AN INTERPRETIVE PHENOMENOLOGICAL ANALYSIS
OF THE EXPERIENCE OF NURSE EDUCATORS
IN USE OF THE
T.R.U.S.T. MODEL FOR INCLUSIVE SPIRITUAL CARE

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ABSTRACT

Literature across healthcare disciplines has come to acknowledge spiritual care as integral to health promotion. However, caregivers often continue to be reluctant to explore the spiritual dimension of health with their clients, even though substantial literature exists about best practices for non-intrusive spiritual care relevant within today’s pluralistic, post-modern context. In order to help caregivers feel more prepared to offer spiritual care, the author has drawn upon the interdisciplinary literature to develop the T.R.U.S.T. Model for Inclusive Spiritual Care, an evidence-based, non-linear model for inclusive spiritual assessment and intervention. Inclusive spiritual care is defined as care which addresses universal spiritual needs, honours unique spiritual understandings, and helps clients to explore and mobilize factors that can help them gain/re-gain a sense of trust in order to promote optimum healing. The T.R.U.S.T. Model is currently being piloted within the undergraduate nursing program in which the author teaches.

This paper presents findings from an interpretive phenomenological analysis of the experience of nurse educators who have used the T.R.U.S.T. Model in their clinical teaching. Analysis of participants’ round table narrative reveals that the T.R.U.S.T. Model had a positive influence on their experience of comfort and confidence in the clinical teaching of spiritual care, helping them to more successfully navigate ongoing barriers to the provision of spiritual care. Three emergent themes are presented: ‘The T.R.U.S.T. Model as a bridge to spiritual exploration’; ‘blockades to the bridge’; and ‘unblocking the bridge’. Included are resulting recommendations and ‘embodied’ resources intended to holistically support teaching and learning of the T.R.U.S.T. Model. These findings are intended to help educators from a variety of disciplines to explore ways of supporting students who are learning to provide inclusive spiritual care.
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Literature across healthcare disciplines has come to acknowledge spiritual care as integral to health promotion (Benefiel, 2009; Carr, 2010; Hodge, 2006; Koenig, 2007; Lemmer, 2010, 2005; McEwen, 2005; Pesut, 2010; Ross, 2006; Wallace, Campbell, Grossman, Shea, Lange & Quell, 2008). The literature also reflects a growing attentiveness to approaching spiritual care in an inclusive manner, given the great diversity of spiritual worldviews increasingly evident in today’s pluralistic, post-modern context (Heelas & Woodhead, 2005; Pesut, 2010, 2003; Hodge, 2006; Park, 2010; Secrest & Fageol, 2008; Wallace et al., 2008). However, caregivers often continue to be reluctant to explore the spiritual dimension of health with their clients, even though substantial literature exists about best practices for inclusive spiritual care (Carr, 2010; Lemmer, 2010).

In order to address the increasing complexity and ongoing reluctance in relation to offering spiritual care, evolution of integrative, interdisciplinary resources and experiences is essential (Lemmer, 2010; Willison, 2008). Educators, students and practitioners require quick-reference, affirming, client-centered resources that reflect and reinforce current best practices and accreditation standards in the fast-paced, often discouraging healthcare environment (Benefiel, 2009; Carr, 2010). As a nurse educator and spiritual director, the author has drawn upon the interdisciplinary literature to develop the T.R.U.S.T. Model for Inclusive Spiritual Care, an evidence-based, non-linear model for inclusive spiritual assessment and intervention that is currently being piloted within the undergraduate nursing program in which the author teaches. This model was developed to help professionals in today’s health care environment to feel more prepared to address the spiritual dimension of health as an integral part of holistic care (Scott Barss, 2008). (See Appendix A for key elements of the T.R.U.S.T. Model.)
This paper presents findings from an interpretive phenomenological analysis of the experience of nurse educators who have used the T.R.U.S.T. Model in their clinical teaching. These findings are intended to help educators from a variety of disciplines to explore ways of supporting students who are learning to provide inclusive spiritual care. Inclusive spiritual care is defined as care which addresses universal spiritual needs, honours unique spiritual understandings, and helps clients to explore and mobilize factors that can help them gain/re-gain a sense of trust in order to promote optimum healing (Caspi, 2007; Hodge, 2006; Mauk & Schmidt, 2004; McCewen, 2005).

AIMS OF THE STUDY

The main aim of this interpretive inquiry was to investigate the experience of nurse educators using the T.R.U.S.T. Model to teach nursing students how to integrate spiritual care into holistic nursing practice. Exploration of this experience was associated with several research objectives. Specifically, the inquiry aimed to discover if use of the T.R.U.S.T. Model increased nurse educators’ confidence and consistency in assisting nursing students to offer inclusive spiritual care. The study also aimed to validate and/or further develop the T.R.U.S.T. Model through identification of nurse educators’ perceptions of the model’s influence on their experience of preparing student nurses to offer inclusive spiritual care. Through this identification, the study aimed to discern whether it would be beneficial to integrate the T.R.U.S.T. Model into curricula for nursing. The intent was also to create a foundation for future inquiry into whether it would be beneficial to integrate the T.R.U.S.T. Model into curricula for other health care disciplines, thus making a contribution to interdisciplinary research and practice which promotes inclusive spiritual care.
LITERATURE REVIEW

While the T.R.U.S.T. Model itself draws upon interdisciplinary literature spanning various helping professions and wisdom traditions, its introduction and study within undergraduate nursing education is rooted in the abundant nursing literature on spiritual care. Three trends within the nursing literature have supported the model’s introduction and interpretive study: the need to address nurses’ ongoing lack of consistent engagement in offering spiritual care, the need for further research in nursing education about what constitutes effective spiritual care pedagogy, and the need for qualitative inquiry into factors that foster spiritual care.

The Need to Address Nurses’ Ongoing Lack of Engagement in Spiritual Care

Existing best practice guidelines, standards of practice, and resources have not been able to address nurses’ overall lack of consistent engagement in spiritual care. Literature reviews by Carr (2010), Lemmer (2010), McCewen (2005) and Ross (2006) confirm that a significant number of nurses rarely attend to the spiritual dimension of practice, often describing themselves as uneasy and unskilled in this regard. Nurses continue to express fear that dialogue related to spirituality is intrusive or irrelevant to their care of the client – or that they feel incompetent, particularly when someone’s belief system is different than their own (Carr; Lemmer; McCewen; Ross). Furthermore, Carr’s recent phenomenological study of barriers and challenges to spiritual nursing care revealed that attitudes, beliefs, and practices of the larger organizational culture profoundly shape the everyday lived experience of nursing in ways that discourage interaction with patients at a spiritual level. Nurses often described their experience as one associated with uncaring, time-pressure, and a technological focus, rather than one associated with a sense of trust and connection (2010).
The nursing literature has offered leadership in relation to spirituality and health through various models and resources over the past three decades (Buck, 2006; Lemmer, 2005; Mauk & Schmidt, 2004; McCewen, 2005; Ross, 2006; Wallace et al., 2008). However, a review of this literature does not reveal an existing model or resource that explicitly addresses nurses’ ongoing fears around competence and relevance. Nor does the literature reveal a resource that succinctly reflects and reinforces current best practices and standards of care, particularly in relation to the provision of inclusive spiritual care.

**The Need for Nursing Research on Effective Spiritual Care Pedagogy**

The literature demonstrates widespread support for the need to prepare nurses to provide spiritual care (Lemmer, 2010; Pesut, 2003; Stern & James, 2006; Wallace et al., 2008). However, much work remains to adequately address this need and determine the nature of effective spiritual care pedagogy. Many nurses continue to report little or no preparation for providing spiritual care in their formal education programs (Carr, 2008; Lemmer, 2010; Wallace et al, 2008). Existing spiritual care education has undergone minimal formal investigation to date (Carr, 2008; Wallace et al., 2008). This is particularly so in relation to evaluating the effectiveness of spiritual education in clinical practice (Wallace et al., 2008). Authors cited in this review are beginning to address this void. Their findings will be integrated into later discussion, given the study’s interpretive nature.

**The Need for Qualitative Inquiry into Factors that Foster Spiritual Care**

The well-documented discomfort of many nurses with spiritual care speaks to a need for better understanding of their experiences and of the supports and resources that would be effective in enhancing their comfort and confidence. Carr leads the way with her phenomenological studies in 2008 and again in 2010 wherein she observes that “more research is
needed that qualitatively explores how everyday nurses experience and view spirituality …” (p. 688). However, parallel literature for nurse educators remains scant, even though they are likely to face the same uncertainties and barriers, particularly in their clinical teaching (Wallace et al, 2008). Understanding the influence of new models and resources on the quality of educators’, students’ and clinicians’ experiences will help to determine their effectiveness in addressing the uncertainties and barriers that influence the quality of those experiences. In particular, there is a need to understand what helps nursing professionals feel better about providing spiritual care, since the literature has demonstrated that, overall, their related subjective experiences have not been positive enough to reinforce its integration into their practice (Carr, 2010; Lemmer, 2010; McCewen, 2005; Ross, 2006).

Phenomenology has been identified throughout the qualitative literature as a natural fit for exploration of lived experiences (Benner, 1994; Christ & Tanner, 2003; van Manen, 2006, 1997). Phenomenology lends itself particularly well to the exploration of spiritual care, given its shared focus on reflection and meaning-making (Carr, 2010; van Manen, 2006). As Carr observes, “phenomenologists draw their analysis from the fullness of human experience and how it is storied. Stories inevitably lead us into spiritual territory. They invite us to explore the sacredness of our experience”(2010, 1382).

Interpretive or hermeneutic phenomenology is particularly relevant, given its strong focus on understanding the ‘life-world’ of self and others, also central to spiritual care (van Manen, 2006, 1997). Based on similar rationale relating to inspirational pedagogy, van Manen (1997) has published widely on interpretive phenomenology as a highly relevant educational research method.
METHODS

Interpretive phenomenology was determined to be the most appropriate choice for this educational research pertaining to the investigator’s model, colleagues and workplace, since this approach to phenomenological inquiry acknowledges and, in fact, embraces the investigator’s involvement and experiences as integral to the process (Christ & Tanner, 2003; Perry, 2009a, 2009b; van Manen, 1997, 2006). Given the investigator’s active role as researcher-participant, it was particularly important that trustworthiness be maintained through rigorous integration of interpretive phenomenology principles at every phase of the inquiry.

Establishing and Maintaining Trustworthiness

It was essential at the outset to reveal to potential participants key aspects of the researcher-participant’s ‘life world’ and its role in the inquiry. This self-disclosure was carried out during faculty in-services on the T.R.U.S.T. Model and at the beginning of the round table discussion. Two key points were shared. One was the holistic practice philosophy arising from the author’s personal experience with seeking and eventually re-connecting with a sense of trust in the wake of her own life threatening illness (Scott Barss, 1999). The other was the author’s resulting passion for supporting others to draw upon their own unique worldview and convictions in ways that promote health and healing.

Several ongoing practices helped to maintain trustworthiness. A research journal and audit trail was kept throughout the process to facilitate investigator self-awareness and document research decisions, ensuring congruence with interpretive phenomenological methods. Other measures to maintain trustworthiness included procurement of formal ethics approval, facilitation of informed consent, promotion of participant anonymity, and validation of interpretive accuracy. Specific related practices are described in the data collection and analysis sections.
Data Collection

Data collection via a digitally-recorded round table discussion was approved by the ethics review board of the author’s employing institution under the auspices of the affiliated, broader qualitative study, The Experience of Faculty, Students and Clinicians in Use of the T.R.U.S.T. Model for Inclusive Spiritual Care. Approval for analysis of faculty data for the author’s M.A. project was acquired from Athabasca University’s ethics review board.

A convenience sample consisted of five round-table discussion volunteers (including the participant-researcher) who had received a minimum of one-hour classroom introduction to the T.R.U.S.T. Model and who had opportunities to use the model as a teaching resource in a clinical setting over a minimum period of six months. Clinical settings represented at the focus group were long-term care, mental health (acute; forensic; community), and medical-surgical acute care. Also represented were all six first and second year clinical nursing courses and theoretical nursing courses that have integrated the T.R.U.S.T. Model. Length of study participants’ experience with using the model in their clinical teaching ranged from six months to two-and-a-half years.

Although phenomenological research typically uses data collected via individual interviews and observation, a round table format was chosen since it was in keeping with the phenomenological principle of carrying out investigation in a naturalistic context (Benner, 1994; Christ & Tanner, 2003; Perry, 2009a, 2009b; van Manen, 1997). Today’s nurse educators most frequently reflect upon and make decisions about pedagogy and curriculum development through use of group process (Benner, 2010; Chinn, 2007). As such, the investigator determined that individual interviews would not only be unnatural, but would not afford the rich opportunity for participants to exchange experiences and explore their implications in the interactive ways to
which they are accustomed. Given the active role of the participant-researcher in interpretive phenomenology, the round table venue also afforded all participants comparable interaction with the researcher-participant. It also created an opportunity for the participant-researcher to appropriately and ethically carry out collegial observations with participants’ informed consent, documented via signed consent forms. Similarly, the round table venue provided appropriate opportunity for the investigator to witness and investigate the interactive process, enhancing the inquiry’s depth (Halkier, 2010; Warr, 2005).

The participant-researcher drew on an ethics-approved discussion guide to facilitate the discussion, beginning with an open-ended question: “What has been your experience of using the T.R.U.S.T. Model in your clinical work with students?” (See Appendix B for the complete discussion guide). Few other prepared questions were used, given the high level of participant engagement and the participant-researcher’s reliance on other active listening and group facilitation skills. It was made known during the orientation to the discussion that the participant-researcher’s experiences and observations also would be contributed, but that this would be done primarily after other participants’ observations had been shared in order to allow participants ample time and sense of permission to freely share their perspective. Participants were then also given time and opportunity to conclude the discussion with any additional responses or perceptions.

Participants also completed an anonymous online follow-up survey to capture demographic information and any supplementary data they may have wished to contribute more privately regarding their experiences using the T.R.U.S.T. Model.


**Data Analysis**

Interpretive phenomenological analysis involves a creative process that balances thematic and expressive interpretation of participants’ narratives (Ohlen, 2003; Perry, 2009a, 2009b; Van Manen, 2006, 1997). This balance honours the voice of participants, while evoking meaning through rich, aesthetic reflections that capture the essence of their experience (Ohlen, 2003; Perry, 2009a, 2009b; Todres & Galvin, 2008; van Manen, 2006).

The appropriate balance and mode of aesthetic reflection is best discerned as the investigator becomes acquainted with the data, since phenomenology calls the researcher to remain true to the “phenomenological device of pliability to the things themselves” (Ohlen, 2003, p. 559). In other words, the investigator needs to adapt the interpretation to the nature of the phenomena being explored (van Manen, 1997).

As such, the author first carried out a thematic content and process analysis of the round table narratives to become thoroughly familiar with the data, drawing upon guidelines from Reissman (2008) and van Manen (1997). Since vivid imagery in participants’ narratives readily lent itself to poetic interpretation, original poems were then written, integrating direct quotations from participants and key themes that were noted to carry the most passion during the discussion (Ohlen, 2003; Perry, 2009; van Manen, 1997). Principles of ‘embodied interpretation’ were also integrated at this point in an attempt to honour the essence of this passion (Todres & Galvin, 2008). In embodied interpretation the investigator listens deeply to what people say in order to fully and holistically carry forward their meaning in ways that ‘call’ or ‘stir’ us emotionally, physically and spiritually, not just cognitively (Benner, 1994; Todres & Galvin, 2008; van Manen, 2006). Feedback was then sought from participants on the accuracy of the thematic interpretations and the ability of the poetic interpretations to embody participants’ intended
meaning. This process was carried out by e-mail, wherein participants provided feedback in response to a document containing key themes, supporting participant quotations, and poetic interpretations of the round table discussion. Two participants provided written comments via e-mail while the other two chose to share verbal comments.

The final layer of investigator analysis involved the integration of relevant literature to deepen and ground the interpretation. This integration was left until last to minimize the literature’s influence on the researcher’s interpretation of participants’ experiences. Of course, the interpretive process is ongoing as new readers reflect upon and bring their perspectives to the data (Perry, 2009a, 2009b; van Manen, 1997).

FINDINGS

Three themes most relevant to nurse educators emerged from the data, all drawing upon the image of a ‘bridge’ which became central to the round table dialogue. One participant referred several times to the T.R.U.S.T. Model as a ‘bridge’, prompting affirming comments from other participants during the discussion and in follow-up feedback as to the appropriateness of this imagery. The three identified themes, then, are: ‘The T.R.U.S.T. Model as a Bridge to Spiritual Exploration’; ‘Blockades to the Bridge’; and ‘Unblocking the Bridge’.

Each theme will be discussed along with relevant literature, a supporting participant quotation, and a sample accompanying poetic interpretation. Excerpts selected by the author are passages most frequently identified in participant feedback as effectively embodying the meaning of their experiences.
A Bridge to Spiritual Exploration

The first allusion to the T.R.U.S.T. Model as a bridge occurred early in the round table discussion:

... you didn’t have to dance on eggshells to get them [the students] to talk about spirituality because these questions really helped to bridge that kind of awkwardness ... It [The T.R.U.S.T. Model] also facilitated a connection between the student and the resident or patient very easily. There wasn’t this awkwardness ... or ‘Do you believe in God?’ or any of those kinds of things. It just was an easy ... like a bridge... just walk across the bridge there into that person’s existential life... and away you go.

The T.R.U.S.T. Model was also described by round table participants in positive terms such as: ‘visual’, ‘inclusive’, ‘comprehensive’, ‘user-friendly’, ‘student-patient relationship-driven’, ‘client-centered’, ‘easy to understand and explain’; ‘far easier to use than anything else I’ve tried’; ‘a relevant link to healing’, ‘ground-breaking’, ‘not just a spiritual model but a holistic model’.

The investigator and other participants noted that less experienced faculty and students viewed the model as an assessment tool while more experienced faculty saw it an assessment and intervention tool. Participants’ dialogue revealed that this distinction correlated with the depth of faculty and student skill development. Users still developing their teaching or learning in relation to assessment were noted to focus on using it as an assessment tool. Meanwhile, users further along in their professional skill development identified ways they used the model to facilitate active intervention.
Study participants stated that the T.R.U.S.T. Model made it easier for students to build rapport and get started in spiritual inquiry. In particular, the model served as a helpful reference point when students were ‘stuck’ and made it easier for students to dialogue with patients whose beliefs were different than their own. For students ready to actively intervene, the model facilitated engagement in and referral to practices in keeping with patients’ worldviews.

[The T.R.U.S.T. Model] helped them[students] to become comfortable with making it about the person, not about them – like it’s irrelevant whether or not I agree or disagree with Buddhism or God ... or ... whether or not I can go with them to the chapel – it isn’t about me – and if that person needs to go there and I’m therapeutically involved with them and this is going to impact their care, it’s irrelevant what I think about that chapel – and that’s a hard thing.

The T.R.U.S.T. Model was used in a variety of ways by participants and students they supervised in the clinical setting. Most frequently, it was a required part of nursing care planning. It was also used as a topic of discussion for students to establish rapport (trust) with clients and as a post-conference resource for enhancing students’ own self-awareness in relation to spirituality. In the introductory clinical course, use of the model was a required part of the systems assessment during the academic year preceding data collection.

For [Year 1 clinical] it really helped them with developing relationships with their residents – just giving them something else to connect over – and I found they did more than just fill out the blanks [in the required systems assessment].
Throughout first and second year clinical courses, the model was spontaneously used by students in care plans, journal reflections and one community assessment (usually by mature learners).

*When I look back into some of my clinical rotations since this has been introduced to our students there’s three examples specifically that I remember without me saying anything that they’ve talked about the theory or integrated it in journaling or in their care planning... each of these learners were a bit more mature with more life experience...*

Participants reported the T.R.U.S.T. Model’s sample questions were not being used in a linear or prescriptive manner, suggesting that the model’s non-linear nature and intent was clear. In this way, participants indicated that the model helped faculty and students to remain client-centered (rather than prescriptive) in their spiritual care endeavors.

Participants offered no suggestions for improvement to the model itself, even when specifically asked in both the round table and anonymous follow-up survey. Nor did the follow-up survey elicit any other new data, beyond the reporting of two new clinical experiences which had occurred between the time of the round table discussion and submission of the surveys. Both new experiences spoke to themes evident in the round table data.

Since the bridge analogy resonated so strongly with participants throughout the round table discussion and interpretation, it inspired the following poetic interpretation that summarizes the ways participants found the T.R.U.S.T. Model helpful. Participants validated that this piece could also speak to the general concept of ‘trust’ in the therapeutic relationship.
Trust is a bridge
over fear,
over difference,
wide enough for each
to walk our own path
side by side in safety
as we each journey
to our own sacred step.

Trust is a bridge
across murky waters,
across intangible torrents
and swells of suffering,
in treacherous times
where we would risk
being swamped by chaos
or swept away by despair.

Trust is a bridge
to wholeness,
to a place
where each is freed
to hear – to really hear
what makes meaning
for the other
and for ourselves.

Blockades to the Bridge

While participants reported that the T.R.U.S.T. Model assisted them to negotiate many of the barriers associated with addressing spiritual care, their round table conversation focused heavily on numerous barriers they continued to encounter in their endeavors to foster spiritual care education. They spoke in depth about the general lack of focus within the healthcare system on intangibles like spirituality. On a related note, they spoke of the actual or perceived lack of time for spiritual care, noting that student perceptions were often affected by their inexperience
and stress overload which resulted in an exclusive focus on physical care. Participants noted student perceptions were further influenced by mixed messages from faculty and clinician role models about the importance of spiritual care. Participants also identified as a key underlying factor student and faculty fear around being intrusive or ‘going too deep’ and not knowing what to do.

A participant picked up on the co-participant’s previous ‘bridge’ analogy in discussing this fear as one of the greatest barriers:

*I think that’s the scary part, of it, too, though, for students because those questions do create that bridge and jump you in there and sometimes then they’re not ready for that – it’s like “oh - you really do have an issue? – now what am I going to do?” So I think sometimes when ... they realize how powerful these kinds of questions would be, then they shy away from it again because they’re worried about what the answers might be.*

Reflecting on the same barrier of fear, another participant observed:

*That’s a big doorway to open, right? You’re afraid to touch that knob.*

Images from these comments inspired a poetic interpretation intended to embody participants’ recognition and validation of common fears which they observed as often solidifying other barriers to provision of spiritual care. This interpretation is also intended to echo participants’ voiced desire to find ways to address this central barrier. An excerpt:
That’s a big doorway.
I’m afraid to touch that knob.
But ... what if I turn it
and gently knock
so that even if it catches awkwardly
or I have to shoulder the door,
the soul awaiting on the other side
knows I enter with care, knowing full-well
how big that door is
and that I open it
only because the one inside is too weary
to heave it open alone
and has invited me in to help?

So what if I find a canyon on the other side?
We don’t have to jump in
because we can build bridge after bridge
to take us down and down as far as my companion bids ...

Unblocking the Bridge

Participants found the T.R.U.S.T. Model most effectively helped to clear existing barriers with students when it was the only spiritual assessment model introduced, reducing confusion and theory overload. They also noted the T.R.U.S.T. Model was more effectively applied in the clinical area when it was adopted by a variety of courses, each cumulatively ‘leveling’ or ‘spiraling’ relevant concepts throughout the first and second year of the program so that faculty and students had opportunity to gradually become familiar with using it in their practice. Participants emphasized the importance of serving as mentors through inspiring, coaching and modeling use of the resource along the way.

To this end, participants identified they felt most prepared to actively take on the mentorship role in their clinical teaching when they received collegial education, support, and
spiritual companionship themselves (such as that which they noted as present during previous in-services, curriculum development discussions and the study’s round table interaction).

Participants highlighted the value of application-focused education and spiritual companionship which they described, in the workplace context, as supportive dialogues wherein they could openly name and explore with colleagues how they might best integrate into clinical teaching their personally and professionally-held convictions about the importance of spiritual care. Each openly described their convictions over the course of the discussion, identifying these convictions as central motivators in their facilitation of spiritual care clinical education.

Overall, participants identified that the T.R.U.S.T. Model most effectively overcame existing barriers when it was a required, ‘normalized’ part of course expectations and clinical practice. The conversation’s primary focus shifted to identification of related conditions that would enhance the T.R.U.S.T. Model’s positive influence:

> What I would like to see is that we incorporate it [the T.R.U.S.T. Model]

in such a way that it does become a natural thing – that even in short
term acute care they are selecting some of these questions and asking
them ... (Another participant interjected: That would be really nice to see.)

Other participants’ observations followed ...

... What I’m hearing is we need to normalize spiritual assessment. It’s like
a social assessment and a heart assessment – all together. ...  

... it’s important to emphasize that there is a minimum standard for
spiritual care, too ...  

... it’s a process where we hope it becomes part of who they are and how
they work.
Participants’ dialogue resulted in several clear recommendations:

- Use ‘T.R.U.S.T.’ as the primary model to promote consistency and avoid theory overload
- Require/mentor clinical use of the T.R.U.S.T. Model (or culturally-safe alternative)
- Emphasize the T.R.U.S.T. Model’s initial assessment questions as minimum standard
- Strengthen spiraling/leveling of spiritual care content throughout curriculum
- Expand use of the T.R.U.S.T. Model as a resource for faculty/student self-awareness
- Increase faculty education at an application level to enhance faculty competence
- Create more opportunities for spiritual companionship amongst faculty
- Deepen developer/participant/researcher’s involvement in education/evaluation

The identified recommendations addressed a question pivotal to the theme of ‘unblocking the bridge’: “How do we help make spiritual care matter?” The following participant quotation links ‘mattering’ and ‘normalizing’:

*Do we help it matter to people if we normalize it [spiritual care] more?*

*The more we normalize it [spiritual care], the more there’s exposure – is there a better opportunity of it mattering?*

The following poem was written to help convey participants’ message that spiritual care ‘matters’ as does caregivers’ trust in their ability to offer it.
It matters
that suffering isn’t safe
if it is left alone
behind a heavy door
by itself
to hurt.

It matters
that everything you need
lies within you
to open the door
together
to heal.

DISCUSSION

The participants’ core message was that the T.R.U.S.T. Model positively influenced their ability to navigate existing barriers to teaching and learning about spiritual care. Their reflections focused largely on how the model’s positive influence could be enhanced. The participants’ emphasis, then, was not so much on whether the model should be used, but on how it could be used most effectively. Throughout their explorations on all three identified themes, participants’ conclusions were similar to those emerging in the literature, fostering further interpretive inquiry. The synthesis of this inquiry and the study’s strengths, limitations, and future implications are presented in this discussion.

Synthesis

In relation to participants’ positive experiences with the T.R.U.S.T. Model, three corresponding trends in the literature are of particular note. First, there is general agreement that spiritual nursing care is deeply relational, centering on interpersonal connections to promote
spiritual comfort and well-being (Carr, 2008; Pesut, 2003; Stern & James, 2006; Wallace et al., 2008.) The model’s reported success in helping students to build trust with their patients and enter into spiritually-oriented conversations suggests that it contributes positively in this regard. Second, there is growing recognition of the need to facilitate spiritual exploration in non-prescriptive ways which are less likely to be experienced as intrusive or uncomfortable for care-givers and care-receivers (Pesut, 2003; Wallace et al., 2008; Wright, 2005). Participants’ experiences and observations of the model being used as a guideline rather than a checklist speaks to it successfully serving as a non-linear resource that helps enhance comfort with spiritual dialogue. Finally, mature students and faculty, particularly those more comfortable with their own spirituality are more comfortable with offering spiritual care (Carr, 2010; Ross, 2006; McCewen, 2005; Wallace et al., 2008). Participants openly conveyed acceptance of this reality within themselves and their students, suggesting that the model could be used in a variety of ways at different levels of personal and professional development, whether as an assessment or intervention tool, or both.

Barriers identified as negatively influencing participants’ clinical experiences are highly congruent with those identified in the initial literature review (Carr, 2010; Lemmer, 2010, McCewen, 2005; Ross, 2006). However, participants noted that these barriers are compounded for them and for their students by inexperience, theory overload, and mixed messages from nursing faculty and clinical agency staff about the importance of spiritual care. Given the paucity of research on nurse educators’ clinical experiences in relation to teaching spiritual care, participants’ accounts add significantly to the literature. Data from participants also expands the literature through their expressed validation of the T.R.U.S.T. Model as a concise, comprehensive
resource that affirms the importance of spiritual care and enhances faculty &/or students’ ability to provide it.

Existing literature offers concrete support for round-table recommendations made to maximize the positive impact of the T.R.U.S.T. Model (Benner, 2010; Carr, 2010; Hodge, 2006; Koenig, 2007; McCewen, 2005; Ross, 2006; Wallace et al., 2008). The quality of these recommendations speaks to the expertise and passion for spiritual care evident within the participants through their openly-shared convictions and genuine excitement about supporting others to integrate spirituality into the healing process. The resulting quality of content and process was a definite advantage of using a voluntary convenience sample. Given the previously-cited literature correlating caregiver interest in spirituality with willingness to engage in spiritually-oriented dialogue, it is no surprise that those volunteering were among those knowledgeable and passionate enough to make significant contributions to spiritual care education and research regardless of their level of experience (Carr, 2010; Ross, 2006; McCewen, 2005; Wallace et al., 2008).

The recommendation to use T.R.U.S.T. as the curriculum’s primary model in order to promote consistency and avoid theory overload is supported by current nursing pedagogy focused on ‘thinning the curriculum’ through prioritizing and reinforcing essentials to holistic nursing practice (Benner, 2010). It also follows the approach taken by Wallace et al. (2008) in their integration of spirituality into undergraduate curriculum wherein one assessment tool was used to plan and evaluate the care provided specific to patients’ spirituality. However, many nursing texts continue to include a variety of models, which both the literature and participants report as confusing for faculty and students (Benner, 2010; Ross, 2006; McCewen, 2005; Mauk &
Schmidt, 2004). The latter suggests that it has been difficult to find a comprehensive, inclusive model that adequately addresses teaching, learning, and care needs in relation to spiritual care.

Required and mentored clinical use of the T.R.U.S.T. Model (or a contextually appropriate equivalent more reflective of a particular cultural or religious practice setting) also speaks to good pedagogy wherein consistency, coaching and cultural sensitivity are considered central to teaching and learning at a context-specific, application level (Benner, 2010; van Manen, 1997). Wallace et al. (2008) highlight the work of several researchers who recommend that a ‘real life’ focus fosters more effective spiritual care education, particularly when offered in combination with a supportive, caring learning environment wherein faculty serve as active role models for learners.

The suggestion to place greater emphasis on the T.R.U.S.T. Model’s initial assessment questions is strongly supported by existing best practices and standards frequently presented in the literature (Carr, 2010; Hodge, 2006; Koenig, 2007; McCewen, 2005; Ross, 2006). The most frequently-cited example of such standards are those put forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) which identifies as a minimum standard of care consistent engagement in spiritual screening/brief assessment, and, where desired/consented to by the client, to engage in comprehensive assessment (Carr, 2010; Hodge, 2006; Koenig, 2007; McCewen, 2005). A global example is the International Council of Nursing which clearly identifies that offering spiritual care is a requisite of quality care (McCewen, 2005). “Spiritual nursing care, therefore, is a responsibility, not an optional extra” (McCewen, 2005). The literature review of Wallace et al. (2008) highlights case studies and targeted assessment tools as useful strategies to reinforce this responsibility. These authors also recommend making
spirituality a part of routine health assessment, echoing participants’ wish to ‘normalize’ spiritual care.

The work of Wallace et al. (2008) also lends support to the idea of strengthening the spiraling/leveling of spiritual care throughout the curriculum. These authors recommend incorporating it as a thread throughout the clinical courses of the program and planning assignments across a variety of courses that exemplify spirituality as a lived experience. They also draw upon van Leuwen and Cusveller’s 2004 suggested framework for teaching spirituality that develops students’ self-awareness, therapeutic use of self, and knowledge of spiritual dimensions within nursing practice (including six affiliated core competencies). Lemmer’s recently-developed one-hour credit course on spirituality in the health-care environment includes several of these concepts and competencies, highlighting two key reflective questions used to promote student self-awareness (2010).

The previous sources also offer credence to participants’ suggestion to use the T.R.U.S.T. Model more extensively as a self-awareness resource to help students explore their own spirituality, given its multiple sample reflective questions from which students may choose. It is possible that the model could also be used in this regard to support suggested opportunities for faculty development and spiritual companionship, a recommendation strongly supported by the work of Wallace et al (2008) who prioritized faculty retreat time as they integrated spirituality content into their undergraduate nursing program. Based on their positive experience, they highlight ongoing student and faculty engagement in their own spiritual practice as essential to provision of quality spiritual care.

Wallace et al. (2008) identify resources and learning activities that promote emotional literacy as another aid in enhancing faculty and student self-awareness and sensitivity, both
essential in tending to patients’ spiritual well-being. van Manen’s work (2006, 1997) also advocates for pedagogy that touches the learner’s mind, body, heart and spirit to guide and inspire. This literature lends support to the possibility that poetic interpretations arising from this data could serve as teaching and learning resources to promote self-awareness, empathy, and confidence within faculty and students. As such, these reflective resources may also help address participants’ central question about spiritual care education: “How do we help make it matter?”

Participants’ clearly-conveyed support for the current inquiry reflected their familiarity with interpretive research, as did their active encouragement for the researcher to become even more engaged in the facilitation and research of the model as an educational resource. While the participant-researcher had remained cautious in order to maintain ethical boundaries with colleagues and students this recommendation emerging from the round table data prompted the author to re-visit the interpretive phenomenology literature as a more objective source of encouragement to be more open and engaged. Perry’s work offers reminder from the hermeneutic literature that the researcher’s own ideas will pervade the research whether the researcher wills it or not, so that the best approach is assessment and acknowledgement of self not only prior to, but during the research process (2009a, p. 238). The following poetic expression emerged from such self-reflection as a deeper, more open declaration of relevant personal convictions that inspire and inform my work. In essence, this reflection represents the closing layer of this cycle of interpretation, having come full circle from the personal to the professional and back again, with a deepened sense of trust in others, self, and the overall process of fostering spiritually-oriented inquiry in nursing practice.
I believe each of us will be okay,
one way or the other
when we trust again
in life, in things bigger,
in all creation
to hold us,
to shape us,
to re-create us,
what ever life brings.

Limitations

Three limitations of the study were identified. Even though an appropriate interpretive approach was chosen and related self-awareness work was ongoing throughout the inquiry, investigator bias was inevitable, given the researcher-participant’s dual role as investigator and faculty member who developed the T.R.U.S.T. Model. While the number of participants was similar to that used in many phenomenological studies employing individual interviews, the sample size is small for a round table discussion (Halkier, 2010; Warr, 2005; van Manen, 1997). Even though participants are known to the researcher as individuals with diverse spiritual perspectives and each possessing high levels of cultural competency, the fact that all were female and Caucasian limits the worldviews represented.

Future Directions

Limitations of this investigation can initially be addressed through completion of the larger affiliated study, The Experience of Nursing Faculty, Students, and Clinicians in Use of the T.R.U.S.T. Model for Inclusive Spiritual Care, wherein further faculty/clinician round tables and student surveys will occur. These additional data sources will enhance the size and diversity of the sample size. They will also reduce the impact of investigator bias, given the surveys’
inclusion of Likert scales measuring self-reported comfort before and after introduction to the T.R.U.S.T. Model. The larger ongoing study will provide an opportunity to further address the research aims and to evaluate the success of recommendations and resources from this study which are currently being adopted by the investigator’s nursing education program.

In addition, external, cross-cultural research involving educators, students, and clinicians from across healthcare disciplines is needed to confirm the trustworthiness of this study’s findings (Carr, 2008; Lemmer, 2010; Ross, 2006; Willison, 2008). Research into the T.R.U.S.T. Model’s influence on the experience of health care consumers is also needed to fully assess the model’s effectiveness in enhancing the quality of spiritual care and its ability to promote healing.

**CONCLUSION**

This research has resulted in preliminary affirmation of the T.R.U.S.T. Model’s ability to serve as a bridge that can help nurse educators navigate ongoing barriers to the provision of spiritual care. The project has also resulted in identification of specific recommendations to enhance its use and in the creation of potential teaching resources to help implement these recommendations. These resources include case studies to reinforce use of the T.R.U.S.T. Model’s initial assessment questions and a package of poetic reflections (emerging from this study’s data) for discrentional use in promoting faculty and student self-awareness, empathy, and trust in their abilities as spiritual care providers.

Thus, this inquiry offers a fruitful beginning exploration of nurse educators’ experience of using the T.R.U.S.T. Model to teach nursing students how to integrate spiritual care into holistic nursing practice. The project has successfully addressed its aims through provision of initial indications that the T.R.U.S.T. Model had a positive impact on nurse educators’ confidence,
competence, and overall experience of assisting nursing students to offer inclusive spiritual care. In so doing, the research has provided a preliminary validation of the resource’s effectiveness in its current state. The research has also produced initial evidence that it may be beneficial to integrate the T.R.U.S.T. Model into curricula for nursing, building a foundation for future inquiry into whether it would be beneficial to integrate the T.R.U.S.T. Model into curricula across health care disciplines. As such, it contributes to interdisciplinary research and practice promoting inclusive spiritual care.

In the process, this inquiry has taken steps to understanding how we might enhance the experience of offering spiritual care education in the clinical setting. This research joins that of others devoted to the evolution of spiritual care within nursing education as we find ways to effectively prepare future practitioners to weave inclusive spiritual care into their holistic nursing practice.
References


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Appendix A

T.R.U.S.T. Model for Inclusive Spiritual Care

Broken spirits
cracked open, exposed
remain
until warmth and light,
the life-giving flow of compassion
takes root,
nurtures forth
new shoots
of trust.

- Karen Scott Barss
TRUST Model for Spiritual Assessment and Care © Karen Scott Barss 2008

Relevant issues to help sort through the individual trusts external resources mentors & internal spiritual/religious

Traditions? (as relevant to care/healing and past community, current individually or in religious practices, spiritual &/or

Searchings? (ie: sustaining spirituality negatively well-being positively and how they influence personal beliefs

Understanding? Reconciliation? How/If these might and exploration of unresolved issues

Challenges current prompted by faith questions &/or existential spiritual/religious

Teachers?
NURSE EDUCATORS' EXPERIENCE OF T.R.U.S.T.

Initial Assessment Questions © Karen Scott Bars 2008

- Are there people of the above?
- Are there people of exploringspiritual
  experiences such as
  traditions or religious
  practices/beliefs/
  about your spiritual
  caregivers to know
  you would like your
  time?
  exploring?

- Are there people of undecided issues/
  unresolved issues
  personal beliefs
  about your current
  challenges you
  would like an
  exploring opportunity to

- Are there people of exploring?
  about your spiritual
  caregivers to know
  you would like your
  time?
  exploring?

- Are there people of exploring?
  about your spiritual
  caregivers to know
  you would like your
  time?
  exploring?
TRUST – Initial Spiritual Assessment – Guidelines (For use with Graphic on P. 34)

Before initiating conversation about this very personal aspect of one’s well-being, it is essential for the caregiver to clearly communicate the relevance of such inquiry. This relevance can be clarified by sharing information such as the following:

As part of offering holistic care, we would like to be aware of anything you consider to be important in relation to the spiritual aspect of your care.

Somewhere in the ensuing conversation (in non-linear, non-intrusive manner) the below questions need to be addressed:

Traditions? – Are there things you would like your healthcare team to know about your spiritual or religious/practices/beliefs/experiences?

Reconciliation? – Are there any unresolved issues you would like support in exploring at this time?

Understandings? – Are there particular personal beliefs that are helping to sustain/comfort you at this time?

Searching? – Are there particular beliefs/practices/experiences you are questioning as a result of your current challenges?

Teachers? – Are there people/groups/resources you find helpful in exploring spiritual questions such as the above?

*Note:
1) Each of the above are closed-ended questions (ie: answerable with a ‘yes’ or a ‘no’) in order to avoid assumption that the individual has/wishes to share related information. Each such question needs to be followed up with relevant open-ended questions and empathetic responses that facilitate identification of how spiritual care can be integrated into their holistic care in an individualized, non-intrusive manner. Specifically …

… if the answer is ‘yes’ … What are these? How can we help to integrate them into your healthcare/healing process?

… if the answer is ‘no’ … Sometimes people become aware of &/or feel more comfortable sharing spiritual concerns as they become better acquainted with the healthcare team. Please feel free to raise any such concerns that may arise at any time and to ask us to help seek out any resources you’d like.

2) It is essential to provide follow-up assessment and intervention as desired by the individual (See ‘TRUST Clinical Resource Package’ for sample questions and resources). The caregiver doing the initial assessment isn’t necessarily the most appropriate person to provide this more in-depth spiritual care, but is the person accountable for ensuring that appropriate referral is made.
Sample Reflective Questions for Ongoing Spiritual Assessment and Care

(In italics are key reflective questions helpful for the client to explore at the appropriate time of readiness. Of course, a variety of therapeutic communication techniques and helping skills would be employed by the care-giver to facilitate this process. Deep listening is essential for the care-giver to discern which questions are currently most relevant to the client. Questions marked with an asterisk* have previously been identified as suitable for initial assessment/trust-building)

**Traditions & Practices**

*Are there things about your spiritual or religious beliefs/practices/experiences you would like me to be aware of? How might these affect how we work together?*

What gives you hope? How can we help you connect to your sources of hope?

How are you creative in your daily life? Your coping? How can this creativity be applied to your current challenges? To your life in general?

What activities or issues are you inspired by/passionate about? How can these passions be integrated into your regular routine?

**Regrets? Reconciliation?**

*Are there any unresolved issues you would like support in exploring at this time?*

Do you find yourself focusing on past choices or actions that you regret? How does this influence your sense of well-being? What do you wish to do with this awareness?

Are there choices or actions of others in your life that you cannot forgive? How does this influence your sense of well-being? What do you wish to do with this awareness?

Have you found anything positive arising yet from your painful experiences? (eg: development of inner strengths you didn’t know you had; closer relationships; deeper trust; lessons learned; deeper appreciation for the good times; a sense of purpose or meaning, more creative coping?)

If so, how does/can this enhance your daily life amidst the difficulties you face? If not, does it feel okay, for now, to grieve the losses associated with your difficulties? What can sustain you until you feel more hopeful/peaceful?
**Understandings (Sustaining?/Distressing?)**

*Are there particular personal beliefs or practices sustaining you/offering you comfort at this time? How can we help you draw upon these for strength?*

*Are you aware of any beliefs or questions that are distressing?/Confusing?/Compromising your well-being?*  
*If so, how do you wish to address these? Does it seem possible to eventually transform them into ones that promote wellness?*

*What gives your life meaning? Is there any meaning that you make in relation to your current difficulties? If so, what? How does this influence the way you navigate your circumstances?*

*Have you ever pondered your life’s purpose(s)? If so, what is your sense about it/them? How does this influence your well-being? Your approach to life/to your healing process?*

**Searching (Questioning & ‘Wrestling’)**

*Are there spiritually-oriented questions about your current difficulties that you would like an opportunity to explore?*

*How have your current difficulties influenced your beliefs? Are there any of your previously-held beliefs that you are currently questioning? How do you feel about questioning these beliefs?*

*What answers about life/death/spirituality are you currently seeking? How difficult is this searching?*

*What/who is a source of disillusionment for you? Have you had an opportunity to grieve associated losses? If not, how might you do so?*

*Has the imposition of others’ beliefs added to your distress? How? How can you protect yourself from these intrusions?*
Teachers - Mentors & Resources

*Are there people/groups/groups/resources you find helpful in exploring spiritual questions? How can they be involved in your healing process?*

*What readings and activities do you find personally inspiring or comforting? How might they contribute to your healing? How can you draw these resources into your regular routine?*

*What resources within yourself can you name and draw upon?*

Additional Considerations:

Such questions are most appropriately and meaningfully explored when …

… they arise naturally out of listening intently to what is uppermost in individuals’ awareness/experience & are individualized to meet the person where they are.

… they are interspersed with sharing information & observations that clarify their relevance & that help individuals apply & mobilize their spirituality to enhance well-being.

… the individual’s beliefs & practices are the clearly the focus.

Throughout the course of assessment and care, it is essential to …

… uphold the principle of human dignity by ensuring that clients’ wishes and preferences in relation to spiritual care are respected. This means only offering spiritual care that each client sees as inclusive, non-intrusive and relevant to their healing process.

… ensure clients’ spiritual, psychological & physical safety by providing appropriate referral and follow-through in relation to concerns shared as a result of applying the T.R.U.S.T. Model. Such protection includes identification of and intervention with levels of distress that pose any risk to the client or others. It also includes facilitation of referral to appropriate resources and to relevant spiritual care professionals of the individual’s choice when questions/issues arise that are beyond the scope of a healthcare worker of another discipline.

Centering our spiritual exploration around the symbol of ‘TRUST’ reminds us to TRUST that …

… we, as care-givers, can foster relevant, safe, and inclusive spiritual care.

… individuals we care for can gain trust in their ability to heal - & that this trust will promote optimum healing.

… conversations at a spiritual level will unfold as trust deepens within & between care-givers & care-receivers.

The T.R.U.S.T. Model is based on current best practices & accreditation standards from the interdisciplinary spiritual care literature. For full references see TRUST Clinical Resource Package (Scott Barss, 2008)
Central Question:

What has been your experience of using the T.R.U.S.T. Model in your clinical work with students?

Supplementary Questions: (For use as needed)

When you used the T.R.U.S.T. Model in your clinical teaching as a guideline for spiritual exploration and care …

1) How did you use it with your students?

2) What, if any, influence, did you observe/perceive it to have on the clinical learning process in relation to provision of inclusive spiritual care?

3) What, if any, influence, did you observe/perceive it to have on students’ willingness to engage in inclusive spiritual care?

4) What influence, if any, did you observe its use to have on client(s)’ healing process?

5) What issues or barriers did you encounter in your clinical rotation with its use?

6) What do you see as strengths of the T.R.U.S.T. Model?

7) What are your suggestions for improvement of the T.R.U.S.T. Model?

8) What other general comments, observations, questions, or ideas would you like to add?