HOW SPIRITUALITY SHAPES THE PRACTICE OF COMMUNITY HEALTH NURSES

WHO WORK IN FIRST NATIONS COMMUNITIES IN BRITISH COLUMBIA

by

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ABSTRACT

In recent years nursing literature has featured a proliferation of discourse pertaining to many aspects of spirituality in nursing. However, there has been a dearth of research related to nurses' personal spirituality and whether or not it helps to shape their nursing practice.

This qualitative study explored how spirituality shapes the practice of community health nurses who work in First Nations communities in British Columbia (B.C.). The twelve participants, purposefully sampled, all had at least 2 years experience working in community health in First Nations communities. Using an interpretive descriptive research design, participants were interviewed to explore their lived experiences of spirituality relative to their nursing practice.

The analysis of the interview data identified that nurses' spirituality is essential to their practice in terms of "providing care spiritually" versus "providing spiritual care" interventions to their patients as typically depicted in the nursing literature. Moreover, their spirituality is discussed as a pervasive nursing ethic and motivation for patient care that manifests as respect, connectedness, love, acceptance, caring, hope, endurance and compassion towards patients. Furthermore, the findings of this study suggest the integration of community health nurses' spirituality into their nursing practice may contribute to the wider aim of health and healing within First Nations communities.

Four major themes are presented as research findings: (a) spirituality influences nurses' ability to remain self aware, open-minded and accepting in relation to others; (b) spirituality as a reflexive approach to grounding one's own nursing practice; (c) spiritual awareness fosters appreciation of the need for community healing, and finally (d) self-

reflection and providing care spiritually as a route to reciprocal interaction. Also, it was identified that nurses' spirituality nurtures their reflexivity and helps them to: (a) foster culturally safe relationships with patients, (b) realize how colonial issues influence health status in First Nations patients, (c) recognize that cumulative work stress and burn out can be reduced and prevented through relational spiritual practices, and (d) work through their own values, beliefs and prejudices in order to practice nursing based on a model of reciprocal interaction, and culturally safe approaches.

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CHAPTER I

Introduction

Background to the problem

Currently, there is increased interest in the subject of spirituality in nursing and it is recognized as an essential component of nursing care (Pesut, 2006). Cusveller (1998) identifies that the subject of spirituality is visibly lacking within nursing theories and models, and is incorporated within other theoretical models or frameworks such as cultural safety. The inclusion of spirituality within cultural safety's framework encourages and promotes nurses' self-awareness by helping them to realize and to reflect upon how their own attitudes and values are shaped by historical, political, and social influences (Richardson, 2004; Nursing Council of New Zealand, 2002).

Spiritual experiences are defined from personal, religious, historical and cultural viewpoints and because they are individually contextualized, they cannot be assumed to have the same meaning and understanding for everyone (Chiu, Emblem, Hofwegen, Sawatzky & Meyerhoff, 2004). To further complicate the issue, nurses' spirituality varies as much as patients' spiritual needs in accordance with their health and wellness and particular nursing environment (Van Leeuwen & Cusveller, 2004). Most often the spiritual needs of patients are the focus of nursing research in palliative care, mental health, and the hospital environment and there is very little known about spirituality in community health settings, although Reimer Kirkham, Pesut, Meyerhoff and Sawatzky (2004) found that nurses consider spirituality more visible in a community health setting where the biomedical model is less prevalent.

First Nations communities are one particular community setting where community health nurses work and often live, and where First Nations peoples in B.C. have longstanding traditional spiritual practices that have been transformed through colonisation, missionaries, and in some cases, residential school experiences (Federal, Indian & Northern Affairs Canada (INAC), 2007; Perry, 2003; Kelm, 1998). Recently, a First Nations Regional Longitudinal Health Survey (RLHS) developed a Cultural Framework to assist in the interpretation of the results from 22,462 surveys from First Nations people living in First Nations communities (Assembly of First Nations (AFN), 2006). The framework conceptualizes total health, total person and total environment. Significantly, the total person concept includes body, mind, spirit and heart that implicitly involve the extended family, social and emotional balance and harmony. First Nations people are defining and creating their own cultural framework to help improve their own health, and according to Battiste (2000), "the challenge for Indigenous peoples is one of restoring their spirit and bringing back into existence health, and dignity" (p. 13).

Problem Statement

Despite all the attention towards spirituality in the nursing literature there is a lack of clarity in the role of spirituality in relation to nursing practice, particularly in exploring how nurses' own values and spiritual beliefs shape their practice. Nurses report a lack of knowledge and a general discomfort in addressing spirituality with their patients within diverse and culturally pluralistic nursing contexts such as First Nations communities in B.C. Perhaps the starting point for community health nurses is to define, describe and to understand their own spiritual beliefs and experiences before addressing the spiritual needs of patients.

Purpose

The purpose of this study is to explore how community health nurses' describe their spirituality and to interpret their experiences of spirituality in relation to their nursing practice in First Nations communities throughout B.C.

Research Questions

1. How do community health nurses working in First Nations communities in B.C. describe their own spirituality?

2. How do these community health nurses describe their own spirituality in relation to nursing practice in First Nations communities?

3. What are the implications for community health nurses practicing within First Nations communities?

Summary

Nurses' personal descriptions and interpretations of spirituality have not been studied at any great depth. Most often the spiritual needs of patients are the focus of nursing research in palliative care, mental health, and the hospital environment. The purpose of this study is to learn how spirituality shapes nurses' practice in a particular community context that is, nursing within First Nations communities in B.C. In addition, it is relevant and timely to establish whether spirituality shapes nurses' practice in First Nations communities, as this may also be significant in other areas of nursing practice.

CHAPTER II

Literature Review

Introduction

The literature review initially discusses the concept of spirituality within the nursing profession. Next, a conceptual process is used to show how conceptual analysis, clarification and concept mapping help to define spirituality. The literature review then moves into exploring culture as a determinant of health, and how spirituality is currently perceived as a component of culture and an expression of human identity.

The roles of community health nurses are then discussed to emphasize why they need to understand how the determinants of health impact on First Nations peoples' well being. Inequities in the health status of First Nations peoples are then discussed from a population health perspective with exploration of linkages between culture, spirituality and health.

The literature review finally moves into a summarized discussion of the historical impact and legacy of colonization, missionaries and the residential school system on First Nations peoples, and how these issues currently impact on the health, well-being and culture of First Nations peoples in B.C. These historical issues continue to impact health and healing in many First Nations communities today, and therefore relate to issues of spirituality.

Spirituality

Research into spirituality is gaining momentum within the nursing profession. A recent integrative literature review of the concept of spirituality found that 65.8% of the 73 studies about spirituality and health care were produced between 1996 and 2000,

compared to only 34.2% between 1991 and 1995 (Chiu, Emblen, Hofwegen, Sawatzky & Meyefhoff, 2004).

Kilpatrick, Weaver, McCullough, Puchalski, and Larson (2005) completed a review of spirituality and religious measures in four peer-reviewed nursing journals from 1995-1999. They identified 67 of 564 research studies that measured one aspect of religion or spirituality. Kilpatrick et al. (2005) found a higher frequency of articles about spirituality and religion within nursing journals compared to any other profession. It is evident the subject of spirituality has recaptured the attention of the nursing profession.

Spirituality in historical and nursing contexts

The longstanding connection between religion and nursing can be traced back to early Christianity, through the Middle Ages, and during the time of the Crusades, when monks were encouraged to become nurses and leave the monasteries (Narayanasamy, 1999). Later, holistic nursing, including spirituality, flourished during the Renaissance period, and was provided by priests and nuns within organized religious orders (Narayanasamy).

Social reform during the Victorian era was very much a middle class occupation, and Florence Nightingale's dedication to the nursing profession evolved from her sincere belief in the betterment of humanity (Widerquist, 1992). Nightingale's spiritual and religious beliefs shaped the nursing profession in the late 1900s because she believed in selfless dedication to serving others, hard work, morality and individual selflessness to achieve salvation with God (Widerquist). Nightingale's religious and spiritual life was synonymous with her professional life as a nurse.

Historically, the relationship between religion and spirituality within the nursing profession has not been deeply analyzed. Cusveller (1998) believes there is currently a trend to separate spirituality from religion, to personalize spirituality and to make it meaningful. In addition, Maclaren (2004) supports the recent separation of religion and spirituality, believing that spirituality cannot be confined purely within religions as it is part of a broader holistic worldview that embraces alternative healthcare practices. Also, patients find satisfaction in various forms of spirituality because it has value and meaning for them (Cusveller, 1998).

Notably, individual personalization of spirituality is happening in cultural environments that are becoming increasing pluralistic, often with migrants arriving in countries like Canada, holding strong ties to creedal religions (Reimer Kirkham, Pesut, Meyerhoff, & Sawatzky, 2004). Therefore, it would not be prudent to exclude diverse religious expressions from nursing, healthcare, and more broadly, social discourse (Reimer Kirkham et al.) given the risk of further marginalizing newcomers to Canada, as well as significant numbers of Canadian citizens who continue to affiliate with creedal religions. Moreover, Reimer Kirkham et al. identify that:

Religion, as a fundamentally social phenomenon, is intensely political, rooted in long histories of conquest, domination, and diaspora. These histories continue to penetrate the religious/spiritual experiences of many. While some leave behind institutionalized religion on account of these histories and seek spirituality outside of religion, others hold to their faith traditions. To move our theory exclusively towards spirituality is to risk being profoundly apolitical, in essence failing to understand people's lives contextually at a time when religion is deeply political,

and increasingly racialized. (p. 165)

Overall, the public religious behaviour of immigrants and persons born in Canada since 1985 is becoming increasingly divergent as the percentage of Canadian-born 15 to 59 year-olds with no religious affiliation or not attending religious services has increased from 33% in 1985 to 48% today, whereas immigrants in this age group have only decreased from 36% to 35% (Clark & Schellenberg, 2006). In addition, the increasing dissimilarity and divergence in public religious behaviours among persons born inside and outside Canada conceal religious diversity among immigrants from different regions of the world (Clark & Schellenberg). Ultimately, as a result of global migration and ethnocultural diversity there is a shift in the religious profile within Canada.

Spirituality in nursing education

Although Pesut (2006) identifies spirituality as being a vital component of nursing care, Narayanasamy and Owens (2001) find that nurses and patients are both uncomfortable talking about spirituality with each other and nurses tend to react to patients' spiritual distress, rather than being proactive and initiating conversation with patients about their spiritual needs (Jackson, 2004). Also, Jackson identifies that nurses who are unaware of their own spirituality are unsure how to initiate conversation about spirituality with their patients. In addition, spirituality remains an intensely subjective concept for both nurses and for patients (McSherry & Ross, 2002), which further compounds nurses' reluctance to initiate conversation about a subject that is so personal.

Notably, McSherry (2006) identifies that spiritual nursing education does increase nurses' spiritual awareness; however, this does not necessarily translate into spirituality

being relevant to patients at a personal level, nor does it ensure nurses are comfortable and able to provide spiritual care. Interestingly, Cavendish, Luise, Russo, and Mitzeliotis (2004) recognize a positive correlation between nurses' ability to provide spiritual care and support after receiving prerequisite spiritual education. However, most nursing education programs do not adequately prepare nurses to care for the spiritual needs of their patients (Callister, Bond, Matsumura & Mangum, 2004). Moreover, the subject of spirituality is inconsistently written about in nursing literature, and nursing programs lack the congruence to use the same mandatory and recommended texts for course work and electives (McEwen, 2003).

Narayanasamy (2006) from the United Kingdom (UK) introduced a self-reflective tool known as the ASSET model, which is designed to guide nurses' training and education in spirituality. In addition, Narayanasamy developed an ACCESS model that stands for "Assessment Communication Cultural (negotiation and compromise), Establishing (respect and rapport), and Sensitivity and Safety framework that is used by nurses in the UK to deliver culturally competent transcultural care. Narayanasamy explains that transcultural care, "Is about attending to someone in the midst of their health crisis with care, compassion and commitment, but this approach is challenged when we reconstruct the person in terms of their diversity and differences" (p. 847). It might be more effective to use the transcultural ACCESS model in conjunction with the spiritual ASSET model because culture, religion and spirituality are conceptually intertwined. Transcultural nursing includes being respectful towards other cultures; however, in reality, nurses' interaction with patients cannot be totally objective (Polaschek, 1998). Thus, as discussed later in this chapter, the concept of cultural

safety with its emphasis on self-reflexivity could also facilitate the spiritual aspects of patient care. In these ways, we see nurse education taking up spirituality as an important concept, albeit without clear consensus of how to best take up the subject.

Defining spirituality in nursing

McSherry (2006) cautions against adopting a generic definition of spirituality as it would be constrained by religious and cultural differences that exist between people, while Pesut (2006) discusses the limitation of having only one view of spirituality within our diverse, pluralistic patient population. In addition, Pesut suggests the presence of a pervading ethical tension "between constructing claims in the hopes of unifying the discipline of nursing and ensuring that nursing world-views adequately represent the views of the patients" (p. 128). Furthermore, Pesut warns against creating a "spiritual discourse" within nursing that purely helps the profession to continue on its own developmental path irrespective of evidence that suggest patients have very different ideas of what they need from nurses in terms of spiritual care. However, in contrast, Habito (2006) suggests the universality of spirituality provides an opportunity for people to have meaningful connections with each other regardless of their differences.

The conceptual process

Nursing knowledge provides a professional and disciplinary identity that conveys how nursing contributes to the healthcare process and provides the profession with coherence and purpose (Chinn & Kramer, 1999). Before examining nursing research for a conceptual definition of spirituality, it is wise to review the conceptual process used by scholars.

Walker and Avant (1995), Rodgers (1993, 1989a), Schwartz-Barcott and Kim (1993), Chinn and Kramer (1987), and Wilson (1963-1969) developed advanced techniques for concept analysis (Hupcey, Morse, Lenz & Tason, 1997; Morse, 1995; Paley, 1995). Unfortunately, most conceptual analytical techniques are missing at least one component. Also, there is a general lack of consensus in the efficacy of any one technique being able to provide a complete process for concept clarification.

Paley (1995) argues that concept clarification in the absence of any theoretical commitment is not beneficial at all. Kramer, cited in Gift (1997), suggests that concept clarification enhances critical thinking, is a search for explicit meaning in language and helps the nursing profession to examine theory and practice.

Gift (1997) views a concept as an abstract image of the phenomenon being studied and suggests conceptual inquiry helps the researcher to delineate, transform, and operationalize the phenomenon. Moreover, she uses the term clarification and analysis synonymously stating, " . . . it is the process of unfolding, exploring, and understanding concepts for the purposes of concept development, delineation, comparison, clarification, correction, identification, refinement and validation" (p. 75).

Qualitative research methods can help to define a concept because words, terms and components are used by participants to describe what the concept means to them. Also, participants within a research study will verbally contextualize how and when the concept is presented. Gift (1997) advocates the use of qualitative research methods for conceptual analysis because they require data collection from participants and then an inductive analysis of the data. Furthermore, Gift suggests that qualitative research methods help to reveal and identify conceptual antecedents, consequences and

attributes. This means a concept can initially be explored by using equivalent groups of words that help to expose its principal features and then move to methodically analyze its meaning (Strauss & Corbin, 1998).

According to Strauss and Corbin (1998), science cannot exist without concepts because they are defined as complex mental formulations of experiences and are the building blocks to the development of theories. Moreover, concepts allow for questioning of the relationship between particular phenomena (Chinn & Kramer, 1999; Strauss & Corbin). The proliferative efforts to conceptualize spirituality in nursing research may simply be a reflection of the difficulty in conceptualizing the ineffable nature of spirituality.

Conceptually analyzing spirituality

Tanyi (2002) uses Walker and Avant's (1995) conceptual technique to clarify spirituality. Tanyi defines the concept of spirituality as a personal search for meaning and purpose, and a connection to self-chosen religious values and practice. Tanyi uses the words, faith, hope, peace and empowerment to explain what is meant by the term connection, and furthermore, suggests a connection results in " . . . joy, forgiveness of oneself and others, awareness of hardship and mortality, a heightened self of physical and emotional well-being, and the ability to transcend beyond the infirmities of existence" (p. 506). Gift (1997) is more critical of Walker and Avant's (1995) conceptual process and I suggest the flaw in Walker and Avant's technique is the use of an invented case. When sufficient data is obtained from qualitative methods there should not be a need to invent a case.

Concept mapping

Walker and Avant's (1995) use of concept mapping is useful in synthesizing the data to enhance the conceptual process. Essentially, concept mapping is a process used to encourage subjective and cognitive interpretation of all the collected information. The goal of the mapping process is to elucidate relationships between information by cross linking, rather than compartmentalizing the information (Irvine, 1995; Morse, 1995). Also, all the words and terms that are used to describe or explain the meaning of the concept are listed and then sorted into groupings with similar themes or features. After groups of words have been formed, the next stage is to merge and to create an actual definition of the concept that is being studied. Figure 2.1 demonstrates concept mapping of spirituality using words already cited in this section of the literature review.

Figure 2.1 Concept mapping for spirituality.

List of terms	Grouping of components	Merging	Emerging Concept
Faith	1. meaning & purpose		
Existential	connected		
Force	whole		The concept of
Energy	self		spirituality is
Transcendence			defined by
Essence	2. transcendence		merging terms
God	essence		from the 3 groups
Meaning & purpose	force		
Self	energy		
Soul	dimension		
Whole			
Connected	3. existential		
Dimension	soul		
	God		
	faith		

Chiu et al.'s (2004) integrative review of the concept of spirituality in the health sciences included a qualitative, quantitative, cross-cultural and historical review of the literature. Chiu et al. analyzed themes from the definitional reviews of spirituality, and the following themes were identified: existential reality, transcendence, connectedness, power, force and energy. Also, within the literature review, specific words were used to describe spirituality such as holistic, personal journey, existential, love, forgiveness, hope, fulfillment, comfort, peace and creativity (Chiu et al.).

Kilpatrick et al.'s (2005) literature review from 1995-1999 identified 53 uses of spirituality and religious terminology. The most commonly used terms identified in the literature review were spiritual well-being, meaning and transcendence, belief in God, faith and religion. Kilpatrick et al. measured spirituality and religion using descriptions and verbatim quotes from participants, and then analyzed the descriptions for emerging themes that could be used to conceptualize and define spirituality.

Kendrick and Robinson (2000) suggest spirituality involves making connections with integrity and peace within and outside the self. The search for personal spiritual meaning includes the context of all human life because, ". . . spirituality is not reliant upon religious, secular or agnostic themes but form the very essence of the human person" (p. 702).

Goddard (1995) suggests there are universal qualities, essences or commonalities within spirituality, which transcend individual experiences to connect and unify our human dimension into an integrated energy that binds us all together as a whole. The idea of spirituality being a dimension or part of something more holistic is further supported by Kendrick and Robinson (2000) who suggest spirituality involves the

whole personality because it seeks to bring together the mind and the body with all human experience and connects beyond the boundaries of the self to the pure essence of self. Two similar reviews of the concept of spirituality conclude with the presentation of faith or acceptance of a belief system, a personal search for meaning and purpose, a connection to others and self-transcendence (Miner-Williams, 2006).

Skolimowski (1993) describes spirituality, " . . . as an articulated essence of the human condition of a given time means that spirituality is not accidental but essential to the human condition" (p. 1). Skolimowski believes all world religions and major spiritual traditions are in agreement that the absence of spirituality would leave us less than human. Whereas Paley (2008) takes on a more naturalistic position arguing that spirituality is an unnecessary concept, a human creation and response to our existential fear of death and extinction that has been converted into a positive illusion to ease our own fears and distress. Yet ironically, spirituality is such a nebulous and indefinable concept.

For the purpose of this research study, I choose to use an existing definition of spirituality that encompasses many of the terminologies used in the concept map in Figure 2.1. The definition has been created from a humanist and phenomenological context obtained from actual human experience and observation. The definition of spirituality chosen for this study is by Elkins, Hedstrom, Hughes, Leaf, and Saunders (1988):

> Spirituality, which comes from the Latin, Spirits, meaning "breath of life," is a way of being and experiencing that comes about through awareness of a transcendent dimension and that is characterized by certain identifiable values in

regard to self, others, nature, life, and whatever one considers to be the Ultimate. (p. 5)

Spirituality and religion

Spirituality is meaningful within existing world religions, and Skolimowski (1993) suggests each religion has its own specific form of spirituality that converges into being one and the same. Interestingly, different beliefs, practices, membership, social organization and non-spiritual concerns and goals of most world religions in the area of culture, economics and politics do not automatically imply the separation of spirituality from religion (Miller & Thoreson, 2003).

Reimer Kirkham et al. (2004) suggest that the total separation of spirituality from religion fails to understand the current reality of living in a global climate where religion is constantly being politicized and racialized. Reimer Kirkham et al. are not suggesting that spirituality must always be affiliated with religion and recognize spirituality as an independent concept. However, they caution the construction of spirituality through a Western lens, as it does not truly reflect the religious plurality that now exists in the West. Furthermore, Habito (2006) suggests how the presence of spirituality within religious traditions helps to have meaningful connections and discussions with one another regardless of the differences between religions and non-spiritual concerns. Spirituality could be the catalyst needed to facilitate the creation of such a new global convergence and consciousness (Cousins, 1993). However, the presence of spiritual commonality is not enough on its own and the real possibility of a global transition from religious divergence to convergence also requires religious transformation, which is deeply embedded within culture, ethnicity and race (Miller & Thoreson, 2003; Cousins,

1993). Currently, any notion towards religious convergence remains thwarted by existing global political tensions and conflicts that continue to be divergent and derisive since 9-11.

Cultural Safety and Nursing

Cultural Safety

The Nursing Council of New Zealand (2002) write about how cultural safety involves nurses learning about their own culture while concurrently learning to understand the theory of power relations between themselves and patients. Significantly, cultural safety requires nurses to reflect on their personal and cultural biases, attitudes and values. In the context of this study, cultural safety could also be helpful in prompting nurses to reflect on how their personal religious and spiritual beliefs and practices influence patient care.

Moreover, cultural safety is a pragmatic and useful theoretical framework (Browne, Smye & Varcoe, 2005), which I suggest could assist in framing and examining the subject of spirituality within the context of pluralism and social diversity. This is important for nurses to consider because patients' values, beliefs and I would argue, perceptions of spirituality are not merely neutral constructions. Rather, these values, as Anderson (2002) suggests, are shaped by historical, social, political factors, and one's ethnocultural positioning. Understood in this way, cultural safety becomes an essential prerequisite for community health nurses who work in First Nations[1] communities in Canada who are not of Aboriginal[2] descent (Vukic & Keddy, 2002).

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[1] First Nations is a term that came into usage in the 1970s to replace the word Indian, however, there is no legal definition of First Nations. Currently, First Nations is a term used to refer to Indian people in Canada, both Status and Non-status, and is sometimes synonymous with the word "Band" (Health Canada, 2003). The term First Nation replaces the term Indian, Inuit replaces the term Eskimo, and

The evolution of cultural safety

The recognition of cultural differences in nursing initially began as cultural awareness, cultural sensitivity and more recently cultural safety. Research into cultural safety reframes the nurse and patient relationship as a power differential that exists when the dominant nursing culture interacts with the minority patient culture:

> Cultural Safety does not accept the culture of nursing is normal to patients. It assumes that the nurse is exotic to the patient . . . cultural safety gives the power to the patient or families to define the quality of service on subjective as well as clinical levels . . . to most people, nurses are "Other". Cultural Safety therefore lies in the establishment of the trust moment and in shared meaning about the vulnerability and power followed by the careful revelation and negotiation of the specifics and the legitimacy of difference. (Ramsden, 2002, p. 110)

The trust moment as discussed by Ramsden is essential in moving the nurse and patient relationship forward to a point of shared meaning, careful revelation and negotiation of any differences between them.

Irahapeti Merenia Ramsden (1946-2003), an indigenous Maori woman, first developed the concept of cultural safety among Maori nurses in New Zealand. It is both timely and appropriate for cultural safety to evolve through the worldview of a Maori woman and nurse whose historical experiences are comparable to First Nations peoples in B.C. Ramsden (2002) suggests the starting point for cultural safety begins

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Métis refers to people of mixed European and Aboriginal heritage. The labels "Native" and "Indian" however, continue to be used in federal legislation and policy (e.g., the *Indian Act*), statistical reports, and public discourses, in spite of being pejorative to First Nations peoples, and negatively used to undermine and marginalize First Nations people (Browne, 2005).

[2] Aboriginal: Descendants of the original inhabitants of North America. The constitution of Canada recognizes three groups of Aboriginal peoples- Indians, Métis, and Inuit people. These separate peoples have unique heritages, languages, cultural practices and spiritual beliefs (Health Canada, 2003).

with awareness, then sensitivity, and finally cultural safety. The terms are not

interchangeable and are not synonymous (Figure 2.2).

Figure 2.2 The process for achieving cultural safety (Ramsden, 2002, p. 111).

1. Cultural safety (indigenous):	2. Cultural sensitivity:	3. Cultural awareness: (Transcultural, Western model)
Is an outcome of nursing and midwifery education that enables safe service to be defined by those that receive the service.	Alerts students to the legitimacy of difference and begins a process of self-exploration as the powerful bearers of their own life experience and realities and the impact this may have on others.	Is a beginning step towards understanding that there is difference. Many people undergo courses designed to sensitize them to formal ritual rather than the emotional, social, economic and political context in which people exist.

To summarize, cultural safety is about inverting the imbalance of power from the

nurse to the patient to achieve the trust moment in the relationship and to develop

shared meaning. Often, First Nations peoples' worldview perspectives are not always

the same as the dominant Eurocentric worldview. Cultural safety could possibly be

helpful in acknowledging and working across differences in order to prevent social

exclusion and othering (Galabuzi, 2002). Cultural safety, by this interpretation, is about

First Nations peoples living their own truths in their own way. Ramsden's (2002) work in

cultural safety validates each and every person's identity and culture because it is the

patient who guides the process with the nurse. Moreover, the nurse's relationship with

the patient will also develop from a place of mutual trust and shared meaning, to foster

a caring, respectful and spiritual relationship.

Defining culture and health

Culture and spirituality are complex and convoluted concepts that are intertwined and difficult to separate. Significantly, Lalonde (1974) includes culture as a determining factor in the overall health status of a population in the field of public health. This is important as Anderson et al. (2003) discuss how the concept of culture is much more complex than just including the beliefs and practices of a particular group and suggest it is folly to consider ethnicity as exotic and separate as differences are really about an imbalance of power and the inequities created by colonial oppression.

The dominant health care culture in Canada is a Western medical model that perpetuates an illness model rather than a wellness model of health. Significantly, Spack (2003) suggests it is the culture of a population that influences their understanding of health, wellness and illness, and their interaction and use of the available health care system. This is further supported by Eni (2004) who suggests that health, healing, religion and spirituality cannot be separated from the culture of a population because they involve social norms and behaviours that are laden with cultural values, shared rules and understanding. Eni (2004) defines health as, " . . . the ability of an individual to fulfill his or her social obligations in accordance with the prevailing environment and beliefs" (p. 11). This definition of health is an attempt to embrace all cultures and to be inclusive and not exclusive, and places the individual within his or her own social, cultural context and community.

The present reality is most groups, regardless of ethnocultural background, are expected to conform to the existing dominant model of health that result in inequality and an imbalance of power (Anderson et al., 2003). Prevailing inequalities and

imbalance of power for many First Nations communities translates into the sense of marginalization that many people experience when they seek health care.

Richardson (2004) believes health care professionals approach the subject of culture from their own perceived place of equality, regardless of people's cultural differences, and furthermore, the provision of the same health care model to everyone relies on the expectation that everyone will be treated equally and equitably regardless of differences. However, the dominant, more powerful culture usually decides on what health care services are available for everyone, which results in the marginalization of people who are culturally different as their health needs are not usually included in the overall decision making process being made by the dominant culture (Richardson). The dominant culture with its own set of values is usually oblivious of the impact and outcome of their own decision-making because they have internalized the differentials of power, dominance and privilege, and are unfortunately only consciously aware of their own perspective and worldview (Eni, 2004; Richardson).

Health inequities and First Nations peoples

First Nations communities in Canada have poorer health than the general Canadian population (Health Canada, 2005). Adelson (2005) explains:

> Health disparities are first and foremost those indicators of a relative disproportionate burden of disease on a particular population. Health inequities point to underlying cause in the health disparities, many if not most of which sit largely outside of the typical constituted domain of "health". (p. 45)

Existing disparities in the overall health of First Nations peoples have been linked to cultural, social, economic and political inequities that result in disproportionate levels of

poorer health for First Nations people in Canada (Adelson). The infant mortality rate in any society is an accurate measure of the health of the population because it is associated with the well-being of infants, children and women (Health Canada). Also, infant mortality is linked to access and quality of health care services, socio-economic factors, public health programming and implementation (Health Canada). Significantly, the First Nations infant mortality rate has declined from 27.6 deaths per 1,000 live births in 1979, to 8 deaths per 1,000 in 1999, to 6.4 deaths per 1000 live births by 2000. However, the infant mortality rate is 1.5 times higher than the Canadian rate of 5.5 deaths per 1000 live births in 2000 (Adelson; Health Canada).

In B.C., First Nations peoples born between 2001 and 2005 have a life expectancy of 75 years compared to 82 years for all other residents in the province (First Nations Health Plan, 2007). Also, in B.C., the Aged Standardized Mortality Rate (ASMR) per 10,000, measuring deaths due to all causes, is 1.5 times higher for First Nations peoples (First Nations Health Plan). In light of these statistical disparities in health status for First Nations peoples compared to the general population, Adelson (2005) deliberated on the meaning of the word "health" for First Nations peoples and determined from ethnographic data that health is much more than the absence of disease and is more an assertion of wellness that includes indicators such as employment, alcohol abuse, drug abuse, family violence, suicide, sexual abuse, and rape. These health indicators as suggested by First Nations peoples themselves reflect the need to address colonial processes as a determinant of health.

Colonial processes as a determinant of health

Within the context of the determinants of health (Lalonde, 1974) First Nations culture has been shaped by colonial processes that have resulted in poorer health outcomes for First Nations peoples compared to the general population. In the area of public health, Lalonde identifies income and social status, social support networks, education, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture as determinants of health. Furthermore, these determinants of health are used within a population health model to establish the health of populations. The most recent First Nations infant mortality and life expectancy rates reflect the present reality that First Nations peoples do not share the same level of health as the general Canadian population.

Non-First Nations people, such as nurses and other health care providers must understand that the process of decolonization for many First Nations peoples and communities will involve a process of reclaiming and rebuilding their own heritage, knowledge, land and language, to form their own perspectives and worldview, and to become self determined and self governed (Battiste, 2000). Also, Battiste recognizes an intimate connection between culture and health that includes the concept of spirituality. Significantly, Battiste suggests that existing conceptualizations of First Nations culture need to be clarified and demystified, and furthermore she believes the survival of First Nations peoples is:

A global issue of maintaining Indigenous worldviews, languages and environments. It is a matter of sustaining spiritual links with the land . . . The

challenge for Indigenous peoples is one of restoring their spirit and bring

back into existence, health, and dignity. (p. 12)

Historical processes affecting First Nations people in B.C.

Many First Nation peoples currently experience the intergenerational legacy of

colonial processes that continue to impact their level of health status. This legacy is a

reminder of the historical dominant ideologies of the day, the effects of which are visible

to this day. Significantly, "postcolonialism always invites us to see the ambiguities, the

partialities, the negotiations" (Dr Sheryl Reimer Kirkham, personal communication, April

9, 2008). With this goal in mind, this section provides an overview of historical

processes affecting First Nations peoples.

By the late 1800s, many First Nations peoples had not survived the fatality of

European diseases such as smallpox, influenza and measles (Waldram, Herring &

Young, 2000). By the mid-1850s, First Nations peoples were segregated and distanced

from their own lands and had to live on farms, while settlers took over their traditional

hunting land. In terms of health care, First Nations peoples were able to survive illness

from disease as they accessed medical services from the settlers who inadvertently

transmitted infectious disease (Report from the Indian Department, 1864). First Nations

were the most dominant group living in B.C. until 1886, when the completion of the

Canadian Pacific Railroad (CPR) resulted in an influx of settlers, government officials

and missionaries (Perry, 2003).

European dominance and missionaries

It must be acknowledged that the role of many missionaries was to reside over

the sick and to teach. For example, in 1844 a Gray Nun group of 17 out of 34 nuns led

by Sisters Valade, Lagrave, Coutlee and Lafrance left Montreal and travelled by

canoe for fifty-eight days to reach the Red River settlement located at the confluence of

the Assiniboine and Red rivers in Winnipeg, Manitoba (Bonin, 1986). Historically, these

nuns were devoted to doing God's work such as helping and feeding the poor, nursing

the sick and teaching (Bonin).

In B.C., First Nations traditional practices varied across the province and many

First Nations peoples were in contact with missionaries and converted to Christianity

(Kelm, 1998). In the context of the day, Christian missionaries assumed that First

Nations peoples needed Christianity in their lives. Unfortunately, missionary ideology

viewed shamanism as satanic, spirit dancers[3] were seen as devils, and Native medicine

was seen as a barrier to converting First Nations peoples to Christianity (Kelm), and as

a result many of these practices were systematically discouraged, often to the point of

eradication.

How missionaries became caught up in governmental officialdom is unclear;

however, by 1895 an amendment was made to the first Indian Act[4] (1876) prohibiting

the Potlatch[5] (Cole & Chaikin, 1990). Health, morality and economics were the three

main issues put forward for the prohibition of the Potlatch by the missionaries and

Indian officials at the time (Kelm; Cole & Chaikin). The Potlatch continued unabated

especially in Kwakiutl until 1922, by which time William H. Halliday, a government agent

at Kwakiutl, under the direction of Duncan Campbell Scott, Deputy Superintendent of

Indian Affairs, succeeded in abolishing the Potlatch throughout B.C. (Cole & Chaikin). A

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[3] Spirit dancers: Dancers during the Hamatsa ceremony (Cole & Chaikin, 1990).
[4] Indian Act: Canadian federal Legislation that sets out certain obligations of the federal government, and regulates the management of Indian lands (Health Canada, 2003).
[5] Potlatch: A ceremonial giving away of all possessions (Cole & Chaikin, 1990).

total of 450 items of ceremonial regalia such as masks, coppers and hamatsa[6] whistles were confiscated in Kwakiutl and sent to the National Museum in Ottawa and beyond. Recently, many artifacts have been returned and are on display in Kwakiutl (Cole & Chaikin).

Missionaries were deeply troubled by the lack of boundaries between First Nations families who lived so closely together and they believed traditional housing in the form of a cedar barn-like structure 110 ft in length and 30 ft across encouraged polygamy and promiscuity (Perry, 2003). Many missionaries did not recognize and understand that intergenerational family housing helped to define First Nations culture, spirituality, gender roles, family, lineage, their strong belief in Potlatch and giving away to those who have less, as opposed to the Eurocentric accumulation of wealth.

The physical separation from each other in terms of family housing was further compounded again by the Indian Act, which gave the Minister for the Department of Indian Affairs (DIA) the authority over First Nations education.

Residential School System

The role of missionaries as teachers was established in the mid 1800s and this may have lead to their enmeshment in governmental educational plans to create residential schools. In 1879, Nicolas Flood Davin, a member of parliament, researched the educational system in the U.S.A. and recommended that industrial boarding schools be built so First Nations children could be educated and learn Christian values away from their own families. By 1920, an amendment was made to the Indian Act to educate children from 7-15 years of age in residential schools. The government ran the schools in partnership with religious organizations until 1969; however, the last residential

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[6] Hamatsa: Kwaguilth, simulated cannibal spirit dance (Cole & Chaikin, 1990).

school did not close until 1996 (Government of Canada, 2004). It has been estimated that 100,000 children passed through the residential school system (INAC, 2007).

The residential school system tried to create cultural conformity by social control (Kelm, 1998). Ideally, First Nations children were supposed to become healthy individuals while attending school and then return home to share their newly acquired education. In reality, Kelm describes how many children contracted tuberculosis and died or became very sick because they were overworked, underfed, sexually abused and suffered physical abuse such as brutal beatings and whippings. The children in residential schools were not allowed to speak their own language or follow any of their First Nations traditions such as singing and dancing (Kelm).

Apology and reconciliation

For many, not all First Nations peoples the residential school system created lasting intergenerational family trauma, cycles of physical, sexual, drug and alcohol abuse, and family violence (INAC, 2007). The Government of Canada (2004) in a 1998 Statement of Reconciliation stated:

> To those individuals who experienced the tragedy of sexual and physical abuse at residential schools, and have carried this burden believing that in some way they must be responsible, we wish to emphasize that what you experienced was not your fault and should never have happened. To those of you who suffered this tragedy at residential schools, we are deeply sorry (Government of Canada).

The 1998 apology, by the then INAC Minister Jane Stewart, was superseded on March 7th, 2008 by the formation of a Truth and Reconciliation Commission (TRC). The Interim

Executive Director of the TRC praised the Aboriginal Healing Foundation on the recent launch of its publication of a collection of essays by distinguished Aboriginal leaders, experts and former students that give voice to the Indian Residential Schools legacy. Specifically, the role of the TRC is to:

> Contribute to truth, healing and reconciliation and will be an official independent body that will oversee a process to provide former students and anyone who has been affected by the Indian Residential Schools legacy with an opportunity to share their individual experiences. (Government of Canada, 2008)

First Nations peoples in Canada and B.C. today

First Nations peoples in B.C. make up four percent (approximately 170,000) of the total provincial population. The population living in First Nations communities is a proportion of this four percent (Government of B.C., 2007). There are currently 203 First Nations communities within B.C. (L. Tulloch, RN, personal communication, July, 31, 2006).

In 2002, sixty-three percent of First Nations respondents in a national public opinion poll believed poorer health among First Nations peoples were attributed to loss of culture and land (Assembly of First Nations (AFN), 2006). Recently, a First Nations Regional Longitudinal Health Survey (RLHS) developed a Cultural Framework to assist in the interpretation of the results from 22,462 surveys from First Nations people living in First Nations communities (AFN, 2006). The framework conceptualizes total health, total person and total environment. Significantly, the total person concept includes body, mind, spirit and heart that implicitly involve the extended family, social and emotional balance and harmony, and currently First Nations people are defining and creating their

own cultural framework, including spirituality, to help improve their own health

(Battiste, 2000).

Community health nurses working in First Nations communities

Currently, in B.C., many non-First Nation community health nurses provide public

health programs in First Nations communities (L. Tulloch, RN, personal communication,

July, 31, 2006). Community health nurses need the knowledge and comprehensive

understanding of the health inequities that exist for First Nations people living in First

Nations communities compared to the general population, and they must also have

knowledge about the historical and current reasons why these inequities exist.

Community health nurses must understand the need for culturally appropriate,

collaborative public health program planning, which includes First Nations peoples as

equal partners in health promotion, protection, injury prevention, communicable disease

control and surveillance. Otherwise, as Anderson et al. (2003) suggest, the dominant

culture continues to be in control of directing health care service delivery and defines

health, wellness and illness from a Eurocentric model.

Furthermore, community health nurses need to understand how First Nations

describe the concept of spirituality through their own perspective and not through a

Eurocentric lens:

Indigenous peoples connect everything with a continuous state of transformation,

creativity or spirituality as the matrix that holds everything together. The

Indigenous vision of creativity . . . is encased in and manifested through

Indigenous linguistic structures. Learning Indigenous spiritual teachings involves

intimate and endless talks with elders and relatives, and is a process that takes

patience and prudence. Indigenous sounds enfold an elegant way of explicating an ecological order. Spiritual teachings comprise complex systems of relationship enfolded in stories, songs, prayers, rituals, and talks. These sounds inform a remarkable connection to the livingness within a spiral of life and to the power to renew livingness. (Battiste, 2000, p. 101)

Although spirituality seems to be such a nebulous concept within the nursing literature, it would be unwise for community health nurses to make any assumptions about the spiritual beliefs of First Nations peoples when they first go and work in First Nations communities. First Nations peoples' history reflects the influence of missionaries and Christianity on their culture, as well as the continued presence and resurgence of First Nations traditions and beliefs. Perhaps the starting point for any community health nurse is to define, describe and understand his or her own spiritual beliefs and experiences first.

Summary

The literature review reflects the complexity of exploring the subject of spirituality within nursing, as it is difficult to conceptualize and there are so many different terms to describe what it means and it how it can be defined. Clearly, the concept of spirituality is deeply embedded within people's cultural and lived experiences, and is entwined with their values and beliefs that have been shaped by historical, social and political influences.

Colonial processes have resulted in existing disparities and inequities in First Nations peoples' health outcomes compared to the general population, and First Nations peoples are trying to decolonize themselves to become self-governing and self-

determined. Community health nurses working in First Nations communities need to be culturally safe practitioners and understand the historical and cultural influences in First Nations peoples' lives that impact on their health outcomes. Once community health nurses have reflected on their own spiritual beliefs, values and practices they may understand Battiste's (2000) comment that "spiritual teachings are found in the ability to apprehend the hidden harmony of changing ecologies and to create alliances with these transforming forces" (p. 100).

CHAPTER III

Research Method and Design

Research Design: Overview

The purpose for this research study was to explore how community health nurses describe their own spirituality and to interpret their experiences of spirituality in relation to their nursing practice in First Nations communities across B.C. Interpretive description was chosen as the most ideal qualitative research method to address the purpose of the study and to answer the research questions. Significantly, the interpretive process contextualized the nature of the nurses' descriptions in the study and the shared reality between them and their work environment (Thorne, Reimer Kirkham & MacDonald-Emes, 1997). Thorne et al. also suggest interpretive descriptions support the value and meaning of personalized experiences and are truths in the same way that shared realities are truths. And furthermore, these truths can coexist within the same construct and context. Moreover, using interpretive description supports the growth and ownership of nursing knowledge and nursing truths and adds to the profession's knowledge base (Thorne et al.).

With the purpose of the study in mind, it became important to remind myself that the nurses in this study all work in First Nations communities where the general health and wellness of First Nations peoples has been greatly affected by colonization, racism, class and freedom (Adelson, 2005). Moreover, I realized how postcolonial theoretical perspectives (Reimer Kirkham & Anderson, 2002) had informed my thinking as they helped me to focus on how history and colonization have shaped health and health care in many First Nations communities, and furthermore helped me to understand how

narrow conceptualizations of culture can, ironically, support the stereotyping of people who belong to particular ethnocultural groups (Browne, 2005; Browne, Smye & Varcoe, 2005).

In this study, the participants all work in First Nations communities in B.C., where the history of loss of culture, colonization, residential school and social exclusion are extremely important issues facing First Nations people who are healing from the past (Kelm, 1998; Galabuzi, 2002). Also, Thorne, Joachim, Paterson, and Canam (2002) suggest my chosen research method depends upon my own historical location and philosophical perspective. It was very important as a student researcher to locate myself within the context of the study and to make the world more visible to the reader (Denzin & Lincoln, 2000). For convenience, I located myself in Chapter Four of the findings section immediately after the twelve participants' biographies.

During the research process I acknowledged that "culture" is a dynamic concept and my responsibility was to refrain from imposing my own cultural meanings on the interviews and data analysis. Using a semi-structured interview process that allowed for further discussion and negotiation during each nurse's interview helped me to continuously be aware of my research role and to refrain from verbally imposing myself into each interview (Anderson, 2002).

Ultimately, Denzin and Lincoln (2000) suggest a researcher is much more than just an observer because all research is interpreted and influenced by personal impressions and feelings about the world. With this in mind, during the analytic phase of the study, I became immersed in the data and waited for the emergence of meaningful words and phrases. After hours of reading, re-reading and analyzing the data,

"meaningful units" slowly emerged from the nurses' rich descriptions. Specifically, words and phrases created "meaningful units", which were collected and sorted into three major themes. It was important not to impose meaning onto the words and phrases from individual nurse's transcripts. I meticulously cross-referenced the presence of words and phrases that emerged from individual transcripts against nurses' recorded interviews and against transcripts.

Trustworthiness (rigor)

Although Sandelowski (1986) suggests it is the artistry and meaningfulness of the end product that is more important than controlling the process, it does not exclude the need for trustworthiness of the research process. Davies and Dodd (2002) emphasize how trustworthiness involves being as objective as possible in the all aspects of the research process, otherwise bias will impact on the truth-value of the research and decrease its overall credibility. However, it is currently accepted that subjectivity cannot be totally eliminated from qualitative research (Davies & Dodd). I had to be aware that my relationship with the nurses could never be totally objective, and any rapport between the nurses and me was based on shared understanding between us (Davies & Dodd).

Davies and Dodd suggest the continual need for journalling and reflexivity; however, they also emphasize the need for empathy and imagination between the nurses and me. During the interview process, I found active listening and long pauses to be extremely helpful in obtaining incredibly rich dialogue from the nurses as they were given ample time to think and phrase their responses. It was very easy for me to be

empathic with the nurses because their stories were shared with such deep thought and emotion that I would cry sometimes or I would laugh with them.

I became very cognizant of my own thoughts, feelings, emotions and reactions during every phase of this research study. Personally, I recognized and admitted to myself when subjectivity was creeping into the research process. I would put my subjective comments and thoughts to one side and label them as being my own personal location or bias within the study. Putting my subjectivity to one side helped me listen more closely to participants' voices, and to recognize my place in co-constructing knowledge with them. Specifically, in terms of process, I would ask myself how I felt, what meaning the descriptions held for me, and then I would jot down words in the margin of the transcripts to remind myself of my thoughts and feelings about certain words, phrases or paragraphs.

Credibility (truth value)

Guba and Lincoln's definition of credibility, as discussed by Sandelowski (1986) was used to ensure the research was subject-oriented and not researcher-defined. I endeavoured to present loyal descriptions and interpretations of the nurses' descriptions in the study. In keeping with my student research role, I needed to recognize how I was being influenced by my closeness to the nurses and their stories. Therefore, after each interview I journalled some of my thoughts and feelings in order to prevent my personal enmeshment in the research process. I needed to balance my own relationship with the nurses because I had to be close enough to enhance the truth-value of the research, yet distanced enough not to threaten the truth-value of the research.

Truth-value was addressed during the telephone interviews and the face-to-face interviews. Specifically, I was always subject-oriented, and I refrained from talking too much, inserting my own views, opinions and experiences into each discussion. This was helped immensely by having the semi-structured interview process where nurses were given the questions to read and review prior to being interviewed, and were prepared to answer each question. Importantly, I reminded myself that although I was the interviewer, each interview truly belonged to the nurse who was the focus of attention. It was very important to welcome and thank each nurse for giving up her time to share her story with me.

Transferability (applicability or fittingness)

Sandelowski (1986) suggests the idea of transferability is illusory because the researcher and the participants are not totally context free. Alternatively, Sandelowski refers to Guba and Lincoln's suggestion to use the term fittingness, that is, when findings from this study could fit into a context set apart from this particular study situation. This study situation applies to other similar community health care nursing environments.

Consistency (reliability or auditability)

Sandelowski (1986) discusses how reliability is an important requisite for validity, whereas Guba and Lincoln use the term auditability over the term reliability. I completed an accurate and detailed decision trail that could be followed by my committee members who would agree with the same findings and not contradict my own. My decision trail was kept primarily in my laptop computer plus three sequential interview

binders with my notes added in the margins and in the texts. I dated and recorded

my decisions and subjective comments about my process.

My audit trail included:

- o My personal interest in spirituality

- o My experiences that related to issues of spirituality when working in

  First Nations communities

- o Articles on spirituality in nursing, many articles, magazines and

  books about spirituality and religion

- o Brief notes on how I interviewed the nurses

- o How I progressively reworked the transcripts for accuracy against

  every recorded interview

- o How I sorted, analyzed and interpreted the transcripts in three

  progressive, consecutive binders

- o And how I jotted notes and reflexive comments after each interview

  to help me process, interpret and recognized personal issues of

  bias within the research process (Thorne, Reimer Kirkham &

  MacDonald-Emes, 1997).

Confirmability (neutrality)

Guba and Lincoln, as discussed by Sandelowski (1986), suggest neutrality or

confirmability is achieved when auditability, truth-value and applicability have been

closely respected and adhered to. My research process respected the need for

confirmability by including an audit trail.

Sampling Selection and Criteria

Ethics

An ethics proposal was completed and submitted to the University of British

Columbia's Behavioural Review Ethics Board. I also completed the Tri-Council Policy

Statement (TCPS) tutorial. The selection process for interviewing community health

nurses fit the minimal risk category as defined by the TCPS and demographically

represented those community health nurses who work in First Nations communities

throughout B.C. There were no exclusion criteria in this study based on culture,

language, religion, race, disability, sexual orientation, ethnicity, gender or age.

Sample selection

Community health nurses who work with First Nations peoples in First Nations

communities throughout B.C. were invited to participate in this study. There are 203

First Nations communities throughout the province and approximately 150 health

facilities. Approximately 120 community health nurses deliver public health services to

First Nations peoples living in First Nations communities (L. Tulloch, RN, personal

communication, July, 31, 2006). Participants for the study were self–selected to

participate.

Convenience or purposive sampling is used as a means to obtain rich

information, experiences or events from the participants about a specific subject

(Sandelowski, 1995). Convenience sampling was used to ensure the recruitment and

participation of nurses who could definitely answer the research questions and who

already had an interest in spirituality and could describe how spirituality shapes their

nursing practice. Nurses were asked to have at least two completed years of community

health nursing experience working in First Nations communities in B.C. No age limit was imposed.

Recruiting participants

The University of British Columbia (UB.C.) research guideline prohibits the solicitation of research participants via the telephone. Permission was obtained from the Regional Director for First Nations and Inuit Health (FNIH) in B.C. to distribute the letter of introduction to the eligible cohort (Appendix A). A resident physician working in our office agreed to email the letter of introduction to nurses who were on a nursing email list. Subsequently, I waited for willing participants to contact me.

When a potential participant contacted me, I explained the consent process and determined whether the participant could be interviewed in person in Vancouver or whether the participant preferred to be interviewed by telephone. Ideally, I would have preferred to interview each participant in person; however, this was not a reasonable request because of the geographic location of the participant's work place and distance from Vancouver. Also, I had no funding to contribute to any travel expenses for either the participants or myself.

Currently, I work as the Communicable Disease Control (CDC) nurse for FNIH, and I am available as a consultant to community health nurses who work in First Nations communities in B.C. Many of the community health nurses consult me on a regular basis for advice about immunization and communicable disease control issues. Significantly, I am not a manager or supervisor, and I am not involved in evaluating and assessing standards of nursing practice. Therefore, my nursing position eliminated the

possibility of coercing participants to take part in the study and facilitated voluntary recruitment.

Sample size

Sample size in purposive sampling very much depends on the need for information. Polit and Hungler (1999) use a guiding principle of data saturation, that is, sampling continues until no new information is found. My thesis committee anticipated that 12 participants could provide enough descriptive information to achieve data saturation and the induction of major themes. Fortunately, 13 community health nurses responded to the letter of introduction and 13 nurses were recruited for the study. One nurse dropped out because there was no convenient date or time to set up the interview. A signed consent form was obtained from each participant (Appendix B).

Dayna, one of the 12 participants, identified herself as First Nations; however, she did not have quite two years of community health nursing experience. I chose to include her in the study because she is a First Nations nurse who has grown up in her own Aboriginal territory and her inclusion was important in addressing the imbalance between the number of First Nations (five) versus non-First Nations (seven) nurses who volunteered to participate in the study. Dayna's inclusion in the study acknowledged the need to ensure a balanced perspective about the research subject because the nurses work in First Nations communities.

Interviews

One face-to-face interview was conducted in the privacy and quiet of my office at work and two face-to-face interviews were completed in a hotel room where the participants felt comfortable enough to share their stories (Morse & Field, 1995). The

other nine interviews were conducted by telephone. Permission was obtained to tape-record all of the interviews. The interviews were conducted through the months of June and July 2007.

Interviews averaged approximately 1.5 hours in length and 15 hours of descriptions were recorded and transcribed. The tape recordings were stored in a locked drawer and coded to protect the identity of the nurses. The taped interviews were transcribed and any identifying or confidential information about the nurses, clients or the community were coded to ensure anonymity. A few nurses were contacted during the data analysis and interpretive phase of the study in order to clarify and confirm the research findings.

Data collection

The interviews were semi-structured. That is, questions were used more as prompts during the interview to allow nurses to freely describe and explain their stories without being led (Morse & Field, 1995). In preparation for the interviews, open-ended systematic questions were prepared to help probe and explore each subject within every research question and prevent confusion, repetition or any misunderstanding between the participant and myself (Appendix C), (Morse & Field). One goal of the semi-structured interview was to guide the process and elicit rich meaningful data that was not hampered by me leading the nurse or providing reflective listening back to the participant (Morse & Field). Further, Morse and Field advise the researcher to " . . . list in sensible order everything you want to know about a topic, then construct question stems for each question to cover the entire domain" (p. 95).

During each interview I wrote down key words next to the question being answered. Then, after each interview, I sat quietly and jotted down my thoughts onto the sheet of paper that held all the interview questions for each nurse. This process helped me to reflect upon each interview, enhanced my personal engagement and encouraged my own persistent observation with the interview discussions (Polit & Hungler, 1999). I also looked at my jottings from previous interviews to determine whether I was maintaining the rigor and trustworthiness of the research process.

My reflexive notes were an opportunity for me to critique my interview skills. I found it difficult to write in any detail, although I gave myself lots of time after each interview to replay and visualise the interview in my own mind. This helped me to jot down relevant words and specific thoughts on the page as I reflected on my process. Later, this became more helpful when I listened to each recorded interview while reading the transcript because I was reminded of the nurse's tone of voice, emphasis on certain words and how each question was being answered.

My novice interview skills became obvious to me every time I had to ask a nurse to elaborate on a particular description because I sounded very clumsy as I tried not to inject my own opinion or lead the nurses in conversation. My own nervousness sometimes made it difficult for me to articulate clearly what I was trying to ask a nurse. Fortunately, the nurses were kind to me and asked me to help them out when they were unclear about what I was asking them.

Morse and Field (1995) highlight the need for me to listen carefully and to follow a nurse's dialogue verbatim just in case the nurse loses her train of thought. I found this part of the interview process very exhausting; however, it was worth paying close

attention and to listen carefully because participants sometimes went off on a tangent and then asked me to help bring them back to the question. I did not interrupt them if they carried on talking because it seemed they needed to talk and it was their interview. The interviews and the questions were not rushed. I really endeavoured to play a passive, non-intrusive role so each nurse was the focus of attention and could freely express him or herself.

I think it was advantageous that many of the nurses had previously met me either at conferences where I was presenting, during telephone consultations or during teleconferences. There was definitely a comfort level between the nurses and myself. I believe my previous interactions with the nurses facilitated sharing their stories with me.

Also, all of the nurses had knowledge of my previous 10-year history of working and living in First Nations communities in Ontario and Manitoba. I felt a shared mutual understanding with the nurses about my own community health nursing experiences in First Nations communities. I believe any shared understanding between us promoted honest, trusting and respectful dialogue.

Transcribing Data, Data Analysis and Interpretation

Interview transcripts can easily be flawed by mistakes in punctuation, difficulty in deciding where sentences should begin and end, transcribing wrong words, using quotation marks incorrectly and excluding comments about a nurse's tone of voice, a laugh, a pause or a momentary sigh (Poland, 2002). Transcriptions included nurses' pauses. However, it was left to me to ascertain punctuation, wording and comments about participants' tone and their emotions. There were times during the interviews when I asked nurses to take their time, slow down and not to rush because we had

plenty of time. I found nurses often spoke quickly when they became excited as if they had to share everything as quickly as possible before they lost the thought or the emotion that was rekindled when sharing the experience with me.

Also, it was incumbent on me to achieve a high level of detail in the quality of every transcription because every interview provided insight into how each subject was being discussed and not just what was being discussed (Poland, 2002). This became most relevant when I analyzed the data because I had to ensure accuracy and truth when interpreting every description. Mishler (1986) defines this whole process as a speech event or speech activities because it includes every aspect of the nurses' relationship with me, from the interview questions, the actual taped interview, the detailed transcription of the interview, the analysis and the interpretation of the data. The accuracy of all the transcripts was checked against the taped interview twice and every transcript included: laughs, pauses, ums, ahs and comments added by me that reflected the emotions being expressed, such as tearfulness or sighing (Polit & Hungler, 1999; Morse & Field, 1995).

In addition, Lincoln and Guba, cited in Polit and Hungler (1999), encourage member checking. This involved the process of providing feedback to nurses to determine the accuracy of my interpretations and the emerging themes. This was an opportunity for me to observe or listen carefully to nurses' responses and reactions. I was very surprised by the emotions nurses had when I performed member checking. Bea started to laugh when I confirmed the themes and findings with her and she added a few more comments. Kate became very quiet and sounded very emotional when she told me she had tears in her eyes because she thought the findings were so accurate.

Lincoln and Guba, cited in Polit and Hungler (1999), also suggest peer debriefing as a method of data analysis, which involves the participation of peers. I requested peer debriefing from a colleague.

Mishler (1986) suggests the, "analysis and interpretation of interviews are based on a theory of discourse and meaning" (p. 66). This means each speech event is an actual story that becomes the subject of analysis and interpretation. All of the nurses' stories communicated some sort of meaning and my role was to interpret the descriptions and identify themes that emerged during the analytic phase of the study.

Polit and Hungler (1999) suggest that data analysis and interpretation occur at the same time because it is impossible to separate one from the other, Sandelowski (1995) warns of being too hasty in analyzing data and reaching conclusions too early based on the researcher's personal and previous assumptions about the research topic. Furthermore, Sandelowski (1995) makes a distinction between data analysis and data interpretation where, " . . . analysis involves breaking the data up or down, interpreting involves making something new up or out of the data" (p. 372).

Although data analysis and interpretation of data are defined quite differently, a major challenge for me was to learn how long it takes to formulate emergent themes after constantly reading, re-reading and analyzing of the transcripts. The process took a few weeks; however, I was absolutely surprised when meaningful words and phrases started to emerge, and moreover, I thought it incredulous how the four themes emerged from the transcripts without me having to force the issue. Significantly, I now understand the need to patiently wait for themes to emerge; otherwise, the trustworthiness and

credibility of the research could be jeopardized. Moreover, I respect and see the need to follow a research process in order to produce credible research.

Sandelowski (1995) states the analysis of data is the first stage of categorizing the information into themes. Once I had thematically categorized the data, I sought advice for the next phase of the research process with my thesis committee. This is when I learned how to structure themes and collapse some of the sub-themes into findings that could be consecutively presented to reflect the ebb and flow of the findings.

Finally, the findings were presented to my thesis committee for final review, comments and feedback. The final stage of the process included a discussion of the research findings that emerged from the research study and submission of the thesis.

Summary

The painstaking efforts to plan the research method and design were invaluable in ensuring the integrity of this study. It was enlightening to find how the themes emerged during the analytical stage and how they slowly evolved with each read of the transcripts. Overall, the research process became its own journey of discovery.

CHAPTER IV

Findings

We are all visitors to this time, this place. We are just passing through. Our purpose here is to observe, to learn, to grow, to love... and then we return home.

Australian Aboriginal Proverb

Introduction

The findings in this study cannot be fully realized and understood in isolation of the participants' and student researcher's lived experiences and beliefs about spirituality. Significantly, the twelve community health nurses who self-selected to participate in this study actively cultivated and nurtured spirituality within themselves and furthermore, they realized the value of including spirituality both in their personal lives and their nursing practice.

This chapter will begin with a descriptive chart to show the demographic characteristics of the twelve participants and will then move into the four major themes that were formulated in the analytic phase of the study. The four major themes are presented as research findings: (a) spirituality influences nurses' ability to remain self-aware, open-minded and accepting in relation to others; (b) spirituality as a reflexive approach to grounding one's own nursing practice; (c) spiritual awareness fosters appreciation of the need for community healing, and finally (d) self-reflection and providing care spiritually as a route to reciprocal interaction.

In general, the nurses who participated in this study found it quite challenging to discuss their spirituality because it was woven into and seamlessly integrated into their lives and was not usually singled out. Therefore, they needed plenty of time to put their

thoughts, feelings and experiences into a dialogue that specifically described how spirituality shapes their nursing practice.

Initially, the nurses were asked to describe their own spirituality. For coherence and clarity, nurses' descriptions of spirituality are woven together within individual biographical summaries that elicit the first major theme identified in the study. This first theme identifies that "spirituality influences nurses' ability to remain self aware, open-minded and accepting in relation to others", and manifests in many different ways such as being receptive towards patients, not being judgemental, accepting patients in the current context of their lives and understanding the historical processes that have impacted First Nations patients' lives. Notably, these descriptions reflect how spirituality helps to shape nurses' practice while working in First Nations communities across B.C...

The second theme identifies "spirituality as a reflexive approach to grounding one's own nursing practice", as the nature of spirituality for the nurses in this study fosters careful self-reflection, examination and evaluation of their professional working life to identify, understand and recognize how the cumulative stress of community health nursing in First Nations communities necessitates self-care and self-healing in order to continue to provide quality patient care. Uniquely these nurses are incredibly self-actualized and spiritually grounded individuals in their personal life and in their professional working life. I feel extremely fortunate these nurses chose to participate in this study because their insight and wisdom into how spirituality shapes their nursing practice is something to be shared and learned by the nursing profession.

The third theme identifies how "spiritual awareness fosters appreciation of the need for community healing" as the nurses who participated in this study fully

understand the importance and meaning for First Nations communities, families and individuals to identify and reclaim their own culture and cultural identity as a healing path towards achieving health and wellness.

The fourth theme explores nurses' "self-reflection and providing care spiritually as a route to reciprocal interaction" as the nurses in this study are constantly aware to not harm patients in any way, to promote and maintain patient autonomy and to be self-directed, independent and self-governing.

The demographic characteristics of the twelve self-selected participants

Figure 4.1 Demographic characteristics of the participants.

	Participant Pseudonym	Age in years	Gender	Ethno-cultural background	Total years of nursing	Years of nursing in First Nations communities	Public Health Community Nursing (PHCN)[7] or Outpost (O/P)[8]
1	Bea	51	F	Euro-Canadian	9	6	PHCN
2	Dayna	26	F	First Nations	2	2	PHCN
3	Edie	59	F	Euro-Canadian	37	11	O/P
4	Esther	44	F	Euro-Canadian	20	20	PHCN
5	Gina	35	F	First Nations	10	4	PHCN
6	Hazel	39	F	Euro-Canadian	9	9	PHCN
7	Iris	59	F	Euro-Canadian	15	3	PHCN
8	Jen	32	F	Euro-Canadian	8	2	O/P
9	Kate	47	F	First Nations	11	8	PHCN
10	Lawrence	35	M	Euro-Canadian	9	9	O/P
11	Lily	37	F	First Nations	15	2	PHCN
12	Molly	47	F	First Nations	18	13	O/P

[7] In this study PHCN is defined as public health nursing in rural or remote First Nations communities in B.C..

[8] Outpost nurses in Canada are closely aligned to rural NPs. They provide services to the underserved northern remote areas and are expected to function as both primary care providers and advanced practice community nurses'. Outpost nurses practice in settings with no physician, no hospital, no pharmacist, no laboratory, and no radiology personnel. These individuals practice in remote areas where there are fly-in/out only services and the nearest hospital may be 2 to 4 hours flying time away (Goodyear, 2002). The designation of rural and small town Canada is used for those communities with core population of less than 10,000 that are located outside the larger urban centres of Canada (which are referred to as census metropolitan areas or census agglomerations), and "rural" as equivalent of rural and small town Canada based on geographic location (northern territories) or outpost or nursing station (Macleod, Kulig, Stewart, Pitlado, & Banks, 2004).

Summary of demographic table

The average age of participants was 34.2 years, and the median age was 41.5 years. The average total years in nursing was 19.3 years and the average number of years working in community health in First Nations communities was 7.33 years. There were five self-identified First Nations participants and seven Euro-Canadian participants in this study. Four community health nurses worked in outpost settings and eight community health nurses worked in public health settings.

Theme one: Spirituality influences nurses' ability to remain self-aware, open-minded and accepting in relation to others

For the nurses in this study their own spirituality enabled them to remain self-aware, open-minded and accepting in relation to others. This was an important finding, as these nurses were being culturally safe and were providing relational spiritual nursing care in order to protect patients and do no harm (Pesut & Thorne, 2007). Specifically, for these nurses their personal reflexivity helped to create meaning between themselves and their patients.

Bea

Bea is a 51-year-old Euro-Canadian woman who lives with her husband and young daughter. Bea also has a grown-up daughter who lives away from home. Bea has been a nurse for 9 years and has been working in First Nations communities for 6 years.

Until she was 5 years old, Bea lived with her grandmother and believes her grandmother shaped who she is today, providing her with a strong spiritual foundation.

Bea's grandmother gave her, " . . . my joyfulness and my sweetness because that's

how I feel". Bea explained how:

> My mom took me back and I didn't know who my mom was at that point because
>
> she had given me to my grandmother when I was a baby. [Up] to five years my
>
> world was pretty secure and there was a routine that felt safe and happy. And in
>
> that routine, there was also uh, my grandmother being a storyteller there was
>
> always uh [pause] stories of God. In any of her discussions at any point there
>
> would be a story about God in some way . . . . She had an open heart, she was
>
> very kind and all those kinds of elements and qualities, I mirrored those things.

Bea moved to a large inner city with a predominantly black population. Historically, this

was the era of the civil rights movement. Bea did not know why her world changed, but

she understood at five years of age that in order to survive, she had to make friends

with the black children in her class because they were now her world. She understood

and knew how they were all the same, "yet different". She recalls the first time she

touched the skin of a black girl in her class:

> I sat very close to this little girl, and I waited just until the right moment, and I took
>
> my finger and I rubbed her skin . . . . I held my hand close to my leg, and waited
>
> until I could get it all the way to my belly, and then I looked down . . . to see if
>
> there was any colour on my finger. I didn't know why they had colour. And I was
>
> wondering if it would come off. And I would look, and it didn't come off. And I
>
> thought, then that colour stays on them, right?

This specific experience was the beginning of Bea's spiritual journey of increasing self-awareness, open-mindedness and acceptance of others that had been initially nurtured by her grandmother. She had:

> Awakenings that I had to figure out on my own . . . that was the beginning of my journeys of learning that first of all that I was on my own, and if I was to survive, I had to be inquisitive, I had to be curious, I had to be open, and I had to learn where I was at, and how I was going to survive, and who was going to be my enemies and who was going to be allies. And what I learned in those years living in that community um, was self-awareness and openness, and my world grew by leaps and bounds because my experiences came rushing in and um, I learned that every experience that came my way held something that would help me if I paid attention.

Bea believes that "we're here together to help each other learn to respond to the things we discover by being open and honest" and is influenced by her spirituality as:

> A way of being versus being connected to a specific religion, so it's about a person or an individual, um having awareness of themselves, um seeking personal understanding of themselves and the world that they live in, taking responsibility of their own actions, thoughts, and values and always striving to go forward [sic] to reach to a higher place [and] seeking that, um element of being truthful, compassionate, honest, caring um, willing to uh step into places that might be painful for them but undoing that pain [and] to interact and be with the world.

Bea believes in God or a truer, higher self, yet she seeks to be grounded in "the [existential] present moment" that enables her to be physically, mentally, emotionally and spiritually present with patients without words as "words are not the most important thing that a person has . . . that you can still do those really caring actions without saying anything". Furthermore, she has learned to understand that "words can get in the way, you can still know what another person is doing and giving without that".

This particular example reflects how spirituality has helped to shape Bea's nursing practice as she has intuitively learned to understand that her relationship with patients is based on what Pesut and Thorne (2007) refer to as "reciprocal interaction", which they suggest is nursing practice that ensures patients well-being and does no harm. Essentially, Pesut and Thorne discuss how:

Relational reciprocity [is] based on a shared humanity [where] effective care occurs to the extent that the nurse can listen and understand to and understand the spiritual worldview of another, building bridges through common existential experiences. (p. 399)

Dayna

Dayna is a 26-year-old First Nations woman who has been a nurse for nearly 2 years. She lives and works in her own First Nations community in southern B.C. close to an urban centre. The only time Dayna has lived away from her community was to attend university to study nursing and to work in a tertiary care hospital as a newly registered nurse.

Dayna is married to a First Nations man from a more remote community much further north. Dayna has grown up in a family who practice traditional Native spiritual

ceremonies. She became aware of her own spirituality after the death of her grandfather:

> Realizing and sensing . . . by standing right there and touching and sensing that there was no energy left in that body . . . the explanation I was told was that the spirit is no longer there, that, that person is no longer there and the body is only the vehicle for the spirit.

Presently, Dayna's spirituality includes a deep self-awareness that we are all spiritually connected. Dayna explains this as a:

> Connection perhaps to a greater spirit or a greater being . . . a higher being, which I often refer to as um the Creator but . . . it's an interconnectedness with uh all things living in the world and the energy that we've all put together in the cycle of life and that connection with Mother Earth, the other side, where spirits flow after um they've left this world.

Dayna shared a patient's life/death experience that exemplifies her self-awareness, her open-mindedness and compassion towards patients. She explains that during a patient resuscitation:

> Maybe I'm doing compressions . . . I have to tell myself, you know, if it's your time to go it's OK, and trying to connect with the [patient's] spirit in a positive way so that I'm in a good place where, whatever the outcome maybe, ready to accept whatever happens and also allowing that person the freedom . . . . But I'm praying for them in my way, respecting them, um praying for myself so that I can be strong to help them in a good way.

Dayna generally believes that many nurses in different areas of nursing practice are "quite connected to that other side . . . [where] the energies are going back and forth especially between life and death".

Dayna first experienced the interconnection of all things when she was very young and attended spiritual gatherings, "um feeling a sense of that energy around you and um clueing in that it was a sensation and energy that you knew was something you didn't experience before". Dayna has learned that spiritual wisdom or "age wisdom" will happen over time and she will experience spirituality differently as she grows older.

Dayna's spirituality makes her very aware, open-minded and accepting of her patients as "there are so many different diverse traditional Native beliefs as well as um, um, new, newer, um introduced spiritual values". Dayna encourages patients to, " um discover their own spirituality whichever um, whichever type or sect that it may be to use it to the fullest to help themselves . . . [and] encouraging them to find their path". Dayna shared a nursing experience that reflects how her own spirituality nurtures her self-awareness, open-mindedness and acceptance of patients:

> So the staff . . . was talking about this First Nations girl who was faking these seizures and uh they couldn't figure out what to do with her . . . and everyone was saying this silly girl is faking seizures she's looking for attention. I thought there's a lot of problems in our communities and whose to say that she's not crying out for help . . . maybe this is a sign she's being abused or . . . she's crying for help maybe not for herself but for somebody else.

Dayna's non-judgemental and open-minded attitude towards this family's predicament helped her to further understand the family at a deeper level by considering the

historical context of the family's life. This approach contrasted to the rest of the staff who did not express a similar depth of insight and understanding.

Edie

Edie is a 59-year-old Euro-Canadian woman who has been a nurse for 37 years. She has grown-up children and is now a grandmother. She has worked in First Nations communities for 11 years.

Edie's spiritual journey began at the age of 5 years after her mother died. Edie did not elaborate on her mother's death, only that she became aware of the impermanence of life. She believes that her spiritual journey has been informed from the grief she experienced after losing her mother and later on in life she recognized a personal need to heal from the deep wound of losing her mother at such a young age. During childhood, Edie knew she had a universal consciousness and her experience of God was always loving and kind and her "expression of Christianity was non-violence and loving kindness".

Edie was brought up in the Presbyterian Church and although she received comfort in the words of Christ, she did not relate to the images of pain, suffering, Jesus on the cross and other such iconic references. Edie spent time reading the Bible and was also influenced by the works of Tolstoy and Carl Jung. In her early twenties, Edie studied Tibetan Buddhism:

> And had a clear light experience [that was] incredibly powerful and incredibly beautiful . . . . I could just see clearly, I understood emptiness, and I understood the ground of being and it was all uh, based in light and energy.

Since this time, Edie has been a practicing Buddhist and practices gentle yoga and meditation. Presently, Edie describes her spirituality as:

> My being in the world uh, spiritually um [thoughtful] manifesting soul in uh, through [thoughtful] my uh expression, um physically, uh emotionally, mentally um, and um, in movement and in actions um, expressions um, ideations, everything [pause] it's everything to me.

Edie's spiritual practice is embedded and inseparable from her personality and automatically shapes her nursing by helping her:

> To remain present um, and to express presence in all of my relationships, um to try to be attentive um to the quality of my communications and to um express love as best as I can . . . I mean, my whole practice is a spiritual practice . . . I believe that all, we are all healers. As nurses we are all healers and it behooves us to remember this, it behooves us to remember that we share sacred space, we share sacred relationships with all of our patients . . . and with all of our colleagues.

Edie's openness, self-awareness and non-judgemental attitude are reflected in how she equalizes the nurse/patient relationship by acknowledging the nurse and patient are both healers and that the "four principles" apply to each and every individual:

> We are healers and um we teach it [pause] . . . . That's what I teach to my patients, you know, that we are all healers. You know the four principles. When I'm teaching a class um, I'll go um [pause], the first principle is you are what you eat. The second, you are what you believe. The third, we are all magnificent beings of energy um, swimming and interacting and dancing in an ocean of

energy that we share with all others [pause] all other beings. The fourth

principle, we are all healers, right? So those, so those are what I try to, to teach

all the time. The last time I did, uh class was a [pause], it was a pre-natal class

actually. The time before that was um teaching a stress um, stress management

skills it was a relaxation class [laughs].

Esther

Esther is a 44-year-old Euro-Canadian woman who is married with one child.

She has been a nurse for 20 years. She initially worked in a hospital and periodically

contracted to work in a First Nations community. She has now worked full time for 10

years in the same First Nations community plus, she also works for the local health

authority. Every couple of years she needs to leave the First Nations community to have

a mental health break for a short while and later returns feeling refreshed, invigorated

and healed from the stress of working with First Nations peoples.

Esther does not believe the following incident was a spiritual experience as she

describes her initial reaction when she first went to work in a First Nations community.

However, it was to become a pivotal moment of personal realization in her life:

I can remember, you know, looking at their lifestyle and their family unit and the

housing, I think that's really, you know, an apparent thing you can look at

and see, and the housing wasn't good where I was. And I can remember

thinking, you know there's more to life than the white picket fence and the house,

and the 2 car garage and the 2.3 children and getting married . . . whose to say

that's the way life should be, and you know, maybe this, maybe this is the way

life should be . . . I just can remember going through a real uh [pause]

thinking and reflective sort of stage that first year.

This moment of realization was the key trigger for her to begin reflecting upon her own

spirituality, cultural beliefs and values. Esther freely admits she does not know whether

spirituality extends beyond this life and she does not have any words to describe it.

However, Esther acknowledges and believes, "something beyond this life, this self, and

the experiences we have on this Earth are given to us from a higher power for our, for

our own learning".

Esther was baptized, confirmed and married in the Catholic Church, and

although she still believes in her faith she does not currently practice Catholicism

because she believes spirituality has a "bigger picture" that excludes attending a

"specific church on a specific day". Esther described:

. . . that bigger picture to me means that you accept other cultures for their

beliefs. You know, who's to say that my God isn't another culture's Buddha, is

another culture's creator . . . perhaps those words are just given a different label

for each culture to make it meaningful for that specific culture. Um, so, my

spirituality right now is . . . not really defined within an organized institution.

Esther's open-mindedness helps her to be non-judgemental and to develop open,

trusting and meaningful relationships with her patients. Esther believes it is the meaning

behind a task that makes it a caring relationship. When giving immunizations to a 2-

month-old baby, the mother, who was emotional and tearful, turned to Esther and said,

"Oh Esther you are so good at your job". Esther explains, "It wasn't like, uh here let's

just give these needles and get it over with, there was more depth and breadth to it all".

Later, I contacted Esther to review the findings of the study. Esther listened carefully and told me she thought the findings were accurate. Esther did not want to add anything more. Esther explains, "I can accept people for where they're at and what they believe in, it doesn't mean I have to agree, I can accept them for that's what they're doing or that's what they believe". This comment is powerful as it reflects how Esther 's spirituality helps to shape her nursing practice as she insightfully realizes the significance of not intruding or judging her patients against her own values and beliefs, and furthermore she naturally understands the need for reciprocal interaction with patients and to do no harm.

Gina

Gina is a 35-year-old First Nations woman who has been a nurse for 10 years. She has worked in First Nations communities for nearly 4 years. Gina is married with two children. She is a Christian and attends her church regularly.

Gina's interview unfolded quite differently than any of the other interviews. Overall, there was less discussion during her interview and no examples of how spirituality shapes her nursing practice. Nevertheless, Gina shared incredibly rich and meaningful thoughts about her own spirituality that reflect its significance in her nursing practise.

Significantly, Gina talked about her spirituality in an uncomplicated manner. She explained to me:

Everybody is connected and everybody has a place. I think you realize where your place is . . . [and] it's connected to who you are and [sic] connected to the people around you".

Furthermore, Gina expressed how she is always the "same soul" inside, irrespective of her various roles as a nurse, mother and wife. Given Gina's various roles and responsibilities in life, I asked whether her own spirituality could fit beneath one big umbrella. Gina told me "it is the umbrella". The umbrella is a metaphor for Gina's spirituality and symbolizes how her spirituality infuses every part of her life.

In addition, Gina told me, "caring is just part of what you do . . . and spirituality is the essence of what you do". Gina summarized her spirituality quite simply by telling me, "I had a minister and he didn't care if you were out hugging a tree, it was about your relationships and your connectedness".

Hazel

Hazel is a 39-year-old woman and has been a nurse for 9 years. Hazel is married with two children. Hazel has been brought up in the Lutheran faith and finds great comfort in praying and talking to God. In times of stress she calls on her "higher power" to help guide her and provide her with the tools she needs to get through the crisis. Her faith helps her to stay positive in life. For Hazel, her God is a person and so is Jesus, and both are always present for Hazel to talk to and ask for help and guidance. Hazel's spirituality originates from her deep commitment to her faith and God, and her religious beliefs and practices extend beyond the walls of her Lutheran Church.

Hazel has been a nurse in a First Nations community for 3 years, and she recognizes her views about spirituality are changing. Taking time to talk to God heightens her own self-awareness and also helps her to solve problems in her working life. Her own relational spirituality helps her to be open-minded and to embrace many aspects of First Nations culture and spirituality. She experiences First Nations

spirituality in the community where she is currently working. "If your spirituality is based on religion um, like don't feel offended if you're in a situation where they're talking about their own spirituality because it's a lot different." Hazel's work deeply enriches her life. As Hazel explains, "I was brought up with you know [sic] the certain things that I do. I don't want to cause any harm to anyone and that's part of my spirituality, and I want to help people". Hazel's provides an example of how her faith and spirituality help her to be accepting and open-minded in her practice:

> Well it helps me stay in the position I'm in um daily [pause]. I'm going through
> different uh, different things that go on at work, in clients, if they're diagnosed
> with something. If I need to help out with kids at the alternate school and
> teaching um, I need to pull together and be strong and talk about different things
> um [pause], I have to be strong for people in a crisis situation and have just been
> diagnosed with say Hepatitis C or something like that, and I have to be able to
> talk with them and help keep them positive too. And so I need to know about how
> they feel about spirituality to help guide them, you know, so they will remain
> positive with even if they have a diagnosis of Hepatitis C, they need to stay
> positive, and what have they've done in the past to help keep them positive. And
> a lot of times it is spiritual work that does keep people focused and positive and
> in the First Nations community and I've learned that [pause], and probably
> always done but just never known it [until the interview].

Iris

Iris is a 59-year-old Euro-Canadian woman who has been a nurse for 15 years. Iris worked in tertiary care hospitals in Vancouver before moving back to a more rural

area. Away from the city, Iris worked part-time in First Nations communities for 2 years and has now been working full-time for 3 years.

When she was 2-years-old, Iris's mother passed away from a chronic illness that is treatable today. Iris went to live with her much older sister who raised her and was deeply inspired by the values and beliefs of her brother-in-law, an atheist, who believed in the "wonder of life", the mountains and the natural world. Iris poignantly described this connection between the Earth and spirit:

He um...died 5 years ago . . . his boys took him to the top of one the local mountain's here that he had climbed 89 times and they put his ashes on top of the mountain so he would have climbed it 90 times and when I fly over . . . I look up, you know [pause], and I feel his [pause] um presence. I feel that he is still with us in someway.

Iris was brought up in the Anglican faith; however, she "never really liked or believed in Christianity. I think Jesus was probably a wonderful man, but, I, I don't believe he was a Son of God". When Iris was sitting in church, she would rather be on the ski slopes. She was brought up with "the virtues and values" of the Ten Commandments and so she never really felt the need for the church's influence, and she did not accept the idea that she would be punished by God or go to Hell if she did not follow Christian expectations.

Iris first became truly aware of her own spirituality after the birth of her first baby and sensed the wonder of life itself. Iris is now a grandmother.

Presently, Iris believes in the Creator and many First Nations traditional beliefs. She finds a dichotomy in, "First Nations spirituality, where they can live with a strong

sense of Catholicism yet still believe in the Creator, um I don't, I don't believe in Catholicism [pause] and that's a real challenge for me".

Iris believes spirituality includes:

Some sort of spiritual um, not a being but an essence I guess, that has some control or has had in the beginning some control over life um, all life [emphasize] and that we are all, all of us who live in this Earth has a right to be here . . .

Iris includes all living things in this last statement and believes we all need to share the same world. Significantly, there is an understanding that we are all connected and responsible for one another and all life and must do no harm. Iris states, "I feel a responsibility um, to care for Earth to care for life in its different forms".

In her nursing practice Iris believes, "I think it's really important we remain non-judgemental but still be able to have our own beliefs, and um being a good non-judgmental caring person, and that's very much part of nursing". In addition, her openness and acceptance towards her patients has been:

Influenced by um First Nations beliefs and the Creator, which um suits me. I think people, including me, who become nurses um [pause] have to be caring people in that, if we didn't um have those values of wanting to be able to help and influence people to be well in the four quadrants, emotionally, physically, mentally and um spirituality um especially in First Nations . . . um nursing.

Iris' spiritual belief in being connected to other people is reflected in her relationships with particular patients. She describes her friendship with an Elder:

He was really special, I would take him out for lunch and he ended up with throat cancer and…um…died last week, so it was…that was a really hard one for me

[sounds very upset and tearful], and being in the arbour and having the funeral service, you know facing the mountains where my brother-in-law is at the top of and um, yeah just the feelings of emotion of, of who, and how our, our lives are controlled and why does one person get cancer and the other not.

Jen

Jen is a 32-year-old Euro-Canadian woman who has been a nurse for 8 years. Jen worked for 5 years in a tertiary care hospital, on an acute care ward, nursing HIV/AIDS patients. Jen has worked in First Nations communities on a contract basis for 2 years. In-between these contracts, Jen works as a nurse for international humanitarian non-governmental organizations (NGOs) in developing countries.

In her childhood, Jen was a Christian and felt quite strongly about Jesus. During her teenage years she began to question the conventions of Christianity. When she was 18-years-old she was travelling in Asia and for some inexplicable reason she stopped to watch a man "out on the field, and he was ploughing the field and he was by himself, and there was nothing and nobody around, and for some reason that image made me leave Christianity completely". Jen explains that in a fleeting moment she realized this man, with no knowledge of Christianity and who did not have an equal opportunity to learn about Christianity, would according to Christian doctrine be punished for it. This was a profoundly life changing moment in Jen's life.

Shortly thereafter, Jen spent time in a Buddhist monastery where she learned about a "universal truth" that made perfect sense to her. Other people from different areas of the world also felt the same way as Jen about what they were all learning in the

monastery. Jen is a now a practicing Buddhist and contemplation and meditation are part of her spiritual practice.

Jen believes that spirituality is about "being one's self" and exceeds "the material things in life, the day-to-day activities and objects". She believes spirituality "can have to do with um God or a greater power but it doesn't have to". Her own spirituality is expressed in her compassion for others and "to let go of her own ego".

Jen decided to become a nurse because she felt a spiritual calling and wanted to do something valuable in life and "nursing is an expression of my spirituality" and compassion for other people. She listens to patients without distraction and is fully present with all patients, such as sitting quietly with the dying to create a comfortable and peaceful environment to "move from life into death". This is an example of how Jen's own spiritual self-awareness shapes her nursing practice as she intuitively understands how reciprocal interaction supports her patient's autonomy even at the end of his or her life.

Jen's self-awareness, her openness and acceptance are reflected in the following experience where two patients who were contemplating suicide came to the clinic for help. Jen's innate understanding of relational spirituality supported these at risk patients by "just keeping in touch with them . . . offering the opportunity to talk, making a connection with that person [because] I honestly really felt compassion for them."

Kate

Kate is a 47-year-old First Nations woman who has been a nurse for 14 years. Prior to moving to B.C., she lived in a First Nations community elsewhere for 11 years. Kate is married with children.

Kate has always found great comfort in prayer. During her childhood she attended a Catholic school; however, her parents removed her early on from the school after she experienced racial comments about her "Nativeness". Kate described a school experience, "I would come home, I would say to my parents, you know they say we're sinners because we're born sinners, we're going to go to Hell you know because you guys are doing this or doing that". When Kate was 5 or 6 years old:

> Like somebody had called me a savage, and I came home and I asked my parents, like so what did they mean? There was a nun who stuck her nails in my head and said [Kate's voice becoming curt and harsh] 'you're gonna have to try extra hard if you're gonna learn this stuff', so I didn't know that I was Native until I went to the school and then had these experiences, called these names, and then went home and told my parents.

Since this time, Kate has questioned Christianity being so judgmental and punishing, especially the idea that we are all born sinners and all sinners go to Hell. Presently, Kate is well-read in Buddhism and other Eastern practices, although her spiritual strength comes from her deep connection with her "Native culture, rituals, stories and beliefs". Kate believes in the Creator. She has reverence and respect for herself, for life and the cycles of life for both humans and animals and believes in the natural laws of cause and effect.

Kate prays at the beginning and at the end of her day to give thanks and gratitude. She practices smudging, attends sweat lodges and performs spiritually cleansing rituals, which help her to reconnect with her own spiritual core. Kate often

feels the love and presence of her spirit guides, her "Grandmothers" who are very close to her and guide her through life.

At an emotional level Kate's spirituality involves finding "hope". She rhetorically asks, "Where do I find hope? What debates me to go beyond . . . [during] very challenging types of times, or people or places? That's the feeling inside, like I feel hopeful". Kate spends time contemplating the meaning of spirituality in her life and how "it effect the decisions I make. How does it influence the ethical issues that come across my path, in my work and in my private life?"

Kate's spirituality includes respect for herself and all her relationships " . . . with my family, my friends, my extended family, the people I work with [my spirituality] it's a reciprocal type of relationship". She believes in the reciprocity of her relationships, that is, being actively engaged with others in order to receive the benefits. This reciprocity extends to the Creator, her belief in nature and the "natural laws of cause and effect".

Kate defines spirituality, "as a reverence for life and um, the cycles of life in different forms like human and animals . . . and just respecting um, those cycles [that] [sic] they're different for everything—everybody". Kate describes respect as a reverence for the "cycles of life in their different forms they're different for everything and everybody".

In this study, the concept of respect is very much associated with these nurses' spiritual beliefs and values, and as Kate describes, the concept of respect consciously helps to shape her practice. Browne (1995) defines respect as:

> A basic moral principle and human right that is accountable to the values of
>
> human dignity, worthiness, uniqueness of persons and self determination . . . the

unconditional acceptance, recognition and acknowledgment of others in

relation to the values of dignity, worthiness, uniqueness and self-determination

for all people. (p. 213)

Significantly, the definition of respect by Browne includes being "accountable to the

values of human dignity" and "unconditional acceptance" of others that are implicit

values in the spiritual lives of the nurses who participated in this study, and help to

shape their nursing practice at a basic level of humanity.

Lawrence

Lawrence is a 35-year-old Euro-Canadian man who has been a nurse for 9

years. Lawrence has always practiced as a nurse in First Nations communities.

Lawrence's family is not religious. However, from 5-15 years of age he attended

church every Sunday and depending on which friend he was with at the time, he would

attend their affiliated church whether it was Presbyterian, Pentecostal or United. As a

teenager, Lawrence attended a Catholic high school and became disillusioned with

religion. He shares his thoughts about his disillusionment with Christianity:

There's a lot of hypocrisy in the church. I could see where it served itself, and I

could see where um, where certain moral teachings were just conventions, social

conventions which weren't actually absolute, but rather ways of um, ye know,

maybe making a society function and stuff. And so I didn't want to be bound by

those things, and so I kind of tried, I basically let go of, of that kind of religious

feeling.

In his early twenties he went backpacking to "explore the world" and in India he chose to

attend a 10-day silent meditative Buddhist retreat. The experience was profound.

Lawrence found it personally meaningful right from the start and since then,

Buddhism has become Lawrence's spiritual path in life. He is a practicing Buddhist and

a few years ago he spent 1 year living in a Buddhist monastery.

Although Lawrence finds it hard to describe his spirituality, he is able to express it

in terms of what is personally meaningful to him. Through the practice of meditation he

is able to:

> Contact that [spiritual] space . . . "it's not a physical space, it's a kind of space in
>
> a way [where he can] get in touch with something that is beyond um [pause] my
>
> personal melodrama, my personal stories . . . it's so much larger . . . it's not
>
> geographic, and it's not something I can define but it feels so much larger than
>
> my personality and than my physical body, and my, my thoughts and my
>
> emotions and my [thoughtful] my, the daily events in my life.

Lawrence's spirituality and meditative practice helps him to be mindful, fully present in

his relationships, to actively listen and to remind himself, "may I harm no one today".

This example reflects how Pesut and Thorne's (2007) model of reciprocal interaction

would fit nursing practice situations.

Lawrence describes his "nursing role as . . . the modern version of a healer in the

past" because his own relational spirituality is infused with all his patient interactions.

Lawrence provides therapeutic touch to clients, which is a non-verbal exercise, "it's

more related to spirituality in a way, while I'm doing it I don't speak to them, to me

feeling energy is like feeling something physical but it's more subtle than a physical

sensation it's more of an energetic sensation".

Lily

Lily is a 37-year-old First Nations woman who has been a nurse for 15 years. She is married with one child. Lily grew up in another province of Canada. She was raised in the Catholic faith and finds it very easy to integrate Catholicism with First Nations spirituality. Lily has lived in a First Nations community for 2 years and feels reconnected with her culture and spirituality. When Lily thinks about spirituality she does not just think about religion because she believes spirituality is integral to the First Nations communities and the belief in the Creator. Lily believes very much in being connected with the land, Mother Earth, all animals and everything around her. Prayer is significant to Lily because prayers are said before meetings and before meals. Lily has spiritual messengers in her life. Significantly, her messengers are birds that come to her. For example, a little red bird came to tell her of her grandmothers passing. Lily describes learning of her grandmother's death from a messenger:

It was a beautiful sunny day and there's a beautiful bird just singing, and uh I looked up and I said, aah what a beautiful, beautiful red bird I've never seen . . . I've never seen again, but that was her visiting because when I went inside, I got the call she had passed away.

Lily's excitement and joy about expressing her own spirituality was very present during the interview. Her exuberance came across when she stated that, "spirituality is just my whole being, it's everything that shapes my work, my home life, um, everything, you know, [breathing] breathe". This comment is extremely powerful because Lily's spirituality is expressed as a life-giving force because the very unconscious or conscious act of breathing gives us all life on Earth. Essentially, Lily's spirituality is the

life force synonymous with each breath that she takes and connects her with everyone and everything surrounding her.

Molly

Molly is a 47-year-old First Nations woman who has been a nurse for 18 years. Molly has lived and worked in First Nations communities for 13 years. Molly is married with children. Molly is a natural storyteller. As a child she spent time with her great-grandmother "Granny Dirty Lake", who taught Molly many Native traditions, values and stories. Granny Dirty Lake was never indoctrinated into Catholicism, which was very unusual at that time. Fortunately, Granny Dirty Lake lived well into her nineties and was able to give Molly her own great-grandmother's name.

Molly, who is First Nations, recalls a conversation with her great grandmother, Granny Dirty Lake:

> She was probably one of the little old ladies that was very, very unusual for a First Nations in her era to not have been indoctrinated into this Roman Catholic religion, and um, they didn't even bury her in the cemetery, they buried her outside of the cemetery because she wasn't a Roman Catholic and she wouldn't participate and go to church.

When Molly was old enough she asked her great-grandmother why she did not attend church and Granny Dirty Lake told her:

> They said it was a house for sinners. People just go there on Sunday and say you're going to be forgiven your sin, and then you do that sin again and again and again, and that just becomes an excuse for you to sin because someone is

going to look on you and say God has forgiven you. No, God looks at you every single day.

Molly was brought up in the Catholic faith and although she is well grounded in her own First Nation traditions and spirituality, her children are baptized. Her sister told Molly she "would appease her Christian sensibilities" and agreed to have her own children baptized in the Long House. Molly balances her Catholic upbringing with her knowledge and wisdom of her First Nations spirituality.

Molly is from a First Nations people who continued their sacred ceremonies and traditions after they had been outlawed in the early 1900s. Her First Nations people took their practices underground and have never since allowed a non-First Nations person the privilege of witnessing or attending certain sacred traditions and ceremonies. In Molly's culture, there is no clan system and an individual has his or her own spirit that is not conceptualized as God or the Creator. The Creator created the environment; however, a person is joined with his or her own spirit "that helps you, that looks after you, that takes care of you". Molly believes that, "feelings of spirituality come as the older you become" and that life experiences will impact on the way a person interacts with another. For Molly, she was always afraid of clients who were dying and it was not until she had her own child and had a near-death experience from a post-partum haemorrhage that her question about death and dying, "the deepest rooted question about my own spirituality" was answered. As she was dying and in great pain, she saw a door opening and it was "the whitest white I've ever seen" and a human form came towards her and picked her up and her suffering immediately ended. The birth of her child was an amazing experience and yet:

The experience of that person carrying me was a greater joy . . . to believe,
to end that suffering, who was there for me, answered the deepest-rooted
question about my own spirituality . . . you're never alone, death is not
necessarily about you dying your last breath, you can have death in small little
doses.

Significantly, Molly's near-death experience has become grounded in her teachings of
spirituality because she believes that when people are suffering they are "never alone".

Perspective of the researcher

I am the student researcher in this study and it has been necessary to place
myself within the findings chapter for the reader to understand the context of my own
life. To add to the trustworthiness of the research process it is relevant for me to
describe some of my lived experiences because they have shaped who I am today and
have influenced why I have chosen to undertake this research study and ask the
research questions.

It is my responsibility to recognize when my subjectivity creeps into the study
because I need to be as accountable as possible, and where possible, "objective" in
relation to the research process. I am a Euro-Canadian woman from the United
Kingdom, and I have been a nurse for nearly 28 years. I am married and do not have
children. I have worked in First Nations health for 18 years and I lived and worked in
First Nations communities for 10 years from 1990-2000.

My mother converted to Catholicism when she was 20 years of age and brought
my two sisters and me up in the Catholic faith. During the early 1960s, my family lived in
Singapore for over 3 years, which was an incredible, multi-cultural experience for me at

such a young age. A few years ago someone asked me what my mother's legacy would be for me. I feel fortunate my mother brought me up to be open and accepting of other people's cultures.

During my teenage years, I occasionally went to church on Sunday; however, during my late teens and twenties, I felt very much alone in my life and I thought God had abandoned me. In 1989, I left England and moved to north-western Ontario to work as a community health nurse in a remote First Nations community with fly-in access only. This decision changed my whole life forever. Living and working in First Nations communities has been extremely meaningful for me personally because I became spiritually awakened and conscious of the natural world around me. The northern wilderness awakened my senses to God and all creation. I felt truly alive and connected with nature and also with some of the First Nations people whom I worked with. My consciousness opened up to a universal truth that all life is connected and we are all part of the natural world and the universe.

I have learned from many First Nations people that listening is part of my spirituality. Listening engages my senses to feel connected to the natural world or to patients. I have learned to listen with my heart and my mind, to listen to what is being spoken and what is not being spoken. Listening helps me to be fully present with my patients in my nursing practice, and I believe it is part of the ineffable or indescribable part of trying to conceptualize spirituality because it must be lived and experienced.

My own lived experience of how spirituality shapes my nursing practice while working in First Nations communities has inspired me to ask the research question as to whether other community health nurses' spirituality helps to shape their nursing

practice. My nursing experiences and reflexivity have helped to shape my own interpretive lens and also my analytical perspectives within this study.

Summary of theme one

Many of the nurses who participated in this study experienced a personal spiritual awakening quite early in life. Specifically, they encountered a personal birth or death experience that somehow translated into a pivotal moment of realization concerning the impermanence of life. These nurses acknowledge and understand there is a deep spiritual significance to birth and death, and it is this sensitivity and compassion they bring to their nursing practice when they are dealing with human joy or human tragedy.

For many nurses who participated in this study, their nursing practice is influenced by Eastern spiritual philosophy and Indigenous thought, which may or may not be influenced or blended with Western Christianity. Such a broad knowledge of spirituality helped these nurses understand that patients' health and wellness may often have a spiritual component and so they are able to recognize and proactively address these issues with their patients.

As was evident in the nurses' interviews, their spirituality nurtured personal values such as doing no harm, being fully present and connected with patients, and allowed them to develop meaningful, caring and respectful relationships, which is in keeping with Pesut and Thorne's (2007) model of reciprocal interaction based on relational spirituality. These nurses talked about being a "better person", "in the moment" and "strong for people in crisis" because they believe in the interconnected, spiritual dimension of all people irrespective of cultural differences. It is their spirituality

that has nurtured these human qualities and shaped their nursing practice in First Nations communities where they work.

Theme two: Spirituality as a reflexive approach to grounding one's own nursing practice

In this study, nurses' relational spirituality has heightened their personal level of sensitivity and compassion towards their patients. According to Ekman (2007) such intense "emotional reflection or resonance" cannot be realistically sustained over a very long period of time without creating excessive personal stress and eventual "burn out". Significantly, the nurses who participated in this study have found a way to reduce their own personal stress and to prevent burn out by using their own spirituality as a reflexive tool to help ground their nursing practice in First Nations communities. Dayna addresses her own personal well-being by "doing that regular maintenance" and reflexivity:

In times of hardship, whether it's a difficult time at work, or a difficult time at home, whether it's a personal issue I may be dealing with . . . we get so busy in the rat race of life that quite often spirituality gets left behind when it's probably the most important thing that we should stay connected to.

Also, Dayna believes in the balance of mind, body and spirit. She said, "If we're ailing in any of those areas, for example, if our spirit energy is low, that will be reflected in our physical health". Dayna understands the complexity of living and working in a rural First Nations community can personally effect her own health: "there's a lot of dysfunction and a lot of problems in our communities that I have internalized", and her own personal suffering is alleviated with the strengths within her own family, where the "traditional

values that are still intact: togetherness, and family, and cohesion of community, connectedness, sharing a meal together with your larger family and community".

Dayna's own personal suffering as a First Nations woman, and the suffering of community members is acknowledged by "dropping everything if there is a death, and um everyone should go um, giving selflessly um giving money, giving food, giving your time, giving time to make food, and giving time to be with". Perhaps cultural, collective sharing and coming together as a family and community during times of suffering is also a collective recognition of the need for First Nations peoples to heal from historical colonial processes together.

Lawrence described his own personal suffering and stress as "dissatisfaction" with his daily routine where "the hardened and fixed self views [which have] a quality of tightness and inflexibility" are dissolved through meditation to find healing, "in my [his] personal sense that it feels calm, it feels peaceful, it feels whole". Once Lawrence has regained his sense of calmness and peace his nursing practice can once again be completely focused and attentive, and to "listen" to patients without being distracted.

Edie believes that relationships are spiritual and have the highest value. For Edie her own spirituality is a "nourishing practice" that helps her to "identify uh, and uh find and take in nourishment in Hell". She explained "in situations where, uh tremendous suffering is, uh arising or being disclosed [by patients], um the heart sharing again allows us to, uh nourish each other, and allows me to receive nourishment". For example, Edie shared a story about an Elder who visited the clinic:

Oh, a woman came in to the clinic . . . an Elder, and she had just, she was ill, she was physically ill, she was feeling nauseated, um, vague kind of symptoms and

obviously in tremendously distress, and when we talked . . . but when we talked, um, she had just um, had a memory from residential school of uh, sexual abuse, and um, she described it to me, and she was so distressed and feeling so um, traumatized to me, you know, she was feeling as though, so uh, little, she's feeling like a frightened little girl again [pause] she, I heard, I heard what she had to say and um when the doctor came in she also told him the story and he wanted to bring her in and analyze it . . . and then when he left she was so upset and I said to her, it just came through me, "you know your spirit, your soul only gives you um, only allows you to see what you're strong enough to see", *and* she looked at me out of the corner of her eye and said, is that true? [Laughs]. Yes, I can tell you, I can absolutely guarantee you that from the very, very, my very heart, yes this is true [laughs]. I said that I would um hold her in prayer, and uh she went off.

Kate described her work as very demanding and the environment as challenging. She described how she takes care of herself:

Everyday I start my day with a prayer of gratitude and everyday I end my day with a prayer of gratitude. But within that um day, like I said I have that thread, right? That thread, that invisible thread. When I move out of, my um, my sense of hope, love, respect, reverence- - when I lose them, that core, then I have to recheck back in and sometimes it's really [sic] it's happened over a period of days, weeks, and months and I actually have to go and get spiritual counselling or I go and I have to go have a sweat or like an immediate fix for me would be

like a smudging and that kind of cleansing the rituals of reconnecting with my

spiritual core.

Moreover, Kate's spiritual guides, her grandmothers, support her during times of stress

and personal suffering. Her spiritual guides provide energy, support and help her to

"engage" at a deeper level within herself, and then with her patients.

I contacted Kate much later to discuss the findings of the study with her.

Specifically, I told her how the nurses in the study recognized the need to look after

themselves through meditative practice and contemplation. Then I described how self-

healing in turn helps nurses to be more mindful and aware of patients, and furthermore,

nurses are better able to care for patients, be compassionate, and better able to

express deep affection or love for patients. At the other end of the telephone, Kate

became very quiet and told me she had tears welling in her eyes because she thought

the findings were true and accurate.

For the nurses who participated in this study, self-healing can take different

forms. Molly shared a story of a critical incident that happened in her community:

I had a gentleman he had 8000 tons of metal hitting on him on the hip, um, spinal

cord injury and major trauma, major organs damaged. He came in, he had

shortness of breath but I knew he had internally bleeding. When he first came in,

the pain, and he looked at me and I said, "Do you have family and where are

they?" And he says, "My wallet is somewhere here", and I said, "I'll make sure

that I get hold of [your wife]". "Will you tell her I'm OK? Will you tell her I'm OK?"

And I said, "Sure, I will tell her you're OK", " Will you tell her I'm not in any pain?

Will you tell them I'm OK? And he became unconscious 7-8 minutes later, and he

was [transferred] out . . . he had emergency surgery there but he died from massive internal injuries.

I struggled with this. We got a thank you letter from the family. I wanted to respond and um, it was later- - a celebration of the day for the people that died in the workplace . . . . Our staff got together and I said I would like to remember all our patients who died in the workplace, who died in our community. He had a wife, 3 sons and um . . . in remembrance of this man I decided I would write a letter. As a staff, we collectively as a group wrote a letter to the wife . . . . And we're returning to you out of respect because our cultural beliefs that any clothing that the person wore at the time that they die is sacred, so I'm returning his work gloves to you, and not to be trite his work gloves to me, they show his hard work and dedication. And I wanted you to know that in the last few minutes of his life his first concern was his wife and his 3 sons, and that I phoned to tell you not to worry about him. And the only thing that I wanted to add was that I wanted you to know that I could visually see that he was breathless before he was in an unconscious state [and] I never saw any outward signs of severe pain. So I hope that's a comfort. I hope that you can appreciate the returning of the pair of work gloves and it's an important part of our culture and we're doing it out of respect. So we sent that letter, we actually sent it with a staff member to hand deliver it to her . . . She phoned me at 11 o'clock at night, she said she read the letter but she just wanted to talk to me about it . . . . We see things that aren't always beautiful, glamorous or wonderful. We deal with some issues that are very painful but you know it was interesting, the staff, you know, the response was we did

absolutely everything we could and we preserved his dignity as much as we

could, if you could say that such a grotesque accident was a peaceful

experience?

Afterwards, Molly held a healing circle for the staff involved and each nurse had the

opportunity to speak about the "critical incident" that had taken place. Molly told me that

"we suffer in our own little holes [inside ourselves]" and each nurse needs the

opportunity to express his or her own thoughts and feelings about the stressful incident.

All Molly asked of the staff was to listen to each other and not to interrupt the healing

process taking place within the individual and communally.

The nurses who participated in this study have a critical level of reflexivity that is

fostered by their own spirituality, and provides them with a level of comfort and support

to help them to recover from any pain and sorrow they have personally acquired during

their nursing practice with patients who are experiencing great suffering in their lives.

Significantly, for these nurses, their spirituality helps them to acknowledge their own

emotional pain and personal suffering, and to actively seek out self-healing practices,

which will help them to reduce their personal stress and also helps them to maintain

their own health and wellness. For instance, Bea described the exact moment when she

knew she would leave hospital nursing because it was too stressful and demoralizing as

she did not have enough time to provide patient care to an Elder:

. . . someone else [was] bleeding in the next room . . . [and] the moment I knew

that I didn't have time to pick up an Elder's slipper who was trying to desperately

get her slipper on, and it was underneath the bed, and she was falling out of the

bed, and I had to say, I will be back in a moment.

The practice of contemplation and meditation

Contemplation and meditation are spiritual practices that help the nurses in this study to recover from excessive stress in the workplace. Lawrence meditates because it "helps me feel like um, I can get in touch with something that is beyond my personal drama" because he spends time on his own to focus on breathing and meditating, which helps to dissolve away his stress and quiet his mind. Edie described meditation as a breathing exercise that helps to relieve the daily stresses of life and work for herself and for everyone else who is experiencing the same feelings:

> I breathe in for everyone who's experiencing this same sensation at the moment on the planet, and I breathe out uh, for instance, I breathe out uh, spaciousness or good enough self, uh not inflated, not deflated, good enough . . . the breath consciousness really plays a part in my daily experience.

The beauty of Edie's description of her Buddhist meditative practice is that it guides her to be "good enough" and to be in a balanced state of mind, body and spirit.

Kate described contemplation as an opportunity to personally reflect on particular issues either at home or at work that are causing her stress:

> My emotions um, to me are a gauge as, um symptoms even overload intellectually, mentally. If any of those other realms are overtaking my life I go back, I go to spirituality to help me get back into check.

Notably, for the nurses who participated in this study, spiritual practices and beliefs have given them the strength and the courage to remain hopeful and to endure the very unpleasant side of their work. Bea's honesty is a reality check against the mythical image of a selfless nurse who is purely all giving:

> Spirituality is my job because it gives me that ability to approach it in a way that I wouldn't do if I only were working from a medical model, and it gives me the strength to endure and hold up with a bit of hope all the time. I would be flat lined from the stuff that I see and experience and see on a day-to-day basis . . . you wouldn't survive.

Jen is also honest about her reasons for being a nurse and does not try to 'sugar-coat' her thoughts and opinions:

> If you look at nursing as a job or a task none of them are very pleasant, you know, a lot of things aren't really very nice and I think, I think, I mean, I mean the pay isn't always good; the social prestige is not there to be a nurse. If I didn't see it as a spiritual task then I don't think it would hold too much. The other benefits to me are not that great it's more the ability to be able to care for people and to express that everyday basically.

Summary of theme two

Significantly, the findings in this theme identified these nurses were under no false illusions about the magnitude of stress and unglamorous aspects of nursing, and furthermore they realized how nursing exposed them to emotionally distressful situations that required personal self-care and healing in order to recover from stress and prevent burn-out. Remarkably, these nurses understood how the quality of their nursing practice is influenced by their own health and wellness in being able to provide the level of nursing care that they personally believe to be in accordance with their own values, beliefs and practice standards.

Theme three: Spiritual awareness fosters appreciation of the need for community healing

For the nurses who participated in this study their spirituality prompted them to be highly reflexive practitioners, and that was very beneficial in terms of them recognizing, appreciating and contributing to (if invited) community directed healing paths. For these nurses, relational spirituality and reciprocal interaction were so intuitively rooted within them that they implicitly understand the need for community healing from colonial processes. Moreover, in this study, First Nations healing becomes an extremely important theme as these nurses' stories reflected how the extent of their nursing practice role included supporting (not directing) First Nations individuals and communities on their chosen healing path to wellness to overcome the historical and colonial processes, which have created health disparities and inequities in their health compared to the general population (Adelson, 2005). For example, Hazel understood and acknowledged the great value in the use of traditional herbs and attends ceremonies and gatherings in the Long House where patients gather to heal.

Lily explained, "it's healing, but you know you have to focus on everything". Lily attended an education session where a health-care provider who works in the Downtown Eastside[9] (DTES) had no knowledge of First Nations children being taken away from their families and placed in residential schools. Specifically, the health care worker had little or no understanding of First Nations peoples who live in the DTES, who are HIV positive, or have AIDS or other addictions. Lily explained, "well how can you be treating any Aboriginal people in your job if you don't understand where they're coming

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[9] Downtown eastside is a demographic area in Vancouver, B.C. where many poor, homeless and marginalized people live, including many Aboriginal people.

from?" Lily continued, "a lot of them, down there on the Eastside maybe for other reasons are down there, but residential school is *huge* [italics added] and has probably impacted their life or their parents, and it goes down generations". As a First Nations woman herself, Lily has personal insight and understanding into how colonization and frequently abusive residential school experiences negatively impacted First Nations culture because so many traditional beliefs and values were banned and outlawed and replaced with Christian beliefs and values. Loss of cultural identity encompasses so many aspects of First Nations peoples' lives such as loss of language, loss of belief in the Creator, spiritual ceremonies and rituals, loss of traditional stories, myths legends, and loss of housing and lifestyle. Lily only spent the first 5 years of her life in a First Nations community. As a young woman she felt:

> Confused about her spirituality for a long time . . . I would say that it was only about maybe 25, when I really knew my spirituality and who I was um you know, being a Catholic, . . . and it probably took a death of a loved one [grandmother] to really figure that out.

The experience of her grandmother's death, as described in Lily's biography, helped to reconnect and reconfirm Lily's First Nations ancestral spirituality and her Nativeness.

The nurses who participated in this study understand their First Nations patients' health and wellness is not only determined by physical illness. They acknowledged health is also dependent upon patients' cultural background and personal history. Edie recognized how some Elders in her community have healed from the mental, emotional and physical trauma of attending residential school, "we are all equal and cherished and beloved and loving beings worthy of respect" as she described Elders who "have

integrated their residential experiences, for instance, and their pain and their um,

own life sufferings, and who are manifesting now as um, mature, uh spiritually mature

beings". Recently, a Coast Salish First Nations colleague shared with me that many

community members were so traumatized from their residential school experience they

have never left their First Nations community since (J. Nahanee, personal

communication, November 20, 2007).

Dayna was very conscious of how she approaches and talks to patients and

Elders in her community. She sees many of her patients as being "on a healing

journey", and she understands how crucial it is to establish a "rapport and a connection

with someone . . . invoking their personal story" and for patients to "feel comfortable

maybe just to trust me enough to take me into their lives as a health care provider". This

is a significant comment as it fits with Ramsden's (2002) trust moment that occurs

between a nurse and a patient and is a basic tenet of cultural safety. Any nurse,

whether First Nations or non-First Nations, cannot assume that patients will

automatically trust and listen to them based purely on their professional status. The

healing journey for many First Nations peoples begins with learning how to trust, and

this also extends to trusting the community health nurse. Dayna makes a powerful

statement by saying, "there's so many people with different kinds of experiences and

background, and disconnection or connection with their community and they're

massively huge". In reference to a young patient who was possibly faking seizures,

Dayna's highly reflexive practice helped her to recognize an alternative cultural healing

path for her patient. Dayna suggested, perhaps:

It was an illness of a spiritual nature . . . and of course I get the raised

eyebrows [from the rest of the staff] . . . . So I sat down with the family and did

sort of a spiritual assessment, something we're taught in school . . . . And I

learned from this family . . . they sensed that it may have been a spiritual illness

in nature . . . and they were very, very [emphasis] afraid to seek help or counsel

from the community . . . because Christianity was um forced in replacement of

their traditional spiritual beliefs . . . . And I said do you feel that um it may be an

illness of that kind of nature? And they said, we think so but we're scared to ask

for help because people might think that we're ridiculous or whatever . . . . I said,

you know those are my beliefs that I believe in [pause] but I'm not someone that

is able to do work of that nature . . . but I can be with, you know I can identify with

you with those feelings and maybe we can say a prayer together. So I offered a

prayer, we joined hands and said a prayer and wished for um, you know, just

prayed for them and their family to have strength at this difficult time.

Dayna's spiritual reflexivity shaped how she approached and performed her nursing

assessment of this family. She did not only think about the physical and mental aspects

of care for the patient and the family; she recognized the need to explore the situation

from a place of intercultural, relational spirituality and reciprocal interaction to ensure

culturally safe and appropriate nursing care.

Moreover, the nurses who participated in this study were very much aware of the

diverse beliefs among First Nations peoples in B.C. and were careful not to racially

define First Nations peoples through a homogeneous lens. Molly addressed this topic

when she stated, "an Indian is not an Indian OK, and so you have to recognize that, that

the Nation that I'm from is different from my experiences I have in other First

Nations communities". Molly continued that in her Nation everyone has their " . . . own

personal spirit, but no, not the Creator. We don't have the concept of God directly so

ours is a little different that way". In addition, Molly's own Nation does not have a

matriarchal clan system in place.

In Hazel's community, she understood and acknowledged the great value in the

use of traditional herbs and attends ceremonies and gatherings in the Long House

where patients gather to heal. Hazel believed in the value of learning all about her

patients because it then helped her provide culturally relevant and appropriate care.

Healing occurs at many levels—healing of the individual, healing as a community

member and healing of the community. For example, Jen described what happened at a

community feast where a man stood up in front of whole community. "He apologized to

the Elders" who, "one-by-one stood up, and gave him advice and told him what they

felt". The man stood up and faced up to three hundred people and he sobbed. Jen

described how, "they walked passed him in a row and, and gave him a hug, or shook

his hand, or said something to him, and this was the community's way of helping him

and it was amazing". According to Jen, this individual's healing journey required, "an

expression of accord and love and forgiveness" from his community members. Thus,

Jen's own spiritual awareness, her personal openness and acceptance of other people

helped her to understand how the context of this man's healing necessitated the

inclusion of his community being part of his healing journey.

Bea described healing in the form of a "unity ride" with the participation of all First

Nations communities in her region. Everyone met at an old mission school where a

"huge healing ceremony" included everyone who chose to participate. It was an event where all differences were set aside because "we all desire something in common, and that's to heal. That healing in itself is going to strengthen who each one of those people are". Bea included herself in the healing process because "we all need to look at own our healing journey". Bea suggested that denial of any need for any personal healing is a denial of one's personal truth, which "holds our judgements, holds our racisms, holds us back, and it keeps us from being compassionate, keeps us from being patient, keeps us from opening our eyes and minds to new concepts". Bea's spirituality fosters her reflexive practice to appreciate First Nations peoples' need to become united and heal together, as Bea appreciates that there is strength and power among the larger group to heal themselves from the pain they have suffered individually, and as First Nations peoples. Moreover, where she is working, Bea has developed a trusting and respectful relationship with the community to understand that she is welcomed to participate in this healing event for her own personal self-healing.

I contacted Bea much later to discuss the research findings. She agreed that the themes resonated with her experiences and perspectives that I discussed with her. When we talked about respecting each other's differences she told me, "Differences do not mean bad things, differences can be good things—differences hold beauty". Bea's spirituality truly allows her to appreciate different approaches to healing. This begs the question whether nurses who are not so spiritually aware could recognize or be so open and accepting of such different healing approaches.

Dayna's own Native culture included different ceremonies that bring her community together to give thanks for each day and thanks for the energy in all of us. Specifically, Dayna described the importance of her Native ceremonies as:

Giving thanks for the energy we have in ourselves and being conscious of um, the things that nourish us and give us life [and] respecting the energies around us we can use them in a good way, hmm, hmm, it's spiritual energy.

Also, Dayna explained how Native ceremonies are important after the death of a community member "attending spiritual gatherings and different ceremonies some of the smudging ceremonies and cleaning ceremonies, and um feeling a sense of that energy around you."

In Lily's community, spirituality and prayer are infused within the activities of daily life. "You can't be without spirituality because we practice it so much, we have prayer before every meeting . . . it's my, my culture." Lily provided an example of how a bird kept knocking itself against her window in the health centre. Lily explained to all of her Aboriginal co-workers the significance of birds being her spirit messengers and her colleagues told Lily, "we have to do smudging, we have to say a prayer, we have to talk to the bird and say why are you here? Tell us in another way".

Lily described how stress could affect an individual's physical health:

I even think of the residential school of the past and how, you know, it effects First Nations communities, and how it effects and influences them in their day to day life today, how they struggle within themselves because they haven't passed that point yet, and then how drinking and drug use and everything else is a part of that kind of escape.

Significantly, for the nurses in this study their reflexivity helps them to understand the social, political and historical context that has profoundly determined the present health and wellness of First Nations peoples, and moreover, how the past has shaped the present generation's need for spiritual healing. Lily was cognizant of how necessary spirituality is for healing, "hmm so everything, everyone I talk to, every member, every, the worker we always consider spirituality . . . if the spirituality isn't there it's going to effect us greatly". Clearly, spirituality brings people together and unites them.

Hazel, a non-First Nations community health nurse attends Native ceremonies, which take place in the Long House[10]. In Hazel's community, ceremonies are gatherings where members of the community include grandmothers and grandfathers in their prayers because they believe ancestors are always with them. "They're in the Long House with them." They also pray and are thankful "for the kids to be aware of their history, their grandmothers and grandfathers are still there, and that they're watching them, and um they call upon them to be at the ceremonies". Hazel is used to attending the local Lutheran church with her own family; nevertheless, Hazel believes that spirituality "involves a lot more than that". Working in her First Nations community, she has learned that, "they're very spiritual to the Earth, to animals, um their past, and the future it's just everything, um medicine, herbs". Hazel now sees her own life a little bit differently, perhaps taking extra notice of the natural world around her for when she sees an eagle she now contemplates, "what would it be like to be that eagle flying". This quote is not provided to "other" or to romanticize Native culture. On the contrary, this quote was chosen to reflect how Hazel's experience of Native culture and spirituality

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[10] Long House: A gathering place for ceremonies, rectangular shaped cedar wood building.

has helped to broaden her own spiritually-lived experiences because she is open to them.

Also Esther, who is non-First Nations, believes that:

Every culture has been given stories and traditions and practices that acknowledge spirituality, and that all the stories, the things that are significant within that culture, those gifts promote . . . the spiritual stories for me, culture, are defined in a culturally meaningful way specific to that culture but the end result is basically um, going to the same place, acknowledging something here and now beyond this Earth.

Being without judgment and accepting of others are human qualities that Ramsden (2002) suggested are essential for understanding cultural safety. Bea provided an example of this awareness when a young First Nations woman miscarried very early on in her pregnancy and wanted to have a funeral for her baby:

They had a fire outside as a tradition; I stepped into the house, all the chairs were lined up, and the couch up against the wall. In big open space, there was an altar with her little baby box there. And inside was a little tissue in a vial. I didn't look in the box, but that's what was in it. And they'd draped a little cloth inside to make it nice and safe, you know inside the box. And the few people that were sitting around the circle were just quiet. And when I walked into that room, I cried. It was like it was putting me in touch with the emotions of the loss, when I didn't think that there were any emotions about the loss because I couldn't see the loss, you know.

Bea learned more about herself "so the reality of that shift of knowledge was huge for me. The acknowledgement that the loss is there without seeing something was really wonderful for me to experience". Furthermore, Bea shared how the medical staff unfairly judged this young patient when she refused to be admitted to hospital for a dilatation and curettage of the uterus the day after her miscarriage. Unfortunately, the medical staff did not spend the time to "emotionally recognize" why the young woman had refused to be admitted to the hospital the following day. It so happens she was responsible for organizing an immediate family birthday party and wanted to be admitted to hospital after the weekend. Bea described the situation:

> It showed me the attitudes of, of, you know uh, a medical staff that no fault of, I'm not blaming them, but it showed me their attitudes from the hospital emergency room perspective, that they didn't really um, understand this young woman. They didn't understand that she was actually upholding her word to a family member, and that's why she was not choosing to come in the next day after the party. She told me this, that week we had the funeral that she could barely move, that she was so overwhelmed with grief that her baby was gone. That's when she felt her loss of her own baby, right?

Bea's reflexivity and relational spirituality has helped her to be open to learning more about herself and in doing so she understands that reciprocal interaction (Pesut & Thorne, 2007) is key in practicing culturally safe nursing care.

Summary of theme three

Relational spirituality and personal reflexivity in the form of self-reflection, meditative practice, prayer and other spiritual practices helped the nurses who

participated in this study to be insightful in understanding how colonial processes

have become a determinant of health, and that First Nations peoples need to heal from

intergenerational past experiences and present health inequities and disparities. These

nurses are intuitively aware of how reciprocal interaction and culturally safe healing

practices support Ramsden's (2002, p. 110) framework of cultural safety that "gives the

power to the patient or families to define the quality of service on subjective as well as

clinical levels". Significantly, for the nurses who participated in this study, their self-

awareness and mindfulness translate into supporting their patients' need to define, lead

and direct his or her methods of healing without judgement or criticism.

Theme four: Self-reflection and providing care spiritually as a route to reciprocal

interaction

The research findings that contribute to this fourth theme further support Pesut

and Thorne's (2007) discussion about the importance of reciprocal interaction in nursing

practice, and furthermore that spiritual care, "is an ethic and motivation of care that

pervades all aspects of care" (Pesut, 2006, p. 128), and is bound to human beliefs and

values as opposed to being a specific nursing intervention.

Notably, respect too is an important ethic in providing nursing care (Browne,

1995), and Dayna believes it is very important to respect everything because

"everything has an energy that's living and that we must work in collaboration and

respect all living things around us to live in harmony and balance". Dayna describes:

. . . there's different ceremonies . . . that I participate in, in my culture, Native

culture . . .there's giving thanks, appreciating and respecting on a daily basis

[and] giving thanks for the day and giving thanks for um the energy we have

in ourselves and being conscious of um the things that nourish us and give us

life".

Dayna's participation in spiritual ceremonies is a way of respecting and caring for

herself and keeping herself healthy because she is aware that any depletion in her own

energy levels could result in her becoming unwell.

Lawrence explains why the nurse and patient relationship depends on the

concept of respect, "it's very, very important to treat people with respect, how you treat

people, also helps build capacity . . . it will have a strong impact on how people will

listen to you and how they will regard you, your work".

Bea shared a story that reflects how she excludes sharing her own spiritual

knowledge or experiences to provide culturally safe nursing practice based on

reciprocal interaction. The following story is about a First Nation's mother and her baby

who were admitted to the local hospital waiting for air transfer to a tertiary care centre:

She [the mother] said that the baby needed to have oxygen, well they [the

nurses] taped these little nasal cannula, they took great care getting these

cannula taped up into that baby's nose, and when I got there . . . the oxygen

wasn't even turned on huh [sighs] and I went to them, and said when is this

oxygen suppose to be on? And they said, oh we forgot to turn it on but we don't

really know because we don't have the right oxygen equipment to manage what

a baby's oxygen percentage would be next to an adult. So they sort of did this

rough calculation, which I found no evidence of, it was sort of guessing work that

they would turn it on 1% when they came in to do it. But instead of owning that

they had made a mistake in not even turning the oxygen on they shoved it under the carpet and diluted it with some excuse. Instead of being forthright, I made a mistake and I'm very sorry, right?

That was her [the mother's] experience . . . in those 2 days she was there. She was still expected to be pleasant to the nurses because they were the people with the power. Well, the mother was still being expected to be pleasant to them and not to get agitated at them . . . . She started feeling [that] if she didn't smile, be nice and be appreciative that things could start going really wrong that maybe they would withhold stuff from her, you know, like, like they called the ambulance to get this baby moved to another hospital but no one would talk to her about how soon the air ambulance was going to come. Like, there again if she asked a question they didn't have the answer to—they would divert the question to be an answer of another question that she never asked. That was the ongoing uh experience for her . . . soon she was feeling intimidated to ask any questions because she didn't know which ones would make things work or be positive . . . . She just then knew . . . they didn't know what they were doing, which made her feel more uncomfortable about them caring for her baby, and . . . they were the only people that were going to be able to help her so she was sort of at there mercy . . . . I knew that she wasn't being treated respectfully, they weren't including her in her child's care and they were minimizing her position, and they need not be doing that [because] she knew more about her baby . . . . I was watching, and learning [sic] how not to be. You know [sic] when someone

asks me a question I try to be very clear, concise and honest. If I don't know the answer, I will say, I don't know the answer, but I can help you find it. Notably, Bea's self-awareness has given her the insight to understand how Ramsden's (2002) cultural safety framework helps her to support patients in defining the parameters of their own spirituality and healing process. This is important as Battiste (2000) explains that human beliefs and values, like essences, are not easily measured and can exist in our minds as abstract thoughts.

Lawrence provided a story of how his own relational spirituality and reciprocal interaction provided culturally safe practice when he attended a community wake. "I just passed on my condolences to the immediate family, and I just sat in a chair", he continued, "I had the sense that people really um, appreciated um, the nurse coming and just being there to support them or show support or some solidarity in their time of grief". This begs the question whether a nurse who is less insightful and less spiritual would feel comfortable to sit quietly with a grieving family and silently provide relational spiritual support singularly through their presence alone.

Furthermore, reciprocal interaction, as discussed by Pesut and Thorne (2007) becomes very relevant in shaping Dayna's nursing practice in how she positions herself when she first meets with older patients. She begins to establish trust by sharing something about herself and her own family because "sharing that, um information is like a disclosure that is therapeutic [for herself and her patients]".

Edie specifically understands her healing role as an "equal exchange of energy . . . it must be a fair trade, otherwise it is not a right relationship". Edie implies a relational equality between herself and her patients that exemplifies the reality of reciprocal

interaction and relational spirituality as a "shared moment arising [where] you share

sacred space together". Furthermore, Edie believes:

> This whole concept of caring is something that one gives, or one does, or one is
>
> constantly giving, giving, giving—this is a skewed way of looking at energetic
>
> functions, it's not healthy, it's not functional and it isn't really holistic, I don't think.

The point to make here is that spirituality in and of itself is neither good nor bad, but

rather it is the intention behind it and how it is manifested that makes it harmless or

harmful to the nurse and to the patient (Dr. L. Chiu, personal communication, October,

29, 2007).

Summary of overall findings

For the nurses who participated in this study their relational spirituality directly

shaped their nursing practice in First Nations communities in the following ways:

1. Spirituality influenced nurses' ability to remain self-aware, open-minded
   and accepting in relation to others.

2. Spiritual awareness fostered appreciation of the need for community
   healing.

3. Spirituality became a reflexive approach to grounding one's own nursing
   practice.

Ultimately, these nurses were well grounded and highly self-actualized individuals. Their

personal reflexivity was inseparable from their spiritual practice that is deeply woven

into a constant self-reflective process that nurtured their spiritual growth, and moreover

helped to shape their culturally safe nursing practice in First Nations communities.

CHAPTER V

Discussion and Implications for Nursing Practice

Introduction

The purpose of this study was to determine how community health nurses describe their spirituality, and to interpret how spirituality shapes their nursing practice in First Nations communities in B.C. Interpretive description was identified as the research method of choice because the interpretive process recognizes how nurses' descriptions of spirituality contextually depend upon a shared reality between themselves and their nursing practice in First Nations communities (Thorne et al., 1997).

There were three research questions. First, the 12 nurses were asked to describe their spirituality; second, nurses were asked to describe how spirituality shapes their nursing practice in First Nations communities, and the third question explored the implications of how spirituality shapes these nurses' practice working in First Nations communities. The analysis of the interview data reflected four major themes that are presented as research findings in the previous chapter.

For the nurses who participated in this study, their spirituality influences their ability to remain self-aware, open-minded and accepting in relation to others; their spiritual awareness fosters appreciation of the need for community healing; spirituality becomes a reflexive approach to ground their nursing practice; and finally, their self-reflection and providing care spiritually becomes a route to reciprocal interaction.

In view of the scarcity of research exploring how nurses' spirituality shapes their nursing practice, the four themes identified in this study have many implications about the professional and ethical responsibility for nurses to provide care spiritually to their

patients' in terms of their level of competency, comfort level and ability to do so. Overall, the four themes identified in this study support Pesut and Thorne (2007) and Pesut's (2006) suggestion that nurses' moral, interpersonal skills and character are much more significant in determining the level of relational spirituality and reciprocal interaction that safely develops between nurses and patients, rather than nurses being taught and learning the competencies and skills to assess the level of intervention required to meet patients' spiritual needs. This is an important issue for discussion in this study as the four themes identified clearly indicate that spirituality is very important in shaping nurses practice. However spirituality does not shape their nursing practice in terms of this group of nurses providing spiritual intervention and spiritual care to their patients as typically depicted in the nursing literature. The nurses who participated in this study did not see spiritual care as discrete interventions per se, but rather as an overall way of being that is pervasive and has helped to shape their own lives.

Providing culturally safe care

There is a dearth of theoretical discussion about intercultural, spiritual care giving meeting the spiritual needs of patients from many ethnocultural backgrounds (Reimer Kirkham et. al. 2004). The first theme identified in this study indicates this group of nurses are highly reflexive about their own spirituality as well as that of their patients. Notably, through spiritual practices such as contemplation and meditation, their spiritual knowledge has been acquired through personal self-reflection and learning a diverse and wide base of knowledge from a blend of Western and Eastern philosophy, spirituality and religion, personal-awareness, open-mindedness and being accepting in relation to other people such as their First Nations patients. Perhaps it is our own

humanism at an individual and personal level that according to Reimer Kirkham et al. acknowledges our capacity to be respectful, loving, to listen and be present with one another and nurtures our intercultural connection with each other. Specifically, a major finding in this study indicates these nurses' reflexive spirituality is intertwined and operationalized within the conceptual framework of cultural safety as it fosters their self-awareness of systems of meaning. These systems include the broader context of their patients' lives such as colonial processes being an important determinant of health that has negatively resulted in creating disparities and inequities in the health status of First Nations peoples. As a consequence, an indirect positive influence in how nurses' spirituality shapes their practice in First Nations communities is grounded in their insightful and intuitive understanding of the crucial elements of cultural safety as described by Ramsden (2002) in Figure 2.2. Moreover, the nurses in this study affiliate themselves with their patients, "as persons in a shared humanity" (Pesut & Thorne, 2007, p. 397) who intersect at a level of intercultural and ethnocultural relational spirituality based on nursing values such as trust, respect and, above all, to do no harm to patients.

The findings within the four themes identified in this study suggest that this group of nurses' relational spirituality may be an important precursor to understand cultural safety in nursing. The nurses who participated in this study are so deeply grounded in their spirituality that they are already personally prepared to provide culturally safe nursing care in First Nations communities as their spiritual reflexivity has given them critical insight into identifying and working through their own human values, beliefs and prejudices. Cottrell and Neuberg (2005) discuss how human values, beliefs and

prejudices can be exhibited in the form of discrete emotional affects such as pity, anger/resentment, fear and anxiety. For example, Bea eloquently described how each one of us needs to look within to find where we need to heal ourselves, as there lies our "our judgements, holds our racisms, holds us back, and it keeps us from being compassionate, keeps us from being patient, keeps us from opening our eyes and minds to new concepts".

Colonial processes and the need for community healing

Significantly, the third theme identified in this study reflects how this particular group of nurses' spiritual awareness fosters appreciation of the need for community healing, as the poorer health of First Nations peoples compared to the general Canadian population is symptomatic of "a history of loss of lands and autonomy and the results of the political, cultural, and economic disenfranchisement that ensued" (Adelson, 2005, p. 559). Specifically, colonial processes are identified as a key determinant of health as they are included within the concept of culture as being a determinant of health as previously discussed by Lalonde (1974) in the literature review.

The nurses who participated in this study are perceptive to the importance of the realm of healing for First Nations peoples, and support patients when they pursue healing as a route to recover from intergenerational grief and loss of culture to achieve individual or community health and wellness. Furthermore, these nurses understand that Aboriginal knowledge supports a new paradigm shift away from only scientific reductionism and reasoning as "[a] ll Indigenous knowledge flows from the same source: relationships within the global flux, kinship with other living creatures and the life

energies embodied in their environment, and kinship with all the spirit forces in the world" (Battiste, 2000, p. 125).

Providing care spiritually

Overall, the four themes identified in this study strongly support Pesut's (2006, p. 128) view that "spiritual care, rather than being an intervention for a particular dimension, is an ethic and motivation of care that pervades all aspects of care", and furthermore, for the nurses who participated in this study, their spirituality is bound to their beliefs and values, which are experienced and expressed as shaping their nursing practice in First Nations communities. The nurses in this study do not provide spiritual care as discrete interventions per se, as they experience spirituality as an overall way of being that supports them to provide nursing care spiritually (Miner-Williams, 2006). This is important to discuss as Sellers (2001) identified that "nurses can enhance [patients] spirituality by understanding the unique human experience of each person through the establishment of a caring human relationship characterized by the art of being present, listening, respecting, and giving of self" (p. 244).

What becomes overwhelmingly evident in this study is how these nurses' spiritual beliefs and practices support their reflexivity and it is their personal insight into their own values and beliefs, which shape their nursing practice in First Nations communities. It is not a question of whether or not some nurses are more caring than others, rather "the manner in which a nurse cares for the patient also has the potential to reach out and minister to the spirit of the patient" (Miner-Williams, 2006). For the nurses who participated in this study, it is the attitude, behaviour and meaning behind their nursing practice that defines and shapes how they provide care spiritually. Furthermore, Miner-

Williams points out that many nurses may already be spiritual in their care; however, it is not until they learn to understand and explore the concept of spirituality that they realize it is already part of their nursing practice. Framed in this way, the conceptual meaning of spirituality becomes less nebulous, less ethereal, more effable and expressed more in terms of how nurses who participated in this study, describe their lived experiences of how spirituality shapes their nursing practice.

Reflexivity helps to support nurses' resilience in their practice

There are many factors that create very stressful working environments for nurses. Nurses are becoming increasingly stressed and morally distressed in the workplace that is resulting in burnout (Edward & Hercelinskyj, 2007). The findings in this study concur with Edward and Hercelinskyj that:

> In the course of the clinical contact undertaken by the nurse, the nurse is often witness to traumatic, life-changing situations and stories related to the client's lived experience of illness. Importantly, these experiences may actually indirectly cause distress and traumatization to the nurse, further compounding the issues of stress and burnout. (p. 241)

Reflexive practice can help nurses to work through problematic issues that occur in the workplace, and to make sense of their experiences and learn how to become resilient to those stresses (Edward & Hercelinskyj). Significantly, for the nurses who participated in this study, their spirituality is a precursor for their reflexivity. Reflexive practices can be encouraged by using healing methods such as journalling, participating in a healing circle (as described by Molly on page 81), attending First Nations traditional healing practices (such as sweat lodges and smudging), prayer, meditation practice, social

networking and sharing experiences with peers. Also, formal reflexive practice can be initiated through employer critical incidence stress and employee assistance programs, and through less formal networking and sharing experiences with colleagues. Professional counselling and therapies such as acupuncture and massage therapy are sometimes approved by the B.C. health care plan or employer health insurance plan.

The importance for nurses who work in First Nations communities to heal from, and to become resilient to, traumatization and distress in the work place should ideally become part of the employee/employer partnership that is formally recognized as part of nurses' work as opposed to personal healing activities that are performed outside of the work environment on nurses' own time. In reality, nurses' busy workloads do not readily support the implementation of reflexive practice in the workplace as it takes time, effort and money (nurse paid time); however, as Esther describes (p. 57) she needs to take a mental health break from her work with First Nations communities every couple of years. This is significant as the rural and remoteness of the geography in B.C. can result in outpost and public health nurses who work in First Nations communities to experience an amplification of patients' issues because the small patient population is so close by.

Difference between caring and providing care spiritually

The nurses who participated in this study frequently use the word caring to express a specific value in how nursing is practiced. Gina believes that caring is something you do (i.e., an action) and spirituality is the essence or nature of what you do.

Smith (1999) discusses how caring has been conceptualized as the essence of nursing; however, there has not been one conceptualization of caring that has been agreed on. For the purpose of this discussion, a description of caring by Rogers (1966) cited in Smith has been chosen to reflect how caring is meaningfully described as:

> It is about people: how they are born, live and die; in health and in sickness; in joy and in sorrow. Its mission is the translation of knowledge into human service. Nursing is compassionate concern for human beings. It is the heart that understands, and the hand that soothes. It is the intellect that synthesizes many learning's into meaningful administrations. (p. 27)

Further discussion is needed to determine whether caring is the essence of nursing or not; however, for the purposes of this study, Gina makes the distinction that spirituality is the essence behind her caring for patients. Essence or *essentia,* is a Latin word for "being" or "to be", (Dictionary, 2007) and when spirituality is believed "to be" the essence of what someone does then it becomes meaningfully apparent and therefore exists. Gina's spirituality is the *essentia* that exists as the driving force behind all of her relationships with her patients and in her personal life, and does not detract from how meaningful caring is within her nursing practice.

Summary

The nurses who participated in this study provide care spiritually to their patients as discussed by Miner-Williams (2006), and it is this distinction that reflects how their spirituality shapes their nursing practice in First Nations communities. Furthermore, the nurses in this study have highly developed levels of spiritual reflexivity that ground their nursing practice. This grounding can be articulated by linking Pesut and Thorne's (2007)

model of relational spirituality with reciprocal interaction to facilitate Ramsden's

(2002) framework of cultural safety.

CHAPTER VI

Recommendations and Conclusion

Introduction

Despite so much being written about nurses' professional and ethical

responsibility to provide spiritual care to their patients as typically depicted in the

nursing literature, the reality of the findings in this research study reflect that nurses in

community health nursing practice in First Nations communities do not see spiritual care

as discrete interventions per se, but rather as an overall way of being. Moreover, it is

how these nurses provide care spiritually that, I suggest, can be contextually framed as

reciprocal interaction that supports culturally safe nursing practice. This chapter will

discuss recommendations on how the findings in this research study can be

pragmatically used in nursing practice, education and research.

The importance of reflexivity in nursing practice

Reflexive practice is a process for nurses to cognitively, emotionally, physically,

socially and spiritually create meaning out of all their personal experiences (Zepke &

Leach, 2002). This group of nurses is not representative of all nurses; however, they

can teach us the importance of how reflexivity can be of assistance in helping to

acknowledge and then to reframe our own prejudices, biases and assumptions about

patients. Also, for the nurses who participated in this study, their own spirituality (as

defined by them) is the catalyst and motivator behind their reflexive practice, which is

key in achieving a deep and insightful level of understanding about themselves and also

how they perceive their First Nations patients. Also, in this study, nurses' spirituality is

closely aligned with their own values and beliefs that nurture their critical level of

reflexivity and foster self-awareness of their judgements and prejudices. Therefore, it might be very helpful for employers to develop interview questions that probe and seek out whether applicants are reflexive, given that reflexivity seems so crucial in understanding the depth and complexity of First Nations health care issues. Therefore, it might be very helpful for employers to develop interview questions that probe and seek out whether applicants are personally and spiritually grounded and practice reflexivity that seems so crucial in understanding the depth and complexity of First Nations health care issues.

Learning reflexivity during orientation for nurses who will be working in First Nations communities

When nurses are hired to work in First Nations communities, a recommendation should be for each nurse to actively participate in a mandatory orientation program that is carefully structured and expertly facilitated to include sessions on the importance of reflexive learning and cultural safety. In essence, it may not be feasible, given peoples' varying orientations to spirituality, to require nurses to work through a mandatory module addressing the subject of spirituality. Rather, the findings of this study point to the need to reinforce the importance of reflexive practice. Moreover, as Sanders (2006) suggests, nurses must understand and reflect on differences in power relationships that exist between themselves and their patients. Differences must be recognized as such, then understood and consciously redirected through the processes of reflexivity. Self-reflexive learning is crucial for newly hired nurses to learn to understand how the origins of their own personal values, beliefs and attitudes have been shaped within a particular social, political and cultural context that may greatly differ from their First Nations

patients. For nurses for whom the notion of practicing spirituality does not resonate, the framework of cultural safety (Ramsden, 2002) is an alternative method of understanding the importance of developing the trust moment between a nurse and patient.

In addition, a formal orientation program should recognize how adults learn and process new information and knowledge. Newly hired nurses could decide for themselves whether journalling could be useful for their learning. As Johnson and Bird (2006) propose, writing a journal or diary can assist nurses in learning reflexivity for the following reasons:

1. It can add a different perspective or clarity to their initial thoughts.

2. Can help them to keep track of new ideas, insights and personal understanding.

3. Can help them to develop questioning and problem solving skills.

4. Increases personal ownership of their own practice.

5. Allows them to express their emotions, values, beliefs and helps them to face and to work through their own prejudice to help them create new meaning about a subject in very practical terms.

When newly hired nurses choose reflexive journalling as their method of reflective practice, they should be encouraged to continue the process to help them reflect on any positive or negative feelings and emotions that are evoked through their daily practice and experiences.

Importantly, the orientation program should include guided sessions for nurses to learn reflexivity. For example, as Gustafsson, Asp and Fagerberg (2007) suggest,

nurses could examine their own assumptions, beliefs, statements and arguments about a subject and come to their own conclusion (for example, any acquired preconceived ideas about First Nations peoples). Second, nurses should reflect on their own moral consciousness and their convictions to explore ethical problems, and visualize ethical dilemmas (for example, how colonizing processes have created intergenerational social problems for First Nations peoples). Third, nurses should reflect on and negotiate the internal and external factors that empower their learning and create new meaning (for example, to increase their knowledge of the historical, political and social impact of colonization on First Nations peoples).

These reflexive types of learning exercises adopted by newly hired nurses will help them to realize, understand and learn how meaning is formed from their subjective experiences that are ethically, morally, and value driven, and generally steeped in their own perceptions and worldview. Significantly, how we create meaning in our lives is constantly being influenced by our experiences that are continually changing.

One crucial goal during the orientation of newly hired nurses should be for them to learn why colonial processes have been identified as a determinant of health for many First Nations peoples themselves. In addition, it is important for new nurses to mentally position or place themselves in the First Nations community where they will be working, and to reflect on how their presence maybe interpreted by community members as a continuation of colonial dominance and paternalism. Ultimately, having nurses learn reflexivity during an orientation program and encouraging them to continue the process in the workplace is a means to constantly remind nurses to reflect on their own prejudices in the short and long term.

Recommendations for nursing research

Specifically, the nurses who self-selected to participate in this study are a unique group of highly reflexive and spiritually-grounded individuals who are self-actualized and self-directed in their nursing practice. It could be useful to determine how nurses' experiences of spirituality shape their practice in other nursing practice areas. Furthermore, it may be worthwhile to explore whether nurses' spirituality attracts them to work in certain fields of nursing practice, and also whether this has any influence on nurses staying in their job, their levels of stress, coping skills, resilience, and job satisfaction.

Some final comments on the incorporation of spirituality in nursing

Currently, there is dissimilarity between nurse academics and educators who tend to view spirituality more broadly compared to nurses in clinical practice who tend to look at the subject within the context of religion and God (Gilliat-Ray, 2003). One suggestion for nurse managers and educators who work for First Nations and Inuit Health (FNIH) is to develop formal academic affiliations with nursing professorial staff in universities in B.C. where there are strong ties to First Nations education programming and knowledge, available courses on cultural safety, spirituality and health, reflexive learning, and the expertise to frame First Nations health within a post-colonial framework. Moreover, in partnership with universities, FNIH could provide in-service educational sessions via telephone/video teleconferencing and long-distance learning via the world-wide-web for nurses who work in First Nations communities in rural and outpost settings. These are practical, less expensive and more economical methods for providing ongoing in-service and education programming. In addition, Reimer Kirkham,

Baumbusch, Schultz, and Anderson (2007) suggest nurses' self-awareness and reflexive thinking could be promoted by learning more sociological, qualitative, and humanities-based knowledge as nursing often relies on relational, contextual, and historical issues to influence practice. Once again, the on-going provision of distance learning programs and courses for nurses who work in remote and rural First Nations communities is recommended to increase their knowledge, keep them current, foster life-long learning, support their reflexive practice and understand the context of their own lives and those of their patients.

Battiste (2000) identifies that the traditional Aboriginal ecological and spiritual worldview is part of a new paradigmatic shifting worldview away from scientific reductionism and towards the "Indigenous need for harmony. Intuitively and passionately we continue to seek to be in harmony with the sacred process and to live with ecological integrity and dignity" (p. 104). Maxwell (2003) also discusses how our thinking within scientific reductionism is compartmentalized, divisive and creates self-focused behaviour. He suggests the paradigm shift is moving towards "widening of our circle of understanding and compassion [that] requires a new mode of perception that transcends the illusion of separateness to discern the unity, the unbroken wholeness, from which emerge the diverse forms of existence" (p. 259). Perhaps intercultural, relational spirituality and reciprocal interaction between nurses and their patients reflect the connection, and the "unbroken wholeness" that Maxwell is proposing. Moreover, a positive finding in this research study reflects that nurses' spirituality is demonstrated aptly as intercultural, relational spirituality and reciprocal interaction. Importantly, the findings of this study suggest it is problematic for spiritual care to be ascribed as nursing

interventions and defined within parameters that do not fit the divergent religious and spiritual contexts of First Nations peoples in B.C. and the general Canadian population.

Conclusion

Historically, nurses have been advocates for their patients, and Meehan (2003) reminds us of an historical legacy that dates back to the 1820s in Dublin, Ireland from Catherine McAuley (1832) who first developed a careful nursing model "associated with a spiritual consciousness fostered by some time spent each day in meditation or prayer [as] it supports a great tenderness in patient care" (p. 102). The nurses who participated in this study are really reiterating a similar nursing philosophy more than 182 years later. On a final note, for the nurses who participated in this study, spirituality seems to be the ineffable essence behind the concept of caring, and caring seems to be the action part (as a verb) or expression of spirituality-- this remains open for further debate. Nevertheless, this group of nurses is an aware, knowledgeable, open-minded, respectful and compassionate group of individuals who realize how their spiritual consciousness and practice (that is, relational spirituality, reflexivity and reciprocal interaction) fosters and supports their culturally safe patient care and helps to shape their nursing practice in First Nations communities.

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APPENDIX A

Information Letter

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
T201- 2211 Wesbrook Mall
Vancouver, B.C., Canada
V6T 2B5
Tel: (604) 822-7417
Fax: (604) 822-7466

Information Letter

Experiences of spirituality in community health nurses working with First Nations' people on reserves in British Columbia.

My name is Karen McColgan. I am a Registered Nurse and I am completing my Master's Degree in Nursing at UB.C.. For my thesis, I am interested in learning more about your personal descriptions and experiences of spirituality working as a community health nurse. I hope this study will provide health care professionals with information that will help us to meet the needs of all our clients who live on reserves In British Columbia.

If you are interested in sharing your experiences with me for my research, I will ask for one hour maximum to interview you. I may need to interview you a second time for one hour maximum. Your involvement in this research is voluntary. You can change your mind and withdraw from this study at any time.

If you would like to participate in this research or if you would like more information, you may contact me at 1-604-666-9113, or fax 1 604-666-2029 or e-mail me at Karen_mccolgan@hc-sc.gc.ca. You may also contact the principal investigator Dr. Lyren Chiu at 604-822-7456.

Thank you again for your attention to my request.

Sincerely,

Karen McColgan, RN (EC), CPM, BScN

APPENDIX B

Informed Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
T201- 2211 Wesbrook Mall
Vancouver, B.C., Canada
V6TB5
Tel: (604) 822-7417
Fax: (604) 822-7466

Informed Consent form

Title of Study: Experiences of spirituality in community health nurses working with First Nations' people on reserves in British Columbia.

Principal Investigator: Dr. Lyren Chiu, Assistant Professor, School of Nursing, University of British Columbia (B.C.). Contact telephone number: 604-822-7456

Co-investigator: Karen McColgan, MSN (student), School of Nursing, University of British Columbia (B.C.). Contact telephone number: 604-666-9113

Purpose:
You are invited to participate in a study that describes your own spirituality in relation to working as a community health nurse in a First Nations community in British Columbia. This study is part of the student's Master thesis in Nursing at the University of British Columbia.

Study Procedure:
You will be asked to participate in up to two interviews. Each interview lasts one-hour maximum. Your total time commitment is thus 2 hours. At your convenience, this interview will be conducted either face-to-face at a place of your choice or by telephone. You will be asked about your description of your own spirituality and your spirituality in relation to your work. You may withdraw from the study at anytime. With your permission, all interviews will be audio taped.

Confidentiality:
All the information provided will be kept in strict confidence. All identifying information will be removed. Your name, the names of any your clients, and the name of your community will all be removed. All tape-recorded interviews and transcriptions will be kept secure in a locked filing cabinet at Dr. Lyren Chiu's research office at UB.C. for 5

years before it is destroyed. Only Karen McColgan and Dr Lyren Chiu will have access to the interviews and the transcriptions.

Risks and Benefits:
There is no potential risk or harm, nor is there any benefit to participate in this study. However, your participation in this study may help you develop a sense of spirituality. In addition, the knowledge you contribute to this study might add to the development of nursing knowledge.

Contacts:
If you have any questions about this study, now or later, please contact Dr. Lyren Chiu (604-822-7456) or Karen McColgan (604-666-9113). If you have any concerns about your rights as a research participant, you can contact the Research Subject Information Line in UB.C. Office of Research Services at 604-822-8598.

Consent:
It is entirely up to you whether you take part in this study or not. You can change your mind and withdraw from this study at any time. By signing this consent form, you are agreeing to participate in this study and acknowledge that you have received a copy of this consent form for your own records. By signing this consent form, you do not waive any of your legal rights.

I have read the above information and I have had a chance to ask any questions about the study and my involvement. I understand what I have to do and what will happen if I take part in this study. I freely choose to take part in this study and I have a copy of the consent form.

_____   _____
Please print name   Signature of Participant

_____   _____
Signature of Witness   Date

*Please indicate that you would like to receive a brief summary of the findings by providing your address in the space below:

APPENDIX C

Interview Questions

1. Could you explain how you personally define spirituality?

2. Could you describe how you became aware of your own spirituality?

3. Could you describe your own spiritual journey to me?

4. Could you explain how spirituality fits in with your life? (at home, at work)

5. And, could you describe what spirituality personally means to you in your role as a community health nurse?

6. Could you explain how spirituality shapes your nursing practice in your role as a community health nurse?

7. Tell me how you go about including spirituality in your daily work as a community health nurse?

8. Could you describe an event where you offered spiritual support to a patient?

9. Could you describe an event at work where you were asked to provide spiritual support?

10. Could you describe an event at work where spiritual intervention was helpful for you own well-being?

11. What would you tell a newly hired community health nurse about spirituality in community health nursing?

12. Is there anything that you might not have thought about before that occurred to you during this interview?

13. Is there anything you would like to ask me? Or anything else you would like to say or add to the interview?

APPENDIX D

U.B.C. Ethics Approval Certificate

CERTIFICATE OF APPROVAL - MINIMAL RISK

	The University of British Columbia Office of Research Services Behavioural Research Ethics Board Suite 102, 6190 Agronomy Road, Vancouver, B.C. V6T 1Z3	
PRINCIPAL INVESTIGATOR:	**INSTITUTION / DEPARTMENT:**	**UB.C. BREB NUMBER:**
Lyren Chiu	UB.C./Applied Science/Nursing	H07-00912
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:		
CO-INVESTIGATOR(S):		
Karen McColgan		
SPONSORING AGENCIES:		
N/A		
PROJECT TITLE:		
Experiences of spirituality in community health nurses (CHNs) working with First Nations' people on-reserves in British Columbia.		
CERTIFICATE EXPIRY DATE: May 18, 2008 **DOCUMENTS INCLUDED IN THIS APPROVAL:**		DATE APPROVED:
		May 18, 2007

The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board
and signed electronically by one of the following:

Dr. Peter Suedfeld, Chair
Dr. Jim Rupert, Associate Chair
Dr. Arminee Kazanjian, Associate Chair
Dr. M. Judith Lynam, Associate Chair
Dr. Laurie Ford, Associate Chair