International Journal of Africa Nursing Sciences 14 (2021) 100254

Contents lists available at ScienceDirect

International Journal of Africa Nursing Sciences

journal homepage: www.elsevier.com/locate/ijans

Clinical supervisors' understanding of spirituality and spiritual care in nursing: A South African perspective (part 2)

Ntombizodwa S. Linda [a,*], Deliwe R. Phetlhu [b], Hester C. Klopper [c]

[a] University of Zululand, Private BagX1001, KwaDlangezwa 3886, South Africa
[b] University of the Western Cape, Faculty of Community Health Sciences, School of Nursing, Robert Sobukwe Road, Bellville, South Africa
[c] Stellenbosch University, Private Bag X1, Matieland 7602, South Africa

ARTICLE INFO

Keywords:
Spiritual care
Spiritual needs
Clinical nursing
Clinical teaching-learning
Spiritual benefits & Spiritual guidance

ABSTRACT

The article provides findings of understanding of clinical supervisors (CSs) on spirituality and spiritual care in nursing practice. These participants who taught nursing skills to nursing students who were registered for R425 SANC Nursing Curriculum. Revealed uncertainties regarding their implementation of spiritual care in clinical nursing. They expressed concernes that despite South African Nursing Council's espoused holistic approach to nursing, a gap still exist in SANC's holistic philosophy. This view is supported and by the lack of guidelines from the SANC. According to the participants lack of guidelines indicates failure of SANC in embracing spiritual care as a vital component of "holistic nursing".

An exploratory interview-based qualitative design was used to explore understanding of spiritual care by CSs. The certificate no: 13/4/22 was granted by the University Higher Degrees Committee. Nine (n = 9) CSs were purposively selected to respond to one open-ended question, "***what is your understanding of spiritual care in nursing***". Participants were included if a written consent was obtained, had facilitated clinical learning for two or more semesters. Data were analysed using Tesch.

Emerged themes from in-depth interviews with the clinical supervisors include: (i) defining spiritual care; (ii) current status of spiritual care in teaching and learning; (iii) benefits of spiritual care; and (iv) need for spiritual care. Each theme is described below to show how it contributed to the objectives of the study.

Spiritual care is needed not only to demostrate the nurses' morality. But more importantly nurses are obliged to alleviate deep human suffering which are met possible through spiritual care on one hand. On the other hand they questioned "how holistic" is "holistic nursing care" without attending to the spiritual health of the patient or client.

1. Introduction

The study was conducted not only to explore how the clinical supervisors understood spirituality and spiritual care in education and training of nursing students; but more importantly, it was also to benchmark how clinical teaching and learning of spiritual care was experienced as an aspect of holistic nursing. This comparative notion was necessary to attain a comprehensive picture of how spiritual care was taught at the school of nursing where the study was conducted. In contrast to the findings from the nurse educators (NEs) their counterpart who prioritised the need for a guiding theory to teach spiritual care in nursing education from in the same nursing school. Clinical supervisors unequivocally expressed a state of urgency to required practice of spiritual care owing to their encounter with the reality of patients' needs. They reiterated lack of preparedness on teaching and practice of spiritual care nursing in health care facilities. The findings of the current study reported lack of and or inadequate preparation of clinical nursing educators (i.e. CSs) with the required skills and competence to teach spiritual care in clinical nursing (Chandramohan and Bhagwan, 2017). It seems that most nursing schools in South Africa have not formally integrated spiritual care education (Mthembu, Weigner & Roman, 2017; Tjale, 2007).

In depth interviews were conducted during face to face sessions to explore how spirituality and spiritual care in nursing was understood and practiced by clinical supervisors (CSs) who taught clinical nursing skills. The findings of the current study provide a complete view of how spirituality and spiritual care is understood by clinical supervisors in contrast to their counterpart "the NEs" who taught theory component of

* Corresponding author.

https://doi.org/10.1016/j.ijans.2020.100254
Received 19 November 2019; Received in revised form 30 September 2020; Accepted 6 October 2020
Available online 13 October 2020

the nursing subjects at the same nursing school where the study was conducted.

In addition to lack of regulatory guidelines for spiritual care in nursing practice; clinical supervisors reported a dire need to prioritise spiritual care when practicing nursing. It is reasonable to assume that if the SANC can meaningfully commit to its philosophy of "holistic nursing care" as espoused; it should reflect on the need to regulate teaching and practice of spiritual care. Failure to do so renders holistic nursing philosophy nothing but a lip service. Findings of the current study are important and crucial in changing the face and practice of nursing in SA. Similar findings were reported by authors such as Chandramohan's and Bhagwan's (2017); Tjale (2007), who did not only agree to the importance of spiritual care in nursing but also prioritised eradication of existing lack of guidelines and regulatory framework. Relevant guidelines and framework for teacching-learning and practice of spiritual care is believed that it will promote effective teaching-learning and practice of "holistic care in nursing". Admittedly so, the urgency to redress teaching-learning and practice of spiritual care as a vital component of "holistic nursing care" appears a fairy tale yet it is a dire need.

In depth interviewes were conducted with CSs who informed 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)*. One of the four emergent themes reiterated the views of the NEs thus affirming some of reported challenges. The CSs' denotative meaning of spiritual care was their most determinating view on which they supported the need for spiritual care. Whilst regarded the connotative meaning of "spiritual care" as was accepted as potentially influenced by culture and religion and addition to an ethical disposition of each individual. Such findings do not only depict the CSs' sense of responsibility, but also expressed their commitment to practice of spiritual care in nursing. Each theme emerged is presented in a table followed by its narration and supporting sub-themes as emerged.

2. Methods and procedures

A qualitative approach and an exploratory-descriptive and contextual design were employed to explore and describe understanding of spirituality and spiritual care by Clinical Supervisors (CSs). In-depth interviews were conducted with participants who were purposively sampled to form a sample of nine (n = 9) CSs. Participants shared their experiences from an emic belief perspective as they responded to one open-ended question "***what is your understanding of spiritual care concept in nursing***". In depth structured interviews were conducted either in the researcher's or the participant's office. Participants were included in the study once they: (i) had signed a written consent form for participation; (ii) were employed on full time or part time basis at the selected nursing school at a particular Higher Education Institution (HEI) in the Western Cape; (iii) were involved in teaching of clinical nursing students for at least two full semesters in the undergraduate nursing students.

2.1. Target Population, sample size and sampling technique

The sample was formed by clinical supervisors (CSs) who facilitated learning of clinical nursing skills; and accompanied nursing students when they were in the clinical placements. These CSs were targeted because they were employed at the school of nursing where the study was conducted and they facilitated learning of clinical skills in the undergraduate nursing programme R425 as regulated by Act 33 of 2005 (SANC, 2014).

2.2. Recruitment and inclusion criteria

Participants were invited either by face to face or email to participate in the study. After potential participants were approached as the initial step to recruit and alert about the study, they were later followed up. Potential particpants whether recuruited by email, telephone or physically negotiarted with were then provided with an official request letter. Participants were included if they met all the condition as spelled out under methods section above.

2.3. The settings

Geographically the university in which the selected school of nursing was situated forms one of the four universities in the Western Cape Province. This school of nursing was identified and selected based on its ideal setting for the study. More necessarily it fitted the needs of the study because the school of nursing offered its R425 nursing progmme under SA Higher Education landscape. The school offers both undergraduate and postgraduate programmes with different specialties. In particular, it offers a four-year Bachelor's Degree in Nursing as regulated by the South African Nursing Council (SANC) under Regulation 425 of the Nursing Act No. 33 of 2005 (SANC, 2014) during the year in which the study was conducted.

2.4. Ethical considerations

The proposal for the study was submitted to the School of Nursing and Faculty Board Committees, and Higher Degrees, Senate and Research Ethics Committees of the university where the study was registered. The approval was granted, with certification no: 13/4/22. Four key ethical principles were observed included the following: ***Respect for Autonomy:*** Participants voluntarily participated only when an informed consent was signed. They were allowed to drop out if they no longer wanted to continue their participation without any penalty imposed. ***Justice,*** which entails a moral obligation to conduct the research process with integrity and according to acceptable standards, was exercised. Furthermore, to servant of fundamental ethical principles was a sign of respect to acknowledge authors of the consultated of sources and databases that were consulted (Brink, Van De Walt, & Van Rensburg, 2006). ***Beneficence:*** Participants were not only treated with respect but they were prevented from harm. **Non-Maleficence,** was observed by providing anonymity and *confidentially* to participants during data collection and analysis. Their names were not divulging at any stage of the study. Audio tapes and transcripts were locked up in safe place at completion of the study. Safety of the study documents was necessary for privacy to ensure that the recorded voices were not unauthorised accessed by individuals. Scientific honesty and reflexivity were 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 were provided as a measure to observe copyright and intellectual property rights. Destroying research hard copy documents after 5 years of this publication of the study results is another principle that was observed by the author. Audio recorded files were labeled accordingly to ensure anonymity before being given to a professional Independent Coder. Information sheets were given to participants once it was read out to the participant clarification questions answered by the research.

2.5. Data collection method

Individual interviews were conducted until data saturation point was reached which implied no new data was forthcoming. Un-obstructive, in-depth interviews were useful in collecting data from participants who responded to one open ended question ***"What is your understanding of the concept of spiritual care in nursing?*** This question was followed by different probes such as "uh, huh," "yes, I see," "right, uh-huh" to stimulate participants to produce more information without injection and interjection. Non-verbal prompts such as head-nodding, frowning and head shaking were at times appropriate to rekindle interest of participants which helped to keep sound communication and

motivated the spirit in participants to continue talking and keeping the discussion vibrant and engaging (De Vos, Strydom, Fouche & Delport, 2011). All interviews were audio recorded with their permission to ensure that no important information was lost in the process. Interviews lasted about forty-five minutes to an hour and thirty minutes on average. Electronic Media files were labelled immediately after collecting data.

2.6. Data analysis

Interviews were transcribed verbatim and data cleaned. Tesch's eight steps of qualitative data analysis were used not only to organise qualitative data but also to guide the analysis process (Tesch, 1992). A table below present how each step was applied in the current study *Tesch, L., 1990 in De Vos, Strydom, Fouche & Delport, 1998).*

Tesch Steps	Criteria for Qualitative Data Analysis	Application in the Study
Step 1	Preparing of data for analysis	Audio/ Media files were labelled, and password protected. Transcribed verbatim.
Step 2	Reading transcripts	The researcher carefully read each transcript repeatedly to obtain a sense of the whole conversation. Repeated reading of each transcript provided the sense of what participants spoke about.
Step 3	Developing categories	The researcher jotted down in the margin of each transcript some ideas as they flooded her mind. This allowed further speculation and examination of data whereby the researcher could examine information provided by participants and made sense of the underlying meaning. Defined the meaning of Themes were defined by after assigning codes to these meanings and kept on differentiating new coming themes from existing ones.
Step 4	Testing the coding system.	A list of themes or topic sentences were developed. Then similar themes or topics were grouped together. Independent Coder independently performed coding which was compared with the researcher coding. Consistence and difference identified, discussed, and reconciled between the two coders. The list of themes or topics were further analysed by associating related or similar topics which were that assigned a code. The codes were written next to appropriate unit of segments of the transcripts. If new units were identified they allowed new categories and codes to emerge
Step 5	Coding all text	After reconciling coding system, the researcher coded all the transcripts. The researcher identified the most descriptive wording for the themes or topics while categorising them according to their associations
Step 6	Assessing consistency	Reading to get the sense of the whole. Each transcript was subjected to this process. The researcher made a final decision on the code or abbreviation for each category and assigned a final code.
Step 7	Drawing inferences	Themes and sub-themes were concluded based on coding system employed. The data material belonging to each category was gathered and a preliminary analysis was performed.
Step8	Presenting findings	The researcher re-coded existing data if it was deemed necessary. Emergent themes and subthemes used to present the findings.

Table 1:

2.7. Trustworthiness

Four strategies by Krefting (1991) were applied to ensure trustworthiness. ***Truth value*** was applied through reflexivity and bracketing to ensure credibility and rigour. Field notes and methodological notes produced during inductive-deductive reasoning analysis were reviewed and reflected on. Bracketing was also used to enhance uncontaminated reflection while the researcher worked with the empirical data. Member checking was undertaken to contrast and affirm emergent codes presented by the researcher and the Independent Coder. ***Applicability*** maintained through clear description of the purposively selected sample, thick description empirical data which were particpants' responses during interviews. Furthermore, thick, *purposive sampling*, as well as description of the *research setting* were done in terms of its geographical and pedagogical stances which provided a unique context for the study. This means that participants' information was not only densely reported and described; but, it was also verbatim to ensure that particiants understanding was not lost while depicted their actual responses to the research question. ***Consistency*** was maintained through member-checking, co-coding, memo-writing, and the immersion of the researcher in the data analysis process. Member-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 further identified. ***Neutrality*** was promoted through a paper trail which would be filed for five years after the study finding have been published. Another strategy was observed the researcher's reflexivity which was promoted through reflection-on-action and reflection-in-action (Krefting, 1991, Polit & Beck, 2011, Holloway & Wheeler, 2010).

Table 1
Themes and Sub-themes emerging from the CSs.

Themes	Sub-Themes
1 Spirituality as a core aspect of spiritual care	1.1 Spirituality as a concept 1.2 Spirituality as an inherent value of humanity dimension
2. Teaching and learning of spiritual care	2.1 The current status of teaching of spiritual care 2.2 Constraints in implementation of teaching and learning 2.3 Awareness, willingness, and desire to facilitate learning of spiritual care
3. Benefits of spirituality and spiritual care in nursing	3.1 Benefits to the patient 3.2 Benefits to the nursing students
4. Need for Spiritual Care	4.1 Essentials of spiritual care 4.2 Essential communication 4.3 Patients' felt needs

2.8. Rigour

Field notes were used as an additional empirical data obtained from interaction with the participants. These notes assisted in making sense of the participants' understanding of spirituality and spiritual care in nursing. Field notes, included descriptive and reflective notes, description of the situation and mood as they transpired in one hand. While on the other the researcher's thoughts reflectively captured the experiences of the participants during the interviews. Rigour was also maintained by use of a qualitative research protocol and procedures for data analysis process as well as by applying measures to ensure trust worthiness (Polit & Beck, 2011). The researcher exercised bracketing and reflexivity to prevent potential biases towards the researcher that could jeopardise the credibility of the study (Brink et al., 2006; Krefting, 1991).

3. Findings of the study

Themes emerged from in-depth interviews with the clinical supervisors were informed by participants agreement that in principle spiritual care fulfils the inclusive wholesomeness spiritual needs for humans; but regrettably it is often not rendered. This attributed to differences emanating from and at the same time causing whie while lack of clarity about the definition of spiritual care. This could mean that diagnosis and management of spiritual needs would vary. This lack of clarity confronted the participants with potential challenges on the basis of which

spiritual care to be provided. Themes emerged from in-depth interviews with the clinical supervisors include (i) Spirituality as a core aspect of spiritual care (ii) Current status of spiritual care in teaching and learning; (iii) Benefits of spiritual care; and (iv) Need for spiritual care. Each theme is described below to show how it contributed to the objectives of the study

3.1. Theme 1: spirituality as a core aspect of spiritual care

The participants' attempt to define "spiritual care" was somehow inextricably similar to how one would define "spirituality". They defined spirituality as an inherent value in a human dimension that influences spiritual care. Despite this theme depicting participants' response of how they supposedly understood the concept of spiritual care; instead, they linked "spiritual care" with inner human aspects. Furthermore, they accepted that a person's behaviour is influenced by what he or she believes in for instance Religious belief was acknowledged, believing in a Higher Being, God or Allah. Clearly, they could not define "spiritual care" without associating it with "spirituality".

Sub-themes that emanated from this theme include (i) spirituality as a concept, (ii) spirituality as an inherent value in human dimension. Each sub-theme is discussed below.

3.1.1. Sub-theme 1: Spirituality as a concept

Despite the participants having difficulty in differentiating "spiritual care", "spirituality" "religion" they described it from an understanding of what it meant in their everyday life. They were not only challenged about such distinction, but they also could not differentiate it from "emotional" meaning. Consequently, they questioned their own religious connotations which they regarded as hindrance in engaging with spiritual care in the workplace. They expressed this as follows:

> *"…I don't think I can define spirituality…"; "…I mostly view spirituality from the religious point of view"…; "…And when I say emotional I usually take spiritual with emotional"; "So the two for me are almost similar"; "I know they are not similar, but it's almost similar for me"*

The CSs' conception of spirituality as relating to religious beliefs and personal characteristics denoted a view that a person's spirituality is influenced primarily by religious affiliation which may or may not include spiritual beliefs. Religion was acknowledged not only as fundamental to certain behaviours; but that which positions a person on a different level of a value system. Religious beliefs were credited positively despite differences in person's religious affiliations or background. Although religious background was believed to contribute positively when dealing with spiritual needs. Regrettably, participants expressed discomfort in attending to such needs in clinical settings due to various reasons. They said:

> *"… and that is why it is difficult to render spiritual care to our patients because we do not want to send them in the wrong way because it is the only time that we render spiritual care when they are dying".*

On the contrary, participants pointed to observable behaviour such as valuing the patient positively which does not necessarily emanate from religious beliefs. Spirituality was therefore regarded as a precursor to holistic nursing care whilst religion was accepted as the influencing factor in one's behaviour. This meant that the nurses religious affiliation and beliefs may or may not play a role towards meeting the patient's spiritual needs in the same way that culture or family background could.

3.1.2. Sub-theme 2: Spiritual care as an inherent value in humanity dimension

Spiritual care was described as an inherent value in a humanity dimension which promotes a "holistic caring attitude" and connects people to essence of their existence. Yet, failure to accept this inborn caring nature of humans was blamed for potential lack of person-centred holistic approach in nursing. This lack was likened to a nurse who claim to be giving "holistic care" without attending to "personhood needs". Acceptably, inherent nature of spiritual care may afford nurses to assertively and spontaneous exhibit a caring attitude. Participants agreed that spiritual care is not only inherent in all humans, but it plays a role when making sense of painful experiences. With the same breathe participants acknowledged "religious beliefs" and "moral values" as responsible for shaping ability to give and receive "spiritual care" Probably, this was due to the fact that most participants were affiliated to a particular religious denomination. They expressed this challenge saying:

> *"You don't value that person as a Muslim, or the religion related to the person. You value that person as a 'human being'…"; "…because when you do [take] the Nurs' Oath, you say regardless of race, of colour, of culture you will treat that [the] person as a human being…".*

3.2. Theme 2: teaching and learning of spiritual care

Since participants were asked about their understanding regarding "spiritual care" in nursing education and practice, they responded on how its teaching is done and or experienced. This theme is therefore founded on the following sub-themes; (i) Current status of teaching and learning of spiritual care (ii) Constraints in implementation of teaching and learning of spiritual care (iii) Awareness, willingness and desire for teaching spiritual care in nursing.

3.2.1. Sub-theme 1: The current status of teaching of spiritual care

"Spiritual care" was acknowledged as not formalised despite acknowledging its importance in nursing. Although they acknowledged having informally engaged with patient's spiritual matters in clinical settings; however, their concern was that it is not formally intergrated in the curriculum. Instead participants acknowledged that they simply transfer spiritual knowledge to students and what and how they were taught. Yet other CSs confessed that they had neither facilitated spiritual related content nor guided students on how to take care of spiritual needs of patients in clinical practice.

Instances of teaching and learning of spiritual care were acknowledged in certain nursing disciplines such as Midwifery and Psychiatry that they intuitively welcome spirituality. For instance, where terrible experience like "loss of a child", "difficult delivery" or "the terror of unseen baby to a primigravid mother" which was a case of Midwifery in one hand; and allowing "silence" and "counterference" as part of managing a psychaitric patients on the other were scenarios where spiritual care materialised. Also, during, midwifery debriefing sessions that are conducted to allay fears of staffs and student midwives if they had encountered emotional touchy clinical experiences. Such as delivery of a stillborn baby, non-premeditated termination of pregnancy (TOP), or where no medical intervention was necessary but required. Therapeutic use of self was also characterised by spiritual engagement. Participants refered to these experiences as "spiritual interface with a life-changing reality". Participants expressed the experience this way;

> *"…This is grief,* [*i.e.* the delivery of dead foetus] *and for the first time in your* [student's] *life and career there is no medicine to apply; no injection to give, nothing to offer except yourself, the only thing that you have in your hand is your spirit"; "Whatever response… to give to the mother who wants to hold the dead baby; smell it; she wants to see that this was mine but a short life".*
>
> *"…then there is human rights question! …"; "… in situations where doctors will start the termination of pregnancy in a ward with premedication and the student will largely be uninformed as to what is actually happening"; "…she* [student] *then becomes an uninformed part and parcel of the …"; "… but you know that she may have a deep Christian faith of which* [that] she or her *would never consent to be part*

of it and yet because it is … she's being persuaded without her being informed".

Participants only informed that they engaged on spiritual care during counselling lessons which are part of HIV/AIDS learning content using a broad communication approach strategy. The strategy protects patients from being interrogated but are given a space to open-up. This allows the student to pick up patient's beliefs without feeling pressurised and violated which would otherwise interfere with patients' personal space. Instead, it permits patients to cope with their inside burdens and by easing them to address personalised needs such as request for religious support. Communication was acknowledged as a vital means when addressing patients' felt needs by following the cues from the patient; For instance:

"… I may conduct a prayer or pray with them"; "If you're not of the same religion, you can also say a prayer and meditate for your patient"; "If patient's religion is not the same as the nurses belonging. It does not prevent rendering spiritual care but that it was very rare"

However, participants verbalised concerns on teaching of spiritual care subject saying that it was not possible to teach students how to feel in a particular way when dealing with bereaved relatives. They were also not clear on how to teach students how to feel for someone who is experiencing a loss as students often appear untouched about a patient's death, grief, loss or any tragedy which was blamed to diversity. Participants also observed that while some students could not handle their first experience of patient death; others appeared untouched about similar encounter. However, they were doubtful in judging these student's response as either overreaction or hardiness in case they misjudge. But never-the-less it was worth bringing up the confusion. Since the participants are teachers of clinical skills less theory related experiences were shared.

3.2.2. Sub-theme 2: Constraints in implementation of teaching and learning

Despite the participants having acknowledged that they did not formally teach spiritual care however, they expressed interest in topics such as caring, communication and therapeutic use of self which they regarded as fundamental to spiritual care. Only when teaching structured counselling they would address issues like how sympathy is different from empathy and therapeutic use of self.

Constraints on teaching and learning of spiritual care did not only affect learning of spiritual nursing skills by nursing students but it equally affected patients and clients care. This view was supported by a concern about lack of attention to a baby's father who often are denied access in the birthing room. This was not only seen as the father being denied an active role, but it was described as a lack of humanitarian approach to caring essence of nursing. Instead these fathers are locked out of labour ward and denied active participation and or proving supportive role during birth process which was also expressed as being denied personhood needs. As a result, fathers would be seen pacing up and down in the corridors wondering about what is going on inside Labour Ward. Yet, if the baby's father could be invited in the labour ward, the tension on birthing woman may changes because of the support, hope and the feeling of security from the man's presence.

This is how they expressed this view:

*"…nurses may not know how much the presence of the baby's father means to both a labouring and mourning mother"; "…But he [*baby's father*] is being withheld, his spirituality barred at the door"*; *he is thinking is that my one that is screaming". "Is that my child that is being born?" "What is happening there?" …and yet you [the nurse] know when the baby's father is invited in, there is an interchange that happens between partners that is truly lovely"*

Another concern that spiritual care can be entwined with cultural beliefs was coupled with a question of to what extent can students render spiritual care. Although participants acknowledged that "spiritual care" has to do with a belief system and what a person believe. However, they did not only accept that the human spirit has nothing to do with religion but agreed that spiritual care relates closely to religion, yet it is not the same with religion. Confusion between spiritual beliefs, personal beliefs and cultural beliefs was yet another contention. However, this confusion was resolved by realisation that all beliefs are within the person so the nurse should only respond to the patient's expressed needs without necessarily distinguishing the source or nature in an attempt to find out which one is which.

Besides the fact that in general, humans are perceived and regarded as caring species. Participants pointed out that other families or communities where caring is not modelled, a caring nature may not be developed in those students as a consequence. At times students would bring their burden to the learning environment which is based on family background where an offensive behaviour which could be difficult to eradicate. This is how the expressed this view:

"… it is difficulty to change the student's untoward behaviour because the behaviour is linked with the student's personal beliefs at times cultural beliefs as well";
"…Families no longer share challenges…"; "… Student will cross over to the profession of nursing without having what it takes…"

Participants also insinuated cultural instances where communication between adult male patient and a female student nurse may trigger cultural taboos no matter the extent of spiritual needs might be. This is how the view was stated:

"… How do we teach students how far to engage and when is it appropriate?"
"… and how will students know that this is where to draw the line" "…or this is where one can go up to so far".

Participants did not only question the extent to which students can be allowed to engaged with patient's spiritual matter but they were more concern about where to draw the line in nursing practice.

3.2.3. Sub-theme 3: awareness, willingness and desire for spiritual care

Participants expressed their desire and willingness to engage with the subject of spiritual care and welcome any possible means to engage them in its implementation. Participants' concerns regarding lack of clarity on meaningful holistic approach in nursing care practice which was confused with nurse's connotation of it as different illnesse in contrast to different dimensions of human needs was pointed out. Their heightened willingness led them to realise that practice of spiritual care should start with their interaction with students where they would instil meaning of spiritual values, improves moral judgement of students. Their interaction was aimed at addressing the inner personhood needs which was acknowledged as often not addressed resulting in the lack of healthy decisions in students. Participants indicated a need for guidance on how to they could teach and guide students on learning and practice of spiritual care. They said:

"Our positive interaction with students will transfer the caring skills to students"; "…students will be able to diagnose spiritual need(s) or ill-health from the patient if students are taught how to take note of the person's attitude that suggests spiritual ill-health"

Participants suggested teaching strategies that equip students how to assess and diagnose a patent's spiritual needs for instance, clues from facial expression, reading the patient's eyes. Assessment skills that go beyond looking at the physical aspects but observe emotional and spiritual appearance of a patient. They used an idiom "your eyes are the windows to your soul" to explain what they meant. Furthermore, students would learn how to observe clues for positive emotional behaviours such as kindness, friendliness, caring, support, helpfulness, compassion, a loving attitude and harmonious living for a positive attitude. They said:

In contrast to positive signs indicating good spiritual health, students can be trained to look for negative behaviours such as hateful attitude, negative behaviour, un-accommodative, not flexible, unapproachable, negative attitude suggesting spiritual discomfort. Group reflections were suggested as ideal to provide students with an opportunity to learn from each other where the teacher may use her/his own personal experiences and ask the students if they have any similar experiences. They said:

"…Students can immediately see in somebody's eyes what they might be going through"; "… People can smile but their eyes are not smiling" "…. Students can check if the patient is sad? Depressed? Happy? Frustrated? or angry?"; *"Then the student may bring in the aspect of spiritual care. But if the student is not on par with spirituality, she cannot see that in a patient"*

In respect of the teaching–learning process, case studies were strongly advocated for. Simulation was not recommended as a method for teaching spiritual care because potentially it hinders feelings from both the simulators and from the student.

3.3. Theme 3: benefits of spiritual care in nursing

Spiritual care in nursing was regarded as helpful for both patients and nurses. Participants supported the sense that spiritual care assists the patient to get their life balanced. They also acknowledged that spiritual care is important when a nurse is caring for a person who is in need of prayer, support or seeking peace because if the patients regain peace and get better quicker. The caring nurse may be self-conscious and aware about how she or he felt at the time and may then decide how she or he would want to behave in a certain context or circumstance or situation in nursing intervention and in own life in general. The below sub-themes support what the understanding of the CSs was.

3.3.1. Sub-theme 1: Benefits to the patient

Participants shared that there are benefits that the patients may gained when nurses incorporate spiritual care as part of their daily duties. The participants reported that the ultimate aim of spiritual care was conceived as a means to instil peace in patients; a feeling of being at peace, self-awareness of what is happening around and the ability to cope. The participants acknowledged that consideration of spiritual care as part of patient's care seem to help patients to improve quicker from their illnesses. Participants further reported that when the spiritual needs of the patient are taken care of, the patient gets balance and is more abled to bounce back to normal life. It is that gap that a nurse can fill to motivate and encourage the patient to hope for something. They said:

"… Where spiritual health, emotional well-being and patient's well-being are promoted…"; "…once a nurse *reminds [the] patient that there is God who has an interest in you and wouldn't plan for you to suffer the patient becomes very much motivated and shines up from a state of being depressed"*

3.3.2. Sub-theme 2: Benefits to nursing students

Participants identified that there were benefits to nursing students when they consider spiritual care as they may experience feelings of contentment by tapping into patients' inner need. The participants agreed that spiritual care entails self-awareness about how one feels and wants to respond in a certain circumstance. Students' competence in perceiving the patient's spiritual needs would sharpen their own spiritual senses in return. Self-reflection as teaching strategy would enhance feelings of satisfaction after treating a patient. This is a feeling that comes from knowing that as a nurse sympathising and assisting a patient is rewarding in a sense. They said:

"…it makes the nurse feel better and knowing that you are helping somebody, and you are aware that patient may say that she feels much better after you have done something". "it makes me feel good…" "… it's a positive response…"

When the nurse empathizes with the patient when she or he puts her/himself in the shoes of the patient and can easily provide spiritual care. Consequently, nurses should internalize introspectively how they would want to be treated when they are sick which in turn would promote a good personal relationship with the patient. Such self-awareness was therefore acknowledged as one of the ways to prepare student nurses not only to engage with the patient on spiritual matters but more importantly to promote self-awareness about own spiritual needs and health. They said:

"…When the nurse puts herself in the shoes of the patient, she can easily provide spiritual care, and she can internalize a view as how she would want to be treated when she is sick".

3.4. Theme 4: Need For Spiritual Care

3.4.1. What are the key issues pertaining the theme?

The key issues under this theme include expressed essential nature of spiritual care by participants and need for purposive communication when attending to patient felt needs. These key issues are presented below and further described under respective sub-themes.

3.4.2. Sub-theme 1: Essentials of spiritual care

Clinical supervisors (CSs) shared that spiritual care incorporates giving and receiving encounter. This means that spiritual care can only be provided where both parties (nurse and patient) are willing and open to engage in different ways including but not limited to: praying for or with the patient, providing therapeutic touch, listening to the patient, advocating for the patient including taking a stand against ethical issues, calling spiritual leaders and a family member, an Imam or a Pastor or anyone according to the patient's request, as well as attending to any request from the patient without judging or taking a decision on behalf of the patient as these might be against the patient's current choices. This will also avoid potential regrets by the patient should a decision made by a nurse on behalf of their patient not work. The role of the nurse in providing spiritual care would be to encourage the patient and help the patient come out of their unpleasant state. Spiritual care was reported as more essential in psychiatric nursing where a mentallly challenged patient can be encouraged and get strength to deal with the situation like to face the outside world. The Psychiatric nurse may first share her views about the situation without judgment. The patient must still take a final decision whether the issue is a health or social problem so that the patient may still take responsibility and own the consequences of the decision taken. The focus should be to come through for patients who are longing and looking for something that will lift their hope and will give them courage to take them higher from where they are. Once a nurse informs them or reminds them that there is God who is there for them, they become very much motivated and encouraged. Participants said:

"If the inner man gets a boost or courage, then the patient would be able to deal with the situation"; *"…and is pulled out of that corner"*; *"…hospitalised patients who are under crisis, stress … it is important to treat them holistically but …."*

On the other hand some CSs reported that they were taught that only faith ministers or pastors were legible to execute spiritual care bacause it was not an appropriate platform for nurses. However, all participants agreed that spiritual needs are a reality and spiritual care a necessity in nursing practice.

3.4.3. Sub-theme 2: Purposeful communication

Despite the focus of the study on spiritual care in nursing which related to rendering of spiritual care primarily. CSs took it close to their

own personal lives before they could reflect on what they meant with purposeful communication. While they applauded this quality, they referred to observation of their own behaviour. Sound communication between CSs and students, and students and patients were believed to be demonstration of a caring nature. They argued that:

> *"If we [i.e. CSs] could display good communication with students, they [i.e. students] would in turn transfer a caring nature to students especially if they were listened to when they report their learning challenges and problems.*

Listening to students describing their circumstances; why they chose nursing, can uncover a lot about where they come from yet an often-missed aspect. But, if these are unattended to or covered up, their intense and internal emotional pain would not be addressed. Therefore, caring for students' personal needs would not only help the CSs to understand how students feel about the programme, but also would instil caring skills which will improve the learning experience in understanding patients and their own needs. Better communication with students and teaching communication skills was realised as a goal to work toward through all year levels.

CSs also emphasised the need to be aware about the student's personal challenges. Listening was agreed as key to caring for both patients and student nurses. Participants affirmed that in turn meaningful communication would improve student's spiritual sensitivity. They acknowledged that students would be motivated to spend time with patients even if it's just a few minutes next to the patient when they are doing nothing. This would be a major step towards meeting patients' felt or personhood needs. CSs admitted that having seen students running around looking for someone to confide to and listen to them; but, they would not get somene to engage emotionally. Participants admitted that if they happen to listen to students' personal issue(s) they would not do it whole-heartedly or a deserved pay attention. This is what they said:

> *"… if you just listened, and just say it will be ok, then it's over. …If the student sees you tomorrow you have completely forgotten that the* student *was crying tears in your office…"; "But if I listen with care every time you will keep on checking on the student, how she is doing! Is she getting any assistance! Every time when the student needs to talk, I'm there for her this is a type of listening that I'm referring to in this case"*

Whilst the CSs acknowledged the power of listening to and presence for patients was necessary; instead, there were always listening in hurry. As a consequently, the patient would close and not express his or her feelings. They admitted this as neglecting patient's inner needs. The emphasis was that nurses should not focus on everything else and ignore talking and listening to the patient to find out how the patient feels. For instance they can ask the patient "how did they sleep? what do they think can be done in a particular situation? They said this should be meaningfully done, not to just listen for the sake of listening but because patients matter as humans.

The clinical supervisor argued that caring should start with them caring for the students.

> *"…and then often our students say, our lecturers, they don't care about us. Once a student says it's over. You need to know that you've lost them…. where are they going to get the drive to carry on? So as facilitators really, we need to be aware of such things"*

This was viewed as potentially transferable skill to students in the sense that they would in return holistically care for patients under their care.

3.4.4. Sub-themes 3: Patients' felt needs

CSs acknowledged the need for spiritual care in nursing as critical and they pointed out to various reasons why a patient would need to be spiritually cared for. They said that spiritual needs can lift and vitalise a sick person's sould and spirit. When a person is feeling down, lonely and hopeless; asking themselves questions such as "why me" through which they lose hope such intervetion can be appropriate. These negative feelings were described as requiring spiritual intervention from the nurses. According to the participants, finding ways to engage patients on spiritual matters, handling certain situations including provision of spiritual health education to complete holistic health for the patient was a way to go. They viewed spiritual health, emotional well-being and patient's well-being as intended patient outcomes that need to be acknowledged by the nurse. This was mostly vital in psychiatric nursing interventions. Particularly, where psychological and social issues might be the source of the psychaitric illness. This positive effect of spiritual care was awarded to an understanding that when caring for the spiritual health and person's beliefs atleast inner issues get addressed if not resolved. This view suggests a critical need for nurses to pay attention to patient's spiritual health and needs and find ways to engage the patient on such matters.

This is how they projected this view:

"When patient's spiritual needs are taken care of the patient becomes grounded and bounce back to original state he or she was before becoming ill…";

> *"…It's more about handling certain situations"; "… Also [*it is needed*] for spiritual health education of the patient" "… [*Providing*] complete holistic health care for the patient"*

Furthermore, participants shared how psychiatric nursing relates to spiritual care owing to different psychiatric diagnoses and different reasons for psychiatric illnesses which often require spiritual approach to care. The connection between spiritual needs and spiritual care was argued on the basis that spirituality is about a person's inner man; meaning his secrets and intimate life. They argued that knowing why a psychiatric patient is admitted is critical for appropriate approach to caring for the patient as the patient may have perceptions of what other people's view is about them. The nurse's intervention should address the root cause of the patient's problem. This is how they put this;

> *"…for some patients it's disappointments and self-pity for others"*;
> *"They are depressed for different reasons"*;
> *"They are worried of what other people are saying about them"*; *"Spiritual care becomes necessary because if everything else has lapsed [meaning has been lost] but only their spirituality would be still inside them as an internal thing [value]…"*

4. Discussion of the findings

Despite participants acknowledging that they did not know how to define spirituality, however, they were aware of its existence (Carr, 2008). Spirituality was described as an inborn and inherent virtue that allows connecting to a supreme power. Hummel (2005) views spirituality as having religious roots; while, Harding, Flannelly, Galek, and Tannenbaum (2008) emphasise distinct constructs of "spiritual care" in contrast to "pastoral care" which is on the decline owing to increase of spiritual attention. The complexity in understanding spirituality is well documented and blamed as a nebulous, ambiguous and abstruse nature of a concept. McSherry, Ross Cash (2004) argue about claims that patients and nurses are aware and understand their spirituality which may not be true for all nurses. Other authors including Adib-Hajbaghery, Zehtabchi, & Fini (2014); Linda (2016) reported that nurses' knowledge of spiritual care is poor despite their willingness to provide spiritual care. To some extent a lack of education and time constraints were also reported in addition to unpleasant feelings and hindrances due to physical, professional, and personal barriers. Hence integrating spiritual care into nursing curricula is necessary to instil a caring nature during the nurse formation process Zehtab and Adib-Hajbaghery (2014). Although some CSs in the current study reported having practically engaged in patient's spiritual matters affirming inborn nature of their

spirituality; regrettably, they expressed that students' response to spiritual issues was largely dependent on the individual student's ability to feel what the patient was going through. Of which, unfortunately, they did not know how to teach students "how to feel" in a certain manner towards patients suffering (Chiang, Lee, Chu, Han & Hsiao 2015). This lack of "know how" might be due to diverse connotations of spirituality which exacerbates the issue as argued by McSherry, Ross and Cash (2004).

Students' feelings towards patient's needs were viewed as a predetermining condition for spiritual care to materialise. Intuitive spiritual care was equated with meeting patient's felt needs. For instance, when an inexperienced student midwife connects with the labouring women through caring values, she attends to less complex patient's needs such as offering water; and she connects with a labouring womam just at that level. Such a self-assured experience is welcomed in one hand; yet on the other hand students from other nursing discipline were depicted as paying less attention to patients' needs. However, participants were uncertain about provision of spiritual care in clinical settings owing to a lack of formal integration in the curriculum. This notion is supported by Mthembu et al. (2017) who acknowledged this challenge basing it on numerous barriers includig lack of formal integration of spirituality and spiritual care in occupational therapy education in South Africa.

When participants were asked how they would teach spiritual care, they responded that they would structure it around patient's presenting personhood needs. During the inteview CSs made a reference to patient's counselling lessons which were driven by HIV-linked modules. They said counslling lessons were aimed at equipping students with observation skills. Meaning that students would be expected to be observant of patient's needs of or from their spiritual standpoint. They said they teach students how "sympathy" differs from "empathy" and "therapeutic use of self" among other values and characteristics. The participants' notion of spiritual care is supported by nursing caring philosophy which accepts nursing intervention as endlessly interlaced with patient's health needs where nurses expressed behaviour of nursing practice is guided by nursing values for human dignity, compassion, love, kindness, compassion, calmness, tenderness, of sympathy, empathy and others.

Failure of this practice may not only cause nurses to neglect caring for themselves and one another but even for patients who are legitimate recipient of care. This view points to the need for formal integration of spiritual care into the nursing curricula throughout the didactic and clinical nursing education as suggested by Bennett and Thompson (2014). This will combat the widespread perception of lack of engaging with patient's spiritual needs and feelings that they are underprepared to meet such needs. South African authors suggested contextual based practice models for giving spiritual care in health science professions and they have raised awareness of this need (Mthembu et al., 2017; Tjale, 2007; Monareng, 2012). A sound teaching model should allow students to reflect, learn from each other, discuss and conduct critical incident analyses, diarise experiences as ongoing practical exercises. Such activities provide mentoring and guidance of students outside class. Participants acknowledge that teaching students how to balance patients physical and spiritual needs was a challenge owing to their current use of assessment models that were not culturally sensitive which was assumed to be difficult.

The benefits of spiritual care are well documented in nursing literature (Chandramohan & Bhagwan, 2017. This increase in documentation of spiritual care indicates the growing trend towards required direction in one hand; and on the other reducing doubts in formalising spiritual care in nursing practice and education. Participants mentioned numerous benefits of spiritual care for both the patient and nursing or health care providers. Diverse benefits of spiritual care including healthy attitudes and positive behaviour outcomes. Various authors have affirmed that spirituality is not only good for helping the patient to have hope but, it actually acts as a buffer against the impact of disease (Zehtab, & Adib-Hajbaghery, 2014; Adib-Hajbaghery, Zehtabchi & Fini, 2014). Research findings further suggest that spiritual coping strategies in the form of a sound relationship with self, others as well as the ultimate "God" or "Nature" can be helpful for a sick person to cope with ailments (Baldacchinno & Draper 2001). Other benefits relate to finding meaning, purpose and hope, which ultimately nurture individuals in their suffering. Adib-Hajbaghery et al. (2014) argue that spiritual care enhances spiritual well-being, performance and quality spiritual life which all has a positive effect on individuals' stress responses and spiritual well-being; and in turn a sense of integrity, excellence, and interpersonal relationships. Spiritual well-being is important for an individual's health, potentially when the experience of illness/hospitalization threatens the pateint's positive oucomes. Whilst Veloza-Gómez, Muñoz and de Rodríguez (2016) reported on the positive impact of spirituality in quality of care and the promotion of best practices among others in one hand. On the other, they argue that spiritual care improves people's spiritual well-being and performance as well as the quality of their spiritual life in the same way other caring activities do (Zehtab & Adib-Hajbaghery, 2014).

The findings of this study approve the notion that spiritual care has positive effects on individuals' stress responses, spiritual well-being keeping the balance between physical, psychosocial, and spiritual aspects of self, sense of integrity and excellence, and interpersonal relationships.

5. Limitations and recommendations

The fact that the study was conducted in a single nursing education institution (NEI) disrepute generalisability of the findings. NEI are institutions of learning that provide education and training of nurses in South Africa under the regulation and of the South African Nursing Council (SANC) and are accredited under Higher Education Quality Act 101 of 1997.

6. Recommendations

More research is required in the South African perspective so that nurse educators can be capacitated on how to teach spiritual care in a manner that assist students to grow their knowledge and skills by so easing the integration of caring values to nursing skills and providing practical learning sessions that allow students to experience connecting to self and others, find meaning, purpose and being aware of what they are going through whilst they clarify confusion through guidance by senior staff or clinical teachers (Linda, 2016).

7. Conclusion

Ideally, spiritual care should be formally integrated in undergraduate nursing programmes in order to promote holistic nursing care. The findings of this study revealed that nurses are morally obliged to alleviate deep human suffering through practicing spiritual care in nursing. The CSs who participated in the study accepted that while defining spiritual care remains a challenge because it is often dependent on one's spirituality which may differ from individual to individual. However, their collectively understanding of spirituality and spiritual care was depicted as connectedness being the most demonstrating attribute. The CSs agreed that if nurses can sincerely attend to human needs when practicing nursing, they will not only assist patients and their clients; but, they will also experience sense of job satisfaction. Job satisfaction will prevent nurses from burnout and lack of fulfilment. Importantly, as nurses address patients' holistic needs they are also taken care of which then becomes a driving force not to ignore patient's felt needs.

Author contribution

Linda NS Main author: As the researcher of the study drafted and

structured the article.

Phetlhu DR Co-author 1: was a co-supervisor of the study. She reviewed the article drafts. Provided suggestions, changes, comments and recommendation which assisted shaping the final version of the article.

Klopper HC: Co-author 2: was a co-supervisor of the study. She reviewed the final draft of the article. As a critical reader she provided suggestions, changes, comments and recommendation which further shaped the structure of the final version of the article.

Declaration of Competing Interest

All authors are legitimate coauthors of the manuscript. The main author was the researcher and the co-authors were the supervisor of the study. All authors contributed significantly towards the development of the manuscript.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijans.2020.100254.

References

Adib-Hajbaghery, M., Zehtabchi S., & Fini, I.A. (2014). Iranian nurses' professional competence in spiritual care University of Medical Sciences, Nursing Ethics 1–12 [a] The Author(s) 2015 Reprints and permission: sagepub.co.uk/journals Permissions. 10.1177/0969733015600910 nej.sagepub.com. Sage Original Manuscript.

Baldacchino, D. R., & Draper, P. (2001). Spiritual coping strategies: A review of the nursing research literature. *Journal of Advanced Nursing, 34*(6), 833–841.

Bennett, V., Thompson, M.L. (2014) Teaching spirituality to student nurses; Online Published: Journal of Nursing Education and Practice, 2015 Vol5, No2 DOI: 10.5430/jnep. v5n2p26, URL: http://dx.doi.org/10.5430/jnep.v5n2p26.

Carr, T. (2008). Mapping the processes and qualities of spiritual nursing care. *Qualitative Health Research, 18*(5), 686–700.

Chandramohan, S., & Bhagwan, R. (2017). Spirituality and spiritual care in in the context of nursing education in South Africa. CURATIONIS: 2015; 38(2): 1471. Published online 2015 Dec2017. doi: 10.4102/curationis v38i2.147IS.

Chiang, Y.C., Lee, H.C., Chu, T.L., Han. C.Y., Hsiao, Y.C. (2015). The impact of nurses' spiritual health on their attitude toward spiritual care, professional commitment, and caring. Nurs Outlook. 2016 May-Jun 64(3):215-24. doi: 10.1016/j.outlook.2015.11.012. [Accessed Nov 2018].

Harding, S., Flannelly, K., Galek, K., & Tannenbaum, H. (2008). Spiritual care, pastoral care, and chaplains: trends in the health care literature. *Journal of Health Care Chaplaincy, 14*(2), 99–117.

Higher Education Act 101 (1997). The Government Gazette: Republic of South Africa, Cape Town; No. 1655; No. 101 of 19 December 1997; Vol 390.

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (3rd ed.). West Sussex, UK.: Wiley-Blackwell.

Hummel, L. M. (2005). By its fruits: Contemporary empirical psychology of religion. *Religious Studies Review, 31*(2), 47–54.

Krefting, L. (1991). Rigour in qualitative research: The Assessment of Trustworthiness. *The American Journal of Occupational Therapy, 45*(3), 214–222.

Linda, N.S. (2016). Practice Theory for Teaching-Learning of Spiritual Care in the Undergraduate Nursing Programme at a Higher Education Institution in the Western Cape. A thesis submitted in fulfilment of the requirement for the degree Doctor of Philosophy in Nursing; University of the Western Cape (UWC); South Africa.

McSherry, W., Cash, K., & Ross, L. (2004). Meaning of spirituality: Implications for nursing practice: Issues in Clinical nursing; Spirituality and Nursing Practice; 2004 Blackwell Publishing Ltd. *Journal of Clinical Nursing, 13*, 934–941.

Monareng, L.V. (2012). Spiritual nursing care: A concept analysis. Curationis, Vol. 35 (28) 1–9. http://doi.org/10.4102/curationis.v35i1. [accessed June 2012].

Mthembu, T. G., Wegner, L., & Roman, N. V. (2017). Barriers to integration of spirituality and spiritual care in occupational therapy education in a South African context. *Journal of Spirituality in Mental Health, 19*(1), 61–79. https://doi.org/10.1080/19349637. 2016.1206843.

Polit, D.E., & Beck, C., (2011). Nursing Research: Generation and Assessing Evidence for Nursing Practice. (E. Ed., Ed.) (Eigth ed.). The Point.: Wolters Kluwer/ Lippincott Willaims & Wilkinss.

SANC. (2014). On line Nursing Act 33 0f 2005 SANC: Retrieved from www.sanc.co.za/pdf/GovNotices/gg35384gon420_20120601 Disciplinary findings [Accessed July 2014]Sussman, S., Nezami, E., & Mishra, S. (1997). On operationalizing spiritual experience for health promotion research and practice. Alternative Therapies in Clinical Practice.

Tesch, R. (1992). *Qualitative research: Analysis, type and software tools*. Routlegde Falmer Tailor and Francis Group.

Tjale, A. A. (2007). *A framework for holistic nursing care in paediatric nursing.* Johannesburg; South Africa: University of Witwatersrand.

Veloza-Gómez, M., de Rodríguez, L.M. The Importance of Spiritual Care in Nursing Practice Guevara-Armenta, C., Mesa-Rodríguez, S., (2016). Journal of Holistic Nursing American Holistic Nurses Association Volume XX Number X XXXX 201X 1–14 © The Author(s) 2016 10.1177/0898010115626777 http://jhn.sagepub.com.

Zehtab, S., & Adib-Hajbaghery, M., (2014). The Importance of Spiritual Care in Nursing Nurs Midwifery Stud. Letter; 2014 September; 3(3): e22261. Published online 2014 September 20.