapy to patients and 29% provided ‘spiritual counselling’. Yet evidence describing how nurses converse with patients about spirituality is sparse and insufficient. What evidence exists will be reviewed.

Spiritual assessment is often accepted as the initial step in the process of providing spiritual care. A spiritual screening, at least, is frequently delegated to nurses to perform (Puchalski & Ferrell 2010). Methods for conducting a spiritual or religious assessment are described in many nursing resources (e.g. Taylor 2012, O’Brien 2014). How to ask questions to a client to collect information for a spiritual assessment is thoroughly described in these sources. Although asking clients about their spirituality can concurrently be an ‘intervention’, asking questions is not always the best response to client expressions of spiritual need (Taylor 2007).

How to formulate verbal responses, especially responses to patients’ expressions of spiritual distress, may be what nurses direly need to know. In a quantitative study of 200 nurses and nursing students, Taylor and Mamier (2013) observed a wide variation in ability to respond to spiritual distress empathically. For this study, participants wrote responses to vignettes illustrating a patient expressing spiritual distress. These responses were coded and quantified using a scale measuring empathic response. The normal distribution of these nurses’ empathic response scores indicated that whereas some nurse responses would be healing, others were potentially hurtful. These researchers observed that even average responses could potentially potentiate patient spiritual distress when nurses fail to listen deeply and respond empathically.

A few qualitative studies have described the process of communication in the context of spiritual care. Considine and Miller (2010), for example, observed hospice clinicians (including nurses) shifting ‘dialectically’ between leading and following as they conversed with clients about spirituality. Belcher and Griffiths’ (2005) findings from surveys of 204 hospice nurses indicated that they were typically comfortable with spiritual care, which they viewed primarily as verbal or nonverbal expression of personal spirituality and religiosity. This spiritual care manifested in being positive, supportive, empathic, accepting, hopeful and respecting client beliefs. Deal and Grassley’s (2012) phenomenological study of ten dialysis nurses’ spiritual care described how this care, which they argued is deeper and more intimate than psychosocial care, involves conversations that require
the nurse to ‘reach deep within to respond to the patient’ (p. 476).

Several studies document the discomfort that nurses have with conversing with patients about spirituality (Swift et al. 2007, Pesut & Reimer-Kirkham 2010, Smyth & Allen 2011, Gallison et al. 2013). This discomfort is usually identified as a barrier to spiritual care. This discomfort typically is explained by nurses in terms like: ‘It is an invasion of patient privacy’, ‘I’m worried the patient will think I’m trying to evangelize’, ‘Where I work there isn’t time or space for such conversation’, ‘I’m embarrassed to talk about it’, ‘I’m not spiritual or religious’ or ‘I’m not trained to do this’. It is no surprise then that surveys of nurses document they perceive they are not adequately trained to discuss spiritual or religious issues with patients (McSherry & Jamieson 2011, Ruder 2013).

This review indicates that nurse–patient conversation (listening and speaking) is central to nursing care intended to ease spiritual distress and promote spiritual well-being. Yet it also suggests that nurses may have discomfort and difficulty with conversations about spirituality. Given the centrality of conversation to spiritual care, and the potential for conversations to harm patients (and possibly nurses), it is important for nurses to know how to converse to assess and support patient spirituality. To begin to understand how to helpfully converse about spiritually with patients, research is needed that describes existing nurse practices in regard to conversing about spirituality.

The aim of this study was to describe the experience of conversing with clients to provide spiritual care from the perspective of nurses identified as exemplary spiritual caregivers. More specifically, the study findings presented here seek to describe (1) how nurses define spiritual care, (2) goals or plans nurses have for conversations with clients about spirituality, and (3) strategies nurses use that guide how they converse to give spiritual care.

Methods

Design

A cross-sectional, descriptive, qualitative design framed by a phenomenological orientation, along with congruent empirical methods, guided this exploration to describe how nurses converse to provide spiritual care. Phenomenologists seek to inductively describe and gain plausible insights about everyday human experience as they appear from the perspective of the expert living that experience. To do so, phenomenological methods value such things as intentionality, intersubjectivity and bracketing presuppositions that could influence the researcher’s awareness and interpretations of the data (Cohen et al. 2000).

Subjects and setting

Nurses identified as spiritual care experts (i.e. ‘information rich cases’) were recruited to participate as informants for this study. Although all nurses are expected to deliver a basic level of spiritual care, some may have particularly well-developed skills because of experience or education. Therefore, nurse spiritual care experts were identified and invited to contact the researchers either through a nurse administrator, word of mouth or an advertisement published in a nursing newsletter. Thus, nurse participants were expert if they recognised this themselves or if a colleague or supervisor recognised this. Additional inclusion criteria included (1) being a registered nurse (RN) with at least three years of work experience, (2) current employment as a RN on average at least ten hours per week and (3) work primarily with adult clients.

Nurse informants were all recruited from urban, southern Californian (USA) hospitals. An attempt was made to recruit informants purposefully to reflect varied demographics and work settings. Likewise, the investigators initially planned to interview nurses from diverse religious backgrounds. Only Christian nurses, however, self-identified or were identified by colleagues as potential participants. Given the prevalence of Christianity among nurses in the USA, and the need to describe how a Christian nurse’s religiosity might affect spiritual care discourse, the sample was delimited. Indeed, the sample may reflect the predominantly Christian culture of southern California, as well as American society where even the entertainment and marketing industries capitalise on the public’s spiritual yearnings and where it is generally acceptable for strangers to banter somewhat superficially about religion.

The sample size was determined by the data, that is, when saturation occurred (i.e. no new themes were identified), data collection ceased. While many phenomenological studies have samples of ten or less informants, Sandelowski (1995) advises that about 25 descriptions of the target experience are needed. In this study, 54 stories of conversing with clients for spiritual care were obtained from 14 informants.

Data collection and procedure

Demographic and career information about the informant was collected via a 1-page survey at the start of the interview process after informed consent was obtained. Next, one of the researchers conducted a semi-structured
interview (JP 13, EJT 1) that was digitally voice-recorded. The questions for the semi-structured interview are presented in Table 1. Note that the first question allowed the informant to provide context, while the final question gave the informant an opportunity to debrief about the interview experience. The interviewer also used follow-up responses to questions with further probes as necessary. When the researcher set up the interview time and location, a copy of the interview questions was offered to those potential informants who wished to premeditate responses. Interviews lasted from 1–1.75 hours. After the interview, each informant was thanked with a tube of hand lotion.

Data management and analysis

Interviews were transcribed verbatim; these were checked for accuracy and then entered into NVivo version 8.0 (QSR International, Burlington, MA, USA). Thematic coding was conducted concurrently with data collection. Each significant idea (word, phrase or paragraph) was assigned a code. Once the data were coded, constant comparison within and among codes occurred. This allowed themes to be grouped when meanings were related, and validated when no data presented discrepancies.

Table 1 Semi-structured interview

<table>
<thead>
<tr>
<th>Question</th>
<th>Notes</th>
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<tbody>
<tr>
<td>(a) For you, what is spiritual care? Follow-up, if necessary: How would you describe or define spiritual care?</td>
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<tr>
<td>(b) Tell me about a time when you provided spiritual care. Follow-up, if necessary: What did you do? What did you say? What prompted you to give this spiritual care? [If the story is one of caring in nonverbal ways only (e.g. being present without speaking), then ask for another example.]</td>
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<tr>
<td>(c) Tell me about the strategies that guided you as you talked with this client about his/her spiritual needs. Follow-up, if necessary: Are there any formulas or tips that you’ve picked up that help you respond to clients like this in a helpful way?</td>
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<tr>
<td>(d) Can you think of a time when talking to patients about spiritual things didn’t go as planned, or as you would have hoped? Tell me about that situation. (What happened? What did you say and/or do? And why do you think this was a not-so-good example)?*</td>
<td></td>
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<tr>
<td>(e) When you talked with this client about his/her spirituality, what goals might you have in your head for the conversation? (Follow-up, if necessary: What did you want to see happen as a result of that conversation?</td>
<td></td>
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<td>(f) What determined whether you initiated this conversation about spiritual matters with this client? (What influences you to say anything that might affect a client’s spiritual health?)</td>
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<tr>
<td>(g) Are there any ethical, philosophical or religious values that might have influenced how you talked with this client about spirituality?</td>
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<tr>
<td>(h) What advice would you give to other nurses about how to talk with clients in ways that promote spiritual health?</td>
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<td>(i) In our interviews, thus far, we’re observing some differences in how nurses integrate spiritual care with nursing care? There are ways we as nurses approach our nursing as caring, and yet there is some point at which it becomes spiritual care. What is it that makes spiritual care different from just ‘good care’? (Do you see it as something that you do which is distinct from providing good care, and how? What aspects of the story you just told do you see as representing good care? And which represent spiritual care)?*</td>
<td></td>
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<tr>
<td>(j) Is there anything else you would like to add about how to communicate with clients to provide spiritual care?</td>
<td></td>
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<tr>
<td>(k) We’ve noticed so far in nurses some seem to have a pretty clear framework in how they approach their giving of spiritual care, and for others after a bit of assessment, it ‘just kinda’ unfolds’. (Where are you in this conception? Or do you have yet another perspective on how you give spiritual care)?*</td>
<td></td>
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<tr>
<td>(l) What was this interview like for you?</td>
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</table>

*Questions that were added to the interview schedule after several interviews were completed.

Given the data were analysed by three investigators, a process for establishing equivalency between the investigators as they coded and clustered themes was essential. This process involved independently coding two interviews, then pairing off and comparing codings. Discrepancies were discussed until agreement was reached. This process generated not only equivalency, but also a common coding schema.

Trustworthiness

Several strategies were employed to promote the rigour of the study’s findings (Lincoln & Guba 1985). They included ‘prolonged engagement’ and collecting in-depth or ‘thick’ descriptions of the phenomenon with each informant, ‘peer debriefing’ when researchers met regularly to discuss the analysis, ‘member checks’ or re-interviewing four informants to clarify significant statements, purposive sampling of nurses from varied clinical settings and having audio recordings (and verbatim transcriptions) of each interview. Because the investigators’ personal religious perspectives and previous scholarship were recognised as potential influences on the interview and analysis processes, ‘bracketing’ or reflecting in a journal on the personal and professional factors contributing to the research process was done at the
beginning of the study and during the data collection phase.

Human subjects

Ethics approval was obtained from the university where the principal investigator was employed. A process of collecting informed consent was completed with each informant prior to the collection of any data. Various strategies were used to protect confidentiality and informants’ anonymity.

Results

Informants included 14 RNs, all of whom were Christians and eight of whom were white. Whereas most worked in inpatient settings as staff nurses, a few worked as clinical educators or in an outpatient setting. Except for two, all worked in a Christian healthcare system. Informants’ ages and number of years working as a nurse varied greatly. Table 2 provides further information about these participants.

Nurse definitions of spiritual care

When asked, ‘What is spiritual care?’, many informants responded initially with answers that suggested it addressed emotional distress or involved the use of religious practices (mostly prayer) with patients. When pressed (especially to distinguish spiritual care from simply good nursing care), however, informants often described at least one of the two features of spiritual care. Spiritual care meant (1) deeply respectful and compassionate care that was ‘beyond’ physical care and involving intentional connection, and (2) assessing and addressing spiritual needs such as the need to have hope, meaning and other ‘soul needs’. These descriptions of spiritual care were articulated well by a particularly insightful nurse (no. 3):

We give spiritual care. Or we give care spiritually, let me put it that way. So in other words we are approaching that patient and giving care from a spiritual part within us that connects with that patient. But then we can also at the same time, deal with those patients’ spiritual needs in giving spiritual care where we actually address some of those issues such as meaning making and relational connectedness, hope, and all of those aspects of spirituality.

Spiritual care was seen as integrated with other nursing care and as a reflection of the spirituality of the nurse. These views of spiritual care become more complete when considering their goals for spiritual conversations.

Goals and plans for spiritual conversations

Many identified general goals for spiritual care discourse, such as ‘lifting one’s spirits’, ‘making a patient feel whole’, giving them comfort, peace, hope, dignity, joy, meaning, ‘making them feel valued’ and ‘cared for’. One nurse stated her goal for a patient would be ‘spiritual wellness – whatever the patient’s goal for spiritual wellness might be’.

Table 2  Sample description

<table>
<thead>
<tr>
<th>Nurse no.</th>
<th>Gender</th>
<th>Age</th>
<th>Work setting</th>
<th>Ethnic/cultural background</th>
<th>Education</th>
<th>Years in nursing</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>46</td>
<td>Educator, intensive and intermediate care</td>
<td>White</td>
<td>AS</td>
<td>7</td>
<td>Christian</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>51</td>
<td>Med/Surg, telemetry</td>
<td>Romanian</td>
<td>AS</td>
<td>3</td>
<td>SDA*</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>26</td>
<td>Neuro-ICU</td>
<td>Argentinian</td>
<td>BS</td>
<td>4</td>
<td>SDA*</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>55</td>
<td>Ambulatory care clinic</td>
<td>White</td>
<td>BS</td>
<td>5</td>
<td>Protestant</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>56</td>
<td>Intermediate care</td>
<td>Hispanic</td>
<td>BS</td>
<td>20</td>
<td>SDA*</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>45</td>
<td>Med/Surg</td>
<td>Filipina</td>
<td>AS</td>
<td>1</td>
<td>Christian</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>33</td>
<td>Medical ICU</td>
<td>White</td>
<td>BS</td>
<td>8.5</td>
<td>Christian</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>51</td>
<td>Medical ICU</td>
<td>Romanian</td>
<td>AS</td>
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<td>9</td>
<td>F</td>
<td>51</td>
<td>Med/Surg, telemetry</td>
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<td>10</td>
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<td>Neuro-ICU</td>
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<td>11</td>
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<td>Ambulatory care clinic</td>
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<tr>
<td>13</td>
<td>F</td>
<td>45</td>
<td>Med/Surg</td>
<td>Filipina</td>
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<td>Christian</td>
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*Seventh-day Adventist.
Several of these informants also identified overtly religious goals. Such goals included aiding the patient to ‘grow spiritually or come to know the Lord’, ‘leading the patient to the ultimate healer of the soul’ or supporting the patients ‘connecting with God’. As one informant stated, ‘When I’m with someone, I want them to know that God loves them, or that they are safe when they’re with me, that they’re accepted’. That is, she believed by being a safe and loving nurse, the patient may have an indirect or vicarious glimpse of a loving God, if a more open awareness of God is not experienced.

Most informants recognised that it was important not to have an agenda for spiritual care conversations and that any plan needed to be flexible. They continually assessed the patient responses to this discourse and let it ‘unfold’, or as one nurse stated, ‘Go with the patient, be entirely open to where the patient is’. Another nurse recognised, ‘I may steer a conversation, but I try not to do it for my own agenda. I try to have it be something that could be of benefit to them’.

While being open and flexible, however, several of these nurses also had a plan that guided their spiritual care conversations with patients. A rather specific plan for spiritual care discourse was developed by an outpatient oncology clinic nurse, who visited all patients over the course of their treatments. As she put it, ‘I’m looking to see where the patient is at, where they think they’re at, and then helping them to get where they want to go’.

The plan for most of the informants, however, was less specific. This framework guiding spiritual discourse reflected a statement made by one nurse that all the informants undoubtedly would have affirmed: ‘Often emotional issues lead to spiritual issues’. Given this assumption, therefore, these nurses described how they intentionally and immediately worked with clients in ways to build trust, relationship and open communication (e.g. by keeping promises, being polite, showing nursing competence, purposefully making their own hearts open towards the patient, viewing the patient as an equal, inquiring about personal interests, using therapeutic communication skills). As one informant described:

‘I’m not just there to perform my skills. I want to connect with them as a person. It might sound bad, but I want to get them in the position where they can feel that being vulnerable is okay, and at that point share their feelings with me or share whatever they need to get off their chest.’

In this context, nurses listened for distress or ‘brokenness’ and then would ‘go from there’. ‘Going from there’ involved using the following verbal strategies.

### Strategies

During the interviews, informants not only described how they talked with patients during overtly spiritual discourse, but also described ways of talking with patients so as to provide good care, which (as discussed above) was seen as a means for spiritual care as well. For instance, informants described what they said to patients to gain rapport and relationship, give information and comfort. Many examples of providing empathy and naming the distress (e.g. ‘I’m sorry you’re going through this now, it must be difficult’) were given. Also, these nurses often described validating and normalising the patient in the context of their problems [e.g. ‘it’s normal to express (anger) this way … because you hurt’]. A poignant example of validation came from a nurse who overcame personal repulsion to ask a transvestite patient about his tattoos and their meanings. By doing so, this nurse understood she was validating not only the tattoos, but also the patient as a person. These basic therapeutic skills of good nursing care were recognised for their inherent healing properties as well as for their likelihood of moving the patient towards spiritual discourse.

This presentation of findings, however, will be delimited to verbal discourse explicitly addressing patient spirituality. Although many overlap, the following themes provide structure to these findings of how nurses talk with patients about spirituality: assessing and establishing connection, overt introductions of spirituality, finding spiritual commonality, self-disclosure, spiritual encouragement, spiritual advice or religious teaching, and prayer. Requisite to any spiritual care conversation, however, was ‘allowing them (patients) to talk’.

### Allowing them to talk

Creating conditions for patients to talk was an essential aspect of spiritual conversation. Nurse 1 discussed the importance of naming the hurt at hand and allowing room for the patient to disclose further:

[I might say] “this must really be a hard time,” and just leave it. And then if they want to come back on that then I would probably let them steer more of the conversation. Pretty much anything I say after the initial acknowledgment is probably too much. I rarely have to try. It usually comes back on me with a big wave!

Nurse 9 described how she used prompts (e.g. ‘Oh really?’ ‘What?’) to elicit further patient disclosure. Nurse 12 likewise believed spiritual care discourse is best left in the patient’s court:
If I open a spiritual conversation, I’m not telling them about God, His goodness, and where He’s at. There’s a lot of times that I’ve done that, but that’s a very small percentage. Most—because I’m not there for me, I’m there for them. If they need that I will share it. But it’s just asking an open-ended question and just letting them say more and more.

Indeed, these nurses represent the majority of these informants in the way they believed spiritual care conversation should not control or manipulate a patient.

Assessing and establishing connection
For these nurses, questions asked for assessment purposes also functioned to foster spiritual conversation. Open questions identified included: Where do you get support? What have you found helpful in the past when you went through a very difficult time? What, if anything, good could come of this (cancer)? Have you ever had a time when you were just in awe of something that you saw was so beautiful? (This question was followed by, ‘This is the spiritual part of you that is experiencing something very deep and valuable.’) Nurse 14 asked questions about religious beliefs to steer conversations and interject her beliefs. For example, with an anxious patient who was a minister, she asked, ‘Are you a Christian? Do you know Jesus?’ After affirmative responses, she got to the punch line, ‘So what are you worried about?’ Nurse 10 recognised that spirituality is not necessarily assessed directly: ‘Asking them how they’re doing, engaging in conversation with them and that will, many times, bring up flags about where they’re at spiritually. It doesn’t have to be a spiritual conversation, because a lot of people won’t go there initially’.

Overt introductions of spirituality
Although spiritual conversations are sometimes initiated by patients [e.g. ‘I have found that when patients are sick and vulnerable, somehow God comes in the picture even when you don’t mention it’ (Nurse 12)], some of these informants broached the topic with patients without using questions. A couple of nurses described forthright approaches. For example, one sometimes told patients, ‘I’m here to care for you spiritually’. A few nurses also dropped obvious hints that would allow a patient to pick up and continue a religious conversation if they so desired. For example, when emptying a urine bag and finding the urine clearer, exclaiming ‘Praise the Lord!’ or when responding to a patient’s appreciation for music on the hospital’s nature channel, saying, ‘Yes, I like that and it talks about God’.

Finding spiritual commonality
Not only did these informants want to connect with patients in general so as to have a therapeutic relationship with them, a few were also eager to establish what they had in common religiously or spiritually. For example, when a patient denied belief in God but in ‘something being out there’, the nurse responded with ‘I believe in a higher power, too’. After a patient asked (male nurse) what his religion was and disclosed his own, Nurse 5 replied, ‘Great! We’re all brothers and sisters; we have the same God, pick up the same telephone!’

Self-disclosure
Some informants described how they shared personal spiritual or religious information with patients. They did so either in direct response to patient queries or because they believed their personal spiritual insights or experiences would be beneficial to the patient. Nurse 2 told of how a patient asked her why she was a Christian. Her answer was brief, and she concluded the story with, ‘I didn’t need to prove anything’. This nurse also told of how after she seemingly miraculously saved the life of a patient and the patient’s family asked her how she did it, she replied with an acknowledgement of Providence. Two nurses described how they shared stories of their husbands’ spiritual transformation with patients experiencing similar challenges.

Spiritual encouragement
This encouragement came in varied forms. Some affirmed the patient’s spiritual practices (e.g. seeing Bible at bedside and saying, ‘This is nice that you nourish your soul’), some used positive framing (e.g. ‘I don’t know how you do this . . . you must find strength somehow’, ‘You are blessed to have a baby that didn’t have as many problems as it could have’), and some affirmed personhood (e.g. ‘you are precious’). Nurse 10 encouraged a patient with these words: ‘I believe you, with God’s help, you can make a difference’. ‘I tell them God has a plan for them. If not, they wouldn’t be alive’.

Spiritual counsel
While some informants nudged patients with what might be spiritual counsel [e.g. to gain awareness of how spirituality affects illness, to ‘walk them through the releasing process’ (coaching family of dying patient to reconcile)], several informants provided distinctly religious counsel. For example, one nurse stated she had on occasion gone ‘through those verses in the Bible that will help and support them’. Nurse 6 described a time when counselling a former military officer, she said to him: ‘It must be terrible feeling not to be in control . . . (patient broke down) But you know
what? There is someone who is in control of the whole universe’. Nurse 2 described how she responds to patients who tell her that God does not listen: ‘God listens to everybody; let’s just say a pray together’. Nurse 3 told this story that illustrates a different tactic for counselling:

[I asked,] “You’re really unhappy with God, aren’t you?” And she said, “Yes, I am.” So we just sat there for a few minutes and let the – just go. And I said, “You know, it sounds to me from what you’ve told me, that your God is big enough to handle this.” She stopped and said, “You’re right. He is.”

While most of these stories suggest a bold expression of nurse belief, the final illustration shows how one nurse counselled a patient using information obtained from the patient.

Praying
All of these informants had stories of praying with patients. Indeed, they suggested that ‘90%’ to ‘99.9%’ of patients said yes to their offers to pray. Several described what a typical prayer might be like. Nurse 2’s prayer is illustrative:

Dear Lord, Please help ___ who is ___. Please help and come into this woman’s heart. Help her feel at ease. Be with this family at this difficult time, and be with this patient. Please help ease their suffering and do what is in your will.

Informants typically tried to have prayers reflect the content of the conversations they had with the patient. While many of the stories of spiritual care these informants told involved verbally praying with a patient, some told of praying privately, or ‘in my mind’, for patients.

Caution to not push
These data show nurses who openly discussed spiritual issues and religion in conversations with patients. These nurses, however, spoke of the considerable caution they observed with regard to such discourse. Generally, they described the importance of letting patients do most of the talking and leading. They also tread ‘gently and softly’ in approaching the topic, assessing for any patient resistance, and not pushing further if any was met. For patients with spiritual or religious issues they could not address, they made referrals to chaplains.

Discussion
In an era of nursing where mandates and expectations for nurses to assess and care for patient spiritual health are prevalent, there is a paucity of evidence describing if and how nurses do this. These findings provide a thick description of such care, specifically how Christian nurses converse with patients to provide spiritual care. Arguably, by understanding how nurses talk with patients about spirituality, much can be learned about how nurses think about spiritual care and actually practice it. These data name specific strategies for how a nurse can initiate and continue discourse on this sensitive topic, as well as goals and plans a nurse can have for such discourse. These goals and strategies identified in the data provide readers with concrete ideas for care that is often awkward and abstract. These data also describe how nurses can integrate spiritual care seamlessly in their work, as Clarke advocates (2013).

The purpose of this study was to describe the spiritual care conversations of nurses, not to evaluate their effectiveness or ethics. Study findings, however, do bring to the fore questions for future research and scholarly discussion. Clearly, the personal spiritual beliefs of a nurse impact how a nurse converses with patients to provide spiritual care. Nursing ethical codes recognise the inherent vulnerability of a patient and the import of nurses not proselytising personal values and beliefs during clinical encounters (Taylor 2012). Even Christian nurses are reminded that their role is that of nurse, not evangelist (Taylor 2011a). While these data suggest there may be times when nurses unethically impose their personal religious beliefs, the data also suggest there may be times when a patient appreciates and moves towards healing because a nurse initiated and shared spiritual beliefs. If this is true, then what are the factors that make such an encounter ethical and healing rather than unethical and hurtful? Given nurses cannot divorce themselves from their beliefs while at work, how can they be guided to appreciate and bracket their worldviews to give ethical care? Future nursing scholarship must strive to support nurses, most of whom are likely religious or spiritually sensitive to some degree (Taylor & Fowler 2011), to better understand how their personal spiritual beliefs and practices are best situated at the bedside.

There are several ways in which these study findings may be limited because of the methods. Although southern California is rich in human diversity, the majority of nurses in this sample were female and white. Likewise, all informants were Christian. Although this was not assessed, interview data suggest that they were committed and evangelical in their religiosity. Furthermore, although congruent with the method, the sample did self-select; it is probable that those who volunteered to participate as informants were more interested in and comfortable with initiating spiritual or religious conversations with patients than their colleagues. Likewise, although the investigators did bracketing about how their personal religious and professional beliefs intersect, their perspectives likely still influence the analyses. Additionally, most of the informants worked in a healthcare system.
with a mission to provide holistic care that includes spiritual care. Because no evidence-based criteria for what constituted an expert existed, inclusion criteria required informants identify (by self or supervisor) as expert in spiritual care. Therefore, the expertise of the informants is debatable.

Relevance to clinical practice
The themes identified in the data provide guidance for nurses conversing with patients about spirituality. A mnemonic, I-CARe, that encapsulates much of the wisdom taught by the informants of this study is offered here:

- Invitation and permission to discuss spirituality (whether patient or nurse initiated, recognizing ‘often emotional issues lead to spiritual issues’, assessment and rapport strategies, using caution to not push so patient boundaries are respected);
- Connection (‘giving care from a spiritual part within us that connects with that patient’, allowing them to talk, finding commonalities);
- Attentive care [addressing ‘felt needs’ or spiritual concerns in ethical spiritual encouragements, counseling (if ethical), prayer]; and
- Reciprocity (appreciating symmetry in the nurse–patient relationship and that patients can bless and teach nurses).

Each aspect is seen as a concurrent approach (vs. linear); throughout spiritual discourse, the nurse can internally consider whether these four aspects are present. I-CARe can be used to teach nursing students and clinicians alike.

Conclusion
Nurses are the healthcare professionals who are typically most physically present to patients. Even when spiritual care experts (e.g. chaplains) are available, the urgency of the situation, the existing rapport in the nurse–patient relationship or a patient’s resistance towards meeting with spiritual care experts may mean that it is the nurse who talks with a patient about spiritual concerns related to health. This research describes how religious Christian nurses talk with patients to support their spiritual health. While the findings illustrate compassionate nursing with specifiable goals and strategies for conversations about spirituality that can inform nurses, they also raise questions about how nurse religious beliefs ethically inform these conversations.

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Disclosure
The authors have confirmed that all authors meet the IC-MJE criteria for authorship credit (www.icmje.org/ethical_1author.html), as follows: (1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content, and (3) final approval of the version to be published.

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