



Spirituality in Nursing: Standing on Holy Ground

God called to Moses out of the bush: “Moses, Moses!” And he said, “Here I am.” “Come no closer,” God said. “Remove the sandals from your feet, for the place on which you are standing is holy ground.”

Exodus 3:4–5

Nursing is really about being intuitive and spiritual. . . . When you see nursing as a calling, you go to this higher level which is the vocation level, which has a spiritual dimension to the profession. . . . I think that whenever there is another human being involved, you see yourself as in a vocation, you really understand . . . “I can make it better” . . . one of my favorite mottos is, and I ask this of the nurses I work with: “if that woman was your grandmother, was your mother, was your sister, if that person was someone near and dear to you, how would you treat them?” That is the charge you have as nurses. Take care of these people like they were your own. That is the ministry way of looking at nursing; that is the spiritual way of looking at it.

Anne, Supervisor of a Critical Care Unit

Perhaps no scriptural theme so well models the spiritual posture of nursing practice as the Old Testament depiction of Moses and the burning bush. In the biblical narrative, God reminded Moses that, when he stood before his Lord, the ground beneath his feet was holy. When the nurse clinician, nurse educator, nurse administrator, or nurse researcher stands before a patient, a student, a staff member, or a study participant, God is also present, and the ground on which the nurse is standing is holy. For it is here, in the act of serving a brother or sister in need, that the nurse truly encounters God. God is present in the nurse’s practice of caring just as surely as He was present in the blessed meeting with Moses so many centuries ago. In an editorial in the *Journal of Christian Nursing*, Judy Shelly reminded us that “the holy ground we as nurses are called to enter may be . . . difficult . . . we face pain, suffering, fear, communication barriers, cultural and ethnic prejudice, injustice, impossible working conditions and constant obstacles” (2003, p. 3). However, Shelly adds, although we may at times “feel inadequate and defeated . . . God is with us. He offers

us his peace” (p. 3). This, I believe, is the gift and the grace of our nursing vocation of “standing on holy ground.” This is the blessing; the precious knowledge that, however great or small our nursing task may be, God is with us and will give us His peace.

This introductory chapter addresses the nurse’s spiritual posture, “standing on holy ground,” while also offering a historical perspective on the spiritual ministry of nursing. The overall relationship between spirituality and nursing practice is explored; the concepts of spirituality—as distinguished from religiosity or religious practice—and nursing are defined with a view to understanding their meaning for the contemporary nurse. Nursing practice is examined in relation to the nurse’s spiritual stance in caring for patients, the nurse’s participation in the provision of holistic care, and the nurse’s role as healer. Finally, a practice model, labeled a “Nursing Theology of Caring,” is described.

The empirical data on the spiritual concerns and needs of the ill in the present chapter, as well as those in the following chapters, are derived from nursing research with persons suffering from a multiplicity of illness conditions in a variety of settings. The author conducted both formal and informal interviewing and observation with these patients, their family members, and their nurse caregivers. The interview and observational data are supplemented by materials excerpted from journals maintained during the conduct of the research and also during a hospital chaplaincy experience.

THE SPIRITUAL MINISTRY OF NURSING: A HISTORICAL PERSPECTIVE

In a small but classic volume, *The Nurse: Handmaid of the Divine Physician*, written in the early 1940s, Franciscan Sister Mary Berenice Beck articulated what a great number of nurses of her era, especially those of the Judeo-Christian tradition, understood as the spirituality of their practice. Historically, nursing was viewed in large part as a vocation of service, incorporating a clearly accepted element of ministry to those for whom the nurse cared. A nurse’s mission was considered to be driven by altruism and empathy for the sick, especially the sick poor. The practicing nurse of the early and middle 20th century did not expect much in terms of worldly rewards for her efforts. She envisioned her caregiving as commissioned and supported by God; to Him alone were the thanks and the glory to be given. This vision of nursing as a spiritual ministry is reflected in Sr. Mary Berenice’s nurse’s prayer:

I am Thine Own, great Healer, help Thou me to serve Thy sick inhumble charity;

I ask not thanks nor praise, but only light to care for them in everyway aright.

My charges, sick and well, they all are Thine.

(1945, p. xvii)

Other nursing authors of the time also supported the concept of nursing as a calling, with a decidedly spiritual element undergirding its practice. As nurse historian Minnie Goodnow (1916) asserted, “Nursing is not merely an occupation, temporary and superficial in scope; it is a great vocation” (p. 17). She added, “It [nursing] is so well known to be difficult that it is seldom undertaken by a woman who has not, in the depths of her consciousness, an earnest purpose to serve humanity” (p. 17). And, in the introduction to a basic fundamentals of nursing textbook, *The Art, Science and Spirit of Nursing* (1954), author Alice Price observed, “Nursing is possessed of a spiritual quality, in that its primary aim is to serve humanity, not only by giving curative care to the bodies of the sick and injured, but by serving the needs of the mind and spirit as well” (p. 3). For the Christian nurse, the frequently quoted scriptural text supporting practice was that of Matthew 25:35–40, “For I was . . . sick and you took care of me. . . . I tell you, just as you did it to one of the least of these . . . you did for me.”

A condition that kept the original spiritual ministry of nursing alive in this country was the fact that many early to mid-20th century nurses received their education in nursing schools affiliated with one of the predominant religious denominations. Prior to the development of contemporary undergraduate and graduate programs in nursing, the 3-year diploma schools that were the norm were generally not associated with academic institutions. Rather they were sponsored by individual hospitals, many of which were religiously affiliated. These schools tended to be small and insular in character, taking on the spiritual élan of the hospital with which they were connected. This was evident in the rituals of passage such as “capping” and graduation that were often conducted in places of worship with the blessing of a cleric included as part of the ceremony.

In the latter half of the 20th century, however, although some U.S. nursing schools did retain a strong spiritual milieu as a characteristic feature, many of the newer university and college-affiliated programs began to focus on the professional character of nursing. Nursing publications and conferences described the characteristics of a profession, and much debate centered around how nursing incorporated specified professional criteria, particularly the criterion of autonomy of practice. These discussions were appropriate, as advanced healthcare technology and burgeoning knowledge generated by the behavioral sciences resulted in the practicing nurse requiring and receiving ever more sophisticated education related to patient care. For a time, at least, the proverbial pendulum appeared to swing toward the science, rather than the art, of nursing. This represented a concerted effort to bring nursing practice up to standard alongside medical practice and that of other caregiving professions.

During the 1970s and 1980s, however, despite the fact that curricula in baccalaureate and newly emerging master’s and doctoral programs in nursing were becoming increasingly more complex in terms of the biologic and behavioral sciences, many

were beginning to acknowledge the need for holistic health care. With the advent of the concept of holism, came a reawakening of the importance of the ill person's spiritual nature and a heightened concern for spiritual needs. In identifying a model for holistic nursing, nurse clinician and researcher Cathie Guzzetta (1988) described holistic concepts as incorporating "a sensitive balance between art and science, analytic and intuitive skills, and the ability and knowledge to choose from a wide variety of treatment modalities to promote balance and interconnectedness of body, mind and spirit" (p. 117). Thus, in the holistic nursing model, patients' spiritual nature and needs are brought into equal focus with their cognitive and physiologic needs.

Recently, an abundance of literature, both professional and lay, has begun to address the spiritual component of the human person. Books and articles abound relating to such topics as prayer, spiritual counseling, "near-death" experiences, interactions with angels, and volunteer activities undertaken for spiritual motives. Many individuals in our society are seeking to find transcendent meaning in their lives. It is not surprising, then, that nurses, now more solidly entrenched in their professional identities, should follow suit. As theorist Barbara Barnum (1994) pointed out, whereas nursing's focus during the past two decades has been on the "biopsychosocial" model of care, more recently nurse scholars have demonstrated a renewed interest in the spiritual dimension of caregiving (p. 114). Barnum's assertion is reflected in an increase in the nursing literature in conceptual and research-based articles related to the association between spirituality and health/illness. One example is the work of Jean Watson (1995) who observed, "At its most basic level nursing is a human-caring, relational profession. It exists by virtue of an ethical-moral ideal, and commitment to provide care for others" (p. 67). Watson's comment reflects a contemporary understanding of the spiritual ministry of nursing practice.

SPIRITUALITY AND NURSING PRACTICE

In order to provide some basis for beginning a discussion of spirituality and contemporary nursing practice, there must be a common understanding of the concepts of spirituality and nursing. Spirituality, as a personal concept, is generally understood in terms of an individual's attitudes and beliefs related to transcendence (God) or to the nonmaterial forces of life and of nature. Religious practice or religiosity, however, relates to a person's beliefs and behaviors associated with a specific religious tradition or denomination. Nurses need to have a clear understanding of this distinction or they may neglect spiritual needs in focusing only on a patient's religious practice (Emblen, 1992, p. 41).

The latter point is strongly supported by nurse practitioner Patricia Alpert (2010) in the article "Spirituality Goes Beyond Religiosity: A Much Needed Practice in Nursing." In the paper Alpert asserts, as noted previously, that "religion and

spirituality are not synonymous” and points out that religiosity may only be “a partial expression of one’s spirituality” and that “in health care, spiritual care may be viewed as religious care” (p. 140). Alpert defines spiritual care as “any act that nourishes the soul or spirit” (p. 141) and describes spiritual care as “fundamental to nursing practice” (p. 141).

Spirituality

Spirituality, as related to holistic nursing, is described by Dossey (1989) as “a broad concept that encompasses values, meaning, and purpose; one turns inward to the human traits of honesty, love, caring, wisdom, imagination, and compassion; existence of a quality of a higher authority, guiding spirit or transcendence that is mystical; a flowing, dynamic balance that allows and creates healing of body-mind-spirit; and may or may not involve organized religion” (p. 24). Pamela Reed (1992) presented a paradigm with which to explore spirituality in nursing by defining spirituality as “an expression of the developmental capacity for self-transcendence” (p. 350). Nurse anthropologist Madeleine Leininger (1997, p. 104) identified spirituality as a relationship with a supreme being that directs one’s beliefs and practices.

Spirituality viewed as a human need has been described as “that dimension of a person that is concerned with ultimate ends and values. . . . Spirituality is that which inspires in one the desire to transcend the realm of the material” (O’Brien, 1982, p. 88). For many individuals, especially those adhering to the Western religious traditions of Judaism, Christianity, and Islam, the concept of transcendence incorporates belief in God. This is reflected explicitly in the conceptualization of spirituality articulated by nurse Ruth Stoll (1989) who asserted, “Through my spirituality I give and receive love; I respond to and appreciate God, other people, a sunset, a symphony and spring” (p. 6). Prayers as indicating a meaning in life have been identified as indications of spirituality (Meraviglia, 1999); spirituality may thrive, however, outside the sphere of organized religion (Kendrick and Robinson, 2000).

Three characteristics of spirituality posited by Margaret Burkhardt (1989) include “unfolding mystery,” related to one’s attempt to understand the meaning and purpose of life; “harmonious interconnectedness,” or an individual’s relationship to other persons and/or to God; and “inner strength,” which relates to one’s personal spiritual resources and “sense of the sacred” (p. 72). Spirituality is proposed as a “cornerstone” of holistic nursing by Nagai-Jacobson and Burkhardt (1989) who suggested that questions appropriate to exploring a patient’s spirituality might include how the individual understands God and what things give meaning and joy to life (p. 23). Each nurse needs to understand his or her own spirituality, keeping in mind that this personal belief system may differ significantly from that of a patient and family.

The nursing literature offers no one clear definition of spirituality. As pointed out by Verna Benner Carson in the *Journal of Christian Nursing* (1993), “Definitions of spirituality represent a variety of worldviews and the opinions of people from divergent walks of life” (p. 25). Common to most descriptions of spirituality, as reflected in the nursing literature, are the elements of love; compassion; caring; transcendence; relationship with God; and the connection of body, mind, and spirit.

Nurse educator Janice Clarke presents a critical view of nursing’s definition of spirituality by suggesting that theology may provide needed insight into the concept. Clarke concludes that the broad explanations of spirituality existing in some of the nursing literature has led to “definitions which have the tendency to result in a type of spiritual care which is indistinguishable for psychosocial care, hard to explain to patients and difficult to put into practice” (2009, p. 1666).

In an article on the “range and diversity of definitions” of spirituality within the nursing literature, however, Swinton and Pattison (2010) argue that “It is in fact the vagueness of the concept that is its strength and value” (p. 226). These authors feel that a “thin” definition of spirituality will increase the usefulness of the concept in practical situations (p. 232). Other authors agree that the concept of spirituality in nursing is appropriately “open to interpretation” (Noble & Jones, 2010, p. 565); that “the concept (of spirituality in nursing) and its application have been the subject of much debate” (Pike, 2011, p. 743); and that “spirituality in nursing is a subject that is not easily defined, interpreted or understood” (Ellis & Narayanasamy, 2009, p. 886).

This diversity in the definitions of spirituality in nursing literature, accepted by Swinton and Pattison, is also supported by Bruce, Shields, and Molzahn in the paper “Language and the (Im)possibilities of Articulating Spirituality” (2011). The authors assert that incompleteness or differences in definitions of spirituality are “perhaps necessary and to be welcomed” (p. 44). They conclude that “lack of agreement [of definitions of spirituality] may suggest a way to protect profound human experiences” from being too cavalierly dismissed and/or the differences in definition may simply reflect “the impossibility of solidifying in language what is too fluid and experiential” (p. 50).

Nursing

Writing in the early 1950s, Alice Price (1954), offered a definition of nursing that incorporated not only the concept of the patient’s spiritual nature, but the altruistic vocation of the nurse as well. She described nursing as neither pure science nor true art, but as a combination of both. “Nursing, as a profession, will embrace more than an art and a science; it will be a blending of three factors: of art and science, and the spirit of unselfish devotion to a cause primarily concerned with

helping those who are physically, mentally or spiritually ill” (p. 2). Price ultimately defined nursing as “a service to the individual which helps him to regain, or to keep, a normal state of body and mind; when it cannot accomplish this, it helps him gain relief from physical pain, mental anxiety or spiritual discomfort” (p. 3). Although Nurse Price was writing some 25 to 30 years prior to the widespread acceptance of the term holistic nursing, her vision of the professional nurse’s role clearly included attention to the needs of a patient’s spirit, as well as to the needs of the body and the mind.

In their book *Introduction to Nursing*, written 40 years after publication of Price’s 1954 text, coauthors Lindberg, Hunter, and Kruszewski (1994) argued that, presently, because of the continual growth and development of the profession, no single definition of nursing can be accepted (p. 7). The authors presented excerpts of nursing definitions articulated by a cadre of theorists from Florence Nightingale in 1859 to Martha Rogers in 1970 but, ultimately, suggested that each practicing nurse develop a definition of his or her own. Lindberg and colleagues did, however, express the hope that, whatever one’s definition, it will contain an emphasis on caring or nurturing as a motivating factor for choosing nursing (p. 7).

Following the suggestions of Price in 1954 and Lindberg, Hunter, and Kruszewski in 1994, a current working definition of nursing follows:

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

The spiritual dimensions of the definition relate to two concepts: first, the sacred ministry of caring on the part of the nurse; and second, the ultimate goal of the patient’s achievement of a state of wholeness, including the wellness of body, mind, and spirit. These concepts are next explored in terms of the nurse’s spiritual posture, the patient’s spiritual wholeness, and the nurse–patient spiritual interaction.

Contemporary nursing authors continue to focus on the importance of spirituality in nursing. Some examples include a discussion of spirituality as a key concept in the nursing models of Betty Neuman, Margaret Newman, Rosemary Parse, and Jean Watson (Young & Koopsen, 2011, p. 7); a critique of nursing’s definitions of spirituality (Clarke, 2009); an analysis of the current debate about spirituality in nursing (Gray, 2009); identification of philosophical approaches to the study of spirituality in nursing (Tinley & Kinney, 2007); and literature reviews on spirituality and nursing and health outcomes (Pesut, 2008; Como, 2007).

THE NURSE'S SPIRITUAL POSTURE: STANDING ON HOLY GROUND

Sister Macrina Wiederkehr (1991) advised, “If you should ever hear God speaking to you from a burning bush, and it happens more often than most of us realize, take off your shoes for the ground on which you stand is holy” (p. 2). How appropriate, it seems, to envision practicing nurses, who must come together with their patients in caring and compassion, as standing on holy ground. God frequently speaks to us from a “burning bush,” in the fretful whimper of a feverish child, in the anxious questions of a preoperative surgical patient, and in the frail moans of a fragile elder. If we “take off our shoes,” we will be able to realize that the place where we stand is holy ground; we will respond to our patients as we would wish to respond to God in the burning bush.

But what does it really mean to “take off one’s shoes”? Sister Macrina asserted that it means stripping away “whatever prevents us from experiencing the holy” (1991, p. 3). She added that God speaks to us in many “burning bushes of today” and that “the message is still one of holy ground”; it is a message that is often missed “because of [our] unnecessary shoes” (p. 3). In the contemporary conduct of nursing practice, nursing education, nursing administration, and nursing research, some of us may admit to having a number of unnecessary pairs of shoes littering our professional closets. First, there are running shoes, which many of us wear as we rush pell-mell from task to task in order to manage the day. As we fly about, feet barely touching the ground, it is easy to forget, in the busyness, that where we are standing is a holy place. Another often relied on pair of shoes are sturdy walking brogues, which provide protection against unwanted intrusions. Unfortunately, their insulated soles, which keep us safe and secure, may also prevent our feet from feeling the holy ground on which we walk. And then there are old, favorite loafers, well worn and cozy. When we are wearing these shoes, we can so rest in their comfort that we need not be troubled by any disturbing bumps in the holy ground. We nurses probably have, I am sure, many more unnecessary pairs of shoes that prevent our feet from experiencing holy ground. But recollections of times past when, literally or figuratively, we have been able to take off our shoes, even if only briefly, well validate the Old Testament message.

HOLISTIC NURSING: THE BODY, MIND, AND SPIRIT CONNECTION

At times one hears an individual described as being truly healthy. The assumption underlying such a remark may relate not so much to the physical health or well-being of the person as to the fact that he or she is perceived as solidly grounded

spiritually. One can be possessed of a healthy attitude toward life, even if suffering from a terminal illness. In order to achieve such a spiritual grounding in the face of physical or psychological deficit, the individual must be closely attuned to the body, mind, and spirit connection; one must understand and accept the value of the spiritual dimension in the overall paradigm of holistic health.

As our society advanced scientifically during the past half-century, it became increasingly more difficult for some in the healthcare community to give credence to the importance of the spiritual nature of the human person, especially in relation to health/illness issues. More recently, however, caregivers are recognizing that sensitivity to a patient's spiritual needs is critical if they are to provide truly "holistic" health care. Nurse and minister Ann Robinson (1995) believes that nurses must "embrace the spirituality of the human community" in order to support their patients' holistic health behaviors (p. 3).

Authors Dossey and Keegan (1989) defined the concept of holism, which undergirds holistic health and holistic nursing care, including the body, mind, and spirit connection, as "the view that an integrated whole has a reality independent of and greater than the sum of its parts" (p. 4). They described holism as consisting of a philosophy of positive, interactionally based attitudes and behaviors that can exist not only in one who is well but also in one who is seriously or terminally ill (p. 5). Nurses practicing care supportive of such holism need to envision the spiritual needs of a patient as deserving of attention equal to that provided in response to physical and psychosocial concerns.

Overall, holistic nursing is supported by and alternately supports the intimate connection of body, mind, and spirit. Nursing of the whole person requires attention to the individuality and uniqueness of each dimension, as well as to the interrelatedness of the three. In *The Wholeness Handbook*, Emeth and Greenhut (1991) described the body, mind, and spirit elements: The body is the physical substance of a person that can be perceived in empirical reality; the mind is that dimension of an individual that conceptualizes; and the spirit is the life principle that is shared with all humanity and with God. "It is the dimension of personhood that drives us to create, love, question, contemplate and transcend" (pp. 27–28).

For the nurse seeking to provide holistic health care, then, the spiritual dimension and needs of the person must be carefully assessed and considered in all therapeutic planning. Spiritual care cannot be separated from physical, social, and psychological care (Lo & Brown, 1999; O'Connor, 2001). Often it is uniquely the nurse, standing either literally or figuratively at the bedside, who has the opportunity and the entrée to interact with patients on that spiritual level where they strive to create, love, question, contemplate, and transcend. Here, truly, the nurse is standing on holy ground.

THE NURSE AS HEALER

The nurse, standing as he or she does on the holy ground of caring for the sick, is well situated to be the instrument of God's healing. In the sacred interaction between nurse and patient, the spiritual healing dimension of holistic health care is exemplified and refined. The nurse stands as God's surrogate and as a vehicle for His words and His touch of compassionate care.

Healing has been described variously as facilitating openness to the "communication of the Holy Spirit, whose message is always wholeness" (Johnson, 1992, p. 21); "the process or act of curing or restoring to health or wholeness, the body, the mind and the spirit" (Haggard, 1983, p. 235); and "to make whole" (Burke, 1993, p. 37). The concept of the nurse as healer incorporates the characteristics of all three definitions; that is, the nurse healer must listen to the voice of God; desire to restore health either of body or of spirit; and attempt to assist the patient in achieving wholeness and integrity of body, mind, and spirit. For the nurse of the Judeo-Christian tradition, spiritually oriented scriptural models of healing abound in both the Old and the New Testaments.

Yahweh's healing power is reflected in Old Testament Scripture in such narratives as Elijah's healing of the widow's son (1 Kings 17:17–23) and Elisha's cleansing of Naaman's leprosy (2 Kings 5:1–14). In the New Testament account of the ministry of Jesus, 41 healings are identified (Kelsey, 1988, p. 43). Jesus healed by word and by touch, sometimes even using physical materials such as mud and saliva. Always, Jesus' healings were accompanied by love and compassion for the ill persons or their families, as in the case of Jairus' young daughter, who her parents thought to be dead. Jesus comforted Jairus with the words, "The child is not dead but sleeping" (Mark 5:39). And then, "He took her by the hand and said to her, 'Talitha cum,' which means 'Little girl, get up!' And immediately the girl got up and began to walk about" (Mark 5:41).

In her doctoral dissertation entitled "Biblical Roots of Healing in Nursing," Maria Homberg (1980) posited that an established biblical tradition reflecting the healing power of such concepts as respect for human dignity and positive interpersonal relationships has parallels in contemporary nursing (p. 2). Homberg suggested that the biblical history of healing can be used by nurse educators to support the importance of these concepts. Dossey (1988) identified the characteristics of a nurse healer as having an awareness that "being present" to the patient is as essential as technical skills, respecting and loving all clients regardless of background or personal characteristics, listening actively, being nonjudgmental, and viewing time with clients as times of sharing and serving (p. 42). These characteristics reflect the spiritual nature of healing described in the Old and the New Testament Scriptures. Finally, nurse educator Brenda Lohri-Posey says that to become a "compassionate healer" a nurse must "recognize the ability to be a healer" and understand that

“healing occasions are unique for each patient” and that “the healing occasion” may change a nurse’s “beliefs about pain and suffering” (2005, p. 37).

The Nurse as Wounded Healer

When a nurse is described as a healer, one tends to focus on his or her ability to relieve suffering. The label “healer” evokes the concept of a strong and gifted individual whose ministry is directed by care and compassion; this is an appropriate image. What may be forgotten in such a description is the fact that sometimes the gift of healing has emerged from, and indeed has been honed by, the healer’s own experiences of suffering and pain. In exploring the nurse’s healing role as an “anonymous minister,” a gerontologic nurse practitioner, Sharon, describes using her own pain in counseling patients: “I may not talk about my pain . . . [but] I understand where they’re coming from if they’re hurting.” Sharon, who imagined this experience as being “united in suffering” with those she cared for, reflected Henri Nouwen’s (1979) classic conceptualization of the wounded healer. Nouwen described the wounded healer as one who must look after personal wounds while at the same time having the ability to heal others. The wounded healer concept is derived from a Talmudic identification of the awaited Messiah:

He is sitting among the poor covered with wounds. The others unbind all their wounds at the same time and bind them up again, But he unbinds one at a time and binds it up again, saying to himself: “Perhaps I shall be needed; if so, I must always be ready so as not to delay for a moment.”

(Tractate Sandhedren, as cited in Nouwen, 1979, p. 82)

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

Two recent discussions that validate the meaning and importance of the “wounded healer” concept in nursing and health care are those presented by Niven (2008) and Graves (2008).

A NURSING THEOLOGY OF CARING

In the previous pages the nurse is described as having the opportunity to heal and to facilitate wholeness, and in the process, to be in the posture of standing on holy ground. But what is it that initiates and supports such nursing practice? What theological or spiritual understanding and beliefs guide the nursing activities

of contemporary practitioners? Perhaps these questions can best be answered in the exploration of a nursing theology of caring. The theology of caring encompasses the concepts of being, listening, and touching and was derived from the author's clinical practice with a variety of acutely and chronically ill patients. The nursing theology of caring is supported by the Christian parable of the Good Samaritan:

A man was going down from Jerusalem to Jericho, and fell into the hands of robbers who stripped him, beat him and went away leaving him half dead. . . . But a Samaritan, while traveling . . . saw him and was moved to pity. He went to him and bandaged his wounds, having poured oil and wine on them. Then he put him on his own animal, brought him to an Inn, and took care of him.

(Luke 10:30, 33–34)

The Gospel relates Jesus' parable of the Good Samaritan, told in response to a question posed by a scholar of the law who asked, "Teacher," he said, "what must I do to inherit eternal life?" (Luke 10:25). Jesus said to him, "What is written in the Law?" In response to Jesus' question, the scholar replied, "You shall love the Lord your God with all your heart . . . and your neighbor as yourself" (Luke 10:27). To justify himself, however, the scholar added, "And who is my neighbor?" (Luke 10:29). Jesus related the parable of the Good Samaritan in reply. At the conclusion of the parable, Jesus asked the scholar, of all those who had seen the beaten man, which one was truly a neighbor. The scholar replied, "The one who showed him mercy." Jesus said to him, "Go and do likewise" (Luke 10:36–37).

In a commentary on the parable of the Good Samaritan, Kodell (1989) noted that Jesus' story was intended to challenge a prevailing but discriminating attitude in the society of the time—the fact that a Samaritan, a member of an ethnic group despised by some, could behave so lovingly. The parable, Kodell pointed out, exemplified the love commandment: while the lawyer suggests that not all persons are his neighbors, Jesus' reply indicates that one must consider everyone a neighbor regardless of nationality or religious heritage and affiliation (p. 62). This Gospel narrative provides nurses with a model of unequivocal concern and nondiscrimination in providing care to those in need; it reflects the conceptual framework to support a nursing theology of caring.

Prior to discussing a theology of caring, on which nursing practice may be based, the key concepts of theology and caring will be explored briefly.

Theology

The term theology comes originally from the Greek words *theos* meaning "God," and *logos* or "science." The contemporary meaning of theology is "an intellectual discipline, i.e., an ordered body of knowledge about God" (Hill, 1990, p. 1011).

The study of theology is often described according to Anselm of Canterbury's conceptualization as "faith seeking understanding." In this context, faith is viewed as "a stance of the whole person towards God, characterized by radical trust, hope, love and commitment" (Fehr, 1990, p. 1027). Each nurse's personal understanding of theology will be informed by myriad factors: religious or denominational heritage, formal and informal religious education, religious and spiritual experience, and current faith practices.

Caring

James Nelson (1976), in his exploration *Rediscovering the Person in Medical Care*, reported that "Underneath . . . important assumptions about the unity of the person and the individual's and community's participation in the healing process lies a fundamental truth: the importance of caring" (p. 62). Nelson added that in healthcare facilities (clinics, hospitals, nursing homes) staff have a primary interest in "curing" certain disease and illness conditions. Ministers and nurses must, however, remember the importance of their vocational call to care (p. 62). Nelson defined caring as "an active attitude which genuinely conveys to the other person that he or she does really matter. . . It is grounded in the sense of uniqueness and worth which, by the grace of God, the other has" (p. 63).

One of the earliest nursing theorists of caring is Madeleine Leininger, who defined the concept as referring to "direct (or indirect) nurturant and skillful activities, processes and decisions related to assisting people in such a manner that reflects behavior attributes which are empathetic, supportive, compassionate, protective, succorant, educational and otherwise dependent upon the needs, problems, values and goals of the individual or group being assisted" (1978, p. 489). In her later writings, Leininger described caring as the central focus or dimension of nursing practice (Leininger, 1980, 1988, 1991). Nurse authors Eriksson (1992); Montgomery (1992); and Benner, Tanner, and Chesla (1996) also identified caring as a central concept of nursing, as did Simone Roach (1992), who postulated five attributes of the concept: "compassion, competence, confidence, conscience, and commitment" (p. 1). In their practice, nurses have always embraced the concept of caring as integral to the essence of the profession (Picard, 1995; Pinch, 1996). And ultimately, through the manifestation of caring nursing practice, nurses engender the kind of trust and confidence in their patients that leads to the promotion of good health (Bishop & Scudder, 1996, p. 41).

Finally, seven characteristics of caring were identified in a study of 200 nurses' stories describing patient care; these were "caring, compassion, spirituality, community outreach, providing comfort, crisis intervention, and going the extra distance" (Hudacek, 2008, p. 124).

The following section, “Dimensions of Caring,” encompasses the characteristics of caring as identified in the theological and healthcare literature and the goal of a healing outcome as understood in the clinical practice of nursing. Patient examples are drawn from the author’s journal chronicling a chaplaincy experience at a research medical center.

DIMENSIONS OF CARING

For the nurse practicing spiritual caring, three key activities may serve as vehicles for the carrying out of the theological mandate to serve the sick: being with patients in their experiences of pain, suffering, or other problems or needs; listening to patients verbally express anxieties or emotions, such as fear, anger, loneliness, depression, or sorrow, which may be hindering the achievement of wellness; and touching patients either physically, emotionally, or spiritually to assure them of their connectedness with others in the family of God.

In and of themselves the acts of being with, listening to, or touching a patient may not constitute spiritual care. These behaviors, however, grounded in a nurse’s spiritual philosophy of life such as that articulated in the parable of the Good Samaritan, take on the element of ministry; they constitute the nurse’s theology of caring.

Being

Being with a sick person without judgment creates space for meaning to emerge and for the holy to be revealed.

E. Emeth and J. Greenhut, 1991, p. 65

The concept of “being” indicates the idea of a nurse’s presence or of simply being with a patient or family member during a time of need. Often, after the therapeutic procedures have been completed, the medications have been given, and the formal nursing interventions have been carried out, ill persons and/or family members long for a nurse to just be with them for a few minutes; to be a caring presence, not listening for they may be too fatigued to talk; not touching for they may be in too much pain for physical contact. But just to be there, to be present during their time of loneliness and suffering.

The association between spirituality and nursing presence was highlighted in an article describing a unique clinical experience for nursing students during which the students worked with the poor and homeless, taking on an advocacy posture for their clients. The students affirmed that the clinical practicum provided “an experience of self-discovery and maturation in understanding spirituality and nursing presence in nursing practice” (Rankin & DeLashmutt, 2010, p. 282).

In fact, a nurse’s presence is viewed as such a well-accepted nursing activity that two nurse theorists have developed a “mid-range theory of nursing presence”

(McMahon & Christopher, 2011). In the theory, professional nursing presence is described as “dependent upon the combination of five variables: individual nurse characteristics, individual client characteristics, shared characteristics within the nurse-client dyad, and environment conducive to relational work, and the nurse’s Intentional decisions within the practice domain” (p. 71). This theory, the authors believe, contributes to an understanding of the “relational aspects of nursing practice within the contemporary healthcare environment” (p. 71).

A description from the author’s journal of an experience with a young cancer patient reflects the importance of being present with a patient in need.

This morning a young man, Michael, who was facing mutilating surgery in hope of slowing the progress of advanced rhabdomyosarcoma, asked to talk to me; he said, “I need you to help me understand why this is happening. I need you to help me deal with it.” I sought consultation both in prayer and from my own spiritual mentor before the meeting. I entered Michael’s room, however, with much trepidation; how could I possibly help him “understand why” God seemed to be allowing his illness. As it turned out, Michael was the one who helped me. As soon as I sat down, he said, “There are some things I’ve been thinking about that I need to tell you,” and the conversation continued with Michael sharing much about his own faith and his attempt to understand God’s will in his life. As I prepared to leave, Michael got up, hugged me, and said, “Our talk has helped a lot”; we prayed together for the coming surgery. Simply being with Michael as he struggled with the diagnosis of cancer in light of his own spirituality constituted the caring. I did not have, nor did I need, any right words; I only needed to be a caring presence in Michael’s life.

Emeth and Greenhut (1991), in their discussion of understanding illness, described the importance of being with patients and families, especially when, as with Michael, they need to ask questions for which there are no answers. “We cannot answer the question, ‘Where is God in this experience?’ for anyone else; rather, we must be willing to be with others in their experience as they live with the questions and wait for their personal answers to emerge. This ‘being with’ is at the heart of health care” (p. 65).

Listening

Many people are looking for an ear that will listen . . . He who no longer listens to his brother will soon no longer be listening to God either . . . One who cannot listen long and patiently will presently be talking beside the point and never really speaking to others, albeit he be not conscious of it.

Dietrich Bonhoeffer, 1959, p. 11

The concept of listening is an integral part of being with a person, as was learned from interaction with Michael. However, as his illness progressed, there were also times when being with Michael in silence was a significant dimension of caring. In some situations, however, active listening, with responsive and sensitive feedback to the person speaking, is important in providing spiritual care. Ministering to Philip, a young man diagnosed with anaplastic astrocytoma, revealed the importance of such listening. Philip, because of his neurologic condition, had difficulty explaining his thoughts, especially in regard to spiritual matters, yet he very much wanted to talk. Philip described himself as a born-again Christian, a fact of which he was very proud.

On my first visit Philip showed me a well-worn Bible in which he had written comments on favorite Scripture passages. As our meetings continued, I began to realize that if I opened the Bible and focused on a particular passage, Philip's speech was helped by looking at the words. I tried to listen carefully, to follow and comprehend Philip's thoughts on the Scripture and its meaning in his life. Our sharing was validated one day when Philip reached out and took my hand and said, "I'm glad you're here; I really like our talking about God together."

In a discussion of spirituality and the nursing process, Verna Carson (1989) recognized the importance of such listening. "The ability to listen is both an art and a learned skill. It requires that the nurse completely attend to the client with open ears, eyes and mind" (p. 165). And, in a poignant case study entitled *A Lesson Learned by Listening*, palliative care nurse Katie Jantzi affirmed the importance of listening to a dying patient, reminding us that patients are our "best teachers" (2005, p. 41).

Touching

And there was a leper who came to Him, and knelt before Him saying: "Lord, if you choose you can make me clean." He stretched out His hand and touched him saying: "I choose. Be made clean." Immediately his leprosy was cleansed.

Matthew 8:2–3

The Christian Gospel message teaches us compellingly that touch was important to Jesus; it was frequently used in healing and caring interactions with His followers. Loving, empathetic, compassionate touch is perhaps the most vital dimension of a nursing theology of caring. At times the touch may be physical: the laying on of hands, taking of one's hand, holding, or gently stroking a forehead. At other times a nurse's touch may be verbal: a kind and caring greeting or a word of comfort and support. Physical touch has been described in the nursing literature as encompassing five dimensions of caring: physical comfort, emotional comfort, mind–body comfort, social interaction, and spiritual sharing (Chang, 2001).

Perhaps one of the most rewarding experiences with the use of caring touch occurred during an interaction with Erin, a 9-year-old newly diagnosed with acute lymphocytic leukemia.

Erin was about to begin chemotherapy and was terrified at the thought of having IVs started; the staff asked if I would try to help calm her during the initiation of treatment. One of the pediatric oncology nurses pulled up a stool for me next to Erin so that I could hold and comfort her during the needle insertion. After the procedure was finished and I was preparing to leave, Erin trudged across the room dragging her IV pole, wrapped her arms around me, and said, “Thank you for helping me to get through that!”

It is not surprising that Carson (1989) identified touch, associated with being with a patient, as critical to the provision of spiritual caring. She suggested that the nurse’s “presence and ability to touch another both physically and spiritually” is perhaps his or her most important gift (p. 164). And, in describing the power of “compassionate touch,” Minister Victor Parachin asserts, “Whenever we reach out with love and compassion to touch another life, our contact makes the burden a little lighter and the pain more bearable. . . . By reaching out and touching someone through deed or word, we provide the extra push that person needs to carry on, rather than give up” (2003, p. 9). “The human touch,” Parachin concludes, “can make the difference between life and death” (p. 9).

Ultimately the activities of being, listening, and touching, as exemplified in Jesus’ parable of the Good Samaritan and in a nursing theology of caring, will be employed in a variety of ways as needed in the clinical setting. This is what constitutes the creativity of nursing practice; this is what constitutes the art of the profession of nursing.

NURSING AS A VOCATION: CALLED TO SERVE

Nursing, as a profession, has developed significantly during the past half-century. The vocation or spiritual calling to care for the sick, addressed earlier in the chapter, somewhat diminished during nursing’s heightened concern with professionalism, is experiencing a reawakening among contemporary nurses. This may be related to the interest in spiritual and religious issues manifested in the larger society. Taking an historical perspective, Nightingale scholar JoAnn Wiederquist pointed out that Florence Nightingale did, from the inception of the nursing profession, consider nursing a spiritual vocation. Wiederquist cited founder of nursing Nightingale’s assertion, “A new art and science (nursing) has been created since and within the last 40 years and with it a new profession, so they say; we say *calling*” (Nightingale, as cited in Wiederquist, 1995, p. 6).

A number of contemporary nursing articles have addressed the topic of nursing as a “vocation” or “calling” to serve the sick. A variety of nurse authors have sought to explain why 21st-century professional nursing may be also appropriately described as an altruistic or spiritual vocation of service. In the book *The Nurse Apprentice 1860–1977*, British nurse educator Ann Bradshaw supports the concept of nursing as a vocation (2002). While admitting the importance of current nursing education, Bradshaw laments the fact that some professional nurses have lost their initial sense of vocation or calling (2002). In a 2010 article on the understanding of the nursing “vocation,” Bradshaw observed that “whether the historical ideal of vocation remains important, negatively or positively, to the attitudes, values and motivations of the clinical nurse and the quality of patient care, is a relevant and significant issue” (p. 3465).

Theologian Mikael Lundmark provided an analysis of nursing as a vocation, commenting on the work of both Bradshaw and Eriksson; their writings, he concluded, both explicitly and implicitly advocated “a vocational understanding of nursing” (2007, p. 778). And, in exploring the concept of professional nursing from an ethical perspective, Karolyn White observed that “nursing is best understood as a vocational occupation” (2002, p. 279). White’s argument was based on Blum’s model of vocations, which identifies a vocation as a calling in which workers identify with “traditions, norms and meanings” (p. 279).

Finally, anecdotal nursing journal articles abound describing a nurse’s personal identification with nursing as a vocation of service, including “Answering God’s Call” (Schmidt, 1997); “Hearing the Call to Nursing” (Jeffries, 1998); “Childhood Interest in Nursing Has Become Lifelong Vocation” (King, 2003); “Responding to God’s Call” (McKoy, 2004); and “God’s Call” (Folta, 2005).

Nursing, as both a vocation and a profession, encompasses a unique commitment to provide both care and compassion for those one serves. The subject of spirituality in nursing practice includes concern not only with the personal spiritual and religious needs of the patient and nurse, but with the spiritual dimension of the nurse–patient interaction as well.

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