Advances in Nursing Science
Vol. 30, No. 1, pp. 71–80
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Three Philosophical Approaches to the Study of Spirituality

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Since the turn of the century, there has been an expanded interest in the place that spirituality has in nursing practice, education, and research. The purpose of this article is to examine the study of spirituality from the perspective of 3 philosophical paradigms: empiricism, interpretivism, and poststructuralism. The strengths and weaknesses of the paradigms are identified through a review of an exemplar article for each. Each paradigm provides a unique approach to the development of knowledge, and thus makes its own contribution to the understanding of spirituality. It is the researcher's responsibility to identify the appropriate paradigm for the question. **Key words:** *empiricism*, *interpretivism*, *nursing*, *philosophical paradigm*, *poststructuralism*, *qualitative*, *research*, *spirituality*

SPIRITUALITY has become a relatively common topic in the nursing literature during the last 10 years. There is little disagreement that spirituality is an appropriate subject for nursing education or practice and it is gaining an increasing presence in nursing research. Yet, there is little consensus about how to define or how to measure spirituality.[1–5] The purpose of this article is to provide an examination of how 3 philosophical paradigms contribute to the examination of spirituality within a nursing perspective. A brief overview of the philosophical underpinnings of empiricism, interpretivism, and poststructuralism is provided as a backdrop for the remainder of the article. A selection from the literature that is representative of each paradigm is reviewed with a focus on its purpose, assumptions, object of inquiry, analytic methods, outcomes, and strengths and limitations. Suggestions are then made for maximizing the contributions from all 3 paradigms in future nursing studies of spirituality.

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Supported in part by: American Cancer Society Doctoral Scholarship in Cancer Nursing, DSCN-03-201-01-SCN; and NCI training grant R25 CA 09383 (Kathi Mooney, PI).

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SPIRITUALITY AND NURSING

Nursing has a long tradition of integrating care of the spirit with care of the body and mind.[6–10] Going back to ancient Greece and Egypt, the profession of nursing has frequently incorporated the dominant religion of the time and region into patient care and literature.[11] Florence Nightingale, often identified as the mother of "modern" nursing education and practice, advocated holistic nursing asserting that spiritual care was essential to healing.[8] During most of the 20th century, spirituality was largely ignored in the nursing literature while a scientific orientation became preeminent. However, in the last two decades, there has been a significant renewal of interest among scholars and practitioners in the place that spirituality has in health and illness.[10] This renewed interest has been made evident by several nursing theorists who have identified spirituality as a central concept in their theories.[12–15]

A search of the CINAHL database was conducted to identify research articles related to spirituality. Delimiters for the search included

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core nursing journals as established by the database, English language, and spirituality as the subject. The search produced 224 references published since 1982. One hundred fifty-six (70%) of those articles have been published since 2000. A growing number of studies have provided evidence that spirituality has an impact on the experience of symptoms and provides meaning to otherwise meaningless suffering,[10] and as such should be a topic of nursing research. Despite all of this scholarly activity, a significant issue in nursing research on spirituality is the lack of conceptual clarity about the term "spirituality."

The lack of conceptual clarity in the nursing literature reflects the multiple understandings of spirituality within a pluralistic society. Spirituality is often described as a component of quality of life,[16] but for many it is more than a part, it is that which provides quality to their lives.[10] Especially for those who are ill or dying, spirituality often provides meaning for their experiences.[11] It goes beyond being a mechanism of coping, it provides a reason and purpose, and may even derive something positive from suffering.[16] Spirituality has a very personal meaning and unique experience for each individual. For some, spirituality is intimately entwined with their religious convictions and practices.[11] For others, spirituality involves their relationship with a supreme being or God outside of any faith-based tradition.[16] For still others who acknowledge no relationship with a higher being, spirituality has to do with their relationships with themselves, with others, and with the environment.[16] It is not within the scope of this article to attempt to provide an all inclusive definition of spirituality, but rather to demonstrate how 3 philosophical paradigms provide different orientations to the acquisition of knowledge, and thus address different questions about nursing and spirituality.

PHILOSOPHICAL PARADIGMS

Empiricism

The foremost characteristic of empiricism is that it is a way of knowing that relies directly on what individuals experience through their senses. Empiricism emphasizes the importance of objectivity, methodical and meticulous observation, experimentation, and verification.[17] Within the empirical paradigm, objects of knowledge, even affective, intellectual, and spiritual properties, are viewed as distinct of the knower's perception of them and can be precisely defined and measured. Parts are the subject of study rather than the whole; parts can be quantified and their relationships can be identified reliably and with validity.[18] Each study of a part is considered additive, leading to knowledge of the whole reality.[19]

The empiricist takes an objective stance in relation to the study participants, being cautious to avoid biasing the data. "The goal of research is explanation, prediction and control and involves making generalizations and cause and effect linkages."[20(p468)] In studies that pertain to thoughts and feelings that are not directly observable, these concepts are restated with numerical values so that they can be measured and statistically analyzed. The methodologies within the empirical framework include descriptive, explorative, correlational, and experimental, with the last being the ultimate goal of the previous 3.[16] The empirical exemplar for this article utilizes a descriptive, correlational methodology for the study of the relationship between spirituality and the demands or burdens of colorectal cancer.[21]

Interpretivism

In the mid-20th century, some researchers looked to existentialism to argue against the prevailing deterministic and reductionistic approaches to the study of human experience.[17] Within the interpretive paradigm, there is no higher knowledge than meaning, not an individual meaning, nor a consensual meaning, but one that is shared through language and culture.[19] The researcher's goal is to understand the participants' experiences and the varied meanings that they assign to them.[17] The focus is on the complexity of the multiple

meanings rather than reducing them to a few categories or ideas.[22]

There are multiple interpretive methodologies with diverse theoretical perspectives, but they all take an inductive approach and share the assumption that we come to know truth through human experience. These methodologies include phenomenology, grounded theory, case studies, ethnography, and narrative research.[22] Grounded theory, which is the theoretical perspective of the interpretive exemplar in this article, explores the basic social or psychological processes of human experience.[23] The goal in grounded theory studies of spirituality is to inductively develop a theoretical framework that is grounded in the views of the participants in the study. In the interpretive exemplar, Halstead and Hull describe the process of spiritual development of women with cancer.[24]

Poststructuralism

Poststructuralism assumes that knowledge will always be incomplete and biased because no one can be independent of the traditions and discourses of their time. Words are not seen as neutral representations of inner thoughts and emotions or an outer reality.[25] Discourse is created through the social reality and at the same time creative of that reality.[26] Discourses are inherently political and serve the interests of the dominant social group.[17] As a research methodology, the focus of poststructuralism is not on what is truth, but rather on how truth is created, by whom and why.[27] The poststructuralist researcher is embedded in the discourses as much as the rest of society.

Opposed to the other two paradigms, text is the subject of poststructuralism. Poststructuralism challenges both what is said and what is not said. The goal is to disrupt the inequities of the current social order by exposing the dominant discourses. The methodologies within the poststructuralism paradigm include discourse analysis and deconstruction focused on binary oppositions.[26] The third exemplar to be reviewed is an analysis of scientific and religious discourses used to construct spirituality within the nursing literature.[25]

THREE ARTICLES FROM THE NURSING LITERATURE

Empirical exemplar

The study chosen as the empirical exemplar for this article examines the relationship between spiritual well-being and the demands of illness among patients with cancer.[21] The authors utilized a descriptive correlational design to carry out this study.

Problem and purpose

In the background for this exemplar study, the authors noted that the demands of illness and spiritual well-being have been studied in people with cancer, but there has been no study of how they relate to each other.[21] The purpose of their study was to determine whether the demands of illness imposed by colon cancer relate to the spiritual well-being of those affected with the disease. At the outset, there were certain assumptions that the authors made either explicitly or implicitly through their choice of methodology.

Authors' assumptions

The authors ascribed to Paloutzian and Ellison's definition of *spirituality* as an affirmation of life in relationship to self, community, environment, and a higher being or God.[28,29] Within this definition, spirituality was seen as having 2 components. The first was a *vertical or religious component* that referred to a sense of well-being in relation to God. The second was a *horizontal or existential component* that referred to a sense of life purpose and satisfaction. By operationalizing this definition with the Spiritual Well Being Scale (SWBS) developed by Ellison,[29] the authors assumed that all of their participants shared a theistic base for their spirituality. By utilizing an empirical method in their study, they also assumed that spirituality could be measured numerically through Likert-type scales.

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Object of inquiry

The relationship between spiritual well-being and the demands of illness imposed by colorectal cancer was the object of study. The 121 men and women enrolled in the study had colon cancer and 70% of them believed their cancer was controlled or cured. These individuals completed 2 questionnaires to assess their spiritual well-being and the demands of their illness. The first was the SWBS, a self-report instrument, which had 20 items with responses in a 6-point Likert-type scale.[29] Ten items assessed the vertical dimension, religious well-being (RWB), which referred to a sense of well-being in relation to God. The other 10 items assessed the horizontal dimension, existential well-being (EWB), which referred to a sense of purpose and satisfaction with life. The derivation of the items in the SWBS was never clearly defined by the author of the scale, but he did acknowledge that it had a conservative Christian orientation.[29] The factor analyses reported by Ellison was unclear since it revealed 3 instead of 2 factors, but in the scale the third factor was subsumed into the second, the EWB.[29] The SWBS has been the most widely used measure of spirituality,[30] and descriptive statistics have been published for a wide variety of groups inclusive of religious groups, college students, prisoners, medical patients, and caregivers.[31]

Demands of illness as used in this study were defined as illness-related thoughts and events experienced as a result of health problems.[32] The demands of illness imposed by colorectal cancer were assessed with the Demands of Illness Inventory (DOII), which has 125 items in 7 subscales; physical symptoms, personal meaning, family functioning, social relationships, self-image, monitoring symptoms, and treatment issues.[32] The development of items in the DOII was based on a review of the literature and content validity was assessed by a panel of experts. The α coefficient for the 7 subscales ranged from .78 to .91 and for the total instrument was .96.

Data analysis

Descriptive statistics were utilized to describe the sample. Pearson's product-moment correlations were calculated to determine the relationship between DOII and SWBS. Analysis of variance was used to test for differences in DOII and SWBS scores and demographic characteristics. Measures of internal consistency with this sample for the DOII yielded α coefficients between .84 and .95. The α coefficient for the SWBS was .93, and for the RWB and EWB subscales, the coefficients were .96 and .87, respectively.[21]

Outcomes

More than half (56%) of the sample was male and 63% reported a Christian religious affiliation. The authors only indicated that the remainder were non-Christian or had no religious preference. Those older than 65 years had significantly lower scores on the DOII than the younger participants ($P \leq .05$). The SWBS scores were significantly higher in women ($P \leq .05$) and in Christians ($P = .05$). Significant negative correlations were found between SWBS and DOII subscale scores related to physical symptoms, monitoring symptoms, and treatment issues ($P \leq .05$). There were also significant negative correlations between the EWB and all of the DOII subscales ($P \leq .05$). There was no significant correlation between the RWB and any of the DOII subscales. The authors concluded that nurses caring for cancer patients need to be aware of the relationship between spiritual well-being and demands of illness and assess for each. They also suggest future research to evaluate the effectiveness in decreasing demand of illness through interventions designed to enhance spiritual well-being.

Strengths and limitations

One of the strengths of the empirical paradigm is that data can be quantified. Quantification facilitated the analysis of the relationship between spiritual well-being and the demands of illness among individuals with

colorectal cancer. On the basis of their findings, the authors recommended that nurses initiate appropriate assessments of spiritual well-being and demands of illness among their patients with colorectal cancer so that they can plan appropriate interventions. However, the lack of control for the threat of selection effects restricts the population to which the findings can be generalized.

A major limitation of this study identified by the authors was the religious orientation of the SWBS. Six respondents did not answer any of the questions on the RWB and their data had to be eliminated from the analysis. Another 9 respondents who completed the RWB indicated a need to interpret the word "God" broadly. The authors sought permission from Ellison to substitute "higher power" for the word God but permission was denied.[21]

Questions about the construct validity related to factor analyses of the SWBS further limited the strength of this study. A related limitation was the operational definition of a concept that is immaterial and eludes a universally acceptable definition. The individual and personal meaning of spirituality speaks against any attempt to define it narrowly, thus necessitating an excessively burdensome instrument that covers all operational definitions or one such as the SWBS that is unacceptable to some participants. This raises a question of whether it is possible or appropriate to attempt to quantify such an intangible, ethereal concept.

An interpretive study of spirituality

Within the interpretive paradigm, there are diverse theoretical perspectives to the study of what it is to be human and what meanings people give to their experiences.[17] Grounded theory is the perspective for the interpretive exemplar by Halstead and Hull in which they examine the process of spiritual development in women with cancer.[24]

Problem and purpose

The problem addressed by this study is the lack of knowledge about the impact of the cancer experience on women's spiritual development that is necessary to inform nurses' spiritual care of patients. The purpose of the study was "to examine the process of spiritual development in women diagnosed with cancer within five years of diagnosis."[24(p1535)]

Authors' assumptions

The authors assumed that caring for the human spirit is part of nursing practice. They also assumed that spirituality is a lifelong developmental process that is influenced by other factors both internal and external to the individual, and thus has unique personal connotations. A third assumption was that a theory of spiritual development in women with cancer can be constructed from data collected through semistructured interviews with women previously diagnosed with cancer.

Object of inquiry

The object of inquiry in this study was the process of spiritual development derived from the self-reported experiences of women who have been diagnosed with cancer. The participants were 10 White women with lymphoma, breast, or ovarian cancer diagnosed 3 months to 5 years previously and not receiving treatment at the time of the interviews. Data were obtained through 2 semistructured interviews lasting 1 to $1^1/_2$ hours with each of the participants. Interview questions included, "What does the term spirituality mean to you?" "What are some of the experiences that have shaped your spirituality?" and "Describe experiences, people or situations related to your cancer diagnosis or treatment that affected your ideas about spirituality."[24(p1535)]

Data analysis

Consistent with grounded theory methodology, the authors utilized a constant comparison technique of data analysis in which theoretical sampling, data collection, and analysis occurred simultaneously.[24] The

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authors immersed themselves in the data as it was conceptualized and reconceptualized. The data were coded and then the codes were collapsed into more abstract categories, uncovering links among the categories until theoretical constructs emerged. Trustworthiness of the data was addressed by having one author conduct all the interviews and analyze all of the data, and then having experienced researchers review the data and the coding. The interpretation of the data was validated by the participants to ensure that it was recognizable and grounded in their experiences of spiritual development. The author kept a log, memos, and a journal to manage her assumptions and to provide an audit trail.

Outcomes

The basic social psychological process derived from this study was one of struggling with paradoxes.[24] This process consisted of 3 phases: phase I, deciphering the meaning of cancer for self; phase II, realizing human limitations, and phase III, learning to live with uncertainty. There were different dimensions to the phases such as in phase II "asking the difficult questions" and "letting go"[24(p1538)] of aspects of their precancer lives. As the women moved through the phases, they encountered paradoxes in each, which were not necessarily resolved and were often revisited in a different way. Examples of the paradoxes associated with each phase include: phase I, "I am alive/Does the cancer diagnosis mean I am dying?"[24(p1537)]; phase II, "God is my personal friend/How can a friend do this to me?"[24(p1538)]; and phase III, "I am me/I am not the same me because my life is changed."[24(p1540)] The women could not separate out the spiritual dimension of their experience without also focusing on the physical and emotional dimensions. Over time, the women learned to live with the uncertainties associated with their cancer experience and to appreciate the spiritual gifts that evolved through that experience. The authors derived 3 conclusions from the data that had not been described in the literature previously. These included spiritual development is not dependant on age, spiritual concerns do differ across the lifespan, and spirituality is strongly affected by both mentors and negative models.

Strengths and limitations

In an interpretive paradigm, data are developed from the perspective of the individual. Participants can relate what is meaningful for them and not have to try to fit their experiences into someone else's point of view. In this study, the individual participant's definition of spirituality was essential. Although all of the women believed in God, their perceptions of who and what God was varied considerably. Their perceptions included a personal God with whom they can have a close relationship; a God that helps in times of need but does not relate with individuals in a personal way; and an Eastern view of God as an energy flow. These divergent views about God cannot be blended together without loosing the true meaning of spirituality for each of these women. Despite the differences in their personal experiences that resulted in the various meanings, these women shared a common process of spiritual development during their cancer illnesses that was identified through grounded theory methods of analysis. Within the phases of that developmental process, the authors were able to identify the multiple paradoxes experienced by the participants. This knowledge could not be acquired by any other means than to ask the women to describe it in their own words.

The small sample size (10 women) in this study resulted in a lack of diversity, thus providing no information about spiritual development among other ethnic or cultural groups or during other disease states. The lack of diversity in the sample limits generalization of the findings. However, the authors produced an audit trail that included a log, memos, and the researcher's journal that would facilitate similar studies with other groups.

A poststructural examination of spirituality

The third exemplar considers how the term spirituality, as used in the nursing literature, has been constructed through religious and scientific discourses. The title, "Constructions of spirituality in contemporary nursing theory,"[25] situates the article within the poststructuralist paradigm.

Problem and purpose

Henery[25] noted that within nursing, many have grappled with the reductionism imposed by science on the topic of spirituality. The analytical approach has been to attempt to define and measure spirituality as a part of the individual. While opposing the scientific and secular approach, nursing writers also have been critical about the limitations on the concept of spirituality imposed by religious views. Yet, the nursing literature on spirituality has not escaped the influence of either science or religion. Therefore, the purpose of Henery was to examine the contradictions and limitations of scientific and religious discourses on spirituality and consider the implications for modern nursing theory.

Author's assumptions

The author assumed that the social and political implications of scientific and religious discourses have constructed spirituality as found in nursing literature.[25] He also assumed that spirituality is a property of the person. A third assumption was that nurses can help patients cope with death, suffering, and illness by addressing the spiritual property. The final assumption was the value of examining the scientific and religious discourses on spirituality to understand the construction of spirituality in nursing and the implications for nursing practice.

The object of inquiry

Text in the nursing literature as a representation of spirituality was the object of inquiry in this study. Henery[25] examined the religious and scientific discourses on spirituality for their impact on the construction of the understanding of spirituality in the nursing literature. Religious and scientific discourses each have provided a unique and contradictory contribution to the construction of spirituality in the nursing literature.

Analysis and outcomes

The author looked to historians' descriptions of premodernity or medieval times to describe the construction of the religious discourses and to modernity or scientific revolution for the construction of scientific discourses on spirituality. From that historical perspective, he then examined the religious and scientific constructions of spirituality and the contradictions and dilemmas that result within the nursing literature. Finally, he proposes an alternative perspective.

The religious discourse on spirituality has had a theistic bias generally constructed by religious institutions, which were prevailingly Christian. There was interdependence between church and state in premodern times that gave the religious leader not just religious but also political power. Within the religious discourse, those whose spirituality was based in religiosity were implied to be superior over those whose spirituality was existential and did not include religiosity. The impact of the religious discourse in the nursing literature has been that attempts to conceptualize a universal spirituality often have traces of values that belong to a specific religious tradition implying a superiority of that tradition.

In the Modern Age, there was a mission to gain a sense of certainty for human comprehension and to demonstrate that certainty. Yet, the scientific discourse on spirituality tended to be vague and contradictory in its attempt to provide a concrete definition of spirituality. Spirituality was defined as a part of the person implying something that can be measured and manipulated in the empirical tradition. As a result of the scientific discourse, there have been many attempts to measure spirituality in the nursing literature, and yet, there has been no clear, precise theoretical definition of spirituality that would allow such

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measurement. The author concluded that attempts to objectify spirituality for the patient might result in alienation.

The scientific discourse was predicated on the internal capacity of the thinking rational human subject as opposed to the religious discourse, which looked externally to a divine authority. Henery suggested a different perspective of spirituality that depends on an analysis of the modern institutional environment, and in which both discourses can be helpful to an individual experiencing illness or injury.

Strengths and limitations

A limitation of the poststructural approach is that it does not provide any information about the prevalence of one construction over the other, nor does it provide a greater understanding of the experience of spirituality among patients or nurses. The strength of this approach is that it reveals the limitations and bias of existing constructions of spirituality within the nursing literature. It brings out the lack of agreement in the nursing profession about what spirituality is and about the need for a different approach to the construction of the meaning of spirituality.

DISCUSSION

Each of the philosophical paradigms reviewed here serves a different but legitimate purpose in expanding nursing knowledge about the spirituality and the spiritual needs of patients. There is no one paradigm that will fit the myriad of research questions related to spirituality and nursing.

Poststructuralism can provide a very important contribution by illuminating the often obscured impact of political and social forces that construct the meaning and interpretations of words such as spirit and soul, spiritual and religious, spirituality and religiosity. Henery[25] has identified the social and political forces of science and religion that have led to competing constructions of spirituality. Examination of the scientific discourse on spirituality illuminates how researchers in the empirical paradigm have come to the idea that spirituality can be measured. The religious discourse has also impacted how many empirical researchers have constructed instruments within the predominate Christian tradition of spirituality. These constructions have excluded other ancient traditions such as Judaism, Hinduism, Buddhism, as well as more contemporary forces such as New Age and Evangelical. These alternate constructions of the meaning of spirituality ought to be explored if nurses are going to be prepared to provide spiritual care in a pluralistic society.

Interpretivism provides each research participant the freedom to define spirituality and honors and preserves his or her very personal experiences. It provides detailed descriptions on which to base interpretations and theory related to spirituality. Its contribution to nursing knowledge and practice is in the appreciation of how spirituality impacts individuals in a myriad of ways. With the individual and personal perspectives derived through the interpretive paradigm, nurses will be able to learn and respect the many faces of spirituality in our society. It is only with that knowledge and appreciation that we can rightfully claim to provide spiritual care to all of our patients.

Empiricism provides the capacity for testing the commonalities and associations with larger groups of people. It allows for controls to be set in place so that findings can be generalized to even larger groups. It will be with empirical research that nursing will be able to test assessment tools and evaluate interventions for the spiritual health of patients. However, valid and reliable results cannot be obtained from a tool that holds no meaning for part of the research sample. It can be argued that existing quantitative tools for empirical studies are not adequate for all groups of people and their use should be restricted to the populations for which they are meaningful.

There is a need for the construction of new instruments that are meaningful for those groups that cannot identify with the existing ones. It may not be possible to develop a universal research tool for measuring spirituality;

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perhaps, it would be better to focus future efforts on the construction of a variety of tools, with each being reflective of the beliefs of a major group such as Christian, Jewish, Islamic, Buddhist, New Age, etc. Another solution to the measurement problem would be the development of individualized assessment tools similar to the Patient-Generated Index that was developed to measure quality of life as defined by the individual patient.[33] The Patient-Generated Index was developed to be congruent with the "conceptualization of quality of life being a dynamic concept assessable only in the person's own terms."[34(p10)]

CONCLUSION

The merit of each philosophical paradigm lies in its appropriateness to answer a specific type of question. It is the responsibility of the researcher to identify the paradigm that is suitable for the research question related to spirituality, and then evaluate whether appropriate measures are available to address the study's aims. As consumers of research, it is the responsibility of all nurses to read critically and to build their knowledge on the basis of the legitimate evidence about spirituality and its place in nursing care.

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