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THE ESSENTIAL STRUCTURE

OF THE LIVED EXPERIENCE OF CONNECTION

BETWEEN NURSE AND PATIENT

A DISSERTATION SUBMITTED TO THE GRADUATE DIVISION OF THE
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I dedicate this dissertation to my parents.

To my mother, Bertha Toshiko Fujimoto

(April 5, 1912 – October 28, 1971)

who taught me to love by loving me unconditionally and

whose quiet and loving presence is with me always.

and

To my father, Edwin Shigeo Fujimoto

(January 15, 1908 - )

who as a lifetime learner

always encouraged me to pursue my dreams.
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To each participant in this study, I thank you for sharing your feelings. You exposed your vulnerabilities, cried in both sadness and joy, and showed a deep love for your patients. Your connection with patients changes the world. You are stellar nurses!

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ABSTRACT

The nurse-patient relationship is the heart and soul of nursing practice. Nurses find the most meaningful relationships with patients are those in which they feel deeply connected with patients. Yet studies show that nurses perceive a lack of adequate time with patients and most nurse-patient interactions as superficial, routinized, and related to tasks.

The purpose of this study was to describe the essential structure of the lived experience of connecting with patients by nurses who said they experience connection with patients as a major aspect of healing. The research design was descriptive, using a phenomenological approach reflected in Colaizzi’s model as adapted by Haase. Purpose and snowball sampling were used to enroll the sample of 13 female Registered Nurses in adult and child health.

Major findings of this study consisted of four Theme Categories: Connection as a Process, The Nurse as Exemplar, Personal Transformation, and Connection as Healing. The results added new knowledge in the areas of nurses as exemplars and connection possibly occurring as a spontaneous reaction. In the essential structure of the lived experience of connection, connection is a process that begins with the selection of a patient, involving cognitive process and spontaneous reaction. The relationship is emotional and personal, and the nurse feels love towards the patient. The nurse feels connection as a “bubble” of energy surrounding herself and patient, and experiences visceral changes in the environment and within herself as warmth, peace, and calmness. The nurse benefits from the connection and gains clarity of purpose in life. The nurse who connects with a patient is an exemplar in both the science and art of nursing.
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CHAPTER ONE

INTRODUCTION

Chapter One presents the background for this study, philosophical orientation, assumptions, problem statement, statement of purpose, research question, definition of terms, and significance of the study.

Over the course of the last ten years, the healthcare environment has been in constant flux, with managed care, reduced reimbursement, and changing technology presenting many challenges to nurses. Economic viability often competes with patient care. Nurses struggle daily to balance the business aspects with the caring and healing aspects of nursing. High technology, high stress, and the financially driven nature of nursing leave little time for nurses to engage in the art of healing. Nurses often find themselves exhausted, unfulfilled, and spending too much time performing technical tasks instead of establishing caring, spirit-to-spirit relationships and connections with patients. As a result, nurses are becoming highly technological caregivers and are at risk of losing the emphasis on nurse-patient relationships that is integral to the art of healing.

The focus of this study is nurses’ perceptions of the lived experience of connecting with patients as a major aspect of healing. Connection between nurses and patients is a healing relationship that benefits both nurses and patients.

Background

The practice of caring is essential to nursing (Watson, 1985). Caring responses by nurses consist of accepting people for who they are and for who they become. The nurse integrates the cognitive with the intuitive, spiritual, and human caring process (Watson, 1985). The relationship between the nurse and the patient is a human process
that incorporates rational, cognitive, technical, and empirical ways, but also calls upon aesthetics, ethical values, moral ideals, intuition, personal knowing, and growth (Watson, 1989). The nurse’s and patient’s consciousness, imagination, and spirit all serve as inner resources for healing. The caring environment fosters developing the full potential of nurses and patients while empowering them to make individual choices.

Patients benefit from caring relationships with nurses (Kendall, 1996; Schubert & Lionberger, 1995). Patients have perceived nurses as caring when nurses created an atmosphere of trust and security (Davy, 1998), provided choices and autonomy (Woodward, 1998), took social and professional interest in patients (Davy, 1998), and recognized patients as unique individuals who need to share feelings and be listened to (Williams, 1998). When nurses have assisted patients in interpreting the meaning of their feelings and have shown respect and concern for patients’ spiritual needs, patients have experienced less anxiety (Williams, 1997). Patients have perceived connection, commitment, and trust with nurses as contributing to their well being (Rieck, 2000). Patients have identified a high degree of human connection, not the degree of their physical illness, as the most important factor enhancing well being (Kendall, 1996). When patients have been intimately connected with nurses, patients have trusted and bonded with them (Schubert & Lionberger, 1995).

It is this caring process that brings nurses back to the full potential of their role as healers. Nurses have found the most meaningful relationships with patients were those in which they felt deeply connected with patients (Milne & McWilliam, 1996; Pieranunzi, 1997). Nurses have reported that the connection between a nurse and a patient was in having a deep personal involvement with the patient and being emotional about this
relationship (Montgomery, 1996). Some nurses who have this level of involvement with patients have experienced spiritual transcendence, found profound fulfillment, and have been able to continue caring for patients without experiencing “burnout” (Montgomery, 1996, p. 52).

In summary, caring relationships and connections between nurses and patients benefit both the nurse and patient. The caring process and caring environment foster the full potential of nurses to focus on the healing aspects of nursing.

Philosophical Orientation

The nursing profession embraces principles of caring and healing. Entering the twenty-first century, a reconstruction from modern to post-modern nursing was taking place (Watson, 1999). One of the major assumptions underlying the paradigm of caring and healing is that the caring relationship is an inter-connected relationship that contributes to the spiritual growth of both the one providing the care as well as the one receiving the care. Caring is based on an ontology of relationship and connectedness (Watson, 1999). In postmodern nursing, “caring is an explicit global ontology of relation rather than separation” (Watson, 1999, p. 97). There is oneness of mindbodyspirit, a unitary caring consciousness, and connectedness of all (Watson, 1999).

The simultaneity paradigm reflected in nursing science characterizes humans and environment as relating openly, and humans as greater than a sum of parts—whole beings participating with others and the universe (Parse, 1987). Fundamental principles relating to energy, consciousness, intentionality, and caring form the framework for healing relationships between nurses and patients (Watson, 1999) and between healers and patients (Byrd, 1988; Harris, Gowda, & Kolb, 1999; Sicher, Targ, Moore, & Smith,
Current knowledge may not explain what is discovered, and rational, linear thinking processes may not always provide the answers. As scientists, nurses expand their frames of reference and play a key role in defining the yet undefined.

This ontological shift to a metaphysical understanding of human relationships (Watson, 1989) requires an understanding of spiritual dimensions for nursing practice (Watson, 1999). The Pew Health Professions Commission established guidelines on the knowledge and skills for nurses who practice holistic care (Dossey & Guzzetta, 2000). Having a sense of self-awareness and knowledge of self as a resource to others, as well as having skills of self-reflection, self care, and self-growth, assist nurses who provide care to patients in a relationship-centered practice (Dossey & Guzzetta, 2000). When registered nurses (R.N.) \( N = 10 \) were asked their view of components of spiritual nursing care, they identified the human spirit as the core of every person’s existence and the power that heals, and spoke of caring, knowing their strengths and limitations, and using their inner wisdom to guide them in the care of the patients (Dennis, 1991). To be effective, holistic nurses reawaken the spirit within (Burkhardt & Nagai-Jacobsen, 1994; Elkins, 1995; Lane, 1987) and continue their own personal spiritual journey, struggling with the tensions of being human (Hover-Kramer, 1989; Starn, 1998).

Assumptions

One assumption underlying this philosophical orientation is that the healing power of a nurse comes from a conscious connection with one’s spirit. To develop the depths of healing relationships with patients, nurses must go inward and connect with their own spirit. A connection to spirit is directly related to the spiritual relationships one has with others (Walton, 1996). The deeper one goes to explore one’s spirit, the greater
the ability to assist the patient in utilizing his/her own spirit for healing. A second assumption is that, to enhance their effectiveness in healing, nurses must take time to heal themselves and understand the process of going inward to reach the depths of their own spirit (Starn, 1998).

Problem Statement

The nurse-patient relationship is the heart and soul of nursing practice (Pieranunzi, 1997). Patients see connecting with nurses as an essential element in the relationship (Milne & McWilliam, 1996) that contributes to their healing (Kendall, 1996; Rieck, 2000; Schubert & Lionberger, 1995). Nurses find the most meaningful relationships with patients are those in which they feel deeply connected with patients (Milne & McWilliam, 1996; Pieranunzi, 1997). When nurses experience a connection with patients, the effectiveness of the relationship is enhanced and both the nurse and the patient benefit (Heifner, 1993). Yet studies show that nurses perceive a lack of adequate time with patients and most nurse-patient interactions as superficial, routinized, and related to tasks (Hewision, 1995; Milne & McWilliam, 1996).

Current economic conditions and accelerated technology present nurses with challenges to efficiently and effectively juggle multiple and sometimes conflicting demands. This situation can be a threat to nurses’ focus on connecting with patients as a major aspect of healing. Nursing literature lacks substantive empirical investigation of the development of a connection between the nurse and the patient as an aspect of healing.

Statement of Purpose

The purpose of this study was to describe the essential structure of the lived experience of connecting with patients by nurses who said they had experienced
connection with patients as a major aspect of healing. A descriptive phenomenological methodology using Colaizzi's model (1978) as adapted by Haase (1987) was used to meet the purpose of this study.

Research Question

The research question was "What is the essential structure of the lived experience of connecting with patients by nurses who say they experience connection with patients as a major aspect of healing?"

Definition of Terms

The definitions of terms included in the research question are introduced here.

Essential structure: The processes and meanings of the phenomenon (Haase, 1987).

Lived experience: That which is “actually lived out—perceived, thought, imagined, remembered...” (Macann, 1993, p.17).

Nurses: Professional health care personnel who identify themselves as R.N.s and say they develop connection with patients as an aspect of healing.

Connection: The joining together of two people at the level of spirit in a healing relationship motivated by the nurse’s unconditional love for the patient (Kutaka, 2001).

Patients: Persons in a position to receive health care from a nurse.

Healing: The bringing together of the body, mind, and spirit that leads to integration and balance of these parts, with each part being of equal value (Dossey & Guzzetta, 2000).
Significance of the Study

This study is significant to nursing science because it contributes to knowledge on the development of the relationship between nurses and patients. Nursing is a practice discipline (Walker & Avant, 1995) whose primary focus is on interpersonal interactions between nurses and patients (Chinn & Kramer, 1995). A phenomenological approach clarifies the conceptualization of the phenomenon, connection, and may lead to concept development. This study describes components in the connecting relationship between nurses and patients, elucidates qualities of nurses who say they experience connection with patients as a major aspect of healing, and generates knowledge that may improve the effectiveness of the interactions between nurses and patients.

This study may benefit patients because the knowledge generated on the lived experience of connection may be applied to nursing practice and used to enhance healing and well being. This study is of significance to nurses because of its contribution to an understanding of how nurses practice nursing. Results can be examined as to how applicable they are to nursing practice. Nurses may benefit by learning the components of connecting with patients, and applying this knowledge to their practice, and experiencing fulfillment in their role. This study may benefit healthcare systems because nurses may use this knowledge to create a caring, healing environment for patients and themselves, thus contributing to patient and staff satisfaction.

Summary

The current healthcare environment presents many challenges for nurses who want to establish meaningful relationships with patients. Connection between nurses and patients reduces patients’ anxieties and contributes to their well being. Many nurses find
connecting with patients as the most meaningful relationship with patients (Milne & McWilliam, 1996; Pieranunzi, 1997). Nurses who have connected with patients at a level of close, emotional involvement have reported experiencing spiritual transcendence, profound fulfillment, and ability to continue caring for patients without becoming burnt out (Montgomery, 1996).

The paradigm of caring and healing is based on an ontology of inter-connected relationships between nurses and patients that contribute to the spiritual growth of both the one providing the care as well as the one receiving the care. This ontological shift to a metaphysical understanding of human relationships requires an understanding of spiritual dimensions for nursing practice.

The purpose of this study was to describe the essential structure of the lived experience of nurses who said they had experienced connection with patients as a major aspect of healing. Fawcett (1978) identifies four components of the metaparadigm of nursing: the nature of nursing, the nature of the person, society and environment, and health (Fawcett, 1978). Knowledge gained from this research contributes especially to knowledge of the nature of nursing, and its potential impact on the other components.

The primary focus of the nature of nursing is the interaction or interpersonal relationship between nurses and patients. This study on the lived experiences of connection by nurses who said they had experienced connection with patients as an aspect of healing contributes to knowledge on the development of a healing relationship between nurses and patients. This study defined the essence of that experience and resulted in the essential structure of the lived experience of connection.
This study also contributes knowledge of the nature of the person and environment. Parse’s (1987) simultaneity paradigm reflected in nursing science characterizes humans and environment as relating openly, and humans as greater than a sum of parts. Humans are whole beings participating with others and the universe (Parse, 1987). The nurse as part of the patient’s environment is an integral part to the patient’s health. This study provides insights to the meanings nurses attach to a connecting relationship and the effects that connecting has on the nurse.

This study also contributes to knowledge of health, which is the integration and balance of mind, body, and spirit with each part being of equal value (Dossey & Guzetta, 2000). Learning more about the nature of nursing may benefit patients if the knowledge generated on the lived experience of connection is applied to nursing practice and used to enhance healing and well being. The nurse who learns the components of connecting with patients and applies this knowledge to practice may enhance fulfillment in their role. Nursing interventions based on the understanding of the lived experience of connection may provide a basis for effective nurse-patient relationships (Cohen, Kahn, & Steeves, 2000)
CHAPTER TWO

CONCEPTUAL ORIENTATION AND REVIEW OF LITERATURE

Chapter Two presents the conceptual orientation and review of literature for this study of connection between nurses and patients. Following the conceptual orientation is the review of literature addressing connection, healing and healers, and healing and spirit.

Conceptual Orientation

Three major concepts provide the conceptual orientation for this study: connection, healing, and spirit. Concepts are mental images of a phenomenon that help to categorize and organize experiences (Walker & Avant, 1995) to better understand the meaning of the phenomenon. Within the concept of connection are the components and effects of connection on the healing relationship between the nurse and the patient. Current literature shows one theory of mutual connectedness (Schubert & Lionberger, 1995) and one contextual model of connection (Swift, 1994) based on Schubert and Lionberger’s theory (1995). Both the theory and contextual model are based on holistic nursing practice and draw from the foundations of Rogers (1990), Newman (1994), and Parse (1987).

Healing is the bringing together of the body, mind, and spirit that leads to integration and balance of these parts with each part being of equal value (Dossey & Guzzetta, 2000). The nurse exchanges energy, truth, and communication with clients to help them utilize their own healing capacities. “Connections are made in which a sensitive, selfless regard for another opens the door for meaningful relationships” (McKivergin, 2000, p. 209). Within a concept of healing is the influence of culture on both healing and practices that aim toward healing. “Culture is the whole of ideas,
customs, skills, arts and other capabilities of a people or group, although as a whole, it is more complex than any one of these elements” (Engebretson & Headley, 2000, p. 284). It is the complexity of social customs, values and expectations that impact how people work together (Frow & Morris, 2000). Cultural beliefs and patterns of group behavior form the group identity. It is through the socialization process that these beliefs and patterns are transmitted from one generation to another. Most of the cultural values are tacit and unexpressed. The concepts of connection, healing, and spirit are the conceptual basis for the research.

Review of Literature

The review of literature for this study addressed connection, healing and healers, and healing and spirit. These concepts guided the direction of the study.

Connection

The first major component of the conceptual orientation, connection, is supported by data based and conceptual literature on connection that shows an interrelationship of multiple concepts reflecting the nurse-patient relationship. Caring, touch, presence, transcendence, and spirituality all have components either related to or a part of the concept of connection. An analysis (Walker & Avant, 1995) of the concept of connection within the context of the nurse-patient relationship revealed five critical attributes, two antecedents, and six consequences (Kutaka, 2001).

Connection is a state of being linked as in a relationship or association such as the linking of ideas, dots, or words (McKechnie, J.L., 1979). Commonly understood definitions of connection from the author's colleagues, relatives and friends included: points of interface as in geometrical designs or in bus routes, connections in wires,
phones, circuits, and electricity, positive connections as in personal relationships between two friends, and negative connections or lack of connections such as in a relationship characterized by tension or detachment.

Critical or defining attributes are those characteristics most frequently associated with the phenomenon under study (Walker & Avant 1995). In a review of the literature, five attributes of connection emerged: intimacy, focused attention on the patient, spiritual transcendence, energy, and relating spirit-to-spirit.

The first critical attribute of connection is intimacy, supported by seven studies (Astrom, Norberg, Hallberg, & Jansson, 1993; Drew, 1997; Heifner, 1993; Kendall, 1996; Montgomery, 1996; Pieranunzi, 1997; Schubert & Lionberger, 1995). Interviews with patients ($n = 18$) regarding the development of the nurse-patient relationship and the perceived effects of the relationship on the patient’s healing resulted in mutual connectedness as the core category and intimacy as contributing to a healing connection between nurses and patients (Schubert & Lionberger, 1995). Intimacy was defined as nurses ($n = 12$) and patients ($n = 18$) getting to know one another by sharing personal and private information about their lives (Schubert & Lionberger, 1995), nurses ($N = 35$) having a deep personal involvement with the patient, being emotional about the relationship, and having unconditional love for the patient (Montgomery, 1996). A limitation of Schubert and Lionberger’s (1995) study is that all participants were female nurses who practiced counseling, teaching, or touch therapy in a private practice setting, a narrow range of nursing practice.

In studies regarding intimacy as an attribute of connection, nurses crossed normally defined professional boundaries and became immersed in the patient’s
experiences (Astrom et al. 1993; Drew, 1997; Montgomery, 1996). Nurses \( N = 45 \) perceived that mutual sharing of life experiences with patients, being intimate with patients, and giving of themselves to patients made a difference to patients (Astrom et al. 1993). The nature of the connection between nurses \( N = 35 \) and patients occurred at a level of involvement of nurses becoming one with the experience of the patient (Montgomery, 1996).

Drew (1997) interviewed nurses \( N = 11 \) and asked them to describe meaningful experiences with patients that stood out for them. Nurses identified meaningful experiences with patients as those in which nurses chose to be themselves, felt deeply connected to the patients, and shared information about their personal lives with patients (Drew, 1997). Nurses stated these interactions gave meaning to their lives and saw working with patients as a gift. Nurses deliberately chose to be involved in painful and emotional experiences with patients at a level of intimacy as distinguished from the highly technological environment (Drew, 1997). The nurses desired this connection and closeness with patients and felt patients needed more than a professional relationship. This elemental need for connection and self-disclosure with patients transcended maintaining professional distance (Drew, 1997).

In a study on positive connectedness, all nurses \( N = 8 \) related personally with patients, acknowledged a mutual benefit to both patients and themselves, and said a positive connectedness enhanced the effectiveness of the relationship (Heifner, 1993). When connection occurred between nurses and patients, sensitive issues were addressed sooner, more frequently, and with less difficulty (Heifner, 1993). Nurses invested themselves and more time with these patients (Heifner, 1993). Nurses in this study
(Heifner, 1993), however, did not mutually share their vulnerabilities with patients. Nurses with fewer years of experience wanted to self-disclose as compared to nurses who had more tenure. Although both the experienced and less experienced nurses related positive connectedness with patients, they maintained their professional stance. The nurses also were resistant to identify similarities they had with the patients, but were less resistant to identify the differences. The nature of the patient population and their illness (psychiatric disorders) may have explained some of these resistances (Heifner, 1993).

The second critical attribute of connection is focused attention on patients, supported by five studies (Astrom, et al. 1993; Bottorff & Morse, 1994; Clark, Cross, Deane, & Lowry, 1991; Fredriksson, 1999; Schubert & Lionberger, 1995). In one study, nurses \( N = 45 \) reported spending long periods of time with patients, conveying a sense of commitment to be with them when needed (Astrom et al. 1993). Nurses \( n = 12 \) often prepared for a meeting with patients by quieting their minds and centering themselves in order to focus their full attention on patients (Schubert & Lionberger, 1995).

In a study to identify spiritual needs of patients, patients \( N = 15 \) were asked if there was any event during their hospitalization that contributed to their well being (Clark et al. 1991). A third of the participants said the most significant contribution to their well being was the nurse’s giving them attention, answering questions, and having a positive attitude (Clark et al. 1991). Bottorff and Morse (1994) studied the use of touch and attending in caring for cancer patients \( n = 12 \). Four patterns of attending were identified in the nurse-patient interactions. One of the types, doing more, was characterized by a relationship between nurses and patients in whom nurses focused primarily on patients with frequent sustained eye gaze toward the patient’s face. The intent was to understand
the patient’s experience of illness. The nurses engaged in intensive, in-depth discussions 
with patients and provided emotionally supportive statements (Bottorff & Morse, 1994).

A research synthesis on presence, touch, and listening resulted in two types of 
caring presence, being there and being with (Fredriksson, 1999). Being there was defined 
as a highly intersubjective presence, in which nurses were there for patients, with focused 
attentiveness on the patients, and listening and communicating an understanding of the 
patient’s experience. Being with was also described as an intersubjective presence but 
one in which the nurses invited the patients to enter into a sharing relationship. The 
nurses were in touch with their feelings and brought their own humanness to the 
encounter (Fredriksson, 1999).

The third critical attribute of connection is spiritual transcendence, supported by 
five studies (Burkhardt, 1994; Coward, 1990; Coward, 1998; Lincoln, 2000; 
Montgomery, 1996). Spiritual transcendence is a connection with a higher being or power 
(Burkhardt, 1994; Montgomery, 1996) and a sense of one’s boundaries expanding 
inwardly, outwardly, and temporally (Reed, 1996). Expanding one’s self inwardly 
(introspection), outwardly (concern for others), and temporally (integration of past and 
future to enhance the present) have shown to increase interconnectedness among patients 
(Coward, 1990; Coward, 1998; Reed, 1991).

In Montgomery’s study (1996) on care giving relationships, spiritual 
transcendence was the overriding theme of caring. Nurses (N=35) experienced 
themselves as part of a force greater than oneself (Montgomery, 1996) and described 
being connected to a higher being, nature, others, self and the universe (Lincoln, 2000; 
Montgomery, 1996). This connection accessed a source of energy that nurses described
as "pulling from abundance" (Montgomery, 1996, p. 54). This energy was used by nurses in their care for patients and themselves and was felt to be energizing (Montgomery, 1996). When spiritual transcendence was present in nurses, they experienced profound fulfillment and were able to continue caring for patients without becoming burnt out (Montgomery, 1996). Nurses who connected with a higher power developed philosophies of life explaining the meaning of their experiences and purpose for living (Burkhardt, 1994; Montgomery, 1996).

The fourth critical attribute of connection is the presence of energy, supported by three studies (Lincoln, 2000; Montgomery, 1996; Quinn, 1992). Lincoln (2000) interviewed nurses (N=36) on their experiences of ecospiritual consciousness. The sense of energy was described by one nurse as flowing through the self, the universe and back to the self. Nurses described a sense of being connected with all of creation. This sense of connectedness to the whole of nature, the environment, and the cosmos was perceived to be held together by an energy exchange among all parts. This energy was also used as a resource in caring for themselves (Lincoln, 2000). In Montgomery’s (1996) study on the nature of caring from the nurse’s perspective, one of the properties of the spiritual dimension of caring was a source of energy. Nurses (N = 35) spoke of a form of energy described as abundance. Connecting with others energized the nurses who accessed this source of energy to care for themselves and for others (Montgomery, 1996).

Quinn (1992) studied the estimated time lapsed for a Therapeutic Touch session as documented by both the practitioner (n=2) and the patient (n=4). In 81% of the estimated times lapsed, the practitioner and the recipient accurately estimated whether the estimated length of the session was greater or less than the actual time lapsed. The results
suggested a “sharing of expanded consciousness experienced by practitioners and recipients” (Quinn, 1992 p. 33). The practitioner and the patient are connected by their energy fields and a healing occurs when there is a repatterning of the energy field between them (Quinn, 1992). Patients reported feeling relaxed, energetic, and deeply cared for after receiving therapeutic touch (Quinn, 1992).

Relating spirit to spirit is the fifth critical attribute of connection supported by three studies (Dennis, 1991; Montgomery 1996; Pieranunzi, 1997). Nurses (N=10) described relating spirit to spirit with patients as resonating between themselves and the patients (Dennis, 1991). Relating spirit to spirit may or may not require any talking between the two persons. These nurses believed that the human spirit is at the core of every person’s existence and is the power that heals (Dennis, 1991). When nurses nourished their spirits and called forth this inner power, healing naturally followed (Dennis, 1991). These nurses did not experience burn out, provided care for their own spirits, and spoke of using their spirit to guide them (Dennis, 1991). Montgomery (1996) similarly described a union between the nurse and the patient that occurred beyond the level of the self and occurred at the level of spirit. Relating spirit to spirit is not driven by ego, but is at the level of something greater. In a study by Pieranunzi (1997), nurses (N=10) saw power as connectedness in their relationships with patients. Power was described as internal, transcendent, and creative. This power emanated from deep within the essence of their being. The nurses connected with patients on a person-to-person basis, at the level of their humanness, and found this connection as the most rewarding aspect of their job (Pieranunzi, 1997).
In conducting a concept analysis, constructed cases of the use of the concept are useful in clarifying the attributes of the concept. Five types of constructed cases are model, borderline, related, contrary, and illegitimate (Walker & Avant, 1995). The five types of cases constructed in a previous work (Kutaka, 2001) clarified the distinct conceptual parameters of the concept.

Antecedents are those conditions or situations that must occur prior to the phenomenon under study (Walker & Avant, 1995). Based on the review of the literature, there are two antecedents to connection. The first antecedent is the nurse recognizing or identifying a patient need (Astrom et al., 1993; Bottorff & Morse, 1994; Drew, 1997; Heifner, 1993; Montgomery, 1996; Pieranunzi, 1997, Schubert & Lionberger, 1995; Schulte, 2000). The need could be a physical, mental, emotional, or spiritual situation that the nurse recognizes as needing attention and intervention.

The second antecedent is intentionality that is, having no agenda other than to provide unconditional love and to connect with the patient. Connection with a patient was perceived by nurses as not having a particular task or agenda to accomplish, not having one’s ego involved in the relationship, but simply being with the patient in an intimate exchange of feelings (Bottorff & Morse, 1994; Montgomery, 1996; Schubert & Lionberger, 1995). The purpose of the relationship was simply to connect and provide unconditional love for the patient (Montgomery, 1996). Schubert and Lionberger (1995) spoke of a caring environment, which was created by the nurse. The nurse was motivated to serve the best interests of the patient, to promote health, and support the patient’s inner healing. This intention led to connection with the patient (Schubert & Lionberger, 1995). Sometimes nurses used a connecting touch to establish closeness with the patient.
In a study on touch, Bottorff and Morse (1994) distinguished connecting touch from comforting touch. In connecting touch, the nurses reinforced their interest in or focus on the patient. This type of touch was not usually associated with a task, and the patient was not necessarily under distress. The intent of the connecting touch was simply to connect with the patient. On the contrary, comforting touch was used to soothe and calm a patient, was generally associated with a task, and occurred when the patient was in acute distress.

Consequences are those conditions or situations that occur as a result of the occurrence of the phenomenon under study (Walker & Avant 1995). Based on the review of the literature, there are six consequences to connection: finding meaning and purpose in life, feeling energized, personal growth and fulfillment, inner peace and relaxation, well being, and healing.

In reported studies, when nurses and patients connected, they developed philosophies of life that explained the meaning and purpose of their existence (Dennis, 1991; Drew, 1997; Montgomery, 1996). Nurses used this wisdom and developed a deep acceptance of situations that seemed tragic and senseless. As a result, these nurses did not experience burn out but were energized by the connections they made with patients (Dennis, 1991; Montgomery, 1996). The nurses grew personally and experienced profound fulfillment in their lives (Dennis, 1991, Fredriksson 1999). Patients experienced a sense of inner peace, relaxation (Quinn, 1992).

Well being was also another consequence of connection. Rieck (2000) examined whether the spiritual dimension of the nurse-patient relationship as perceived by the patient contributed to the patient’s well being \(N=98\). The Spiritual Dimension Inventory
(SDI), of which connection is a subscale, is a 25 item, self-reported, four-dimensional scale, with a five point Likert score ranging from five-strongly agree to one-strongly disagree. The SDI, an instrument developed by Rieck (2000), has, in addition to the 25 items, two open-ended questions asking for characteristics and behaviors that contribute to well being. The SDI measures the construct, the spiritual dimension of the nurse-patient relationship, which has four attributes (connection, empathy, commitment, and trust). The predictive validity of the SDI was tentatively supported by regression analysis. Connection, commitment and trust explained 53% of the variance of well being. Content analysis of two open ended questions tentatively supported connection, empathy, and trust in the nurse patient relationship as they relate to well being.

As a result of the concept analysis of connection, the definition of connection in the context of the nurse-patient relationship is: the joining together of the nurse and the patient at the level of spirit in a healing relationship motivated by the nurse’s unconditional love for the patient. Nurses focus their attention on the patient. Nurses and patients engage in an intimate exchange of vulnerabilities, emotions, and life experiences and bring their individual humanness to those relationships. Nurses experience a connection within, with others, and with a higher being, that is held together by a form of energy. Nurses use this energy to nourish themselves. Connection between the nurse and the patient results in nurses finding meaning and purpose in life, experiencing inner peace, well being, and healing. Nurses grow from these experiences and are able to continue caring for patients without feeling burnt out.

In summary, research supporting the conceptual definition of connection is from studies showing intimacy (Astrom, et al.1993; Drew, 1997; Heifner, 1993; Montgomery,
1996; Pieranunzi, 1997; Schubert & Lionberger, 1995), focused attention on patients (Astrom, et al. 1993; Bottorff & Morse, 1994; Clark et al. 1991; Fredriksson, 1999; Schubert & Lionberger, 1995), spiritual transcendence (Burkhardt, 1994; Coward, 1990; Lincoln, 2000; Montgomery, 1996), presence of energy (Lincoln, 2000; Montgomery, 1996; Quinn, 1992), and relating spirit to spirit (Dennis, 1991; Montgomery 1996; Pieranunzi, 1997) as components of the concept of connection between the nurse and the patient. Literature shows two antecedents to connection: the nurse recognizing or identifying a patient need (Astrom et al. 1993; Bottorff & Morse, 1994; Drew, 1997; Heffner, 1993; Montgomery, 1996; Pieranunzi, 1997; Schubert & Lionberger, 1995; Schulte, 2000) and the intention of the nurse to provide unconditional love and to connect with the patient (Bottorff & Morse, 1994; Montgomery, 1996; Schubert & Lionberger, 1995). Based on the review of the literature, the five consequences to connection are finding meaning and purpose in life (Dennis 1991; Drew, 1997; Montgomery 1996), nurses feeling energized and not experiencing burn out (Dennis, 1991; Montgomery, 1996), personal growth and fulfillment (Dennis, 1991; Fredriksson 1999), inner peace and relaxation (Quinn, 1992), and well-being (Rieck, 2000). The review of literature identified a gap, that is the lack of research on the experience of connection and the development of connection between the nurses and patient, which is the focus of this study.

Healing and Healers

The concept analysis of connection shows that the connection between a nurse and a patient is a healing relationship (Dennis, 1991). Patients find important the caring and healing aspects of care, which are at risk today (Ramos, 1992; Williams, 1998).
Nursing is a science and healing art (Nightingale, 1992). Nurses are in a critical position to facilitate the process of healing with patients. To enhance their skills as healers, nurses may benefit from studying the practice of healers, their perspectives on healing, and their relationships with their patients. To initiate exploration of this developing body of knowledge, a focused ethnographic study was conducted to address the perceptions of healers about aspects of a healer’s life (Kutaka, 2000).

**Qualities and Development of Healers**

A computer search on healers resulted in ten studies in which healers were participants. These studies addressed the cultural beliefs, practices, and development of traditional healers (Carrese & Rhodes, 1996; Chipfakacha, 1997; Geissler et al., 1999; Green, Jurg, & Dgedge, 1993; Ovuga, Boardman, & Oluka, 1999; Selepe & Thomas, 2000; Shai-Mahoko, 1996; Struthers, 2000; Troskie, 1997; Wright, 1997) but did not focus on the process of healing, nor on the relationship between the traditional healer and patient. Interestingly, the computer search did not produce nursing-related literature on healers. Searches using key terms of nurse healer and healing relationships did not produce any studies.

As reflected in the reviewed studies, traditional healers incorporated their cultural beliefs and rituals into their healing when treating patients (Carrese & Rhodes, 1996; Chipfakacha, 1997; Geissler et al., 1999; Green, Jurg, & Dgedge, 1993; Ovuga et al., 1999; Selepe & Thomas, 2000; Shai-Mahoko, 1996; Struthers, 2000; Troskie, 1997; Wright, 1997). Traditional healers used language and thought to shape outcomes (Carrese & Rhodes, 1996), reinforced rituals and ceremonies to maintain health of the people (Selepe & Thomas, 2000), used herbs for medicinal purposes (Green, Jurg, & Dredge,
1993; Wright, 1997), conversed with spirits (Green, Jurg, & Dgedge, 1993; Ovuga et al., 1999; Struthers, 2000; Troskie, 1997), and restored balance of evil and good spirits (Chipfakacha, 1997; Selepe & Thomas, 2000).

In the area of development, traditional healers developed their skills in various ways. They believed they were chosen by a higher deity, ancestors, or elders to do healing (Selepe & Thomas, 2000; Struthers, 2000). Prior experience of traditional healing either by treatment, training, or family practice was a precursor to becoming a healer (Ovuga et al., 1999). A survey of traditional healers (N=29) in Uganda on their beliefs, knowledge, attitudes and practice towards mental illness showed many of the healers (n=26) received treatment for an emotional illness or obtained training with other healers prior to becoming healers themselves.

An exploratory descriptive survey to identify the conditions that indigenous healers (N=35) treated showed more than half (54%) were taught the art of healing by their ancestors through dreams (Shai-Mahoko, 1996). Some (31%) of the participants received formal training and 14% were trained through an apprenticeship by an experienced healer. The period of training for most (94%) of the healers was between two and five years. Troskie (1997) reported many of the traditional midwives in South Africa had little or no formal education but apprenticed with grandmothers, mothers, and mother in laws or other family members from ten to fifteen years.

In the area of qualities of healers, traditional healers were a valuable resource to communities (Chipfakacha, 1997; Shai-Mahoko, 1996), and were sometimes seen as the only legitimate experts because of their knowledge of cultural traditions (Wright, 1997). Healers were already fully integrated into their communities, had a deep understanding of
the culture, were able to understand the values and beliefs and incorporate them into their practices, and were recognized as community leaders (Chipfakacha, 1997). Many of the healers were older and had been practicing for many years (Carrese & Rhodes, 1996; Chipfakacha, 1997; Geissler et al., 1999; Selepe & Thomas, 2000; Shai-Mahoko, 1996; Struthers, 2000; Troskie, 1997).

Traditional healers saw their role as helping others, doing good for other people (Carrese & Rhodes, 1996) and transmitting knowledge of cultural history to others (Struthers, 2000). Ojibwa and Cree women healers believed that healing was helping others and that they were instruments of the Creator in the healing process (Struthers, 2000). The women healers believed in the power of prayer, had a trusted connection with the spirit world, used their intuition in healing others, and had great faith in the Creator and Mother Earth (Struthers, 2000). The Ojibwa and Cree women healers also believed in the interconnectedness with all including nature, the Creator, and others, and lived a balanced life of harmony taking care to heal themselves before healing others (Struthers, 2000).

In summary, although researchers studied healers, little has been published in the health sciences literature in this area. Studies on healers refer to traditional healers and focus on the incorporation of cultural beliefs and values into practices that are based on cultural history and generational transference of knowledge. Healers are designated to their role through dreams, by elders, or by a higher deity. Healers learn the skills and art of healing through apprenticeships with other healers who are frequently family members or elders in the community. These studies did not address the process of developing relationships between healers and clients.
In contrast, studies on nurses as healers did not surface through computer search on healers. Instead, studies on the relationship between nurses and patients focused on qualities of the nurse-patient relationship. Patients identified trust (Davy, 1998), autonomy (Woodward, 1998), social and professional interest (Davy, 1998), recognition as unique individuals who need to share feelings and be listened to (Williams, 1998), respect, and concern for spiritual needs (Williams, 1998) as reflective of caring behaviors of nurses. Nurses identified three levels of increasing emotional involvement with patients (Ramos, 1992). Studies reviewed did not address the process of developing healing relationships between nurses and patients. The review of literature supported the need to study healers’ relationships with patients as an aspect of healing.

Healing and Culture

As healers, nurses account for the cultural context of which their healing takes place. “Cultural beliefs and values influence the perceived meaning of health and illness for clients and their families“ (Gaydos, 2000, p. 55). Culture influences the relationship between the client and the healthcare provider. The nurse must be aware of the cultural environment, values, and meanings of experiences of both oneself and others when establishing the healing relationship. To study the influence of culture on healing and to study the lives of healers, a focused ethnographic study on the perceptions of healers (N = 4) about aspects of a healer’s life was conducted and resulted in five cultural themes (Kutaka, 2000) from interviews and participant observation.
Cultural Theme 1: Healers connect spiritually with self, others, and a higher being.

Healers used the term, spiritual connection, as part of their healing relationships with self and others. Connecting with self was described by the healing touch therapist as meditating, grounding self, and emptying the mind in order to maintain the ability to heal. Connecting with others was described as being there and focusing on the other person, and experiencing a sense of connectedness with that person. A massage therapist described massage as having intimate relationships with clients that open up vulnerabilities, sensitivities and awareness for both the client and the healer. Connecting with the client meant providing unconditional love and compassion.

At other times, the connection was with a higher being or spiritual being. A lomi lomi therapist said, “Lomi lomi works only if we are one with God. We are all connected with God.” The massage therapist and a healing touch therapist spoke of the presence of other spirits and concentrated to hear specific messages from them. The massage therapist spoke regularly with her deceased loved ones to seek guidance and comfort.

Cultural Theme 2: Healers use intentions of best wishes and unconditional love and compassion in healing.

The concept of intentions was used in healing. The healing touch therapist wished her clients the best either with prayer or thoughts. The lomi lomi therapist started and ended each massage session with prayers. The massage therapist spoke of extending unconditional love and compassion to every person she encountered.
Cultural Theme 3: Healers are vessels or conduits for healing.

The participants identified themselves as vessels or conduits for healing. Phrases such as, “I help people heal themselves; I bring tools for people to heal themselves; I don’t do the healing” were used. The lomi lomi therapist referred to a higher being who does the healing and who used the lomi lomi therapist as the conduit for that process.

The participants identified everyone as healers and seemed embarrassed and, at times, offended to be called a healer. The massage therapist saw herself as part of the general population and being no different from anyone else. She said, “I am just an ordinary person.” Every human being was thought to have an innate ability to heal themselves and do so everyday unknowingly. The label or title of “healer” conjured an image of someone on a different level. The healing touch therapist put it succinctly, saying healing was “simply to be able to connect with someone and make a difference in that person.”

One way the participants recognized their ability to heal was when others acknowledged their skills or showed a desire to talk and be with them. Another way was through a personal life crisis. The massage therapist described having received an outpouring of love and support from others when a family tragedy occurred. This experience of love from others made her want to “give back to the community”. From this crisis, the massage therapist learned gratitude and love. As a result, she was determined to live a life mission of unconditional love and compassion in every encounter. When the lomi lomi therapist had a personal crisis, his family nurtured and supported him and guided him to an elder for healing. This support and love helped him accept his life circumstance and guided him into learning lomi lomi massage from his elder.
Cultural Theme 4: Healers benefit from healing.

While healers perceived clients benefiting from the healing, the healers felt they got just as much out of the healing. The healing touch therapist experienced an openness and expansiveness of self that allowed her to be there for another person. The massage therapist said healing others left her feeling really good and supported her ego.

Cultural Theme #5: Healers learn their skills through formal training and/or apprenticeships with elders.

In the area of development, the lomi lomi therapist experienced healing from an elder before learning to become a healer and learned the skills from the elder. The massage therapist experienced speaking to a spirit of a deceased person for guidance and support.

In summary, the conceptual orientation for the study (Kutaka, 2000), consisting of the concepts of culture and healing, was reflected in the results of the study. The cultural themes supported the complexity of the culture concept. Healing, as presented, reflected wholeness of person. The concept of vessel of healing was meaningful to the healers. The researcher’s use of the word, healer, to describe the participants generated strong feelings of objection. Although the healers were quick to state everyone is a healer, they were not comfortable being labeled as one. The term healer connoted a sense of being above others, generating expectations from others, and singling them out as different from the general population. One of the healers acknowledged God as the higher being who is responsible for the ultimate healing. The profile of the healers in this focused study was similar to findings on research on connection found in literature on spirituality (Burkhardt, 1994; Dennis, 1991), nurse-patient relationships (Heifner, 1993; Pieranunzi,
1997; Schubert & Lionberger, 1995), wellness (Rieck, 2000) and environment (Lincoln, 2000). In these studies, similar themes of connections with self, others, and a higher being, reciprocity of well being (benefits) to both parties that engaged in a relationship of connectedness, feelings of compassion and caring for another, having a sense of purpose in life, and focusing on the client emerged.

Healing and Spirit

The theme of spirit was evident in the review of literature on connection and in the literature addressing healers and healing. Nurses have come to recognize the healing power of the spirit (Dennis, 1991; Hall, 1997; Montgomery, 1996). When patients are confronted with a life threatening disease, they begin a search for the purpose and meaning of life (Coward, 1990; Coward & Reed, 1996; Hall, 1997). Through reflection and introspection, patients describe a connection with their spiritual selves and an awakening occurs that creates a sense of well being (Coward, 1990; Kendall, 1996), connectedness to others (Coward & Reed, 1996), increased worth in self (Coward, 1990; Coward & Reed, 1995), and love for self (Hall, 1997).

Although clinical, conceptual, and ontological knowledge of spiritual dimensions has increased over the past several years, there is no consistent definition of spirit. Spiritual self, spirit, soul, inner presence, and spiritual essence are terms used to describe a phenomenon that has power to heal. A literature review on spirit resulted in five themes: positive manifestations (Brennan, 1993; Hall, 1997; Lane, 1987; Newton, 1998; Pearsall, 1998; Picard, 1997; Walton, 1996; Zukav, 1990), dualistic framework (Hall, 1997; Lane, 1987; Newton, 1998; Walton, 1996; Zukav, 1990), immortality (Brennan, 1993; Newton, 1998; Pearsall, 1998; Picard, 1997; Zukav, 1990), purpose and meaning...
in life (Brennan, 1993; Hall, 1997; Lane, 1987; Pearsall, 1998; Walton, 1996; Zukav, 1990), and capacity to heal (Brennan, 1993; Pearsall, 1998; Zukav, 1990).

The first theme of positive manifestations included descriptions of unconditional love, compassion, serenity, joyfulness and fulfillment. People who connected with their spirit experienced these positive feelings. The second theme of dualistic framework was described as spirit being separate from ego, personality, or the physical body. As compared to ego and personality, spirit was described as one’s true self or core being. Spirit was the observer of ego. Ego was that social construct that defined one’s external personality. The more alignment one had between ego and spirit, the more harmony one experienced. The third theme of immortality showed spirit as separate from the physical body and existing beyond time and physical death. Having a sense of purpose and meaning of life was the fourth theme. When a connection was made with spirit, people uncovered the purpose and meaning in life. The fifth theme was healing capacity. Connecting to spirit enhanced one’s ability to heal and cope with life’s stresses. Three other attributes were: spirit as being one with the universe or one with a higher being, spirit as a form of energy, and spirit as being an inner wisdom, which guided one’s life.

Based on this review of literature, every person embodies a spirit, which is immortal, and the essence of one’s being. Spirit is a demonstration of unconditional love, compassion, joyfulness and harmony within oneself and others. As a source for healing, spirit is always present and guides one to a state of higher good and happiness. Spirit is energy and is part of the larger universe. Collectively, spirits have memory, and once connected with other energies, stay connected forever. Connection to spirit through
introspection, reflection and quieting of the mind leads one to find meaning and purpose in life.

The process of connecting with one’s spirit has been labeled inward turning (Lane, 1987), spiriting (Burkhardt, 1989), self-reflecting (Elkins, 1995), and introspecting (Rew, 1989). A model of spirit (Walton, 1996) shows the direct relationship between the depth of knowing one’s spirit and the depth in one’s relationship to a higher power, others, or nature. Awareness of and intentionally caring for one’s spirit are important factors in the process of integrating spirituality into practice (Burkhardt & Nagai-Jacobson, 1994). Some ways to connect with spirit are taking time for self and relationships with others (Burkhardt & Nagai-Jacobson, 1994), mindfulness and paying attention to one’s body and knowing when to take time for oneself (Burkhardt & Nagai-Jacobson, 1994), meditation (Brennan, 1993), prayer (Burkhardt & Nagai-Jacobson, 1994), connections with significant people, play, rituals, and expressing oneself creatively (Burkhardt & Nagai-Jacobson, 1994).

The development of spirit is described as a spiritual journey in search of the purpose and meaning in life (Keegan, 1991) that begins with an awakening (Keegan, 1991; Moody & Carroll, 1997). Moody and Carroll’s (1997) 20 years of experiences with spiritual searching by people resulted in the identification of five developmental stages of spirit. The first stage, the Call, is an awakening by a disquieting inner voice. People experienced discontent or lack of fulfillment in their lives despite having all the material accouterments. The call is not an event, but a process that begins the search for the spirit within and continues throughout life. Attention shifts from external events to
one of inward experiences that resulted in a commitment to a life of kindness, compassion, and love for others.

The second stage, the Search, is a quest for knowledge that was initially sought externally through books, spiritual practices, the arts, music, and dance. Eventually, people turned inward, and began the search for spirit. The third stage, the Struggle, is the confrontation with external and internal stresses. The Struggle begins the spiritual journey. The fourth stage, the Breakthrough, is a sudden sense of knowing one’s purpose and meaning in life. A sense of peace, joy, happiness, and connection with something greater than oneself occurs. The fifth stage, the Return, is a continuation with one’s usual life with a deep commitment to serving community, and living with love and compassion towards others.

In summary, healing and spirit are integrally related. Connecting with one’s spirit and caring for one’s spirit benefit the nurses and are important in the integration of spirituality into nursing practice. Developing one’s spirit begins a healing process for the nurse to begin living a life with love and compassion for others.

Summary

This chapter began with a description of the conceptual orientation consisting of the major concepts, connection, healing, and spirit. A review of literature relative to the connection between nurses and patients identified the components, antecedents, and consequences of the concept of connection. A conceptual definition of connection in the context of the nurse-patient relationship is the joining together of the nurse and patient at the level of spirit in a healing relationship motivated by the nurse’s unconditional love for the patient.
A review of literature relative to healing and healers addressed the qualities and development of healers, healing and culture, and healing and spirit. The qualities and development of healers were reflected in five cultural themes of a focused ethnographic study (Kutaka, 2000) on what it is like to be a healer. The cultural themes supported the complexity of the culture concept. Although different terms are used to describe spirit, five themes emerged from the literature. The review of literature revealed a gap in research addressing the process of developing relationships between nurses as healers and patients, which was the focus of this study.
CHAPTER THREE

METHODOLOGY

Chapter Three presents the methodology for conducting this study describing the essential structure of the lived experience of connecting with patients by nurses who said they had experienced connection with patients as a major aspect of healing. This chapter includes the definition of human science, definition of qualitative research, description of phenomenology as a philosophy and methodology, the research design, setting and sample, protection of human rights, representation, recruitment, data collection procedure, data collection instruments, data management, data analysis, and procedures for establishing trustworthiness of the study.

Human Science

In an effort to understand and know the world in which we live as human beings, Human science research questions the way people experience the world (Van Manen, 1990). By intentionally attaching one's self to the world and becoming a part of the world, one can know and understand it. William Dilthey is credited for the distinction between Human Science and Natural Science (Van Manen, 1990). Dilthey spoke of Naturwissenschaften (Natural Science) as "the study of 'objects of nature', 'things', 'natural events', and 'the way that objects behave'" (Van Manen, 1990, p. 3). In contrast, Geisteswissenschaften (Human Science) is the study of "beings that have 'consciousness' and that 'act purposefully' in and on the world by creating objects of 'meaning' that are 'expressions' of how human beings exist in the world " (Van Manen, 1990, p. 3-4). Natural Science uses detached observations, controlled experiments, and
mathematical or quantitative measures as investigative methods. Human Science uses description, interpretation, and self-reflective or critical analysis as tools of inquiry.

A humorous yet thought-provoking story exemplifies the need to do Human Science research. Diogenes, a Greek philosopher living in the fourth century B.C, was an unconventional thinker in his time who used pantomimic gestures to expound on life’s lessons. One day, Diogenes walked throughout the city in broad daylight holding a lit lantern, as though looking for a lost object. People came up to him and inquired what he was trying to find. Diogenes told them that even in daylight he could not find a real human being. People laughed at him and pointed to themselves as examples of what Diogenes was looking for. Diogenes waved a stick and chased them away shouting he wanted real human beings. This anecdote elucidates the complexity of understanding human nature. What is the essence of a human being? What complexities influence a human being’s feelings, thoughts, and perceptions? Diogenes’ demonstration was meant to raise the consciousness of people who settle for easy answers to such profound questions (Van Manen, 1990).

Qualitative Research

Qualitative research is a field of inquiry that studies things and people in their natural settings where the phenomenon occurs (Denzin & Lincoln, 2000). Truth is temporal and cultural, and determined by the interpretations and meanings given to the phenomenon by those who experience it (Munhall, 1989). A qualitative approach is used to describe a phenomenon when little research has been done to reveal components of the phenomenon or when there is no theory developed. Qualitative research consists of multiple interpretive practices and utilizes approaches of ethnomethodology,
phenomenology, hermeneutics, feminism, participant observations, ethnography, history, case studies, grounded theory, and others (Denzin & Lincoln, 2000; Munhall, 1989). Using these research practices, researchers intend to understand the nature of human thoughts, human behaviors, and to make visible the world in which they live (Denzin & Lincoln, 2000). Qualitative research uses an inductive process in understanding phenomena. The researcher immerses oneself in the details of the data, allows time for thinking and becoming aware of meanings, captures one's intuitiveness to achieve understanding of the experience of participants, and integrates and synthesizes the pieces to construct the lived experience (Janesick, 2000).

Qualitative research is based on beliefs, values, and assumptions about the nature of human beings and reality (ontology), the relationship between the inquirer and the known (epistemology), and the methodology of how knowledge is gained (Denzin & Lincoln, 2000). One of the major interpretive paradigms that structure qualitative research is constructivism (Denzin & Lincoln, 2000). "The constructivist paradigm assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent cocreate understandings), and a naturalistic (in the natural world) set of methodological procedures" (Denzin & Lincoln, 2000, p. 21). The inquiry aim of constructivism is understanding and reconstruction of knowledge. The voice of the researcher is passionate about the phenomenon and control of the research is shared with the participants (Lincoln & Guba, 2000). Goodness or quality of the research is based on the trustworthiness of the data.

The ethical underpinnings of qualitative research methodology focus efforts toward understanding human experience and not changing human beings (Munhall,
1989). Human beings are free to be as they are, and there is reverence for the human experience. Reality is determined by the people experiencing the phenomenon and not by the researcher's assumptions and beliefs (Munhall, 1989).

Phenomenology as a Philosophy and Methodology

Phenomenology is a philosophy and methodology of qualitative research based in the Human Sciences. It is the study of lived experience that brings insight to the nature and meaning of everyday life, and provides a deeper understanding of everyday experiences (Cohen et al., 2000; Van Manen, 1990). Edmund Husserl (1859-1938), founder of twentieth-century phenomenological philosophy, defined lived experience to mean that which is "actually lived out--perceived, thought, imagined, remembered..." (Macann, 1993, p. 17). The method for the investigation of lived experience "must remain with human experience as it is experienced...This can be achieved only by the phenomenological method of description..." (Colaizzi, 1978, p. 53).

Phenomenological researchers study the world as one experiences it rather than as one conceptualizes or theorizes about it (Van Manen, 1990). Merleau-Ponty's *Phenomenology of Perception* emphasizes the difficulty to unlearn all that was learned, yet retain the critical acumen to see and understand the phenomenon as those living it (Macann, 1993). Phenomenological researchers question the way people experience the world, address questions of what it means to be human, and seek to understand the lived experience as those having the experience understand it (Van Manen, 1990). In phenomenology, reality is defined by the perceptions of people's experiences. Individuals experience a phenomenon, assign meaning to it, and create their own reality regarding the
phenomenon. The subjective experience of the objective world becomes one. Oiler (1986) posits:

This is not to be confused with truth. As access to truth, perception presents us with evidence of the world not as it is thought, but as it is lived. Perception of an amputated limb as an ambivalent presence is not truth but it is reality. (p. 87)

Van Manen (1990) describes phenomenological research as a caring, thoughtful act because the researcher seeks to know what is essential to being. Phenomenology questions the intimacies and mysteries of the world and brings the world into being. The answers to these questions may lead to a deeper understanding and enable people to act more thoughtfully and tactfully. To care is to share one's being with the one loved and to truly know the loved one's nature (Van Manen, 1990). Van Manen (1990, p.6) references Frederick Buytendijk, in his 1947 inaugural lecture, who said, "love is foundational for all knowing of human existence". The greater the desire of the researcher to truly understand the perceptions of a phenomenon as it is lived by a person, the deeper the appreciation and understanding of that lived experience may be. The love for human nature and the quest for knowledge to enhance human science resort to the passion of the researcher.

The ethics of phenomenology dictate that the researcher accurately represents the lived experience of the participants as it is perceived and described by the participants (Beck, 1994; Tedlock, 2000). The researcher may experience a paradoxical struggle to be immersed in and out of the collection of data simultaneously (Lipson, 1991). The outcome of phenomenological research is the heightened awareness of the researcher's consciousness (Beck, 1994).
Research Design

The research design for this study was descriptive, using a phenomenological approach reflected in Colaizzi’s model (Colaizzi, 1978) as adapted by Haase (Haase, 1987).

Setting and Sample

The settings for this study consisted of locations that were quiet, relaxed, and offered adequate privacy, in homes, offices, parks, and restaurants, and were selected by participants as convenient for them. Sample size in qualitative research is generally smaller than in quantitative research. In naturalistic sampling, the sample size is determined by informational considerations to obtain maximum information on the phenomenon of study (Lincoln & Guba, 1985). In this study, the sample size was 13. The purpose of sampling is to achieve as much detail and variation within the unique context about the phenomenon of study, and to generate a broad range of information from which to base the emerging design (Cohen et al., 2000; Lincoln & Guba, 1985). Sampling continues until there is redundancy in categories (Lincoln & Guba, 1985). The sample size for some qualitative research has been reported as six (Beck, 1998), 10 (Drew, 1997), and 20 (Milne & McWilliam, 1996). Sample recruitment ceased when redundancy of categories was reached. Inclusion criteria for this study were:

- English-speaking
- 18 years of age or older
- Registered Nurses who said that, in their role as nurses, they had experienced connection with patients as a major aspect of healing
- Ability to articulate the experience of connection with a patient
The lived experience of experiencing connection with patients by nurses who said they had experienced connection with patients as a major aspect of healing is most likely to occur among practicing nurses who are in relationships with patients in a health/illness context. For this reason, participants were recruited from the Hawaii Nurses' Association, which is the professional organization and bargaining voice representing 10,000 Registered Nurses in Hawaii, of which 3,700 are members. Most of these members are nurses who practice nursing in acute care settings, communities, schools, or clinics. Participants were also recruited from Sigma Theta Tau, which is the national honor society of nurses, and from the University of Hawaii School of Nursing and Dental Hygiene.

Two sampling techniques were used concurrently in this study: purposive sampling and snowball sampling. Purposive sampling is selection from a population that has experienced the phenomenon of study. In purposive sampling, there is no a priori specification of the sample (Lincoln & Guba, 1985). Each participant is chosen serially to extend information already obtained, add new information that may support or contrast with previous data, or to complement existing data (Lincoln & Guba, 1985). The objective is to obtain variation and specifics of the phenomenon of study (Lincoln & Guba, 1985). The researcher continuously adjusts or focuses on particular aspects of the sample based on issues that emerge as relevant. Purposive sampling ends when a point of theoretical saturation (Glaser & Strauss, 1967) or informational redundancy (Lincoln & Guba, 1985) occurs, that is, further interviews result in no new data or information.

Snowball sampling is the identification of participants who have experienced the phenomenon under study and whom the researcher asks to identify other potential
participants (Lincoln & Guba, 1985), who then are contacted. In this study, the researcher asked participants from the purposive sample to refer other nurses whom participants thought experienced connection with patients as a major aspect of healing. The researcher recorded the names, phone numbers, or e-mails of these referrals, contacted them within three to seven days of referral, explained the purpose and voluntary and confidential nature of the study, and screened them for eligibility.

Protection of Human Rights

The researcher received approval to conduct this “Exempt” study from the Committee on Human Studies of the University of Hawaii at Manoa (see Appendix C). An Agreement to Participate (see Appendix A) form was given to each participant. Before beginning data collection, the researcher explained the content on the consent form, invited the participant to read the written version, and provided the opportunity to ask any questions about the research, including the purpose of the study, audio taping the interview, benefits and risks to participants, the voluntary nature of the study, and the approximate number and length of meeting times. The researcher identified participants by code numbers.

Once the study was completed, the original audiotapes were erased. A list of participants was seen only by the researcher and kept in a locked file. On computer files, a code number was assigned to each participant. Computer files were kept confidential and was accessed only by the researcher.

Representation

Throughout the course of any research, a dynamic and reciprocal interaction occurs between the researcher and the research environment. In phenomenology, the
researcher makes a conscious effort to represent the participant's experiences and not what the researcher wants to see. Critical reflection is identifying the researcher's personal biases, assumptions, and preconceived ideas about the phenomenon of study. Two techniques to identify the researcher's personal biases are bracketing and reflexive journaling.

Introduced by Husserl, bracketing is a tool used by phenomenologists to expose their own prejudices about a phenomenon (Beck, 1994; Crotty, 1996). Phenomenological researchers set aside their preconceived ideas, notions of theory, and biases of the phenomenon and, instead, allow themselves to remain open to the richness of the data (Crotty, 1996; Macann, 1993). At the outset of the research, the researcher makes explicit one's beliefs, values, attitudes, and assumptions regarding the phenomenon, and documents these preconceived ideas to be used for self-reflection and external review (Knaack, 1984; Lamb & Huttlinger, 1989).

Prior to beginning data collection, the researcher bracketed her pre-existing ideas and assumptions about the phenomenon, connection. The researcher's bracketed pre-existing ideas and assumptions about the experience of connection in relationships between nurses and patients were:

- Many nurses focus on tasks rather than on connection with patients.
- Nurses want to connect with their patients.
- Some nurses do not know how to connect with their patients.
- Connection with a patient is healing to both the nurse and the patient
- Connection between nurses and patients has personal meaning to nurses.
Reflexive journaling is the second technique of critical reflection in which the researcher records insights in a journal. Reflexivity is a type of critical thinking in which the researcher seeks to understand how personal feelings and experiences influence a study (Lamb & Huttlinger, 1989). Reflexivity requires the researcher to have a conscious awareness of self, the participants, and other conditions in the environment. Practicing reflexivity in research not only enhances the outcome of the study but also cultivates the researcher's personal growth (Lamb & Huttlinger, 1989). Kahn (1993) suggests researchers focus on two types of relationships in their journaling: (1) relationships with participants and (2) relationships with data. Both types of relationships generate ideas and challenges to the researcher's understanding of the phenomenon. The journal is a rich source of data that adds credibility to the data during analysis (Lincoln & Guba, 1985). The researcher kept a reflexive journal and documented personal reflections, thoughts, insights, and biases regarding the collection and analysis processes (Lamb & Huttlinger, 1989). Throughout this study, the researcher discussed the contents of the journal with the dissertation Chair to further enhance rigor in this process of inquiry.

Recruitment

Four strategies were used to recruit participants: announcement (see Appendix D) sent electronically to Hawaii Nurses Association members, announcement sent electronically to faculty and graduate students at the University of Hawaii School of Nursing (UHSON) and Dental Hygiene, announcement printed in the Sigma Theta Tau newsletter, Hawaii Chapter, and word of mouth referrals from participants as part of snowball sampling.
These approaches were most likely to reach nurses who were in relationships with patients in a health/illness context. The announcement included an invitation to Registered Nurses to participate in a research study by sharing stories of an experience of connecting with patients as a major aspect of healing. The announcement also included methods of directly contacting the researcher by telephone, e-mail, or pager. To ensure participants met the inclusion criteria, within three days of contact the researcher conducted a telephone screening of potential participants who responded to the recruitment announcement. After confirming eligibility and interest of the potential participants, the researcher verbally explained the study and mailed a copy of the Agreement to Participate (Appendix A) form and Data Generating Question (Appendix B) to participants to give them a period of time to decide whether to participate. Within one week of mailing these documents, the researcher phoned the participants to see if they were still interested and, if so, made appointments for an interview at a time and place of their convenience. When no phone number was available, the researcher mailed a letter to potential participants inviting them to participate and included a copy of the Agreement to Participate (Appendix A) form and Data Generating Question (Appendix B). Within two weeks of mailing these documents, the researcher phoned the participants to see if they were still interested. After confirming eligibility and interest of the potential participants, the researcher verbally explained the study. Participants who wished to participate were given appointments for an interview at a time and place of their convenience.

Of 29 potential participants who were contacted by researcher, 13 agreed to participate, three declined (refusal rate of 10%), three were not interviewed due to lack of
fit with study inclusion criteria, three were unable to be contacted, two did not respond to phone calls or letter, one was not interviewed because of membership on researcher’s Dissertation Committee, and four were not interviewed because the data had reached redundancy. All 13 participants were the result of purposive and snowball methods. One participant responded to the announcement to faculty and graduate students at the University of Hawaii School of Nursing and Dental Hygiene. Faculty or graduate students at the UHSON and Dental Hygiene referred six participants. Other participants referred seven participants.

Data Collection Procedure

Two data collection methods, interview and observation, were used concurrently in this study. The goal of the interview is to collect as much detailed information of the lived experience of the phenomenon as determined by the participants and not by the researcher (Haase & Rostad, 1994). The researcher collects current constructions and reconstructions of persons, events, and feelings that occur in the present, past, and future (Lincoln & Guba, 1985). Through interviews, researcher collects constructed and reconstructed data on the phenomenon of connection between a nurse and a patient. The interview is unstructured and overt (Lincoln & Guba, 1985).

The researcher observed the participant and the setting during the interview. Observation involves more than visual data gathering. All the human faculties of smell, touch, hearing, and taste are part of the observations (Adler & Adler, 1998). Observation is overt and takes place in the natural setting (Lincoln & Guba, 1985). The researcher observes non-verbal behaviors (Lincoln & Guba, 1985), particularly congruencies and incongruencies between verbal and non-verbal behaviors. A conscious effort is made to
pay attention to the participant’s intonations, facial and physical gestures, and other nuances of behavior. The participant is viewed as an exquisite human being, rich with experiences, memories, and feelings. To access these data, the researcher listens with the “totality of his being and with the entirety of his personality” (Colaizzi, 1978, p. 64). A caution regarding observation is the concept of going native, which is the failure to maintain scientific objectivity during interactions with and observations of participants (Angrosino & Perez, 2000, p. 674) and attempting to be one of the participants. Observations were recorded in the interview as part of the transcription and reviewed with the Chair of the Dissertation Committee for objectivity.

The first interview occurred on February 7, 2002, and the last interview occurred on May 17, 2002. The interviews for this study lasted 18 minutes to 80 minutes ($M = 48.1$). At the time of the interview, the researcher verbally reviewed with the participants the contents of the Agreement to Participate (Appendix A) and invited them to read it. With the participant's permission, the researcher audiotaped the session, beginning with asking the Data Generating Question (Appendix B). The interview continued until the participant said there was nothing else to share. After the completion of the interview, the researcher asked the participants to complete the Demographic Data Record (see Appendix E), which provided descriptive information about them. After the participant completed the demographic data record, the researcher thanked the participant and requested to make contact by telephone to arrange another meeting to review the results for accuracy.

During one interview, a participant (09) said she saw the researcher’s energy and spirit guide behind the researcher. The participant giggled and apologized for being
distracted. The researcher paused and asked the participant if she wanted to wait awhile before continuing. The participant continued the interview saying the spirit guide was gone. When the interview was over, the participant and the researcher hugged each other, laughed, and teared over this incident. The researcher shared this experience with the Chair of the Dissertation Committee, and cried, as she felt honored to be in the presence of an energy form as perceived by the participant. When the audiotape of this interview was transcribed, the transcriber commented that many words were missing from the tape. When the researcher reviewed the tape for accuracy with the transcription, the researcher also noted that parts of the conversation were missing.

During the interviews, the researcher often felt overcome with emotions. The researcher discussed these emotions with the Chair of the Dissertation Committee, and upon reflection, realized the researcher was affected by feeling the love the participants had for their patients.

After completing data analysis and determining the essential structure, the researcher contacted each of the 13 participants and scheduled a meeting at a convenient time and place. Eight participants met with the researcher in person, two participants chose to respond by telephone, and two participants chose to respond through e-mail. One participant who agreed to meet with the researcher received a copy of the essential structure through e-mail, but follow up phone calls to obtain her comments were not successful. At their request, nine participants received either a hard or electronic copy of the essential structure before the meeting to give them time to review the material. At their convenience, two participants met together with the researcher.
The researcher explained the purpose of the meeting, telephone conversation, or e-mail was to validate the data with the participant, and to clarify any information on the Demographic Data Sheet. At this meeting, the researcher shared the meaning of the data and the essential structure, and provided the opportunity for questions, clarifications, changes, and additions. Seven participants supported the essential structure as written by the researcher. Five participants provided comments relating to the words control, pain, and love that clarified the essential structure. The researcher integrated their ideas to clarify the final version of the essential structure.

The researcher also clarified responses with the participants to two questions on the Demographic Data Record: specialized training or certificates, such as in specialized healing, and number of years in specialized healing practice. At the end of the conversation, the researcher thanked the participants for their contribution to the research.

Data Collection Instruments

"In phenomenology, the researcher's self is the major instrument for collecting data" (Beck, 1994, p. 500). A relationship develops between the researcher and the participants and it is through this interactive involvement that the essential nature of the lived experience is understood (Beck, 1994; Bergum, 1991). The essential structure of the lived experience is the integration and synthesis of the common components of the phenomenon of study (Haase, 1987). The observer (researcher) is not separate from the observed (participant). The researcher and the participant are “united in being in the world…. and meaning is constructed as an intersubjective phenomenon” (Beck, 1994, p. 501). In addition to the researcher, the instruments for this study were the Demographic Data Record (Appendix E) and the Data Generating Question (Appendix B).
Demographic Data Record

After completing the interview, the researcher asked the participant to complete the Demographic Data Record (Appendix E) by providing written information on: gender, age, ethnicity, highest nursing degree earned, number of years in nursing practice, number of years in specialized healing practice, major clinical area, religion, practices used to enhance one to experience connections with patients, frequency of use of the practices, and statement of purpose(s) in life.

Two questions on the Demographic Data Record showed to be unclear to the participants. The question, “Please list specialized training or certificates, such as in specialized healing”, was intended to obtain information on formal or informal training in healing practices. Many participants did not respond to this question. The question asking participants for the number of years in specialized healing practice was intended to be a related question to the previous one. Several participants included years in their clinical practice as part of the years in specialized healing practice. The researcher clarified the intent of these questions with the participants when the researcher talked with the participants for the follow up interview on the essential structure. With clarification, the participants responded to both questions.

Data Generating Question

In phenomenology, the researcher uses a minimal number of broad data generating questions to obtain descriptions of the lived experience of the phenomenon (Haase & Rostad, 1994). In this study, the Data Generating Question (see Appendix B),
mailed to participants was verbally presented to the participants at the time of the interview. The researcher began the interview with the following question:

"Please tell me what it has been like for you as a nurse to have experienced connection with patients as a major aspect of healing. Tell me everything you can remember happening that might relate to the experience of connection—everything you have thought and felt about it."

During the interview, the researcher used probing questions such as "Tell me more about that," or "What does that mean to you?" in order to obtain clarity and fullness of the description (Haase & Rostad, 1994).

Data Management

The researcher paid two transcriptionists to transcribe the data from audiotaped interviews as soon as possible after the interview. The tapes were placed in an envelope with the date and place of the interview. The researcher compared the printed transcriptions with the audiotaped version as many times as necessary to assure accuracy, making corrections in the transcript as needed. Data were stored in the researcher’s personal computer, on disc, and on hard copy.

A system to manage the data assures accuracy, accessibility, and organization.

The word processing program used in this study to produce transcripts and records of the process of analysis of the narrative data was Microsoft Word 2000.

Data Analysis

Analysis of transcriptions followed the procedure for the analysis of written protocols by Colaizzi (1978), as adapted by Haase (1987). The steps in this method are as follows:
1. Acquiring a sense of meanings of protocols: The researcher listens to the audiotapes and reads the transcriptions a minimum of several times to become familiar with and get a sense of the meanings and feelings of the content. Colaizzi (1978) refers to the participant’s descriptions as protocols.

2. Extracting significant statements: The researcher extracts from the protocols significant statements pertaining to the phenomenon, while eliminating repetitions.

3. Restating the significant statements: The researcher reformulates the significant statements into restatements.

4. Formulating meanings: The researcher discovers the hidden meanings from the significant statements and derives the formulated meanings. The meanings relate back to the original protocols (Colaizzi, 1978).

5. Identification of themes: The researcher identifies themes from the formulated meanings. Although a theme may contradict or be unrelated to other themes, the researcher avoids prematurely discounting a theme.

6. Organizing theme clusters: The researcher organizes the aggregate meanings reflected in themes (Haase, 1987) into theme clusters. The researcher checks the theme clusters against the descriptive statements of the participants in order to validate them (Colaizzi, 1978).

7. Defining theme categories: The researcher defines categories that represent the themes.
8. Describing phenomenon: The researcher integrates the themes, theme clusters, and categories of themes into an exhaustive description of the structure of the lived experience of the phenomenon.

9. Creating the essential structure: The researcher integrates and synthesizes all the components of the phenomenon identified in the exhaustive description into the essential structure. The essential structure includes a description of the processes and meanings of the phenomenon (Haase, 1987).

10. Confirming the essential structure: The researcher validates the meanings of the data with the participants and integrates new data into the essential structure.

Initially, the researcher and Chair of the Dissertation Committee listened to the audiotapes of the first two interviews together, made necessary corrections to the transcriptions, and identified significant statements. The researcher listened to the remaining audiotapes, compared the tapes to the transcriptions and made necessary changes for accuracy, identified significant statements, formulated their meanings, and identified themes. The researcher submitted transcriptions to the Chair for comments, and the Chair returned them to the researcher to incorporate suggestions into the analysis as appropriate. The researcher went through much iteration of these steps of the analysis and compared current data with data already collected.

After each transcription was analyzed for significant statements, formulated meanings, and themes, researcher reproduced each transcription on a different colored paper that corresponded to each participant. The researcher took each colored
transcription and cut the significant statements with the accompanying formulated meaning and grouped them by themes. There were several iterations of clustering and relabeling themes to better describe the meanings. The researcher then assigned categories to the theme clusters. The researcher and Chair reviewed the theme clusters, themes, and categories and made changes as appropriate, after which the researcher generated the essential structure of the lived experience of connection between nurses and patients as a major aspect of healing.

Procedures for Establishing Trustworthiness

Trustworthiness is the "truth value" of the research (Lincoln & Guba, 1985). The naturalist shows the multiple constructions are represented adequately and are credible to the constructors of the data (Lincoln & Guba, 1985). To establish trustworthiness, the researcher must be able to describe and defend how the data collection and analysis processes were conducted. Criteria for trustworthiness of this study are credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). The positivist's equivalents for these criteria are internal validity, external validity, reliability and objectivity (Lincoln & Guba, 1985).

Credibility

Credibility by the naturalist is the equivalence of internal validity by the positivist. Credibility is the accurate representations of the perceptions of the constructors of the data (Lincoln & Guba, 1985). For this study, three major activities to establish credibility were used: (1) increasing the probability that credible findings will be produced by prolonged engagement, persistent observation, and triangulation; (2) providing an external check on the inquiry process, by peer debriefing, and (3) testing the
findings and interpretations with the participants who provided data through member checking.

Prolonged engagement is spending enough time with the participants to learn about their culture, to detect personal and participant distortions, and to build trust with the participants (Lincoln & Guba, 1985). To assure adequate time was spent with the participants, the researcher built in flexibility on the time allotted for the interview (Cowles, 1988). Participants were given as long or as short a time needed to share their experiences. At the end of the interview, researcher gave participant time to share more comments by asking participant if there was anything else the participant wanted to add. The researcher also reviewed the reflexive journal with the dissertation Chair, who looked for biases or personal distortions of the data. One insight to look for is consistency with what the researcher predicted. This consistency may be an indication that the researcher is not spending adequate time to shift from her ethnocentric position (Lincoln & Guba, 1985). To detect personal and participant distortions, the researcher clarified with the participants any perceptions of not understanding the question, trying to please the researcher, not being responsive, or being deceptive (Smith, 1999). To develop a trusting relationship, the researcher assured confidentiality, was truthful with no hidden agendas, allowed participants to influence the inquiry process, and honored both the participant’s and the researcher’s best interests (Lincoln & Guba, 1985).

Persistent observation is the second technique that contributes to credible findings. Whereas prolonged engagement allows the researcher time to absorb multiple realities in the large context of the phenomenon of study, persistent observation identifies those elements that are most relevant. The researcher focuses on these salient factors in
detail, sorting the relevant from irrelevant factors. “Premature closure” (Lincoln & Guba, 1985, p. 305) may inhibit the potential benefits of persistent observation. The researcher, pressed for time, may come to closure prematurely and may mis-identify salient factors or exclude factors that may be relevant. In this study, to conduct persistent observation, the researcher and Chair checked the themes, theme clusters, and theme categories against the significant statements to validate them. The researcher also consistently compared recent data with earlier data from interviews.

Triangulation is the third technique that contributes to credible findings. Triangulation means using different sources, methods or investigators to promote credibility (Lincoln & Guba, 1985). In this study, to conduct methodological triangulation, the researcher used interview, a demographic questionnaire, and observation to collect data.

Peer debriefing is a technique that provides an external check on the inquiry process, and thus increases the credibility of the data. The debriefer is a peer who has no vested interest in the study and who challenges the investigator to expose the thinking behind decisions, probes biases and interpretations, suggests next steps in the method, and clears the mind for sound judgment. In this study, to conduct peer debriefing, the researcher recruited a peer in nursing to listen to and challenge the researcher's thoughts, feelings, and reactions during data collection and analysis (Cowles, 1988). The researcher met with the peer reviewer twice; once to go over the data collected and another time to go over the essential structure.

Member check, the most crucial technique to establish credibility, is a procedure that allows the participants to review the data, categories, interpretations, and results for
accuracy (Lincoln & Guba, 1985). Member check offers the participants the opportunity to assess intentionality, to correct errors of fact or interpretation, to provide additional information, to record their disagreement with the original data as well as agreement with the corrections, to summarize the data, and to assess overall adequacy of the data. The researcher used a modified version of Hoffart’s (1991) model of member check to assure the data represents the participant’s experiences and realities. The procedure consisted of validating with the participants the meanings of the data and the essential structure. New data were incorporated into the essential structure.

**Transferability**

Transferability by the naturalist is the equivalence of external validity by the positivist. In a strict sense, the extent to which the study findings can be generalized to a similar population is not possible using a qualitative approach (Lincoln & Guba, 1985). In qualitative studies, a description of the context and time to which the data holds true can be established (Lincoln & Guba, 1985). The investigator is responsible to provide a "thick description" of relevant data that enables other investigators to make transferability judgments of the findings (Lincoln & Guba, 1985). In this study, the researcher provided a thick description of the process and product of data analysis, which is a thorough account of how data were managed and analyzed to produce the essential structure of the lived experience.

**Dependability**

Dependability by the naturalist is the equivalence of reliability by the positivist. Dependability is the consistency of the data. Triangulation (Lincoln & Guba, 1985), reflexive journaling (Knaack, 1984), and especially the inquiry audit, support
dependability. The inquiry audit is examination of the process of inquiry and the product of the inquiry such as the data, findings, interpretations, and recommendations (Lincoln & Guba, 1985). The inquiry audit is discussed under confirmability.

To substantiate dependability, the investigator identifies, explains, and supports inquiry decisions and methodological shifts. There is evidence to reduce inquirer biases, a resistance for early closure, an accountability of all data, an exploration of all areas, a consideration of both positive and negative data (Lincoln & Guba, 1985), and thoroughness in decision making about the sampling population, design, data collection, and data analysis (Lincoln & Guba, 1985). In this study, to support dependability, the researcher provided an audit trail for the dissertation Chair to conduct a confirmability audit (Lincoln & Guba, 1985).

**Confirmability**

Confirmability by the naturalist is the equivalence of objectivity by the positivist. Confirmability is the ascertainment that the findings are grounded or supported by the data rather than in the investigators personal constructions (Lincoln & Guba, 1985). The confirmability audit (Lincoln & Guba, 1985) or the audit trail (Rodgers & Cowles, 1993) is credited Halpern, who in 1983 completed his dissertation on this topic (Lincoln & Guba, 1985) and who suggests six components of the audit trail: raw data, data reduction and analysis products, data reconstruction and synthesis products, process notes, materials relating to intentions and dispositions, and instrument development information (Rodgers & Cowles, 1993).

To determine confirmability through the audit trail, the findings or interpretations of the data are traced back to the raw data that support the results (Lincoln & Guba,
1985). Raw data are inclusive of the interview transcriptions, reflexive journal, field notes. Inferences based on the data are logical, category labels are appropriate, and the category structure is clear and fits the data (Lincoln & Guba, 1985). Confirmability is also supported if the investigator demonstrates confirmability through triangulation, and reducing personal biases (Lincoln & Guba, 1985). In this study, the researcher provided an audit trail for the dissertation Chair to conduct a confirmability audit. As described in previous sections, triangulation and reducing and explicating personal biases supported confirmability in this study.

Summary

Chapter Three addressed the methodology for the study, beginning with a description of Human Science and Phenomenology, which is a qualitative approach to research on the lived experience of human beings. In this study, purposive sampling and snowball sampling provided access to nurses who said they had experienced connection with patients as a major aspect of healing. The data collection methods were interview and observation. The instruments were the researcher herself, the Demographic Data Record, and the Data Generating Question. Protection of Human Rights was through IRB review and the ethical conduct of the research. Prolonged engagement, persistent observation, triangulation, peer debriefing, and member check supported trustworthiness.
CHAPTER FOUR

RESULTS

Chapter Four presents the results of this study describing the essential structure of the lived experience of connecting with patients by nurses who said they had experienced connection with patients as a major aspect of healing. This chapter includes the description of sample, an exhaustive description of the results of the analysis of data, the essential structure, and summary.

Description of Sample

Thirteen Registered Nurses participated in this study. All 13 nurses were female and ranged in age from 29 years old to 57 years old \((M = 47)\). Nine nurses were Caucasian, two were Asian, one was Filipino, and one was Hawaiian (mix). Ten nurses were currently practicing nursing, two nurses were in purely administrative or faculty positions, and one nurse did not indicate a position. The number of years in nursing practice ranged from five years to 37 years \((M = 22.6)\). Eight nurses specialized in adult health nursing and five nurses specialized in child health nursing.

Twelve nurses listed the following specialized training in healing practices: healing touch, therapeutic touch, aromatherapy, prayer, shamanism, trance, massage, and magnetic therapy. One nurse listed no specialized training in healing practices. Twelve nurses said they took classes in healing touch or therapeutic touch. The number of years in specialized healing practices ranged from one year to 30 years \((M = 7.4)\).

Table 1 presents age, ethnicity, and religion or spiritual identity of the nurses. Table 2 presents their educational level in nursing, specialized training, major clinical
area, years in nursing practice, specialized training in healing, and years in healing practice. Table 3 presents practices nurses used in their personal lives to enhance healing.

All 13 nurses regularly used some form of practice in their personal lives to enhance connection with patients. Eleven nurses used some form of practice daily and two nurses used a practice weekly. The three practices most frequently used were prayer (8), meditation (6), and massage (4).

Analysis of the content of the statements of personal views of the nurses' purposes in life showed three themes: helping others, living a life of enjoyment, and serving God. All 13 nurses included helping others as one of their purposes of life. Three nurses included living a life of enjoyment. Two nurses included serving God. Table 4 presents the purposes in life by the three themes.

Exhaustive Description of the Results of the Analysis of Data

The exhaustive description of the phenomenon of connecting with patients by nurses who said they had experienced connection with patients as a major aspect of healing is the collection of themes, theme clusters, and theme categories, integrated from the 1,108 significant statements derived from the interviews with 13 nurses who were participants. The formulated meanings of these significant statements resulted in 41 themes, 12 theme clusters, and 4 theme categories. The exhaustive description of the theme categories, theme clusters, themes, and sub-themes follow.

Theme Category: Connection as a Process

The first Theme Category is Connection as a Process. Nurses experience connection between nurses and patients as a process. Like flutists in a duet, nurses and
<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Religion/Spiritual Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>48</td>
<td>Okinawan</td>
<td>Zen Buddhism</td>
</tr>
<tr>
<td>02</td>
<td>53</td>
<td>Japanese</td>
<td>Buddhist</td>
</tr>
<tr>
<td>03</td>
<td>57</td>
<td>Caucasian</td>
<td>Catholic</td>
</tr>
<tr>
<td>04</td>
<td>49</td>
<td>Caucasian</td>
<td>Catholic</td>
</tr>
<tr>
<td>05</td>
<td>46</td>
<td>Caucasian</td>
<td>Episcopalian, Buddhist</td>
</tr>
<tr>
<td>06</td>
<td>29</td>
<td>Hawaiian, Chinese,</td>
<td>Catholic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Portuguese, German,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>French, American Indian</td>
<td></td>
</tr>
<tr>
<td>07</td>
<td>45</td>
<td>Caucasian</td>
<td>Christian</td>
</tr>
<tr>
<td>08</td>
<td>50</td>
<td>Caucasian</td>
<td>Christian</td>
</tr>
<tr>
<td>09</td>
<td>54</td>
<td>Caucasian</td>
<td>Catholic</td>
</tr>
<tr>
<td>10</td>
<td>46</td>
<td>Caucasian</td>
<td>Christian/Raised Catholic</td>
</tr>
<tr>
<td>11</td>
<td>32</td>
<td>Caucasian</td>
<td>Buddhist</td>
</tr>
<tr>
<td>12</td>
<td>53</td>
<td>Filipino</td>
<td>Catholic</td>
</tr>
<tr>
<td>13</td>
<td>49</td>
<td>Caucasian</td>
<td>Episcopalian</td>
</tr>
</tbody>
</table>
Table 2. Educational Level in Nursing, Major Clinical Area, Years in Nursing Practice, Specialized Training in Healing, and Years in Healing Practice

<table>
<thead>
<tr>
<th>Participant</th>
<th>Educational Level in Nursing</th>
<th>Major Clinical Area</th>
<th>Years in Nursing Practice $M = 22.6$</th>
<th>Specialized Training in Healing</th>
<th>Years in Healing Practice $M = 7.4$</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>AD Nursing</td>
<td>Adult Health</td>
<td>28</td>
<td>HT, TT, Aromatherapy</td>
<td>8</td>
</tr>
<tr>
<td>02</td>
<td>AD Nursing</td>
<td>Adult Health</td>
<td>27.5</td>
<td>HT</td>
<td>8</td>
</tr>
<tr>
<td>03</td>
<td>MS Nursing</td>
<td>Child Health</td>
<td>37</td>
<td>HT</td>
<td>3</td>
</tr>
<tr>
<td>04</td>
<td>MS Nursing</td>
<td>Adult Health</td>
<td>30</td>
<td>HT</td>
<td>1</td>
</tr>
<tr>
<td>05</td>
<td>MS Nursing</td>
<td>Adult Health</td>
<td>20</td>
<td>Prayer Shamanism, Trance, Healing, Touch, Massage</td>
<td>20</td>
</tr>
<tr>
<td>06</td>
<td>BS Nursing</td>
<td>Child Health</td>
<td>6.5</td>
<td>HT</td>
<td>2</td>
</tr>
<tr>
<td>07</td>
<td>MS Nursing</td>
<td>Adult Health</td>
<td>5</td>
<td>TT</td>
<td>1.5</td>
</tr>
<tr>
<td>08</td>
<td>BS Nursing</td>
<td>Adult Health</td>
<td>29</td>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>09</td>
<td>Diploma</td>
<td>Child Health</td>
<td>20</td>
<td>HT</td>
<td>6</td>
</tr>
<tr>
<td>10</td>
<td>BS Nursing</td>
<td>Child Health</td>
<td>24</td>
<td>HT, TT</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>BS Nursing</td>
<td>Adult Health</td>
<td>8</td>
<td>TT</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>BS Nursing</td>
<td>Adult Health</td>
<td>30</td>
<td>HT, Magnetic Therapy</td>
<td>30</td>
</tr>
<tr>
<td>13</td>
<td>MS Nursing</td>
<td>Child Health</td>
<td>29</td>
<td>Healing Touch</td>
<td>7</td>
</tr>
</tbody>
</table>

*Note.* AD = Associate Degree; BS = Bachelors of Science; MS = Master of Science; HT = Healing Touch, TT = Therapeutic Touch
Table 3. Practices Used Regularly to Enhance Connection

<table>
<thead>
<tr>
<th>Participant</th>
<th>Frequency</th>
<th>Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Daily</td>
<td>Meditation-mindfulness, yoga</td>
</tr>
<tr>
<td></td>
<td></td>
<td>imagery, healing touch, aromatherapy</td>
</tr>
<tr>
<td>02</td>
<td>Daily</td>
<td>Meditation, tai chi, chi kung, diet of no meat</td>
</tr>
<tr>
<td>03</td>
<td>Daily</td>
<td>Walking, whirlpool bath, 8 hours sleep per night</td>
</tr>
<tr>
<td>04</td>
<td>Weekly</td>
<td>Women’s group, walking</td>
</tr>
<tr>
<td>05</td>
<td>Daily</td>
<td>Meditation, prayer, oracular work; dance; massage</td>
</tr>
<tr>
<td>06</td>
<td>Weekly</td>
<td>Prayer</td>
</tr>
<tr>
<td>07</td>
<td>Daily</td>
<td>Prayer</td>
</tr>
<tr>
<td></td>
<td>Three times a week</td>
<td>Yoga</td>
</tr>
<tr>
<td></td>
<td>Once every 2-3 months</td>
<td>Shiatsu massage</td>
</tr>
<tr>
<td>08</td>
<td>Daily</td>
<td>Prayer, connection with others, reflection</td>
</tr>
<tr>
<td>09</td>
<td>Daily</td>
<td>Meditation</td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
<td>Journaling</td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
<td>Healing touch with massage, facials</td>
</tr>
<tr>
<td>10</td>
<td>Daily</td>
<td>Prayer</td>
</tr>
<tr>
<td>11</td>
<td>Daily</td>
<td>Meditation, prayer, yoga</td>
</tr>
<tr>
<td>12</td>
<td>Daily</td>
<td>Prayer, relaxation, exercise, massage, meditation</td>
</tr>
<tr>
<td>13</td>
<td>Daily</td>
<td>Prayer</td>
</tr>
</tbody>
</table>
Table 4. Themes of Purposes in Life

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of Participants Reflecting the Theme</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helping Others</td>
<td>13</td>
<td>“Mentor others, help facilitate personal growth”; “service and healing”; “help and love others, make a difference in the lives of others”; “always be there for my husband and children”; “raise happy children, encourage others to do good in life and help those who need it”; “follow my path of healing through love”; “give hope and confidence in the face of fear”; “work in a profession in which I can help others and have fun”.</td>
</tr>
<tr>
<td>Living a Life of</td>
<td>3</td>
<td>“Be connected to those around me and enjoying personal contact with others”; “live life to the fullest”; “learn love”.</td>
</tr>
<tr>
<td>Enjoyment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serving God</td>
<td>2</td>
<td>“Be a feather on the breath of God, the new rule is this—shatter the wine glass and fall into the breath”; “love God and serve people”.</td>
</tr>
</tbody>
</table>
patients begin as two individuals expressing their unique melodies that blend to create a third and greater synergy of vibrations. Four theme clusters describe this category: the selection, the bonding, the bubble, and the memories. Table 5 presents the theme category, Connection as a Process, with its three theme clusters, themes, and sub-themes.

*Theme Cluster: The Selection*

The first theme cluster, the selection, consists of four themes: levels of intensity, across different cultures, using a cognitive process, and having spontaneous reactions. When nurses connect with patients, they use either a cognitive process, have a spontaneous connection, or experience both with different patients. Nurses described providing good clinical care to all patients and connection as above and beyond this level of care.

*Theme: levels of intensity.*

Five nurses provided data that supported this theme. Nurses are clear there are patients with whom they connect and others with whom they do not. The level is related to the condition of the patient.

12: “Whereas with other patients, it’s really more and just do the job and get it done. I guess it’s the level of connectivity—the degree of connectivity.”

The nurses described having different levels of intensity when connecting with patients.

07: “For me, the connection when its death and dying is much more stronger.”

12: “Because yes, I connect with all my patients as a nurse in that I am providing the treatments, the procedures, the therapy that they need in order to get better."
Table 5. Theme Category: Connection as a Process

<table>
<thead>
<tr>
<th>Theme Category</th>
<th>Theme Cluster</th>
<th>Theme</th>
<th>Sub Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connection as a Process</td>
<td>The Selection</td>
<td>Levels of Intensity</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Across Different Cultures</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Using a Cognitive Processes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Having Spontaneous Reactions</td>
<td></td>
</tr>
<tr>
<td>The Bonding</td>
<td>Accepting Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spending Time with Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Focusing Attention on Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Becoming Emotionally Involved</td>
<td>Hearing the Stories</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identifying with Patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part of Each Other’s Lives</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Giving Personal Time</td>
<td></td>
</tr>
<tr>
<td>The Bubble</td>
<td>Setting the Intention</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sensing Energy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feeling Love for Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Having Visceral Reactions</td>
<td>Changes in Environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feelings within Nurses</td>
<td></td>
</tr>
</tbody>
</table>
Table 5. (Continued) Theme Category: Connection as a Process

<table>
<thead>
<tr>
<th>Theme Category</th>
<th>Theme Cluster</th>
<th>Theme</th>
<th>Sub Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting Aside Ego</td>
<td>The Memories</td>
<td>Keeping in Touch</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Remembering Patients</td>
<td></td>
</tr>
</tbody>
</table>

With these two, it seemed like—it felt like I connected on another level. It went deeper with that.”

*Theme: across different cultures.*

Six nurses provided data that supported this theme. Nurses connect with patients of different ethnic groups, languages, and ages. Nurses are respectful of the patient’s ethnicity and pay respectful attention to their values and beliefs. In describing a 19-year-old Filipino girl scheduled to have surgery the day before Christmas, the nurse discovered that the patient’s father had to work and would not be present for the surgery. The nurse informed the surgeon, who responded that the father needed to set priorities and be present for the surgery if this was important.

07: “I tried to explain to them (surgeons) that a lot of these guys, specially the Philippine workers that we have, because it’s a big (inaudible) for the Filipino race that guys work really hard. Sometimes they support many family members besides at home or in the Philippines. So I said it’s not like you can blow it off and tell him to get his priorities straight.”
Another nurse reported spending a lot of emotional energy to ensure respect for the patient’s culture when attending a funeral.

10: “When I went to his funeral, this was a local family, and I hadn’t been in Hawaii all that long. So I had asked ---my East Coast upbringing where, very somber, respectful, closed funerals--- what do I wear? So I did my best to put on my most, keeping with being respectful and as casual as I could.”

Although connection crosses ethnic groups, nurses believe that being of similar cultures facilitates connection. One nurse reported a comfort and ease of relating to each other when both the nurse and patient spoke “pidgin” and understood the lifestyle of Waianae families.

Theme: using a cognitive process.

Eight nurses provided data that supported this theme. The nurses use a cognitive process to select specific patients with whom to connect. Some nurses questioned whether the patient selected them or vice versa. Nurses select patients who are in a crisis, have a special need, or have no other nurse take an interest in them. Nurses described their patients as people with whom they would ordinarily be friends had they met under different circumstances.

04: “But I also sensed a need from them. How would I describe that sense of need? It’s like a child.”

13: “And she had big hydrocephalic eyes and she was just so cute that we just felt sorry for her. I’m like, oh my god, nobody comes to visit you. But for some reason, I think she had a very dysfunctional family.”

68
Theme: having spontaneous reactions.

Six nurses provided data that supported this theme. These six nurses also used a cognitive process to connect with patients. While some nurses use a cognitive process to select patients, other nurses reported the connection occurred spontaneously. Nurses used phrases such as “instant bonding”, “you sort of click”, and “it’s just a chemistry that happens.” One nurse, who was not comfortable with teenagers, found herself connecting with a teen patient. The nurses seemed joyful when relating stories of patients; nurses cried, smiled, giggled, clutched their hearts, swayed, and glowed.

05: “There are many times that I suddenly realize that I have connected—that that ‘thing’ has happened that happens between me and a patient.”

05: “I’m interviewing a patient and the bubble just starts forming.”

Theme Cluster: The Bonding

The second theme cluster, the bonding, consists of nine themes: accepting patients, spending time with patients, focusing attention on patients, becoming emotionally involved, having reciprocity, and developing trust. The theme, becoming emotionally involved, has four sub-themes: hearing the stories, identifying with patients, part of each other’s lives, and giving personal time. Once connection with patients occurs, nurses begin to bond with them.

Theme: accepting patients.

Five nurses provided data that supported this theme. The nurses are very accepting of patients. Nurses accept the patients’ behavior (not showing up for appointments on time), emotion (grumpiness), physical condition (patient likely to die),
or rejection of the nurse. The nurses do not pass judgments on patients and place the
behaviors within the context of their developmental age or reaction to circumstances.

09: "...especially with teenagers, what happens is you just allow them to be their
normal selves and somehow they sense that really well and then there's that connection."

11: "...to me, it's just that at that point, maybe she couldn't deal with who I was
or what I stood for at that point and wasn't really wanting to talk about those
things because she had lost certain things like that."

Theme: spending time with patients.

Ten nurses provided data that supported this theme. Connection with patients
involves time. Nurses visit with their patients, learn what issues are of importance to
them, prepare them for procedures, or just talk with them. Spending time with patients
makes connection easier to establish, develops nurses' intimacy with patients, and result
in more accurate clinical judgments. Spending time with patients was contrasted with
running into the patient's room, rushing to give medications, and focusing on nurse-
patient ratios, which were described as being counter productive to establishing
connections with patients.

07: "I think when you spend the time finding out what their issues are that's
where you really connect."

12: I had time to spend with him, time to find out what interested him, what made
him tick, what his dreams and wishes were."

Theme: focusing attention on patients.

Nine nurses provided data that supported this theme. When connecting with
patients, nurses focus their attention on patients. Nurses sit with patients, use touch, make
eye contact, and use clinical tasks and humor as ways to convey to patients their sense of importance. When sitting with patients, nurses sometimes do not speak, and if they do, speak of what patient’s deem important.

01: “And what may have been more appropriate or healing for our client is to just sit down there for maybe five minutes and actually talk or listen to them if they had wanted to talk about their razor that’s not working.”

10: “And I sat there for like forty-five minutes with every one of these people and did nothing. I just sat there with them. And we might be talking or something else, but we might not.”

13: “…how very little you need to do to someone in order to feel like you’ve made a connection with them. And whether it’s just me sitting on the bed with them, holding their hand, reading the book, and really feeling that that was the most important thing we should have been doing at the time…”

Nurses find the use of touch to be very powerful in connecting with patients. Nurses hold hands with patients until they fall asleep, massage their feet, or place their hands on patients’ chests.

05: “And I looked and saw this little hand going like this—it was groping to find this (my) hand that had held him. And it was the first time I remember seeing how incredibly potent that connection was to that little child.”

10:” …a special magic kind of connection has happened when I’ve been holding people’s hands, when I’ve been able to totally be there for them.”

Nurses also use clinical tasks as vehicles to get to know patients. Though the focus is initially on the task, the focus is soon replaced with just time to talk.
"...you can actually talk to people about something that they’re interested in while you’re changing that bandage. And you can even talk to them about how the skin appears or if it’s a wound, how the wound is doing. But then you incorporate, well, how do you feel, how are you doing, what are your thoughts right at this moment?"

**Theme: becoming emotionally involved.**

Twelve nurses provided data that supported this theme. Nurses become emotionally involved with their patients. Nurses feel very close to their patients, cry with them, keep vigilance over them when not assigned to their care, are protective, and are ready to drop whatever they are doing to care for their patients. Nurses reported although they were taught in school not to get too close to patients and to keep the professional distance, this “never worked for me. I don’t think that true nurses are like that. I think nurses who really love their jobs do get involved.” Another nurse reported she “crosses the barrier” that was taught in school not to cross, and maintains perspective of her patient’s situation with greater understanding. The theme, becoming emotionally involved, has four sub-themes: hearing the worries, identifying with patients, part of each other’s lives and giving personal time.

The first sub-theme is hearing the stories. Of the 12 nurses who provided data to support the theme, becoming emotionally involved, nine nurses reported data in this sub-theme. The nurses feel it is important for patients to have someone “who really hears you”. The nurses listen to whatever the patient needs to talk about and encourage patients to share their feelings. The nurses listen to patient’s fears of having a stoma, meanings of cancer and what might have caused it, descriptions of their life growing up, plans for
resuming their lives after hospitalization, and concerns about family relationships. The nurses want to know what is going on in their patients’ lives at that very moment, what happened in their past to understand the present, and what plans they have for the future to help them resume their lives. Hearing the patients’ stories facilitate the development of the connection between nurses and patients.

01: “There’s communication happening and I’m listening. I’m actually hearing what the person is saying. And the person is hearing and also feeling that there is concern with him or her as an individual—on a person level and not just what I need to do to you or for you or show you how to do.”

01: “Because sometimes they’re just plain old scared. They’re going to have to amputate my leg. Or, ‘I’m really sad because I won’t be able to go dancing with my wife anymore.’ ‘And, I won’t be the same person that I was before this injury happened.’”

05: “I have a theory about patients that they’re each a deep mystery and what we do as nurses is to just look deeper and deeper into the mystery and...how is their relationship with this disease really and what is their connection with wellness really?”

12: “So I found out...that she was one of the original pioneers, had come over the Okanagon trail in a covered wagon.”

The second sub-theme is identifying with patients. Of the 12 nurses who provided data for the theme, becoming emotionally involved, eight nurses reported data to support this sub-theme. The nurses identify with the patients with whom they connect. One nurse said, (07) “when you can relate something in your life to them that seems like that is
when you make more of a connection with most of the patients.” Having similar experiences, putting one’s self in the patient’s position, associating the patient with a personal family member, being of similar age or having a child of similar age, having similar personal interests such as music, and having similar personalities are some of the ways nurses identify with patients.

12: “The connection was more like—I felt like this was my grandma.”

11: “Like maybe it’s me. Maybe I connect with her on the level that I might be that way too with tubes and this and that and not to think, ‘oh how terrible—she’s getting twisted in her tubes.’ Because I always try to put myself in that position.”

06: “I can’t imagine as a parent going through that. But I can feel the parent’s pain too you know when you bond like that and then you see them just agonizing over this at that end stage.”

The third sub-theme is part of each other’s lives. Of the 12 nurses who provided data to support the theme, becoming emotionally involved, eight nurses reported data in this sub-theme. As the bonding intensifies, the nurses and patients become a part of each other’s lives. Friendships develop and patients and nurses not only exchange personal information (schools their children attended and places of husband’s employment), but also participate in each other’s significant life events.

04: “And so then I mentioned to my husband about the idea of getting together and doing something and I said, ‘would you come along because I think it might be nice.’ So the three of us went out, we saw the theater, we went to the play, and then we went to dinner afterwards.”
06: “To be a part of the process of their healing, for them to let us in their lives at this point when they are so challenged. You know they let us in and we are like part of their family, it just really gives you a warm and rewarding feeling,”

11: You know, he's already trying to figure out how he's going to videotape my wedding.”

Nurses feel gratitude when patients and their families let them be a part of their lives. One patient’s family included the nurse in the obituary.

The fourth sub-theme is giving personal time. Of the 12 nurses who provided data to support the theme, becoming emotionally involved, six nurses reported data in this sub-theme. The nurses use personal time to assist patients. The nurses socialize with patients, check up on them if they have not heard from them awhile, visit them at home, and bring them special food treats while in the hospital. Giving of personal time is within the context of helping patients get well.

04: “So when she got back, she called me and then we actually planned a little party together for her and some of her friends. And so I thought that I was able to be instrumental in helping her readjust back to her life. And she continued to live probably another ten years, I think. I mean, we would do little things socially off and on, exchange birthday cards. But I always felt that that was really an important step.”

Theme: having reciprocity.

Nine nurses provided data that supported this theme. Nurses share reciprocity with patients and get as much from the relationship as their patients get from them. Receiving love, understanding, and patience from patients reinforced the nurse’s
connection with them. Nurses feel there is a (04) “give and take” between themselves and patients, that patients show respect and concern for nurses, respond positively to suggestions, and show happiness when seeing the nurses.

09: “You know, I’m just as lucky to have that patient as that patient is lucky to have me.”

10: “On your day off, you bring him in a McDonald’s. And you’re getting as much from that child as the child is getting from you. The love is a back-and-forth love.”

Theme: developing trust.

Eight nurses provided data that supported this theme. The nurses develop a relationship of trust with their patients. The nurses are (10) “safe” people with whom patients share their fears, frustrations, and anger.

06: “The connection I guess is that they feel so comfortable telling me exactly what they really feel, you know, where as they might not say such things to the doctor.”

09: “First of all, I think there’s an honesty and trust element in there that’s deeper than with another person.”

Nurses are honest with patients regarding their medical condition and sense their patients recognize that trusting the nurses is imperative for them to get well. The nurses feel the connection allow patients to (05) “let go” and be unstable because patients trust the nurse would (05) “hold it together” for them.
Theme Cluster: The Bubble

The third theme cluster, the bubble, has five themes: setting the intention, sensing energy, feeling love for patients, having visceral reactions, and setting aside ego. The theme, having visceral reactions, has three subthemes: changes in environment, feelings within nurses, and resonance with patients. The "bubble" is an environmental space that surrounds the nurse and patient who connect. One nurse described the "bubble" as "holding space" or creating a safe environment around the nurse and patient in which the nurse allows whatever emotions to flow from the patient. Sometimes the term "caring presence" was used to describe this environment that encases the nurse and patient.

01: "The term of caring presence. When you are fully present, your presence somehow—I wish I could draw this—it just exudes from you, your own being. And it’s as if there is somehow you’re just creating a very safe environment—like a plastic balloon or bubble."

05: "OK, you walk in the door, you introduce yourself, and of course you’ve washed your hands. But then you make the bubble. Well, you make the bubble, you know?"

Theme: setting the intention.

Four nurses provided data that supported this theme. The nurses sometimes set an intention for specific outcomes when creating the "bubble". Some intentions are to protect, to provide a safe environment, and to love. One nurse reported if intentions are not set "from the heart from a loving viewpoint, then none of the other stuff will happen."
01: “I’ve learned that you start as, I am someone who is coming to you and I hope that you’re going to receive me coming in to see you. And the hope is that there is some kind of interaction—or if you want to use the word connection—that happens.”

05: “And my intention in that was very specific and I don’t usually make that thing—make that connection—with a specific intention but in that case, I was very, very clear that protection—it was a little globe of protection or something.”

*Theme: sensing energy.*

Six nurses provided data that supported this theme. The nurses described an energy surrounding themselves and patients when they connected with each other. The nurses use this energy with patients in the form of healing touch.

03: “He was in quite a bit of pain one night at camp so I did healing touch on him.”

04: “Of the warmth. I’m thinking—there’s a couple things that visually come to my mind. It would be like an aura around a person. There’s the aura of lights that surround a person. I think it has to do with an element of a sense beyond our five senses. I think—and I think that’s probably part of what is in the sense of being able to communicate with passion—being able to help somebody.”

05: “Mostly it seems like a physics thing because it feels like an energy field.”

10: “It’s almost like a passage between you that goes through when you’re very quiet and you’re not doing anything. You’re just holding the hand.”

The nurses and patients connect into that energy which transferred between the two of them.
04: “It’s connecting into that element—that sense beyond the immediate five senses. And when you can connect into that level, then you can help the person.”

The nurse’s love for their patients becomes part of this energy that is used for healing.

09: “I do believe in the energy field and I think that that’s really important. And when you’re coming from heart-centered or a loving center where you actually are coming from a focus of love where you care about another person, that’s in your energy field and it connects with your patient’s energy field.”

Theme: feeling love for patients.

Five nurses provided data that supported this theme. The nurses use the word “love” in describing their feelings for their patients. This love emanates from the nurse’s heart.

09: “I still love that individual patient. You know, just for being themselves and who they are and for being a human being in this (inaudible).”

12: “Whereas with this woman, it’s like, OK, gosh—how does one describe one’s feelings to it? I can only think of abstract words. It’s more the respect for an elder, it’s a little bit of love, I guess.”

The nurses also feel they receive love from their patients. (08) One nurse reported feeling uncomfortable when her patient told her, “I love you” and questioned the professional boundaries.

08: “One of the things I remember her telling me is that she loved me. At that point in time, I was really uncomfortable with it. I think I felt also that I had love for this woman too. But I wasn’t really sure in terms of the professional
relationship. I wasn’t real comfortable with that amount of intimacy. So I never
told her that I loved her and that is something I regretted.”

10: “And that learning that incredible love that, a child can give you—that total
unconditional love. And the pointing out to you how important love is…”

Theme: having visceral reactions.

Ten nurses provided data that supported this theme. The theme, having visceral
reactions, is comprised of three sub themes: changes in environment, feelings within
nurses, and resonance with patients. The nurses experience the bubble (05) “like stepping
into a big pool of warm water. If I were to grab descriptors, it would be warm, it would
be liquidy…the visceral experience of it is different.” Some nurses found it difficult to
describe but said they (13) “know when it happens.”

The first sub-theme is changes in environment. Of the 10 nurses who provided
data that supported the theme, having visceral reactions, three nurses reported data in this
sub-theme. Changes in environment are experienced as color (being surrounded by a
golden ball), temperature (warmth), or viscosity (thickness of air).

01: “For me, what happens is it can be an outdoor, it can be an indoor, but there’s
just a difference in the way the air feels in that moment. You know, it’s a settling,
it’s a warmth, and it can be a soft silence around people that I work with.”

02: At that point the room became very quiet. I mean the air was thick and still.
There was a really warm feeling so I just stood by her side, held her hand…There
was a deep peace in that room and a warm feeling.”
The second sub-theme is feelings within nurses. Of the 10 nurses who provided data that supported the theme, having visceral reactions, five nurses reported data in this sub-theme. Feelings within nurses are experienced as a calmness or stillness.

01: “It’s a quieting. You don’t feel yourself inside quivering trying to make a decision. It’s a sense of standing still—you’re being your own self. And by doing that you allow or you create, again, that environment where the patient, client, family or even your coworkers, stop running and trying to control things and allow things to happen.”

05: “So there’s this stationary quality to it, there’s a slowing down quality.”

07: I don’t know if it’s because I have the calm with me when I talk to them about it, because at that time I am calm.”

The third sub-theme is resonance with patients. Of the 10 patients who provided data that supported the theme, having visceral reactions, nine nurses reported data in this sub-theme. Resonance with patients is experienced as (09) “coming from the heart” and feeling (09) “warmth” towards patients, (09) “feeling comfortable and good around the patient”, knowing what their patients (03) “are thinking without them saying”, and (11) “just a feeling that you’ve built a connection”. Nurses had difficulty describing their feelings and said sometimes, the connection was (07) “unspoken.”

Theme: setting aside ego.

Three nurses provided data that supported this theme. Nurses who connect with patients set their egos aside. The nurses are humbled by the experiences of connecting with patients. They do not focus on themselves, do not want the experience to be self-inflating, and do not perceive themselves doing anything great.
01: “You always want to leave the ego somewhere else—or work with it so it’s not up-front all the time….But I really have to emphasize that it’s not what I am doing—it’s not what ‘I’ am doing.”

The nurses do not credit themselves for connecting with patients, but feel grateful and privileged to be a part of that experience. The nurses feel they get much more from the connection with the patient than what they give to the relationship. Experiencing the love from a patient, one pediatric oncology nurse considered the connection (10) “a gift...how wonderful to have been chosen” to be able to experience connection with a patient. One nurse reported she did not call herself a healer although she supposed she was one. She said the label, healer, did not resonate with her. She described connection with patients as being on (05) “holy ground”.

O5: …that place was some kind of holy ground and that I felt as privileged and honored and changed by it. I was privileged and honored that that person’s walking with me there."

Theme Cluster: The Memories

The fourth theme cluster, the memories, consists of two themes: keeping in touch and remembering patients. Nurses are quick to identify patients with whom they connect. As they recalled the experiences of connecting with patients, nurses often cried, got choked up, smiled, clutched their hearts, or laughed about the memories. Their faces glowed with radiance, and they became quite animated and excited.

Theme: keeping in touch.

Three nurses provided data that supported this theme. The nurses keep in touch with their patients long after discharge and sometimes, even after death. Sometimes,
patients themselves initiate the continued contact with nurses. One nurse stated, (11) “If these people come into my life and have contributed something to my life, and have meant something special to me, then I really like to continue that relationship.”

04: “So about a month later, I had discharged her. Because about a month later, I called just to check in and see what she was doing.”

11: “I see his parents every year. On Christmas we go to the grave...I can think of another patient I had. He died in 1999 and I still see his parents every year and I’ll be inviting them to my wedding.”

Theme: remembering patients.

Five nurses provided data that supported this theme. The nurses continue to think about the patients with whom they connect. Some of these experiences occurred many years ago but the memories seem embedded in the nurse’s hearts. When one nurse (10) spoke of a patient she remembered, her face softened and she got very teary eyed. Her whole demeanor became very relaxed.

08: “And she is somebody that I will remember for always.”

12: “I thought about them through the years periodically as I’ve gone from setting to setting.”

Theme Category: The Nurse as Exemplar

The second Theme Category is The Nurse as Exemplar. The nurses who connect with their patients are exemplars in nursing. They were critical about nursing curricula and expressed having felt unprepared to handle the healing aspects of care. Yet these nurses are at the expert level in practice. They are passionate about nursing care, the profession, and making a difference in the lives of their patients. Four theme clusters
describe this category: the learning, having passion, caring for self, and expert nurse.

Table 6 presents the Theme Category, The Nurse as Exemplar, with its four theme clusters and themes.

Theme Cluster: The Learning

The first theme cluster, the learning, consists of two themes: realizing lack of knowledge and developing the art. Nurses feel unprepared to handle the healing aspects of care. They were critical of nursing curricula and health care systems that they perceived supported a medical or curative model of patient care. Nurses have difficulty articulating what connection is. One nurse reported unless there was language to describe connection, connection became invalid.

Theme: realizing lack of knowledge.

Six nurses provided data that supported this theme. When the nurses had completed their education in nursing, they had great expectations of themselves as nurses. Upon entering the workforce, the nurses had realized they lacked the knowledge to handle the healing aspects of care.

01: “...you come out thinking you can work with people and help them through their journey. You know, finding that inner aspect of what’s going to make them heal. I’m not talking about the curative aspect. I’m talking about the healing aspect.”

Nurses said the patient model taught in school was segmented into physiological or functional parts such as the biological system, psychological system, and social system, and the emphasis was on curing the patient of a disease. This disease model is
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contradictory to the holistic patient model the nurses use. Nurses reported they did not learn the skills to connect with patient, and they were (05) “trained out of that”.

07: “At least you are told, do not connect. I mean that’s what they teach you in nursing school, do not become emotionally involved with the patients, nor should you do it with their families.”

Theme: developing the art.

Seven nurses provided data that supported this theme. Although nurses feel their education did not prepare them to connect with patients, they do not feel connection could be taught as an intellectual process.

08: “I don’t think that we can teach connecting because teaching implies an intellectual process. I don’t think it’s something that you can teach in that sense.”

Nurses believe connecting with patients is an art that has to be developed. As an art, nurses are creative with patients and use (12) “things other than scientific information and data to help someone get to the next level in their care.” To develop the art of connecting with patients, the nurses suggested self-reflection, mentoring, and apprenticing with healers as tools.

12: “…part of journaling is self-reflection in terms of, ‘how do I feel doing this, what precipitated this feeling’?…but self reflection has to go to how do we—what does that mean to me—me the person, not me the nurse or me the student. Me the person and what does it mean to my life—my own life.”

One nurse learned the art of connecting from her mother.

05: “I also had experiences when I was little of my mother teaching me how to do massage because she was an old school nurse and still did massage on patients. And I
remember vividly her teaching me how to connect with a person although I don’t believe she ever used that phrase. There was something about—I think I remember the phrase she used. She said, ‘when you lay your hands on the person, it’s like you’re trying to touch the fire that’s inside of them. It’s drawing close to the warmth.’ And I don’t know why that communicated so effectively to me as a child, but I remember vividly reaching down inside of the person to contact something. And even as a child, I was an extraordinarily good masseuse and it was something that carried into my practice as I got older.”

*Theme Cluster: Having Passion*

The second theme cluster, having passion, consists of four themes: caring and compassion, taking risks, having burning issues, and making a difference. The nurses are full of passion. Nurses speak with intense feelings, challenge physicians, take strong stands on professional issues, and go that extra mile to make a difference in patients’ lives.

*Theme: caring and compassion.*

Seven nurses provided data that supported this theme. Nurses strongly believe patients need to be shown care and compassion. Nurses are proactive, advocate for patients, arrange support systems, work out details, and do whatever it takes to provide comfort and care for patients.

11: “I think that it’s so important that people do know that you care… It’s like right now that we’re showing her that we care, now she’s walking.”

13: “But I do care about you and I care what happens to you.”

A nurse (04) who initiated sending a patient on a ventilator home to die demonstrated caring and compassion for patients. With the wife’s concurrence, the nurse
coordinated care of this patient with the oncologist, cardiologist, pharmacist, ethicist, staff nurses, and family. The nurse arranged to have someone train the wife of the patient to manage the total parenteral nutrition (TPN) and morphine drip. Throughout the course of the patient's illness, the nurse provided emotional support to the wife. All these interventions were done on the phone. The nurse had no physical contact with the patient or the wife. During the researcher's interview with this nurse, the nurse pulled out the newspaper clipping of the patient's obituary. In the obituary, the family acknowledged the nurse's help. The nurse was so touched by this gesture, she kept the clipping with her and became teary-eyed remembering this honor bestowed upon her.

Theme: taking risks.

Four nurses provided data that supported this theme. The nurses take risks while caring for their patients. The nurses stand up to physicians, administration, and to peers to advocate for their patients.

10: “We got out there and the nurses probably did not appreciate us at all. They were ready to wrap and bag him and put him in the morgue. And I said, 'no—the family's not ready.' And she said, 'We have a shift change.' And I go, 'I don't care. The family's not ready to say goodbye. I'm not ready to say goodbye.'

'Well, who are you?' And I go, 'I've cared for this child for the last four years and you haven't washed him and you haven't done anything yet. The family is calling people in still. They have the right to say goodbye to this child.' ‘Well, they will at the funeral parlor.' And I go, 'No—it's not the same.' So this was the supervisor I was fighting with.”

Nurses also take risks when becoming close to patients.
13: “I put myself in a position where now my feelings are going to be hurt (when patient dies). I may say I won’t do that again. And I don’t think that’s true. I think I probably will do it again.”

13: “Well, I think there’s risks in overstepping your boundary. Is this a person that some people realizing that they already have a mother and you’re not it. Realizing that your concerns may not be in the best interest of this person and they are your concerns. And what does that do to your professional reputation?”

*Theme: having burning issues.*

Six nurses provided data that supported this theme. The nurses take strong stands on professional issues and have tremendous needs to talk about them. Nurses reported being upset and frustrated with what they perceived to be a focus on a disease versus a holistic model of care. Nurses reported the focus on staff ratios threatened adequate time to build relationships with patients and that nurses spend too much time attending meetings and doing paperwork that take them away from the patient’s side

02: “Nursing is not like what it was before, you know, connecting patient/nurse wise, there are a lot of other things, paperwork. It takes away from the bedside, and I feel as a nurse we belong at the bedside.”

Nurses feel relationships between nurses and patients are critical in nursing. They expressed frustrations with the nursing educational system, which they felt needed to focus on a more humanistic relationship between nurses and patients.

01: “But the way things are set up—and things being our health care—I mean, I’m going into the whole damn system, but unless something is changed, we’re pumping out robots, we’re pumping out academics.”
05: “And yet I think there are enough of us experiencing that (connection with 
patients) that we’ve got to look at it. And we’ve got to think about it and develop 
some ways of talking about it and teaching it and understanding what is that thing 
that goes on with a really good nurse and a patient.”

Theme: making a difference.

Ten nurses provided data that supported this theme. The nurses believe they make 
a difference in the lives of their patients. The nurses look beyond the treatment plan and 
ask themselves, (13) “What needs to happen to make a difference.”

04: “So I sensed there was a potential—there was something I could do to 
enhance her life, to enrich her life again, to keep her from feeling it was over.”

The nurses feel good about the impact they have on patients. Whether the impact 
is a smile on the face or instilling hope, nurses believe the connection with 
patients make a difference on patients’ conditions.

04: It made me feel like—-you know, like I really was instrumental in helping that 
person to regain their sense of life.”

07: “To me, those are the kind of connections that I would say have made a 
difference in nursing.”

Theme Cluster: Caring for Self

The third theme cluster, caring for self, consists of two themes: setting boundaries 
and living balanced lives. Nurses take care of themselves in order to have the capacity to 
connect with and love their patients.

09: “Because I think that in order to be able to have that loving feeling coming 
from the heart and project it, the person who is giving it has to actually be a very
centered person and has to be comfortable with themselves and in a good place.

So that would be me as a nurse. I have to feel that way about myself and I believe
in self-care and if I take care of myself, then I can give more to others around me.

In fact, I won’t be able to do that if I don’t take care of myself.”

*Theme: setting boundaries.*

Ten nurses provided data that supported this theme. The nurses set boundaries
with patients in order to care for themselves. In the process of connecting with patients,
the nurses become very close to patients and become emotionally involved in the care
and personal lives of their patients. The nurses become friends with patients, do personal
favors for them such as buying special foods and clothes. The nurses’ primary concern is
for the patient’s welfare, which serves as a guideline for maintaining boundaries. The
nurses care for themselves by not compromising their emotional integrity for patients.

13: “So who is benefiting from this interaction? Is it the baby or is it you? So to
me, that’s too close. I think there’s an imaginary line you can’t cross.”

However, nurses did not compromise self-care for patients.

11: “I think when you start to compromise yourself for your patient---compromise
taking care of yourself---you know, whether that staying after work to a certain
time to help or going out on your own time and doing things for a patient. Now I
don’t think this is always overstepping the boundary and especially---but you
need to be clear within yourself of when is it becoming---I get a feeling, I think.
It’s like, you know, it’s like stress. It’s stress or something that, ‘Oh, I’ve got to
go do this and I told so-and-so I’d do this,’ but knowing that it’s OK if you
don’t.”
Theme: living balanced lives.

Eight nurses provided data that supported this theme. The nurses balance their lives as a way to care for themselves. Nurses do not overextend themselves by connecting with too many patients at one time.

08: “...there could be a time when I would feel a connection with a patient and choose not to let it happen. If something extraordinary was going on in my personal life and I didn’t think that I had the emotional capability to sustain the relationship, I could see not doing that.”

13: “I think that there were times I chose to be assigned to some that I could just do the regular stuff (nursing) ---to take a break.”

Both attending and not attending a patient’s funeral keep nurses in balance. Nurses attended patient’s funerals if they had a need to say goodbye. Other nurses stayed away from funerals if they needed distance from the situation.

Nurses balance their lives by taking a day off from work, taking a vacation, meditating, seeking support from husband, and getting involved in other activities (co-editing a book). One nurse (09) uses humor as a way to keep things in perspective. The nurses reported that living balanced lives enables them to continue engaging in close and emotional relationships with patients.

Theme Cluster: Expert Nurse

The fourth theme cluster, expert nurse, consists of seven themes: having clinical expertise, using intuition, letting go of control, enhancing independence, being cheerleaders, viewing patients holistically, and involving the family. The nurses are at the expert level of performance and look at the gestalt of the experiences with their patients.
They intuitively focus on the pertinent components of what is happening to patients and appropriately involve the family and healthcare providers. The nurses rely on past clinical and life experiences to assess and care for patients.

*Theme: having clinical expertise.*

Six nurses provided data that supported this theme. Nurses are expert in providing clinical care and focus above and beyond the fundamentals to connect with patients.

01: “Of course, you assess them and make them comfortable with medication if that’s needed or oxygen. But it kind of stretches beyond that. Our role as nurses is to, again, hold that space. To provide that opportunity to open the door for them so that family or individuals can see that this is a moment and to just live it, you know, ...”

05: “And I was definitely at the expert level of practice at this point and able to do the basic critical care, yadayada stuff with my eyes closed. So I began to be more actively incorporating some of the things that fascinated me. And at that point, I became much more intentional about incorporating connection.”

Nurses are comfortable and relaxed with their level of knowledge. One nurse (05) observed other nurses who connected with patients as being able to maneuver interventions skillfully and sensitively in a safe manner.

05: “…when the nurses that connected with the patient is they can perceive what the patient can tolerate physiologically and what they can’t. So what I would see them do is they would turn the Dopamine down and the blood pressure would start to crash and they (nurses) would tolerate it. They (nurses) would ride it out and wait, maybe increase it by one cc and then they would start to come back up.
Their tolerance for riding the person’s physiology was different. They behaved differently in even something as mechanical as titrated drips.”

Theme: using intuition.

Eight nurses provided data that supported this theme. The nurses use and trust their intuition when providing care to their patients. The nurses intuitively know what questions to ask, when to use touch, and what their patients are thinking. Nurses said they knew when patients were in distress and often accurately anticipated a call at home when their patient’s condition deteriorated.

01: “But you begin to develop I think a sense, or awareness, intuition you can call it. You’ve got a gut feeling that something lifts within yourself.”

10: “He died. And it was at nighttime. I was at home asleep and I woke up and sat up in bed and started getting dressed. Soon the call was coming in—-the call came in—-that [name of patient] was—-he hadn’t died yet, but he was bleeding out and had been transferred.”

Nurses are confident using intuitive skills and base some decisions on their visceral feelings.

13: “If this feels like the right thing to do, it’s a good thing. It’s just go ahead and do it and then you know, lot of people don’t think that’s a great criteria, I think, for making a decision.”

Theme: letting go of control.

Three nurses provided data that supported this theme. The nurses do not have a need to control the outcomes of situations with patients. The nurses do not attempt to...
“fix” problems but guide patients to a (01) “quality life”. Nurses see patients as owning their conditions. Nurses used phrases such as (01) “their journey---their process”.

01: “…just say, you know, I can do all I can do, wish the best and then I need to let go.”

07: “The rest I just kind of leave to what will happen. Every time else it seems like it works out pretty well.

Theme: enhancing independence.

Seven nurses provided data that supported this theme. While nurses allow control of situations to be in the hands of their patients, they know when to step in and take charge. In either situation, the nurse’s intent is to enhance independence and have patients and their families regain control of their lives. The nurses give patients choices. Whether the choices relate to sharing information, taking medications, or dying, nurses are committed to have patients control the situation.

11: “But we can’t give up unless you want not to give up, but if you’re just tired and you need to just let this go because you’ve been really, really sick, then that’s what we’ll do. But if you want, we’re still going to fight.”

10: “And basically, I was giving him--I gave him permission to move, to go---it was OK to die. It was OK. He had suffered long, he fought hard, everybody would miss him, but he would be remembered and loved. And soon after that, he completely---his heart stopped.”

When the nurses sense patients need to be pushed to become self-sufficient, independent, and no longer in need of the nurse’s assistance, they step in and take charge.
The nurses closely follow up with calls to patients, set limits with them, and do not give them much leeway to not comply.

04: “...’what are you doing?’ ‘Oh, I’m watching TV.’ ‘OK, well, I’m in your neighborhood—I’ll be by ten minutes. Get dressed. Let’s go!’ I wouldn’t give him time to say no.”

10: “Well, there’s no way I can do this.’ ‘Yes you can. You can do this and I’m here to help you. You’ll do it. It’ll be OK.’”

11: “‘And then my goal is to get you out of this hospital. And this is what we’re going to do—right?’”

Theme: being cheerleaders.

Three nurses provided data that supported this theme. The nurses are cheerleaders. They keep a positive outlook on situations, provide patients with hope and purpose for living, and keep the team upbeat and focused. The nurses do not give up, and find that one piece of sunlight when all else looks bleak.

04: “And I remember working with him in the hospital and he just said, ‘I’m going to go to a nursing home.’ ‘And I said, no you’re not! You’re not going to go there. You don’t need to go there. You don’t need to give up.’”

11: “and I think other people had these same feelings, but we just said, ‘okay.’ But one day, I just said ‘no, we can’t just let this happen because she’s not dead.’”

11: “And let’s just try to get him back there. Let’s try to get him back. He shouldn’t be here. He should be out driving his new truck and out partying with his friends and you know, whatever nineteen-year-olds kids are supposed to do.”

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**Theme: viewing patients holistically.**

Eleven nurses provided data that supported this theme. The nurses view patients holistically. They do not label patients with diseases but see the patient as unique human beings. The nurses are concerned about the physical body and the spiritual as well as social and psychological aspects of the person. The nurses look beneath the patients’ emotions to understand the patients’ experiences of the illness. As a result, the nurses truly know their patients.

01: “And you realize that you’re not walking in and you’re not going to work with a textbook case. That is a human being— that’s an individual.”

10: “…because you aren’t just a physical body—you are a spiritual body—and you’ve got to connect with that rest of who the person is.”

11: “Who are you? You know, who are you? We all are somebody, right? We’re not just a leukemia patient. You know, we have other interests and other things going on. And I think that’s really important to learn who are your patients. What are their interests? What’s important to them? What are they missing the most when they’re here?”

**Theme: involving the family.**

Six nurses provided data that supported this theme. The nurses become very involved with their patients’ families. Nurses make themselves available to families and deal directly with tough issues. For example, the nurses address with families the planning of the funeral, issues of resuscitation, and life without their child. Being closely involved with families help nurses understand their patients.
10: "The more you are connected with the family, the more understanding you have, the more you have of who they are, the more you can help them and the more you can take and give them that hope and give them---empower them. And give them the confidence in the face of fear."

13: "And being able to say the tough things. 'So what have you thought about, what have you talked about, what---where do you want to be a year from now.' And realizing that the person---one of the people that is sitting there isn't going to be in that plan."

*Theme Category: Personal Transformation*

The third Theme Category is Personal Transformation. The nurses who connect with patients experience a personal transformation. They personally change the way they see themselves and the world in which they live. The nurses find meaning in their lives and make life decisions based on these meanings. Two theme clusters describe this category: spiritual transcendence and growing personally. Table 7 presents the Theme Category, Personal Transformation, with its two theme clusters and themes.

*Table 7. Theme Category: Personal Transformation*

<table>
<thead>
<tr>
<th>Theme Category</th>
<th>Theme Cluster</th>
<th>Theme</th>
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<tbody>
<tr>
<td>Personal Transformation</td>
<td>Spiritual Transcendence</td>
<td>Believing in a Higher Power</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clarity of Purpose in Life</td>
</tr>
<tr>
<td></td>
<td>Growing Personally</td>
<td>Taking Time to Reflect</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Being Lifetime Learners</td>
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</table>
Theme Cluster: Spiritual Transcendence

The first theme cluster, spiritual transcendence, consists of two themes: believing in a higher power and clarity of purpose in life. The nurses believe they are part of a force greater than themselves. This force provides guidance and comfort to the nurses.

Theme: believing in a higher power.

Six nurses provided data that supported this theme. The nurses believe in a power or force greater than themselves. This power is sometimes God, an inspirational figure, or spirit of a person. The nurses turn to this power for guidance and comfort.

02: "These are the Queen Emma eyes, no matter if you are ten feet away, it seems like they follow you and they are trying to connect with you in some way or another. These eyes are like sadness or hope and strength and holy too. It's the kind of feeling, the warm kind of feeling, and it gives you direction like, 'Okay, you are a nurse, you have to do your job and this is what you have to do.'"

10: "It was a feeling of that he had come by to say goodbye. But it wasn't strong. It was just --so I headed in. I got there to ICU (intensive care unit) before he died just as they were about to extubate him and I got a chance to say goodbye. And I felt I had very much connected with him spiritually and that it was almost like he was waiting for me to be there before he stopped breathing."

13: "Well, for me, I know its God, you know? But you know, everyone has their own beliefs who. I have friends who think that's a female. I'm not quite sure yet. It really doesn't matter to me what sex God is. But he's the person that I think is running my show."
Theme: clarity of purpose in life.

Six nurses provided data that supported this theme. The nurses search for answers to personal crises and reflect on the meanings of life experiences. They become clear in the meaning and purpose in their lives. The experiences of connecting with patients reinforce their decision to become nurses.

01: “And I guess the way you see things—sometimes you need to see it as a challenge or hey, the cup that’s half empty or full. But at least you have a cup—take it a step further.”

02: “I hope, not I hope, I think I helped her with that connection on that day, you know because it helped me with my connection to my deep questions about nursing and what is my purpose really in this world as a nurse, as a mother, as a human being, what do I have to do?”

10: “... the car’s not important, the house isn’t important. What’s important is love and that’s what you’ve got to put your focus on.”

12: “You know, that’s why I went into nursing. I went into nursing to try to make a difference in people’s lives.”

Theme Cluster: Growing Personally

The second theme cluster, growing personally, consists of two themes: taking time to reflect and being lifetime learners. Nurses who connected with patients experience personal growth. They expose themselves to situations that (13 “made me stretch because it got me out of my comfort zone” and force them to (08) “push the envelope to some extent,”
**Theme: taking time to reflect.**

Five nurses provided data that supported this theme. The nurses take time to reflect on relationships with their patients, their emotional reactions to situations, and their purposes in life. By stepping back and asking questions, the nurse hope to gain a different perspective of the situation.

02: “Why I am in nursing? Why am I doing this?”

03: “That you have to recharge your battery, you have to refill yourself, you have to step back.”

07: “Well, it brought up my own emotions and memories, so I had to deal with those also.”

13: “Well, you know, being close. Is this therapeutic? Am I creating a dependency? What are my motives?”

**Theme: being lifetime learners.**

Seven nurses provided data that supported this theme. The nurses who connect with patients are lifetime learners. They take their jobs very seriously and challenge themselves to continuously learn. The nurses draw from their life and patient experiences to improve their skills. When adverse reactions occur, the nurses question their interventions and are hard on themselves. The nurses seem to be in continuous pursuit of improving their skills.

01: “So for me, I go through and look at a lot of textbooks to make sure I’m not missing anything.”

07: “...but by the time he came back in, he was so severe in CHF (Congestive Heart Failure) and I questioned my discharge teaching with him. I remember
going through my mind going, let’s blame our discharge teaching because he should have never come in.”

Theme Category: Connection as Healing

The fourth Theme Category is Connection as Healing. Nurses see connecting with patients as healing and the “more the nurse becomes connected with the patient, probably the better outcome the patient will have in healing.” Healing occurs with both patients and nurses. To describe healing, nurses use a variety of phrases such as having no fear, a certain touch, not being a robot, being a human nurse, caring, and a positive relationship between nurse/doctor and patient. Two theme clusters describe this category: healing the patient and healing the nurse. Table 8 presents the Theme Category, Connection as Healing, with its two theme clusters, themes, and sub-themes.

Table 8. Theme Category: Connection as Healing

<table>
<thead>
<tr>
<th>Theme Category</th>
<th>Theme Cluster</th>
<th>Theme</th>
<th>Sub Theme</th>
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<tbody>
<tr>
<td>Connection as</td>
<td>Healing the Patient</td>
<td>Facilitating Healing</td>
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<tr>
<td>Healing</td>
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<td>Healing is Holistic</td>
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<td></td>
<td>Healing the Nurse</td>
<td>Feeling Healed</td>
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<td></td>
<td></td>
<td>Having Mixed</td>
<td>Positive Feelings</td>
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<tr>
<td></td>
<td></td>
<td>Feelings</td>
<td>Negative Feelings</td>
</tr>
</tbody>
</table>

Theme Cluster: Healing the Patient

The theme cluster, healing the patient, consists of two themes: facilitating healing and healing is holistic. Nurses believe connecting with patients heal patients, and if nurses are not connected with patients, nurses are missing a big part of the healing.
Theme: facilitating healing.

Nine nurses provided data that supported this theme. The nurses facilitate healing but believe patients heal themselves. Patients’ willingness to look within themselves and to use their inner strengths is in the patients’ control. The nurses believe they facilitate the healing of patients by having patients reflect on themselves as people and by reconnecting patients to their internal resources for healing. Through their connection with patients, nurses convey caring and comfort and remove fear. Nurses believe their presence facilitate the healing of patients.

01: “It’s how they (patients) go back into themselves and how wide-open are they looking back within themselves.”

01: “It is trying to help them—whatever they have within themselves, you know, to—the inner glow. We use the term inner wisdom, inner guide. Helping them just reconnect to some sort of inner strength.”

04: “So it makes me realize that we have a strong power within us. A strong internal power within us to provide the means for people to heal. But it’s illusive to me what that actually is—that power. But it is there.”

Theme: healing is holistic.

Eight nurses provided data that supported this theme. The nurses treat their patients holistically. They are concerned with more than the medical and curative aspects of care, and feel the spirit and mind are essential components of healing. Nurses believe a healed spirit gives the person a sense of peace and acceptance of their present and future. A person with a healed spirit also has the strength to deal with changes that happens to her.
12: “Well, if I think of healing as healing mind-body-spirit, then healing when you connect with someone—when you connect with your patient, I think you’re really looking at mind-body-spirit. Whereas when I look at my interaction with other patients, I’m really only healing body maybe—healing body, not getting to the spirit. Maybe some of the mind, but getting to that spirit aspect, it’s the difficult piece.”

11: “…people when they’re sick, they lose their role identity to an extent. So to try and bring that back in a way is a really important aspect of healing. And because I think that gives them back a sense of control, a sense of self, and a sense of giving.”

**Theme Cluster: Healing the Nurse**

The second theme cluster, healing the nurse, consists of two themes: feeling healed and having mixed feelings. The theme, having mixed feelings, consists of two subthemes: positive feelings and negative feelings. Nurses believe connecting with patients is like (05) “stepping into a pool of water” with patients that affect both patient and the nurse. While the entire process of connection is healing, nurses experience both positive and negative feelings.

**Theme: feeling healed.**

Four nurses provided data that supported this theme. The nurses feel healed by the experience of connecting with patients. The nurses believe the experience changes not only patients but also persons involved with the patient.

02: “So it was part of my healing, part of the patient’s healing and I am sure that the nurse’s aid in the room will never forget this.”
05: “That’s very clear—-that everybody that’s on that ground gets changed regardless of what their role is…”

**Theme: having mixed feelings**

Eleven nurses provided data to support this theme. The nurses who connect with patients find the experiences both rewarding and draining. The nurses find the experience of connecting with patients rewarding, gratifying, and “way much fun that it wasn’t like work”. Yet, many of the same nurses find the experience draining and leaving them with feelings of sadness and helplessness. The theme, having mixed feelings, consists of two sub themes: positive feelings and negative feelings.

The first sub-theme is positive feelings. All of the 11 nurses who provided data that supported the theme, having mixed feelings, reported data in this sub-theme. Nurses express positive feelings both verbally and non-verbally. The nurses had big smiles on their faces, squealed with delight, held outstretched hands in joy, and cried. The nurses experienced having felt gratified knowing they had helped patients through a major crisis and made a difference in their patient’s lives. The nurses get excited when their patients make progress, find it “magical” to see patients walk through the door and calling out their names, and are much less aware of a power differential between themselves and their patients. One nurse described the experiences as a “warm and rewarding feeling. I would never do any other nursing but this.”

12: “What was it like? I guess for me, it would be like winning the lottery. Something—the connection with him was really more—-yeah! Kids will say, yes! That’s the only way I can describe the connection. It was like we hit something.”
"It was a very gratifying experience. At that time I was going out there, I was going out as much for myself as I was for the family."

“It’s like I feel very peaceful, I feel happy....we had no fear...”

“And I thought, that, to me, was probably the most rewarding experience in knowing that I really helped this person to reconnect into her life.”

“It was extremely emotional, there were tears everywhere. Yet there was happiness inside knowing that he had come back to resolve these issues instead of running.”

The second sub-theme is negative feelings. Of the 11 nurses who provided data that supported the theme, having mixed feelings, seven reported data in this sub-theme. The same nurses who found the experience positive expressed negative feelings. The nurse who said she would (06) “never do any other nursing but this” also said she felt (06) “very emotionally drained” being with the family who’s child was nearing death. When a child patient died or had a recurrence of cancer, this nurse described the experience (06) “as devastating to me as it is to the family.”

A nurse who enjoyed spending much of her personal time with patients eventually found the time commitment (04) “emotionally draining” and beginning to (04) “take over the time when I could do other things that I wanted to do. I was limiting my exercise time, I was limited in doing the fun things I wanted to do.” This nurse eventually left her job to work in a position that required no direct patient contact. In this subsequent job, this nurse again developed a very personal and emotional relationship with a patient but did not use personal time to do so.
The negative feeling identified by most of the nurses related to the death of their patients. The experience of connecting with patients and losing them through death was described by one nurse as the "make or break" point in which nurses decide "you're out of nursing because you can't handle it. Or you realize how much love you had received that you would never have received had you not been doing the work you did."

**Essential Structure**

The essential structure of connection between nurse and patient as a major aspect of healing is a description of the essence of the nurse's experiences of the phenomenon of connection. The essential structure of connection follows.

Connection between a nurse and a patient is a process that begins with the selection of a patient with whom to connect. Selection occurs both cognitively and spontaneously and crosses over ethnic groups, ages, gender, and consciousness. Once the nurse identifies or recognizes that connection has occurred, she begins to bond with patients. The nurse views the patient holistically and accepts the patient for who she is as a human being. The nurse spends time with the patient to find out her dreams, wishes, and interests. By focusing attention on the patient, the nurse conveys a sense of value, respect, and caring. The relationship between the nurse and the patient is emotional and personal, and both become a part of each other's lives. The relationship is reciprocal and the nurse benefits as much as the patient. Love, understanding and patience from the patient reinforces the nurse's connection with patient. The nurse provides hope, enthusiasm, and positive outlooks and engages family members in their endeavors. The
nurse develops trust and honesty and believes she creates a safe environment for her patient.

The nurse feels connection with patients is a “bubble” of energy surrounding herself and her patient. The nurse experiences visceral changes within herself and between herself and her environment often using words such as warmth, peace, and calmness. A resonance vibrates between the nurse and her patient, and the nurse expresses love for her patient. Connection is not about egos. The nurse feels humbled, honored and grateful for being part of her patient’s life as if the connection is walking on “holy ground”.

The nurse who connects with a patient as a major aspect of healing is an exemplar. She is passionate not only about her patient, but about issues relating to her profession. The nurse shows caring, compassion, and risk taking often challenging her peers, physicians and health systems. The nurse is at the expert level as clinician and uses intuition in making decisions about patients. She has no need to control the outcomes of situations. She is empowering in her relationship with her patient and intuitively knows when to let the patient lead the way and when to take charge.

The nurse who connects with a patient takes care of herself and goes through a personal transformation that results in a personal philosophy of life. She maintains holistic balance of herself by setting boundaries with her patient. The nurse incorporates some form of practice in her personal life to enhance her abilities to connect.

The nurse experiences connection with her patient as healing to both herself and her patient. She facilitates healing but believes her patient heals herself. The patient’s willingness to look within herself and to use her inner strength is in the patient’s control.
While the nurse feels healed by the connection, she experiences mixed feelings of joy as well as pain. Despite the mixed feelings, the nurse continues to connect with her patient and says this is the reason she is in nursing.

Summary

This chapter was a presentation of results of the analysis of data from interviews with 13 participants, which produced 40 themes, 12 theme clusters, and 4 theme categories. An exhaustive description of the theme categories, theme clusters, themes, and sub-themes was presented, supported by direct quotes from the interviews.

The four theme categories were: Connection as a Process, The Nurse as Exemplar, Personal Transformation, and Connection as Healing. The first Theme Category, Connection as a Process, has four theme clusters: the selection, the bonding, the bubble, and the memories. The second Theme Category, The Nurse as Exemplar, has four theme clusters: the learning, having passion, caring for self, and expert nurse. The third Theme Category, Personal Transformation, has two theme clusters: spiritual transcendence and growing personally. The fourth Theme Category, Connection as Healing, has two theme clusters, healing the patient and healing the nurse. Each theme cluster contains themes derived from the formulated meanings for significant statements.

A synthesis of the components of the phenomenon of connection was presented as the essential structure of the lived experience of connecting with patients by nurses who said they had experienced connection with patients as a major aspect of healing. Connection between a nurse and a patient is a process. As the nurse bonds with the patient, the relationship becomes emotional and personal, and the nurse and patient become a part of each other’s lives. The nurse feels connection with the patient as a
"bubble" of energy surrounding them. The nurse experiences visceral changes within herself and the environment as warmth, peace, and calmness. A resonance vibrates between the nurse and the patient and both express love for each other.

The nurse who connects with a patient is at the expert level as a clinician. She takes risks, is passionate about patient and professional issues, and is empowering in her relationship with her patient. The nurse takes care of herself and goes through a personal transformation that results in personal philosophies of life. Although the nurse facilitates healing of her patient, she believes the patient heals herself. The nurse experiences mixed feelings when connecting with patients. These feelings are both joyful and painful. Despite these mixed feelings, the nurse continues to connect with patients and says this is the reason she is in nursing.
CHAPTER FIVE

CONCLUSIONS AND IMPLICATIONS

Chapter Five begins with a presentation of the relationship of results of the study to the review of literature and to the philosophical and conceptual orientation of the lived experience of connection between nurses and patients as an aspect of healing. It concludes with a discussion of the limitations of the study, implications for nursing, and recommendations for further research.

Relationship of Results to Review of Literature

The review of literature for this study included research on connection, healing and healers, and healing and spirit. The following is an interpretation of the study’s results in relationship to the review of literature.

Connection

The results of this study that are consistent with the review of literature on connection are in three Theme Categories: Connection as a Process, Personal Transformation, and Connection as Healing. Two results of this study that add to the literature on connection are the Theme Category, The Nurse as Exemplar, and the theme, having spontaneous reactions.

Results Consistent with Review of Literature

Theme Category: Connection as a Process.

The Theme Category, Connection as a Process, was particularly consistent with the literature. In the theme cluster, the selection, the nurse sometimes identifies a patient need that may precipitate the connection. This finding supported studies reported by several authors (Astrom et al. 1993; Bottorff & Morse, 1994; Drew, 1997; Heifner, 1993;
Montgomery, 1996; Schubert & Lionberger, 1995; Schulte, 2000; Pieranunzi, 1997). In the theme cluster, the bonding, the nurse who connects with a patient becomes personally and emotionally involved with the patient. The nurse shares information about herself, spends personal time with the patient, and involves the patient in her personal life. These findings supported the literature by Montgomery (1996), Schubert and Lionberger (1995), and Drew (1997) who used the term, intimacy, to describe these characteristics.

These findings question the traditional boundaries or therapeutic distance between a nurse and a patient. The nurse who connects with a patient enjoys the closeness, develops a friendship, and involves the patient in her personal life. In a study on the caregiving relationship, Montgomery (1996) had reported similar findings that “challenged the conventional understandings of the helping relationship” (Montgomery, 1996, p. 52).

Other findings under the theme cluster, the bonding, that were consistent with the literature included focusing attention on the patient (Astrom et al. 1993; Bottorff & Morse, 1994; Clark et al., 1991; Fredriksson, 1999; Schubert & Lionberger, 1995), spending long periods of time with the patient (Astrom et al. 1993; Heifner, 1993), listening to the patient and communicating an understanding of the patient’s experience (Fredriksson, 1999), using touch to establish closeness with patient (Bottorff & Morse, 1994), identifying with the patient (Heifner, 1993), and acknowledging a mutual benefit (Heifner, 1993).

The findings in this study under the theme cluster, the bubble, also supported the literature. The nurse sets intentions to connect with, protect, and love the patient (Montgomery, 1996), feels connected to the patient’s energy fields (Quinn, 1992), and
sets her ego aside (Bottorff & Morse, 1994; Montgomery, 1996; Schubert & Lionberger, 1995).

Theme Category: Personal Transformation.

Data from the Theme Category, Personal Transformation, supported previous literature. The nurse who connects with a patient goes through spiritual transcendence (Burkhardt, 1994; Montgomery, 1996), and develops a philosophy of life that explains the meaning of the experience and purpose for living (Burkhardt, 1994; Montgomery, 1996). The nurse who connects with a patient grows personally, takes time to reflect, and integrates the past and future to enhance the present (Coward, 1990; Coward, 1998; Reed, 1991).

Theme Category: Connection as Healing.

In the Theme Category, Connection as Healing, the nurse benefits from the experience. The nurse has profound fulfillment, feels healed when connecting with a patient, considers connecting with a patient as a gift, and feels both pain and positive emotions about the experience. These findings supported studies reported by Montgomery (1991) and Drew (1997).

Results of this study did not support themes in the literature describing the nurse accessing a source of energy from the universe to be used to care for patient and herself (Lincoln, 2000; Montgomery, 1996), and the nurse relating spirit-to-spirit with patients (Dennis, 1991; Montgomery, 1996). Although 11 of the 13 nurses received formal training in either Healing Touch or Therapeutic Touch, they did not indicate using energy from the universe in connecting with patients. Both Healing Touch and Therapeutic Touch are energy-based approaches in healing.
Results Not Reported in Previous Literature

Theme Category: Nurse as Exemplar.

A result of this study that had not been reported in the literature is the Theme Category, Nurse as Exemplar. Another result not reported in the literature is the theme, having spontaneous reactions.

In the Theme Category, Nurse as Exemplar, the nurse is a model for excellence in both the science and art of nursing. The term, Exemplar, is commonly used to mean, “a person regarded as worthy of imitation” (McKechnie, 1979, p. 640). Findings in this category show four characteristics of the nurse who connects with a patient that were not reported in the literature. The first characteristic is the nurse not feeling adequately prepared in the art of practicing nursing. The nurse who connects with a patient feels her education focused on skills, curative aspects of care, and a human model that is not an integrated holistic being, and not on the art of connecting with or healing patients. After graduating from nursing school, she had great expectations of being able to handle any nursing situation. Entrance into the working world made her realize she did not have the skills to connect with patients nor to facilitate the healing of patients.

The second characteristic is having passion. A nurse who connects with a patient is a caring and compassionate person who takes risks. She asserts her views to physicians, administrators, and peers. She questions the status quo, advocates for her patient, and asks what can be done to make a difference in the life of her patient then proceeds to do so. This nurse does not watch things happen; she makes things happen. She connects with the patient knowing she risks feeling the pain of losing a patient she loves. The nurse who connects with a patient has strong opinions regarding professional
and healthcare issues and has a need to talk about them. She admonishes the support of a medical model of care that neglects viewing the patient as an individual and unique person. She feels nurses need to be at the patient’s bedside, not in meetings or doing paperwork. She is vocal that changes need to be made in academia to prepare nursing students to relate to patients as a holistic human being and not as a disease. She advocates that nursing students need to reflect on why they, as persons, pursued this profession in order to understand human beings.

The third characteristic is caring for self. The nurse takes care of herself by setting boundaries and living a balanced life in order to connect with and love her patient. She is clear on the needs of both herself and the patient. The nurse’s primary concern is the patient’s welfare, but she does not compromise her needs when giving personal time to patients. The nurse balances her life by not connecting with too many patients at the same time, and chooses not to connect with a patient if she does not have the emotional capability to sustain the relationship.

The fourth characteristic is being an expert nurse. The nurse who connects with a patient has clinical expertise and considers connecting with a patient as above and beyond this level of care. The nurse does not attempt to control the outcomes of her relationship with the patient, but skillfully lets the patient control situations and knows when to take charge in order to enhance the patient’s ability to regain independence. The nurse uses intuition to make decisions, views the patient as a holistic being, brings hope to the patient and involves the family in the care.

The nurse who connects with a patient characterizes many of the competencies of Benner’s (1984) expert nurse in the domain, the helping role. Benner (1984) posits the
expert nurse views patients holistically, recognizes subtle changes in the patient’s condition, provides emotional support, often sits and listens attentively to patients, use touch, advocates for patients, and encourages independence and control. Benner (1984) posits, “experience is a requisite for expertise” (Benner, 1984, p.3). The number of years in nursing practice of the nurses in this study ranged from 5 to 37 years ($M = 23$). The nurses in this study reflect Benner’s description of expert nurses being experienced nurses.

*Having Spontaneous Reactions.*

Another result that had not been reported in the literature was the theme, having spontaneous reactions. When selecting a patient with whom to connect, the nurse sometimes connects spontaneously with a patient. Phrases such as “a chemistry happens”, “instant bonding” occurs, and “we just clicked” were phrases used to describe this spontaneous reaction. As the nurse establishes a relationship with a patient, she suddenly realizes a connection has occurred and is aware of what the patient is thinking and feeling without the patient disclosing these things. The nurses could not explain what this spontaneous reaction was but did know when it occurred.

*Healing and Healers*

Results of this study reflected the literature on healing and healers. The themes, believing in higher powers, setting the intention, facilitating healing, feeling healed, and learning the skills supported previous literature. The nurse who connects with a patient experiences connection with a power greater than herself. This finding supported the ethnographic study by Kutaka (2000) in which healers felt connected to God, to the spirit of a loved one who died, to others, and to themselves (Kutaka, 2000). The nurse who
connects with a patient does not indicate she connects with herself. The nurse who connects with a patient sets the intention to connect, to love, or to protect. This finding is similar to the results of one study on healers (Kutaka, 2000) who use intentions of unconditional love and compassion when healing others.

A finding of this study indicated a nurse who connects with a patient facilitates healing by removing fear and reconnecting patients to their own internal resources for healing. This finding supported the literature on healers who believed they brought tools to people to heal themselves or were conduits for a higher power who did the actual healing (Kutaka, 2000). Another finding was the nurse benefits from the connection. The nurse feels healed by the experience of connecting with a patient. This finding supported the literature on healers who felt healed by their relationship with their clients (Kutaka, 2000).

A finding of this study indicated the nurse learned the art of healing from ancestors, or through formal training. Two nurses reported learning massage and energy healing from their mother and grandmother. These two nurses spoke in reverence of their ancestors and reported being influenced by the apprenticeship. Although twelve nurses received formal training in healing touch or therapeutic touch, the majority of nurses did not report practicing it with their patients. This finding supported the literature that healers learn their skills through formal training and/or apprenticeships with elders (Kutaka, 2000).

The similarities between this study’s results on the nurse who connects with a patient and the earlier study on healers are interesting because the healers were a mix of nurses and massage therapists. Healers (Kutaka, 2000) reported connecting to others
when healing. The process of healing others and the process of connecting may have similar qualities. Perhaps the discipline is not as important as the process.

Healing and Spirit

Results of this study partially reflected literature on healing and spirit. The nurse who connects with a patient speaks of healing the mind, body, and spirit; the nurse does not reference the notion of connecting with a patient on a spirit-to-spirit level. In the literature on healing and spirit, when people connected to their spirit, they described having positive manifestations such as unconditional love, compassion, serenity, joyfulness, and fulfillment (Brennan, 1993; Hall, 1997; Lane, 1987; Newton, 1998; Pearsall, 1998; Picard, 1997; Walton, 1996; Zukav, 1990), uncovering purpose and meaning in life (Brennan, 1993; Hall, 1997; Lane, 1987; Pearsall, 1998; Walton, 1996; Zukav, 1990), and having the capacity to heal (Brennan, 1993; Pearsall, 1998; Zukav, 1990). In this study, the nurse who connects with a patient has these same experiences. Perhaps the significance is the process of connection and not whether the connection is to a person or to spirit. The results of this study did not support the spirit being dualistic, nor spirit being immortal.

In summary, results of this study that supported the literature were in the Theme Categories: Connection as a Process, Personal Transformation, and Connection as Healing. The results of this study also supported the literature on healing and healers and partially supported literature on healing and spirit. The new contributions of this study to the literature were in the Theme Category, The Nurse as Exemplar, and in the theme, having spontaneous reactions.
Relationship of Results to the Philosophical and Conceptual Orientation

This inductive study did not use a formal conceptual framework to guide the proposal. Three concepts, connection, healing, and spirit provided the philosophical and conceptual orientation for this study. The results of this study reflected the concepts of connection and healing as presented in the review of the literature, and partially reflected the concept of spirit.

One of the assumptions underlying the philosophical orientation of this study was that the healing power of a nurse comes from a conscious connection with her spirit. The results of this study did not support this assumption. There were no findings that the nurse who connects with a patient as a major aspect of healing goes inward to connect with her spirit. A second assumption of this study was that to enhance her effectiveness in healing, the nurse takes time to heal herself and understands the process of going inward to reach the depths of her spirit. The results of this study partially supported this assumption. A finding in this study showed the nurse takes time to care for herself by keeping her life balanced. The results of this study did not indicate the nurse goes inward nor understands the process of going inward to reach her spirit.

Within the concept of healing is the influence of culture on healing. The results of this study reflected the cultural aspects of healing. The nurse who connects with a patient values the human being as a unique person. This value influences how she relates to the patient. The nurse takes the time to get to know who this patient is as a person, including the patient’s desires, dreams, and past experiences. She focuses her attention on the patient to demonstrate her respect and valuing. The nurse is sensitive to the patient’s cultural beliefs, and takes the time to follow the patient’s cultural practices. The nurse
values a holistic approach to healing. She believes her relationship with the patient facilitates healing of both herself and the patient. She pays attention to the mind, body, and spirit and feels unless all are addressed, healing will not occur.

In summary, connection between the nurse and the patient is a process that crosses cultures and results in the holistic healing of both nurse and patient. The connection is a personal and emotional bonding characterized by a sense of energy and love for the patient. The nurse grows from this experience and gains clarity in her purpose in life.

Limitations of the Study

A limitation of this study was that all nurses were female. Although the interviews generated meaningful data, the homogeneity of the participants' gender limits the assurance of redundancy relevant for male and female nurses in the theme categories. A second limitation was none of the nurses' clinical areas was in psychiatric nursing, which may influence the nurses' willingness to share personal information about themselves as part of the bonding. In a study by Heifner (1993), psychiatric nurses maintained a professional stance and did not self-disclose. Heifner (1993) questioned whether the diagnosis of the patients contributed to this finding. A third limitation was that no patients were participants so they could not validate or invalidate nurses' perceptions of connection.

Implications for Nursing

Because the practice of nursing is based on the caring relationship between a nurse and a patient, the results of this study may be applicable to nursing if further studies indicate patients perceive connection with nurses beneficial and positive. This study is
preliminary work in the connection between nurse and patient. There is a need to learn more about how other nurses of different gender and in different specialties experience connection. The results of this study indicate four implications for nursing.

The first implication is a redefinition of professional distance. The results of this study indicate that the nurse establishes a deep personal and emotional involvement with the patient, develops a friendship, and shares personal information. If further research confirms patients' positive perceptions of this process, the results may lead to a redefinition of professional distance or boundaries between the nurse and the patient. Conventional practice has been to maintain an emotional distance from patients to maintain objectivity so clinically appropriate decisions can be made. This study shows the nurse benefits from the closeness, feels healed, and finds fulfillment.

The second implication is the value of spending time with a patient to enhance connection. The results of this study indicate spending time with a patient enhances the nurse's experience of connection. The nurse who connects with a patient spends time sitting with a patient, holding the patient's hand, or hearing stories to get to know the patient as a person. This result supports these nursing activities that can be incorporated into care paths and care plans. How time is spent between a nurse and a patient is a critical clinical and economic issue in nursing practice. A focus in healthcare today is to treat patients quickly and efficiently. The value of these simple activities is they enhance connection, which nurses perceive is healing to the nurse and patient.

The third implication is a focus on the art of nursing in nursing curricula. Results of this study indicated nursing curricula did not prepare the nurse to connect with patients and to facilitate healing. Further findings indicated the patient model used in nursing
school was not holistic and focused on a disease label. The nurse who connects with a patient advocates more emphasis on teaching nursing students to develop a humanistic relationship with patients. Connecting with patients is an art of nursing. The nurse must know self in order to understand the patient as a person. Knowing one's self also keeps the nurse’s personal needs in perspective in order that patient’s needs are met. One of the results of this study indicated the use of self-reflection, mentorship, and learning journals as tools to assist a nursing student in gaining a personal perspective of rationale for becoming a nurse.

The fourth implication is that clarification of the concept of connection may eventually lead to the development of a theory of connection. Clarifying concepts is the first step in the process of theory development that contributes to nursing science (Walker & Avant, 1995). The creative process of clarifying the mental images of the phenomenon of connection is the first step in theory development. The results of this study define the essential structure of connection, which are the processes and meanings of the phenomenon (Haase, 1987) based on the limited sample population of female nurses in adult and child health.

Recommendations for Further Research

Based on the results of this study, further research should be conducted in four areas: patients’ perceptions of the effects of connection with nurses, the concept of spontaneous reaction, replication of this study to include a broader sample of nurses, the nurse as exemplar, and effective way to teach the art of connection to nursing students.

A first recommendation is a study to explore patients’ perceptions of the effects of connection with nurses. A result of this study showed nurses become emotionally
involved with their patients as part of bonding. Aspects of bonding to explore are patients’ perceptions of nurses sharing personal information, involving patients in their personal lives, and spending personal time with patients. Although nurses perceive this connection to be healing and beneficial to themselves and to patients, patients’ perceptions can validate or invalidate nurses’ perceptions. A study of patients’ perceptions of the effects of specific behaviors identified by nurses will add knowledge that may contribute to the redefinition of professional distance or boundaries.

A second recommendation is a study to explore the concept of spontaneous reaction that occurs when a nurse and patient connect. When selecting a patient with whom to connect, the nurse sometimes uses a cognitive process and other times, experiences a spontaneous reaction with a patient. Exploration of how a nurse selects a patient with whom to connect may add knowledge to the phenomenon of connection.

A third recommendation is a replication of this study to include a broader sample of nurses. Two limitations of this study were the homogeneity of the participants’ gender and the lack of psychiatric nursing as a major clinical area. These conditions limited the assurance of redundancy relevant for male and female nurses of different clinical areas.

A fourth recommendation is to explore the concept of caring for self, which was a characteristic of the nurse as exemplar. A study to explore the effect on the nurse who gives personal time to a patient may contribute knowledge on the definition of professional distance or boundaries.

A fifth recommendation is a study on effective ways to teach the art of connection to nursing students. One result of this study showed that the nurse as an exemplar does not feel adequately prepared in the art of practicing nursing. Nursing education was
described as focusing on tasks, diagnoses, and a patient model and approach to care that was not holistic. While there was uncertainty whether connection could be taught, the nurses suggested tools such as mentorship, learning journals, and self-reflection. Perhaps the mentor of the nursing student could be a practicing nurse in the community. Effective tools to teach connection may contribute to nursing curricula.

In summary, these recommendations for further research may generate knowledge adding to clarification of the concept of connection. Concept clarification is the first step in developing nursing theory. Further research to identify components and processes of the concept of connection may lead to nursing theory.

Summary

This chapter presented a discussion of the results of this study in relation to the review of the literature and to the conceptual orientation, limitations of the study, implications for nursing, and recommendations for further research. The results of this study reflected the literature on connection, and partially reflected the literature on healing and healers and healing and spirit. The results of this study added new knowledge in the areas of nurses as exemplars and in the area of connection being a spontaneous reaction between a nurse and a patient.

Limitations of this study are all nurses were female, none of the nurses’ clinical areas was in psychiatric nursing, and no patients were participants. Four implications for nursing are in the areas of the professional distance between nurse and patient, the value of spending time with a patient to enhance the nurse’s perception of connection, the focus on the art of nursing in nursing curricula, and the concept development of connection.
Recommendations for further research are in the areas of: patients' perceptions of specific aspects of connection identified by nurses, exploration of the concept of spontaneous reaction, replication of this study to include a broader sample of nurses, the nurse as exemplar, and effective way to teach the art of connection to nursing students.
APPENDIX A: AGREEMENT TO PARTICIPATE

Dear Nursing Colleague, January 2002

I am a doctoral student at the University of Hawaii Department of Nursing, and I am conducting research on the nurse-patient relationship. I would like to interview you about experiences you have had connecting with patients as a major aspect of healing. There will be two interviews. The first interview may be approximately one to one and half hours, in which I will ask you to describe the experiences you have had connecting with patients. With your permission, this interview will be audiotaped. I will also ask you to complete a demographic data sheet. The second interview may last up to one hour, in which I will ask you for feedback on the accuracy of my analysis of the first interview.

Your participation is voluntary and only I will know your identity. There is no direct benefit to you except the opportunity to share your thoughts. By sharing your experiences, you may contribute to knowledge about improving the effectiveness of the nurse-patient relationship. The only risk is the loss of privacy that occurs when sharing personal information with me. However, your identity will be kept in complete confidence to the extent allowed by law. The audiotapes will be kept in a locked cabinet and will be destroyed at the end of the study. The transcripts of the taped interviews will not be identifiable.

By participating in this interview, you are giving consent to participate in this research. If at any time you wish to withdraw from the research, you may do so. If you have concerns or questions about your rights as a participant in this research, you may call the University of Hawaii Committee on Human Studies at 956-5007. If you have any questions about the research you may call me at 239-6125, or my faculty advisor, Dr. Lois Magnussen, at 956-8939. I thank you in advance for your collaboration and assistance. Your thoughts and experiences are very important to me.

Aloha,
Gayle S. Kutaka PhD(c), MS, RN
APPENDIX B: DATA GENERATING QUESTION

"Please tell me what it has been like for you as a nurse to have experienced connection with patients as a major aspect of healing. Tell me everything you can remember happening that might relate to the experience of connection—everything you have thought and felt about it."
MEMORANDUM

December 11, 2001

TO: Gayle S. Kutaka
Principal Investigator
School of Nursing and Dental Hygiene

FROM: William H. Dendle
Executive Secretary

SUBJECT: CHS #11486- "The Essential Structure of the Lived Experience of Connection"

Your project identified above was reviewed and has been determined to be exempt from Department of Health and Human Services (DHHS) regulations, 45 CFR Part 46. Specifically, the authority for this exemption is section 46.101(b)(2). Your certificate of exemption (Optional Form 310) is enclosed. This certificate is your record of CHS review of this study and will be effective as of the date shown on the certificate.

An exempt status signifies that you will not be required to submit renewal applications for full Committee review as long as that portion of your project involving human subjects remains unchanged. If, during the course of your project, you intend to make changes which may significantly affect the human subjects involved, you should contact this office for guidance prior to implementing these changes.

Any unanticipated problems related to your use of human subjects in this project must be promptly reported to the CHS through this office. This is required so that the CHS can institute or update protective measures for human subjects as may be necessary. In addition, under the University’s Assurance with the U.S. Department of Health and Human Services, the University must report certain situations to the federal government. Examples of these reportable situations include deaths, injuries, adverse reactions or unforeseen risks to human subjects. These reports must be made regardless of the source funding or exempt status of your project.

University policy requires you to maintain as an essential part of your project records, any documents pertaining to the use of humans as subjects in your research. This includes any information or materials conveyed to, and received from, the subjects, as well as any executed consent forms, data and analysis results. These records must be maintained for at least three years after project completion or termination. If this is a funded project, you should be aware that these records are subject to inspection and review by authorized representatives of the University, State and Federal governments.

Please notify this office when your project is completed. We may ask that you provide information regarding your experiences with human subjects and with the CHS review.
process. Upon notification, we will close our files pertaining to your project. Any subsequent reactivation of the project will require a new CHS application.

Please do not hesitate to contact me if you have any questions or require assistance. I will be happy to assist you in any way I can.

Thank you for your cooperation and efforts throughout this review process. I wish you success in this endeavor.

Enclosure
**Protection of Human Subjects**

**Assurance Identification/Certification/Declaration**
(Common Federal Rule)

Policy: Research activities involving human subjects may not be conducted or supported by the Departments and Agencies adopting the Common Rule (56FR28003, June 18, 1991) unless the activities are exempt from or approved in accordance with the common rule. See section 101(b) the common rule for exemptions. Institutions submitting applications or proposals for support must submit certification or appropriate Institutional Review Board (IRB) review and approval to the Department or Agency in accordance with the common rule.

Institutions with an assurance of compliance that covers the research to be conducted on file with the Department, Agency, or the Department of Health and Human Services (HHS) should submit certification of IRB review and approval with each application or proposal unless otherwise advised by the Department or Agency. Institutions which do not have such an assurance must submit an assurance and certification of IRB review and approval within 30 days of a written request from the Department or Agency.

### 1. Request Type
- [ ] ORIGINAL
- [ ] GRANT
- [ ] CONTRACT
- [ ] FELLOWSHIP
- [x] FOLLOWUP
- [ ] COOPERATIVE AGREEMENT
- [ ] EXEMPTION
- [ ] OTHER:

### 2. Type of Mechanism
- [ ] GRANT
- [ ] CONTRACT
- [ ] FELLOWSHIP
- [x] FOLLOWUP
- [ ] COOPERATIVE AGREEMENT
- [ ] EXEMPTION
- [ ] OTHER:

### 3. Name of Federal Department or Agency and, if known, Application or Proposal Identification No.

### 4. Title of Application or Activity

"The Essential Structure of the Lived Experience of Connection"

### 5. Name of Principal Investigator, Program Director, Fellow, or Other

Gayle S. Kutaka

### 6. Assurance Status of this Project (Respond to one of the following)

- [x] This Assurance, on file with Department of Health and Human Services, covers this activity:
  - Assurance identification no. M-1217
  - IRB identification no. 01

- [ ] This Assurance, on file with (agency/dept) ____________________________________________________________________________ , covers this activity.
  - Assurance identification no. __________
  - IRB identification no. __________ (if applicable)

- [ ] No assurance has been filed for this project. This institution declares that it will provide an Assurance and Certification of IRB review and approval upon request.

- [x] Exemption Status: Human subjects are involved, but this activity qualifies for exemption under Section 101(b), paragraph ___ (2) ___.

### 7. Certification of IRB Review (Respond to one of the following IF you have an Assurance on file)

- [ ] This activity has been reviewed and approved by the IRB in accordance with the common rule and any other governing regulations or subparts
  - on (date) by: [ ] Full IRB Review or [ ] Expedited Review

- [ ] This activity contains multiple projects, some of which have not been reviewed. The IRB has granted approval on condition that all projects covered by the common rule will be reviewed and approved before they are initiated and that appropriate further certification will be submitted.

### 8. Comments

CHS #11486

9. The official signing below certifies that the information provided above is correct and that, as required, future reviews will be performed and certification will be provided.

10. Name and Address of Institution

| University of Hawaii at Manoa |
| Office of the Chancellor |
| 2444 Dole Street, Bachman Hall |
| Honolulu, HI 96822 |

11. Phone No. (with area code)

(808) 956-5007

12. Fax No. (with area code)

(808) 539-3954

13. Name of Official

William H. Dendle

14. Title

Compliance Officer

15. Signature

[Signature]

16. Date

12/5/01

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OPTIONAL FORM 310 (Rev. 1-98)

Sponsored by HHS/NIH
APPENDIX D: RECRUITMENT ANNOUNCEMENT

CALL FOR REGISTERED NURSES

Registered Nurses are in a primary position to establish caring relationships with patients. If you have experienced connection with a patient(s) as a major aspect of healing and would like to share your stories as part of a research study, I would like to talk with or hear from you. As nurses, we can and do make a difference in our patients’ lives. Here is your opportunity to make one more difference!
Call:

Gayle S. Kutaka PhD (c), MS, RN
University of Hawaii
School of Nursing and Dental Hygiene
239-6125 or 363-2357
gkutaka@hotmail.com
APPENDIX E: DEMOGRAPHIC DATA RECORD

1. Gender

2. Age

3. Ethnicity

4. Please check all that apply:
   - [ ] AD in nursing
   - [ ] AD in another field (please name)
   - [ ] Bachelor’s degree in nursing
   - [ ] Bachelor’s degree in another field (please name)
   - [ ] Master’s degree in nursing
   - [ ] Master’s degree in another field (please name)
   - [ ] Doctoral degree in nursing
   - [ ] Doctoral degree in another field (please name)
   - [ ] Please list specialized training or certificates, such as in specialized healing:

5. Number of years in nursing practice

6. Number of years in specialized healing practice

7. Major clinical area

8. Religion or Spiritual Identify

Please briefly state in your own words:

1. Practices you use regularly in your personal life that enhance your connection with patients. (e.g. meditation, prayer, relaxation).

2. Your frequency of use of the practices.

3. Your personal view of your purpose(s) in life
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