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# Nurse educators' understanding of spirituality and spiritual care in nursing: A South African perspective (Part 1)

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ABSTRACT

*Introduction:* The nurse educators' (NE's) expressed lack of confidence to facilitate spiritual care when teaching undergraduate nursing correlates conversely to reported lack of formal integration due to slow uptake of spiritual care in most nursing schools in South Africa. In this study, "spiritual care" relates to holistic care which is designed to reach the invisible, deep human needs that are important to meet personhood needs such as good health, search for meaning, hope, inner strength and peace. "Spirituality" refers to 'inherent-inborn-inner motives that give meaning and hope in one's life; and the essence that gives meaning and purpose to one's very existence.

*Objective:* The purpose of the study was to explore and describe the understanding of spiritual care in nursing practice by *nurse educators*.

*Methods and procedures:* A qualitative approach using an exploratory and descriptive design was used to explore and describe the understanding of "spirituality" and "spiritual care" by the NEs. In-depth structured interviews were conducted. A sample of (n = 10) NEs who were purposively selected responded to the open-ended question "*what is your understanding of spiritual care in nursing education and practice*"?

*Findings:* Three themes emerged include: (i) defining "spirituality" within a nursing context; (ii) spiritual care as a missing component in the curriculum and (iii) perceived challenges and constraints in the teaching and learning of spiritual care.

*Conclusion:* Despite lack of spiritual care guidelines posing a problem, NEs unequivocally exemplified their willingness to teach students how to engage with patients' spiritual needs. A need for a guiding theory and philosophy to formalised teaching of spiritual care in nursing education was acknowledged.

## 1. Introduction

The study was motivated by the widely reported lack of formal teaching-learning of spiritual care in nursing which invariably is associated with inadequate preparation of educators with the required teaching skills to address patients' spiritual matters (Chandramohan & Bhagwan, 2016). Despite nurse educators who participated in this study having expressed experiencing lack of confidence in facilitation of spiritual care in the undergraduate nursing; it appears that most nursing schools in South Africa have not formally integrated spiritual care education (Mthembu, Wegner, & Roman, 2017; Tjale, 2007). To achieve the objectives of the study the researcher used in-depth interviews to explore and describe the NEs' knowledge, experience and perceptions on teaching, learning and practice of spiritual care in the nursing profession. Regrettably, despite the South African Nursing Council's (SANC) espoused holistic approach to nursing, it does not provide clarity on what its conceptualisation of "holistic nursing" is and the role of spiritual care. This lack of clarity has led to inadequate if not a complete lack of guidelines on the teaching and practice of spiritual care.

The article provides findings of the study that investigated the understanding of NEs on the teaching-learning of spirituality and spiritual care in the undergraduate nursing programme. These NEs teach nursing students who are registered for the R425 Curriculum as regulated by the South African Nursing Council. NEs were interviewed to inform the main study which was conducted to generate a *Practice Theory for the Teaching-Learning of spiritual care in the undergraduate nursing programme at a higher education institution (HEI)*. Emergent themes are presented

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but it will not be expanded on how they were further condensed into conclusive statements which were used to develop theory. However, only the views of NEs that depicts their understanding at the time of data collection are presented in this paper. The findings showed that Nurse Educators unequivocally depicted spiritual care as an important moral obligation which does not only complements holistic nursing but rather completes it.

The findings align themselves with the World Health Organization's (WHO) reaffirmed view about the importance of spiritual care in health and healing, which is evidenced by the organization's attempts to include the "spiritual element" in the definition of health as a vital component (World Health Organisation, 2012). Yet, in contrast, there is a lack of commitment on spiritual care in nursing by the South African Nursing Council which supposedly advocates for "holistic nursing practice" as an all-inclusive method to restore health. The slow uptake and lack of formalised teaching-learning of spiritual care in nursing education and practice has been a factor in the lack of visibility in teaching of spiritual in South Africa (SA) (Chandramohan & Bhagwan, 2016). Furthermore, the findings of the study show that NEs did not only support the need for the formal teaching of spiritual care but they actually prioritised the need for a sound theory and philosophy when teaching spiritual care, the lack of which was blamed for the failure of teaching of spiritual care in nursing education. The findings of this study are also in line with those of Mthembu et al. (2017) who argue for a guiding theoretical framework for teaching spiritual care. The purpose of the study was to explore and describe the understanding of the teaching-learning of spirituality and spiritual care in the undergraduate nursing programme by Nurse Educators. This objective was achieved through delving into participants' knowledge, experiences and perceptions using in-depth interviews.

### 1.1. Conceptions of spiritual care

In this study, "spiritual care" refers to as an aspect of holistic care which is designed to reach the invisible, deep human needs that are important to meet personhood needs such as good health, search for meaning, hope, inner strength and peace (Lowry & Conco, 2002). "Spirituality" refers to 'inherent-inborn-inner motives that give meaning and hope in one's life. (Narayanasamy, 2014) accepts spirituality as the essence of human being that gives meaning and purpose to one's very existence. This study views "spirituality" and "spiritual care" as closely related but not the same thing. The World Health Organisation (2012) has recognised the importance of spirituality in health by including "spirituality" as one of the vital components in their redefinition of "health". Regrettably, the South African Nursing Council (SANC) which advocates for "holistic nursing practice" has not embraced spiritual care as vital to the recuperation from ill-health. Given the trend towards incorporating spiritual care in nursing education globally, as one of the vital components of the determination of health as seen in countries such as Canada and Australia (CNA, 2010; Winslow & Wehtje-winslow, 2007), there is a need for the SA nursing education institutions to reconsider spiritual care in teaching, learning and practice.

### 1.2. Spiritual care and spirituality in the teaching-learning of nursing

Despite the trend towards the teaching-learning of spiritual care being increasingly welcomed on one hand there are challenges concerning the lack of universal understanding of spirituality and spiritual care in the nursing field (Mthembu et al., 2017) on the other hand. Helming (2009) not only argues that published work on spiritual care in nursing practice is very sparse, but also highlights the dearth of knowledge of spiritual care as a precursor to lack of teaching-learning and practice of it in nursing. In spite of effective good nursing education programmes worldwide in an attempt to address the "human needs", teaching spiritual matters remains a desolate area in nursing. Some of the reasons for the lack of implementation of spiritual care in the nursing curriculum and in practice do not only relate to a lack of understanding and/or different conceptualisations of spirituality, but to issues that arise from the perception that spirituality is a sensitive and personal matter. This notion of sensitivity does not only create detrimental effects on nursing practice but also exacerbates the challenges and fears of nurse educators and nursing students; who at all costs avoid confrontations with self-reflection and introspection. Consequent to these challenges, a state of incompetence in the teaching-learning and provision of spiritual care has been reported (Burkhart & Schmidt, 2012; McSherry, Gretton, Draper, & Watson, 2008). These authors point to the slow uptake of spiritual care in formal pedagogical education of nurses as a cause for concern.

In the United States of America (USA) the American Nurses Association (ANA) (2002) has openly and formally embraced the notion of spiritual care in nursing education and practice as a critical component of health. A similar trend is noted in Canada (CNA, 2010) and Australia (Winslow & Wehtje-winslow, 2007). The International Code of Nurses (2000) alludes to the fact that nurses are expected to create a caring environment which promotes spiritual care among other human values and cultural belief needs. The lack of training of nurses regarding their own and their patients' spirituality poses challenges in addressing patients' spiritual matters (Monareng, 2012: 14). Yet, education of nursing in South Africa has not seriously considered adopting spiritual care as one of the fundamental areas that prepare nurses to practise holistic nursing. This is evidenced by the fact that most nursing schools have not explicitly adopted a curriculum with a strong component of spiritual care.

## 2. Methods and procedures

A qualitative approach using an exploratory and descriptive design was used to explore and describe the understanding of "spirituality" and "spiritual care" in nursing education by the NEs (Brink, Van der Walt & Van Rensburg, 2010; Mouton, 2009). In depth structured interviews were conducted either in the researcher's or the participant's office. The researcher ensured that participants were emotional and psychological comfortable by informing them about their right to exit the interview anytime they feel like to do so. Information sheet was read out once more for the participant. This was to ensure that the participant is reminded and informed about that purpose of the study.

### 2.1. Target population and sample size

The population of the study comprised of all the NEs in the Western Cape Province. The targeted population was all the NEs who were employed at the school of nursing where the study was conducted and who taught in the undergraduate nursing programme R425 as regulated by Act 33 of 2005 (SANC, 2014). The nurse educators' emic perspective including their beliefs, experiences and perceptions were explored using in-depth interviews. A sample of ten nurse educators (n = 10) who were purposively selected responded to the following open-ended question "*what is your understanding of spiritual care in nursing practice?*" An eclectic approach was used to collect data using qualitative research methods. This ensured that rich data from the study participants was obtained.

### 2.2. Recruitment and inclusion criteria

Participants were recruited by email as the primary means to reach out to potential individuals. In cases where the opportunity presented itself, such as during the staff meetings or academic gatherings, an invitation to participate was extended verbally. Email and physical recruitment methods were followed up by a formal request letter. Participants were included in the study if they: (i) signed a written consent form for participation; (ii) were employed as nurse educators at

the selected nursing school at a particular Higher Education Institution (HEI) in the Western Cape Province; (iii) they taught undergraduate nursing students.

### 2.3. The settings

The school of nursing from which the study participants were drawn is part of one of the higher education institutions in the Western Cape. The school offers both undergraduate and postgraduate programmes with different specialties. The school offers a four-year Bachelor's Degree in Nursing regulated by the South African Nursing Council (SANC) under Regulation 425 of the Nursing Act No. 33 of 2005 (SANC, 2014).

### 2.4. Ethical considerations

The proposal for the study was submitted to the School of Nursing, Faculty, and Senate Board Research and Ethics Committees in the university where it was registered. The approval was granted, with certification no: 13/4/22. Scientific honesty and reflexivity was maintained through abstinence from plagiarism as well as by providing full citation and a reference list of sources used. A full description of data and selected methodology that was applied in order to observe copyright and intellectual property rights regarding other authors' work. Furthermore, the principle of justice, which entails a moral obligation to conduct the research process with integrity and according to acceptable standards, was exercised not only as a fundamental ethical principle; but, also as a sign of respect for the authors of the information sources and databases that were consulted (Khanyile, Duma, Fakude, Mbombo, Daniels, & Sabone, 2006; Brink, 2006). Participants were anonymously treated and data confidentially managed by not divulging their names at any stage of the study data management. Audio tapes and transcripts were locked up in safe place at completion of the study in order to ensure that their recorded voice is not accessed by individuals who are not research officers. Research hard copy documents will be destroyed no earlier than 5 years after publication of the results.

### 2.5. Data collection

Data was collected between August and September 2015. In-depth interviews were conducted in English after ascertaining if the participant felt comfortable to speak in English. If not, she or he would be allowed to express themselves in a language in which they were comfortable (for example, Zulu or Xhosa which the researcher is familiar with), after which the translation to English would have been done. However, as it happened, all participants were conversant with and comfortable in communicating in English. Interviews were held in different places as determined by the participants. These included their offices, the researcher's office and other available spaces on the university campus, such as boardrooms. All interviews were audio recorded with the permission of the participants to ensure that no important information was lost in the process. They lasted about forty-five minutes to an hour and thirty minutes on average. Audio recorded files were labeled accordingly to ensure anonymity before being given to a professional transcriber. Distraction was avoided by using private offices, put the telephone hand set aside and posted a note on the door indicating that an interview was in progress. The participant was made aware when the audio recording was put on after requesting for a specific permission to record the interview.

### 2.6. Data analysis

Interviews were transcribed verbatim and data cleaned. Tesch's eight steps of thematic data analysis was used to analyse the data (Tesch, 1992). Brink (2006, 2) cautions that during the data analysis process the researcher should restrain preconceived ideas through bracketing and reflexivity to prevent potential biases towards the researcher which might influence interpretation of data. The eight steps of qualitative data analysis were used not only to organise qualitative data but also to guide the analysis process. The researcher read carefully through all the transcripts to get a sense of the whole. Each transcript was reviewed to find out what it was about, based on identified topics. These topics were then written on the right side margin of the transcript. Each identified topic was placed on a flip chart sheet under a designated column per participant. The topics were compared across the columns for similarities and differences.

Identified topics were coded with abbreviated codes and a topic number as identifiers. All transcripts were treated similarly by writing codes next to the appropriate segments of the text. New categories and codes emerging at this stage were considered and written down in analytic memos. All topics were descriptively labelled and categorised. Topics were further reduced by grouping related topics into new categories and subcategories which were recoded, with some codes falling into more than one category. A structure of categories was devised where data belonging to same category were put together, after which the researcher examined one category at a time focusing on the content of each category. At this point, the data was checked for relevance to the research question. The data was analysed by the researcher as well as an independent co-coder, who exercised bracketing and reflexivity to prevent potential biases which could jeopardise the credibility of the study (Krefting, 1991). After the analysis the researcher and co-coder met to discuss the themes and sub-themes until consensus was reached.

### 2.7. Trustworthiness

Four strategies to ensure trustworthiness were employed to ensure that academic rigour and credibility of findings were maintained (Krefting, 1991). *Truth value* was applied throughout data collection, reflexivity and bracketing. *Field notes* and *methodological notes* produced during inductive- deductive reasoning analysis were reviewed and reflected on. B*racketing technique* was also used to enhance reflection while the researcher worked with the empirical data. *Member checking* was undertaken to ensure that the study findings were credible and acceptable.

*Transferability* is possible through clear description of the purposively selected sample, thick description of data and a well-defined contextual setting. *Purposive sampling*, and description of the *research setting* in terms of its geographical and pedagogical stances provided a unique context for the study. Participants' reported data was clearly, sufficiently and *densely described* to give a good grasp of the understanding, opinions and experiences of participants in responding to the research question.

*Dependability* was maintained through co-checking, co-coding, memo-writing, and the immersion of the researcher in the data analysis process. Co-checking of emergent themes by the independent coder was done to improve rigour and coherence. Saturation of data themes and categories denoted that no new concepts or dimensions were identified. *Neutrality* was promoted through a paper trail by which the processes of the research and documents would be filed for five years. The researcher's reflexivity was enhanced by reflection-on-action and reflection-in-action (Holloway & Wheeler, 2010; Krefting, 1991; Polit & Beck, 2011).

### 2.8. Rigour

Field notes refer to additional information obtained from interaction with the participants during an interview that can be useful in making sense of empirical data obtained. According to Polit and Beck (2011) field notes, including descriptive and reflective notes, describe the situation and mood as they transpire, while the researcher's thoughts reflectively capture the experiences of the participants during the interviews. Rigour was also maintained by use of a qualitative research

**Table 1**
Themes and Sub-themes emerging from NEs.

| Themes | Sub-Themes |
|---|---|
| 1. Defining Spirituality within a nursing context; | 1.1 Spirituality as connectedness<br>1.2 Spirituality as an inherent virtue in human beings<br>1.3 Conceptualising spirituality and spiritual care<br>1.4 The caring nature of humans |
| 2. Spiritual care as a missing component in the curriculum in the curriculum | 2.1 Lack of visibility of spiritual care subject matter<br>2.2 Teaching-learning of spiritual care |
| 3. Challenges with teaching and learning of spiritual care in nursing | 3.1 Concerns about myths and perceptions<br>3.2 Concerns about conflicting ideas and beliefs |

protocol and procedures for the data analysis process as well as by application of measures to ensure trustworthiness.

## 3. The findings of the study

The findings are presented according to the following themes and sub-themes that emerged from the data: (i) defining "spirituality" within a nursing context; (ii) spiritual care as a missing component in the curriculum and (iii) perceived challenges and constraints in the teaching and learning of spiritual care in nursing. Table 1 below shows the themes that emerged.

## 4. Theme one: defining spirituality within a nursing context

Despite the participants coming from diversified religious belief systems such as a Christianity or Islam, African religion, and others they all agreed that "spirituality" is not only an influential source for spiritual care to occur, but is responsible for shaping a person's daily living through values and beliefs. Participants defined spirituality as an attachment to something significant, such as God to some, Allah and ancestors to others, which is the most common denominator and a familiar type of attachment. Spirituality was defined on the basis of inner connectedness and inherent virtue in humans.

### *4.1. Sub-theme one: spirituality as connectedness*

Connectedness and attachment to a significant other was depicted as influential in nature. The participants' view of the Higher-Being as not only influencing one's "spirituality" but also functioning as a precursor to "spiritual care" which by its nature is not limited to religious practices. This is what one NE said:

> *"… Spirituality relates to believing in God or a higher power; it's a relationship with God or the Superior Power or anything that is important. Spirituality is within you [*i.e. *a person]. It's there, in your [one's] background, it is in your [one's] values when growing up."*

### *4.2. Sub-theme two: spirituality as an inherent virtue*

Participants viewed spirituality as the inherent and in-born connection with the higher power or God. The innate nature of spirituality is suggestive of the possibility of it being activated in students when teaching ethics, morality and value judgement. For instance, it can be applied practically when students are able to capture the essence of what the Nurse's Oath requires of them. They said that:

> *"… it [the Oath] is binding to [nurses'] conscience with moral obligations of the profession which guides our [nurses'] interaction with the patient regardless of race, colour or culture". "…they will treat the person [ patients] as human beings as valued by God".*

Participants also warned about a potential threat in a situation where untoward reactions may manifest due to an interface of cultural diversities and differences in human beings, especially if students lack prior exposure to spirituality. Such a lack of prior exposure was blamed for students' unpleasant, bad, and wicked behaviour with different beliefs and understandings being major causes of contention. Participants viewed students as inseparable from their varied past belief systems when entering the nursing profession. Participants expressed the following views:

> "…So it depends where you [i.e. person] come[s] from … your background…" "…So peace can mean different things as it will be based on where a person comes from, who is influencing the person and so forth."

The participants' view on the "inherent virtue" of spirituality was emphasised when teaching spiritual care in nursing, although it was only an espoused wish.

### *4.3. Sub-theme three: conceptualising spirituality and spiritual care*

Participants explained how spirituality influenced their everyday living; yet, it was open to different interpretations. They identified the giving and receiving of spiritual care as an essential part in the make-up of the human belief dimension that goes beyond religion. A reference to somebody's spirit as being high or low was acknowledged as having nothing to do with religion; but rather having everything to do with inner values. Thus inner values were conceived not only as that which inspire and or motivate a person, but as that component highly influential in one's behaviour. They expressed this notion by saying:

> "… Truly, it is more than a religion or something of that sort…". "…And when a person's spirit is high it means that the person is alive, energetic and full of life…".

Participants questioned *where the spirit goes when a person dies*. Due to the participants not fully comprehending spiritual subject they did not delve deeply into this inquiry but agreed that the human spirit has nothing to do with religion although it comes close to it. A confusion between "spiritual beliefs", "personal beliefs" and "cultural beliefs" was noted but participants resolved it by realising that patients' expressed needs should be addressed without necessarily distinguishing the source from which they come or nature of the patient's belief. Participants acknowledged that spiritual care is a vital means to meet every human needs. Different beliefs were not discussed at length but were acknowledged as important. They stated that:

> "…Nurses should attend to patients' beliefs and human needs as a means to offer harmonious care to patients".

### *4.4. Sub-theme four: the caring nature of humans*

The NEs spoke at length about how nursing students are expected to care for the patients. Yet, they are often aloof and reluctant to interact with patients' spiritual needs. A lack of caring attitude in nursing students was as a worrying factor in view of the fact that nursing education is required to produce carers. A participant said:

> "… Despite students being taught nursing care in all nursing

modules from first to fourth year of training they remain impassive"

In reference to a midwifery case study in which it was mentioned that students did not understand the essence of caring, it was said that:

*"… they [*students*] can't connect the dots as they [students] often are too young to use their intuition in their nursing interventions".*

Participants were not only unclear about whose responsibility it was to teach spiritual care, but they were also unable to say how they might have contributed since they were unaware of the existing gap regarding the 'essence of caring' and "nursing skills-based interventions" subject content. Whilst agreeing that a caring attitude, paying attention to details, and showing concern or interest were examples of spiritual care in one hand. On the other hand, their lack of commitment in teaching spiritual care was not necessarily perceived as part of the challenge. Instead, they blamed lack of caring skills on students' different backgrounds. This revealed lack of insight from the NEs' point of view.

Other examples of caring included awareness of personal space, and being comfortable to spend time with silence. The notion of silence was explained in detail from a mental health care perspective, with reference to cases of gender-based violence where a victim is often not ready to divulge the cause of the of his or her crisis. 'An intuitive response, whereby a nurse would go by gut feeling when interacting with mental health patients, is crucial. The principle of interference and counter-interference was depicted as guiding in interventions with mental health patients. One NE said:

"… I have learnt through reflection that interjection disturbs the patient's line of thought which they need in order to take control of their lives…"

## 5. Theme 2: spiritual care as a missing component in the curriculum

This theme was built from the following sub-themes: (i) lack of visibility of spiritual care in the curriculum and (ii) Challenges with the teaching-learning of spiritual care. Each of these sub-themes are narrated below.

### *5.1. Sub-theme one: lack of visibility of spiritual care in the curriculum*

Participants admitted that they do teach spiritual care to a certain extent where they address different religious requirements as a means to sensitise students about the different faiths and religious needs. However, the basic understanding of religion was regarded as having a similar meaning to spirituality. As one participant stated:

*"… so if students are sensitised about different religions they will remember to attend to patients' religious needs, which assist the patient to connect to God and cope with the illness".*

Participants were unclear not only as to where teaching of spiritual care gets lost in the process, but were also puzzled about who should teach it. They admitted to a lack of visibility of spiritual care content and subjects in the curriculum. Participants explicitly voiced out that if the objective 'spiritual care' is not clearly specified in the curriculum it will always disappear. The nurse educators' views were expressed as follows:

*"…it [*spiritual care*] is not adopted as subject matter into the curriculum…"; "…We do not teach it and we do not assess it, despite the fact that by its virtue spiritual care is closely linked to nursing".*

The participants accepted that spiritual care was not as visible as it should be. This is how the concern was expressed:

*"Again, you just hope that it will be there, it will be applied, it is some of the things that are very [much] neglected…"; "… and that's why we are experiencing unprofessional behaviours…." "Students don't have those basic interpersonal skills, basic communication, basic professionalism, the basic aspects of care, you know..., you don't see it".*

According to the participants, the lack of visibility of spiritual care subject matter in the curriculum contributed to its absence and it not being taught in the undergraduate nursing programme. There was no allocated time to focus on spiritual care skills.

### *5.2. Sub-theme two: teaching-learning of spiritual care*

A need for theoretical and philosophical clarity on differences between religion and spirituality was pointed out as a dire necessity. This would assist students to appreciate that it is acceptable for a person to belong to any religion. But the need to meet the patients' deeper personal or personhood needs which enhance their relationship with God was critical. A sound guiding theory and philosophy for teaching nursing at the school was vital for formal integration of spiritual care because spirituality is a sensitive subject. This is what one participant said:

*"We don't know what is the school's philosophy and theory that underpins the undergraduate curriculum; … The school must show high regard for its beliefs and values that are expected to translate to student's learning and graduate attributes. As nurses we need to have our own theories and not borrowed ones; "A real stand would be necessary…"*

A strong critique was levelled against borrowed philosophies which may introduce misunderstanding when teaching spiritual care where such philosophies contradict with a particular spiritual belief for example, the "existentialist view" which contradicts "Christian philosophy" on the account of spiritualism because it only acknowledges power within a person and no further. Whilst the Christian philosophy goes beyond human capabilities by acknowledging God as source of everything. The same participants stated that:

"Existentialism actually negates spiritualism."

In contrast to this view another participant said:

*"Christianity is branded as something that is not to be mentioned overtly… … because people want to be politically correct and do not questions things."*

When nurse educators were asked how they preferred to teach spiritual care, they suggested that it would be ideal to have a breakdown of the teaching content across each year level and objectives towards holistic nursing with clear objectives for each year level. For instance, for a first year programme broad objectives may be directed to awareness about spiritual care and sensitising the students through discussions in class. The learning process should allow students justify why they believe what they believe or do not believe, as such a case-based learning (CBL) strategy and method were suggested as ideal. This is one NE said:

*"…CBL method is an analytic way of learning, affording the students with detailed learning, peer and social learning. It allows a rich discussion on the subject matter".*

For the NEs spiritual care contents should include expressions of empathy, sympathy, compassion, tender-loving-care (TLC), talking to patients, praying with or for the patient, giving the patient what he or she wants, awareness about spiritual needs, sacrifice, kindness, love, openness, readiness for intervention and observing the body language as part of communication, solemnity care (which is the nurse's inward declaration to the patient that "I'm here for you"). The value of humility, trust, support, and respect for each other as also emphasised.

Spiritual care content was also related to building relationships through communication and emotional support as fundamental to prioritised caring. Basic interpersonal skills, basic communication and basic professionalism were all viewed as basic aspects of care as a more holistic way that can deal with anxiety and depression through

counselling. This was perceived as dealing with the patient's difficult inner feelings and increasing hope, strength, and resilience.

Formal assessment of spiritual care was acknowledged as ideal because assessment should focus on issues like diversity and cultures amongst patients in order to assist students to make sense of and appreciate the patients' prevailing deepest needs. 'Participants regarded the use of MCQs to gauge students' religious knowledge as inappropriate for assessing spiritual care competencies'.

## 6. Theme three: perceived challenges of the teaching and learning of spiritual care

Challenges and concerns faced by NEs involve issues of myths, perceptions and conflicting ideas about nursing principles versus spiritual principles, as well as the lack of role models in the nursing profession. These issues are discussed simultaneously because participants interrelated them with minimal distinctions.

### *6.1. Sub-Theme one: concerns about myths and perceptions and conflicting ideas and beliefs*

The issue of conflicting beliefs was addressed when the participants described what spirituality meant to them and how it differed from religion to religion. This was also a concern for teaching of spiritual subject matter where different beliefs could cause disagreements when taken outside the confines of nursing, especially in SA where there are multi-racial and multi-cultural populations. However, they agreed that the nurse should be guided by the patient who may give an indication that you must not trespass or you must be cautious not to enforce your own view on a patient. Another concern was with regard to unacceptable practices that are claimed to be religious beliefs by some individuals yet not for others. In such cases participants suggested that the teaching of spiritual care should be obligatory for all patients where caring is accepted as non-discriminatory intervention when rendering nursing care. They caution the need to prohibit patients' activities that do not promote health and are not pro-life. In response to this concern, it was suggested that:

> *"… The curriculum should be clear on teaching and provision of spiritual care and religious care which should be guided by the universal ethical principles and be grounded on great parameters of the universal principles for humanity and the Spirit of Ubuntu, as well as basic principles of ethics of care"*

Furthermore, preferences for traditional medicine over western medicine and vice versa was a point of contention; however, the issue was resolved by agreeing that the South African Human Rights Act guards against anti-human behaviour such as violence and abuse, whilst allowing SA citizens freedom of choice. Participants actually agreed that there should be no contradiction between "professionalism" and "cultural" beliefs nor contradiction between "professionalism" and "spirituality", as well as personal and professional because all humans need spiritual care. In contrast, atheists and agnostics were not viewed as a threat to provision of spiritual care in nursing as they are regarded as humans too, and deserving of such care when it is needed like anybody else; because they also have spiritual and emotional needs despite the fact that they believe in their own self-agency.

## 7. Discussion of the findings

The discussion focuses on two main findings from the NEs: (i) issues around the definition and understandings of spirituality and spiritual care which was pointed out as a potential source of contention, and (ii) challenges in the teaching and learning of spiritual care. A view that spirituality was predominantly focusing on religion potentially presents a gap in the understanding of spirituality, as it assumes that a person's religious spirituality is the originator for spiritual care, which therefore excludes non-religious people. This understanding is in contrast to Winslow and Wehtje-winslow (2007) who view spirituality as a nearly universal human trait that arises from the human need for hope and meaning. Attempts to define spirituality have evolved over the last few decades yet no universal definition has been reached. While the participants in the current study were not able to define spirituality; their understanding of its essential nature in human life is supported by authors such as Lowry and Conco (2002) in their attempt to define it.

In response to the growing need not only to understand spirituality in nursing, but more importantly to respond to the obligation of the provision of holistic care, efforts to define spiritual care within the context of nursing practice and education are in progress (Garcia & Koening, 2013). Nurse educators, practitioners and researchers are called on to further explore the meaning and understanding of spiritual care. Whilst working towards obtaining a universal definition of spiritual care that views health needs as beyond personal and cultural needs which may vary from fear, worry, a need to talk, a need to pray or be religious, and/or belief rituals (Lewinson, McSherry, & Kevern, 2015) but merely spiritual needs. In this study religion refers to routine faith-based practices such as citing a prayer, going to church or reading a Quran/Bible without necessarily engaging deeply with the inner being. Whilst on the other side, spirituality relates to deep seated need, questioning of one's self, introspection and or reminiscing about purpose for living; as well as need for peace and meaning of suffering as well as achievements that are conceived as supernatural among other spiritual experiences. Most definitions of spirituality support the notion that it is associated with an existential search for meaning and purpose in the complex questions about life (Koening, Larson, & Larson, 2001). However, it presents challenges to people who do not ascribe to this existentialist philosophy. This means that whilst it is necessary to provide spiritual care in nursing, and the existential search appears to provide a fairly clear defining characteristic of spirituality, existentialism is not necessarily Christian spirituality (Hill et al., 2000; Sawatzky, 2002). Thus, a need to distinguish spiritualties such as existential pursuits and other ideologies of life-giving practices that support sacredness. George, Larson, Koening, & McCollough (2000), Hill et al. (2000). These authors refute the contention that "when the term 'spirituality' is invoked to describe ideologies or lifestyles that do not consider notions of the sacred, they are bluntly not spiritualties but are ideologically elaborated lifestyles".

Sussman, Nezami, and Mishra (1997) suggest that "spirituality involves a transcendental process that supersedes ordinary existence in contrast to religion which involves subscription to a set of beliefs which are organized and institutionalized and explains the concerns regarding different backgrounds such as transpersonal psychology, humanism, existentialism and formal religion". This concern also transpired from the study participants where issues around different definitions of spirituality, the role of religion in spirituality and the existentialist view of spirituality indicate possible different philosophical views about spirituality and these were acknowledged as potential threats to providing spiritual care in nursing. MacLaren (2004) supports a post-modernist approach to spirituality and warns against any view that potentially reduces the essence of spirituality as this may cause spiritual turbulence or clashes. It is thus important to be cautious about a notion against postmodernist views of spirituality which is prone to the risk of decontextualizing the meaning of faith and religion in particular situations or contexts (Beyer & Beaman, 2019). This may be true for the South African context where spirituality is heavily dependent on religious beliefs and connotations (Mahlungulu & Uys, 2004). Despite existing issues such as lack of a universal definition which leaves spiritual care as an indefinable occupation, it should be acknowledged that it is nevertheless the most important component of care for all humans (World Health Organisation, 2012). The importance of spiritual care as a vital component of health demands that nurse educators and practitioners to renew their thinking and view spiritual care for what it really is and what it can do for a sick person, such as helping them to

cope with illness and disease (Carr, 2008).

The findings of the current study not only identified a gap in the teaching-learning of spiritual care, based on a variety of reasons including but not limited to different cultures, beliefs, and lack of required skills as existing challenges, but also the need to provide it. Authors such as Winslow and Wehtje-winslow (2007) suggest that when attending to patients' spiritual needs it is advisable to first find out about the distinctive religious beliefs and spiritual backgrounds of the patient as these are important when providing spiritual care. Furthermore, the findings suggest that a guiding theory and philosophy for the teaching-learning of spiritual care is critical. Challenges, including myths about the subject of spirituality and spiritual care in nursing, were reported as most requiring attention. Therefore, teaching of spiritual care should demarcate the boundaries of spiritual care (Beyer & Beaman, 2019; MacLaren, 2004). This may reduce the challenges regarding inherent views that are often misleading based on the ambiguity, complexity and vague nature of the very concept of spirituality. Contrary to these inherent intuitive views, which some nurses use in between their caring activities, those nurses who are insensitive in identifying the patient's spiritual needs may miss the opportunity to identify, provide and evaluate spiritual care interventions (Monareng, 2012). Furthermore, authors such as McSherry (2006) affirm that nurse educators may need to be prepared on how to use spiritual care teaching skills in order to redress existing educational gaps in caring interventions that would otherwise assist patients and families to face loss, sickness, disability and death. Workshops and seminars on the teaching-learning of spiritual care are necessary to promote skills implementation of spiritual care in nursing practice such as diverse management and caring interventions, including assisting patients and families on how to face loss, sickness, disability and death as priority areas (Barlow, 2011; McSherry, 2006).

The formal integration of teaching-learning of spiritual care should be founded on a sound philosophy and theory, as proposed, where the unique values of the nursing education institution are congruent with the values of the nursing profession. Grosvenor (2000) suggests that professional guidelines should be used to guide the integration of spiritual care with formal teaching. Mthembu et al. (2017) similarly attest to the need for guidelines for integrating spiritual care that would guide educators, students, and clinicians who are increasingly working in culturally, spiritually, and religiously diverse societies.

When teaching culture-based topics such as spirituality a constructivist learning model is an ideal teaching strategy that may promote students' attentive-listening-presence and use of spiritual-cognitive skill (Klopper, 2009). Students are motivated to engage critically so that they deal with patients in a way that is meaningful for both themselves and the patients. The role of spirituality and spiritual care in nursing was acknowledged by nurse educators such as the Canadian Nursing Association (CNA, 2010; Carr, 2010; Pesut, 2005; WHO, 2012). Also, a study conducted by Rogers and Love (2007: 690) on nurse educators' perspectives on the role that spirituality plays in the pedagogy of spiritual care indicated a need for nurse educators to be alert to the critical and sensitive nature of spiritual care and to assume the necessary stance. Yet, at times, NEs regard the affective domain as difficult to assess and as a result they pay less attention to this aspect of knowledge. Principles of spiritual care can be applied across all phases and settings for the seriously ill without clashes with culture, religion, tradition, or spiritual frames of reference Puchalski et al. (2009) Students' spiritual and cultural background often sets a positive tone for spiritually focused lessons. This view is supported by Chiang, Lee, Chu, Han, and Hsiao (2015) who agree that students' own spirituality contributes positively in the learning of spiritual care. The study participants also suggested that selection of nursing students should consider evidence of a caring attitude in the community and a certain level of spiritual awareness. This would protect the teaching of spiritual care from potentially conflicting views such as that of spiritual matters being perceived as private and personal (Bradshaw, 1997). New understanding of nurses who should neither trespass into patient's personal matters by compelling them to partake in spiritual matters nor engage in unethical religious practices requires wisdom to embrace different spiritualties without jeopardising the essence of nursing (MacLaren, 2004).

In response to this challenge Rudolfsson, Berggren, and da Silva (2014) propose an integrative review of spiritual care that would be appropriate to alleviate contention. There authors view spiritual care as having a positive impact on spirituality and spiritual values within the context of nursing; because it regards spirituality as 'being part of a 'greater wholeness' (Rudolfsson et al., 2014). Furthermore, this view acknowledges 'developing inner strength', 'ministering to patients', 'supporting patients to maintain a sense of humanity', ' viewing life as a gift', which evokes a desire to 'give back', and 'achieving closure' as a description of the spiral process in spiritual care, and as something which is achievable outside of any religious denomination but lies within every Human Being. This further warrants that it be taught to students and provided to patients. Whittemore and Knafl (2005) integrative review of spiritual care may be helpful in contextualising teaching of spiritual care through evidence-based practice. Rogers and Love (2007) recommends a client-centred approach to care which is non-directive care through which carers show a supportive attitude that models human values and acceptable communication as advocated.

## 8. Limitations of the study

The limitations of the study relate to the fact that the study was conducted in a single HEI and the finding thus cannot be generalisable. However, a thick description of the findings provides a basis for the reader who may want to replicate the study.

## 9. Recommendations from the study

It is recommended that nurses should be involved in patients' spiritual health by providing spiritual care in the same manner that they care for other aspects of patients' health needs. This could be effectively implemented if the SANC prioritised formalising spiritual care in education and training of pre-service nurses in South Africa. Nurses should recognise that spirituality is a normal part of 'human beings' life path through which they only respond by 'being human'. This requires caring beyond technical nursing tasks (Carr, 2008). Conducting further research on spiritual care in nursing will assist nurses to increase their level of knowledge and competence of spiritual care required for the teaching, learning and practice of spiritual care in the undergraduate nursing programme.

## 10. Conclusion

The participants from this small-scale study problematised the lack of spiritual care guidelines from SANC by unequivocally acknowledging the value of spiritual care in nursing practise and exemplified their willingness to teach students how to engage with patients' spiritual needs. Furthermore, they acknowledged the need for a sound nursing theory and philosophy in the undergraduate nursing programme. This finding is in line with the global trend towards formal integration of spiritual care in education of nurses.

## CRediT authorship contribution statement

**D.R. Phetlhu:** Supervisor. **H.C. Klopper:** Supervisor.

## Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to

influence the work reported in this paper.

## Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijans.2019.100187.

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